SGI-12
11/15

Dependent Eligibility Certification Form

People First
STATE OF FLORIDA HR

If you cover dependents under *any* State Group Insurance plan, you **must** certify their eligibility by completing this form before any changes to your insurance can be processed.

In accordance with Chapter 60P, Florida Administrative Code, dependents must meet specific eligibility requirements to be covered under State Group Insurance plans. Eligible dependents include:

- Your **spouse** – a person to whom you are legally married. The term "spouse" does not include common law marriage partners, registered domestic partners or other partners of relationships not defined as marriage under the law of the state or foreign county in which they were entered.
- Your **child** – your biological child. Dependent children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **child with a disability** – your covered child who is permanently mentally or physically disabled. This child may continue health insurance coverage after reaching age 26 if you provide adequate documentation validating disability upon request and the child remains continuously covered in a State Group Insurance health plan. The child must be unmarried, dependent on you for care and for financial support, and have no dependents of their own.
- **Legal guardianship** – a child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **grandchild** – a newborn dependent of your covered child. Coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered.
- Your **Legally Adopted child** – your legally adopted child pursuant to a Judgment of Adoption; or a child placed in your home for the purpose of adoption in accordance with applicable state and federal laws. Dependent children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **foster child** – a child that has been placed in your home by the State of Florida Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **stepchild** – the child of your spouse for as long as you remain legally married to the child's parent. Dependent children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **over-age dependent** – your child after the end of the calendar year in which they turn age 26 through the end of the calendar year in which they reach 30, if they are unmarried; have no dependents of their own; are dependent on you for financial support; live in Florida or attend school in another state; and have no other health insurance.

Based on the definitions above, please list all eligible dependents below that are currently covered under ANY state insurance plan or those you want to add to a plan(s). If you do NOT list a covered dependent, the dependent will be removed from coverage as of the first of the month following this notification if you are requesting a QSC (Qualified Status Change), or as of January 1 if this is an Open Enrollment Change. Attach enrollment forms as necessary. * Required to be completed.

*Name (Last, First, MI) Please Print	*Social Security Number	*Date of Birth	*Gender	*Relation

I hereby affirm and attest that the dependent(s) listed above meet the requirements of eligibility. If any dependent is determined to be ineligible or I fail to notify People First of a loss of eligibility or any supporting documentation is not provided upon request, I understand that I may be liable for any and all claims paid for any dependent deemed ineligible.

***People First ID Number:** 0 | | | | | | | |

***Signature**_____ ***Date**_____

SGI-08
11/15

Pretax Premium Waiver Form

People First
STATE OF FLORIDA HR

Learn about plans, use the cost estimators and more at mybenefits.myflorida.com. For help, call (866) 663-4735 or TTY (866) 221-0268 weekdays, from 8 a.m. to 6 p.m. Eastern time.

SECTION A Employee Information - REQUIRED FIELDS*

People First ID* (0 + 7 digits)

Date of Birth (MMDDYYYY)*

Gender* ☐ M ☐ F

Area Code – Primary Phone

Area Code – Alternate Phone

First Name*

Last Name*

Suffix

Home Address Line 1*

Home Address Line 2

Home County*

City*

State*

ZIP Code*

Country*

Notification E-Mail Address

☐ **Check this box if your mailing address is the same as your home address.**

Mailing Address Line 1*

Mailing Address Line 2

City*

State*

ZIP Code*

Country*

SECTION B Payroll Information

Name of Employer (Department, Agency, University, etc.): _____

I am paid: ☐ Biweekly ☐ Monthly ☐ Other

SECTION C Pretax Election

Pretax premiums increase your take-home pay benefits, increasing your spendable income and reducing the amount you owe in income taxes. Your health insurance premium is deducted from your salary before taxes are calculated.

If you do not wish to participate in the Pretax Premium Program, select option A.

Option A ☐ I elect not to participate in the Pretax Premium Program.

If you previously elected not to participate in the Pretax Premium Program and now wish to participate, select option B.

Option B ☐ I elect to participate in the Pretax Premium Program effective January 1.

Pretax Premium Waiver Form

People First ID*

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SECTION D Employee Certification

I understand the benefit of participating in the Pretax Premium Program (Program) and understand that my signature waives my right to participate in the Program. I acknowledge that my next opportunity to elect to participate is during the next open enrollment period, with an effective date of January 1 of the next plan year.

If I wish to join the Pretax Premium Program after electing not to participate, I must submit this signed form to the People First Service Center during open enrollment for the next plan year.

Employee Signature* _____ **Date*** _____

Mail this **completed form** to People First Service Center • PO Box 6830 • Tallahassee, FL 32314 or fax to (800) 422-3128

Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. People First is required to refer such cases to the State of Florida.