



# HEALTH INSURANCE 2008 ENROLLMENT FORM

(Please Print)



Select your Enrollment Type:

New Hire       Open Enrollment

Qualifying Status Change

Note: If checked, you must also complete and submit a Qualifying Status Change form.

SSN:

EEID:  0  0

Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Sex (M/F): \_\_\_\_\_ Birth Date: / /

Home County: \_\_\_\_\_ Work County: \_\_\_\_\_

**PART 1: STATE HEALTH INSURANCE - Please check (✓) your choice.**

**WAIVE** my Health Insurance

**CHANGE** my Health Insurance

**ENROLL** me in Health Insurance

**CANCEL** my Health Insurance

If selecting **ENROLL** or **CHANGE** from above, select a Plan Type:

State PPO Plan

State HIHP PPO Plan

Health Maintenance Organization (HMO) Plan

HIHP Health Maintenance Organization (HMO) Plan

HMO PLAN NAME: \_\_\_\_\_

**NOTE:** You must work or reside in a county the HMO serves.

Indicate your Coverage Level:

Individual       Family

Coverage Effective Date:

/

(must be the 1st day of the month - refer to back of this form)

**PART 2: ADD / DROP DEPENDENTS - Please Print (Attach additional page if necessary.)**

You may: **ADD** eligible dependents not currently covered and/or **DROP** ineligible dependents.

**\*RELATIONSHIP:** Put the number that is next to the relationship, an example is Spouse-1 then you would put the 1 in the "Rel." column below.  
Spouse - 1, Child - 2, Legal Guardianship - 3, Grandchild - 4, Legally Adopted Child - 5, Foster Child - 6, Step Child -7, Unborn Child - 8

Add	Drop	Name (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yyyy)	Sex M/F	*Rel.
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					

**PART 3: EMPLOYEE CERTIFICATION**

I elect the coverages noted above for which I am or may become eligible, and authorize deductions of the required contributions (if applicable). I understand my enrollment and/or changes are IRREVOCABLE, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand I must request such changes within thirty-one (31) calendar days of the Qualifying Status Change.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**SEE REVERSE SIDE FOR ADDITIONAL INFORMATION**

## COMPLETION OF THIS FORM MEANS THAT YOU HAVE READ AND AGREE TO COMPLY WITH THE FOLLOWING:

- Review your current benefits and the available plans and options.
- Select the benefit options **most suited** to your personal needs.
- Submit supporting documentation, if required, for dependent enrollment to the People First Service Center (refer to address below).
- **You must drop all of your ineligible dependents.** If you are dropping **all** of your dependents, you must change your coverage to individual.
- If you **cancel** your health insurance **you will not be able to enroll again until the next annual open enrollment period unless you experience a qualifying status change.**
- If enrolling in an **HMO**, you **must work or reside** in the HMO service area.
- Health plan participants should receive plan information and their I.D. cards in a timely manner. If you do not receive your I.D. card in a timely manner, call the health plan you selected.
- If you wish to enroll in the spouse program, do **NOT** complete this form. **Both** participants must complete the Spouse Program Enrollment Form **and** submit the required documentation to the People First Service Center.
- You may obtain any needed forms via the People First website at <https://peoplefirst.myflorida.com> or the People First Service Center at 1-866-ONE-HRFL (1-866-663-4735).
- Unless you experience a qualifying status change, as defined by the Internal Revenue Code and/or the Florida Administrative Code, your elections will remain in effect for the remainder of the calendar year.
- The **effective date** you elect must coincide with receipt of your enrollment elections (this completed form) as well as the corresponding elected effective month's premium payment (personal check, if applicable).

### If you pay for your premiums, please note:

- Pre-tax premiums **increase your take-home pay** because your health insurance premiums will be deducted from your salary before taxes are calculated.
- If you **do not wish to have your health premiums deducted on a pre-tax basis**, you **must** complete a Pre-tax Premium Waiver Form.

Please **MAIL** or **FAX** your completed and signed enrollment form and Qualifying Status Change form, if applicable, to the People First Service Center at the address or fax number provided below.

People First Service Center  
Post Office Box 6830  
Tallahassee, FL 32314  
FAX: (904) 828-6092