Department of MANAGEMENT SERVICES
Division of State Group Insurance

People First Service Center • 866-663-4735 • Hours: Monday - Friday 8 a.m. to 6 p.m. ET

Dear State of Florida Retiree:

Congratulations on your retirement! As a new retiree, you need to be aware of State Group Insurance benefit options available to you. Please read each section carefully.

Section A: Summary of options to continue your current coverage

- **Health**—continue through COBRA for up to 18 months or elect retiree coverage
- **Basic life**—choose either the $2,500 or the $10,000 benefit (optional life is not available)
- **Dental and vision**—continue through COBRA for up to 18 months
- **Other supplemental plans**—contact your insurance company about converting your policy or buying an individual plan
- **Health savings account**—make contributions until enrolled in Medicare, but the state will no longer make contributions
- **Healthcare flexible spending account**—continue through the grace period of the following plan year if you pay the balance and complete the form
- **Dependent care flexible spending account**—ends with your last employee payroll deduction, but you can file claims incurred before your termination date

Section B: Information you should receive in the mail

If you are enrolled in the plan at the time of your retirement, then you should receive two packets by mail:

1. **COBRA rights information packet:**
   - **Health:** Federal law (COBRA) provides that insured employees and their covered dependent(s) may continue employer group health coverage for up to 18 months from the date employment ends or until they become covered under another group plan, whichever is first. Take note of enrollment deadlines in the COBRA package.
   - **Supplemental dental and vision:** The enrollment forms in your COBRA information packet have information about your current state group dental and/or vision plans (if any). You can only continue your dental and/or vision plans under COBRA for up to 18 months.
2. **Retiree enrollment packet (enclosed with this letter)**:
   - **Your personalized benefits statement:** Shows your current insurance coverage with the state. Please carefully review this statement and the important messages.
   - **Dependent Eligibility Certification Form:** You must complete this form if you cover dependents.

Section C: When coverage ends

- **Your employee insurance plans** automatically end the last day of the month following your termination date; for example, if your termination date is June 7, your coverage ends July 31.
    - If your last pay warrant will not cover the remaining premium balance, please submit check, money order or cashier's check to the People First Service Center.
- **Flexible spending accounts** automatically end the day of your termination. Only expenses incurred before your last payroll deduction are eligible for reimbursement. File by April 15.
- **Retiree health and life and COBRA dental and vision** automatically cancel if you send no payment by the last day of the coverage month. If your coverage cancels for <u>any</u> reason, you will not be allowed to join the State Group Insurance health and/or life plans at a later date as a retiree.

Section D: To continue your coverage if you currently have insurance benefits

1. **Make smart choices:**
    - You must make State Group health and life insurance elections through People First within 60 days of your employment termination. If you do not, you will not be able to enroll at a later time as a retiree.
    - **New Retiree Health and Life Insurance Election Form:** Use to continue or end your coverage. You must enroll within 60 days of your last day of work if you are currently enrolled in health and/or life insurance. You must also send the appropriate premium payments to remain covered.
    - Review your enclosed benefits statement to see your coverage options. Upon retirement, you can change from family to individual coverage, but you can only change plans if you have an appropriate qualifying event, such as moving out of a Health Maintenance Organization (HMO) service area. You're allowed to make any changes to plans you are enrolled in during open enrollment.
    - Contact the insurance carriers directly to convert your supplemental pretax policies or to buy an individual plan. Go to mybenefits.myflorida.com for contact information.
    - Call People First at 866-663-4735. TTY users call 866-221-0268 for help.
    - If you and your spouse are both State of Florida retirees with no eligible dependents, think about changing your level of coverage from family to two individual policies. This may be cheaper than the family plan.
    - When your spouse is a State of Florida employee:
        - **Health insurance:** If you are listed as a dependent under your spouse's health plan, do nothing. If your spouse is listed as your dependent, you should both call People First to have your spouse enroll in employee coverage and add you as a dependent. As long as you maintain continuous coverage, you will be able to enroll in retiree health insurance later when your spouse retires or ends state employment.
        - **Life insurance:** Your spouse should enroll in spouse life coverage. This coverage provides a higher benefit at a lower monthly premium than retiree life insurance. As long as you maintain continuous coverage, you will be able to enroll in retiree life insurance later when your spouse retires or ends state employment.

2. **Complete the enclosed New Retiree Health and Life Insurance Election Form to continue coverage as a retiree.** If you call People First and make your choices over the phone, you don't need to complete the form. Mail and fax information are on the form.

3. **Pay the required premium payments for each month of coverage. You have three options to pay:**

   - Have the premium deducted on a post-tax basis each month from your Florida Retirement System (FRS) monthly pension benefit. Your benefit must be sufficient to cover the premium.
     - Call the Division of Retirement at 888-377-7687 to find out when your monthly pension payment will begin; Tallahassee residents call 488-4742.
     - Then call People First to set up the deduction. You must send payments to People First until your deductions start.

     Call People First if you are a retiree under an optional retirement plan or if your FRS monthly pension payment, including the Health Insurance Subsidy, will not cover your monthly health and life insurance premium deductions. Be sure your mailing address is correct and People First will send you payment coupons.

   - Send a personal check, money order, or cashier's check. Write your People First ID number on your payment, made payable to Division of State Group Insurance and send it to:

     People First Service Center
     PO Box 863477
     Orlando, FL 32886-3477

     You can pay up to six months in advance, but you must pay by the 10th of the month for the next month's coverage; for example, payments for July coverage are due to People First by June 10. If your payment is not received by the 10th, your coverage will be suspended for the next month and you will not be eligible for services until the full payment is received. If your payment is not received by the last day of the month in suspension, your coverage will be cancelled and you will not be able to re-enroll.

   - Automatic Online Bill Pay System. You can contact your financial institution if they participate in automatic online bill pay services and have them set up the automatic bill pay service to have your premiums submitted directly from your account to People First each month. This will ensure your payment is submitted timely each month.

4. **Submit your application for the Health Insurance Subsidy.** The health insurance subsidy is an employee benefit of the FRS. (Investment Plan members are eligible for the HIS benefit only if they meet certain requirements.) Retirees who carry qualified health insurance receive a monthly supplemental payment based on years of service. If you are an FRS pension plan retiree, the Division of Retirement Payroll Section will send the HIS-1 form to you in your retiree packet. If you are continuing your State Group Health Insurance as a retiree or if you are a covered dependent under your spouse's State Group Health Insurance plan, complete the HIS-1 form and send or fax it to:

People First Service Center
PO Box 6830
Tallahassee, FL 32314

Fax: 800-422-3128

People First will process this form to certify to FRS that you have State Group Health Insurance coverage and return it to the Division of Retirement. If your retiree health insurance coverage will be through a private vendor or Medicare, follow the instructions for submission on the HIS-1 form. People First can only certify State Group Health Insurance coverage. Go to dms.myFlorida.com/Retirement to learn more.

5. **If you are enrolled in a healthcare flexible spending account and have money remaining in your FSA, you can continue your benefit under COBRA through the grace period** (March 15 of the following plan year). To avoid forfeiting your money, complete and submit the Continuing Your Healthcare FSA When Employment Ends form, located at mybenefits.myflorida.com in the Forms and Publications section. This form gives you the option of paying the balance of your account on a pretax basis from your sick or annual leave payout, or you can pay by personal check on a post- tax basis. Once you make the election, you will have until March 15 to incur claims and April 15 of the following plan year to file claims.

Section E: Medicare

For specific information about Medicare, including eligibility and coverage, visit www.medicare.gov or call 800-Medicare (800-633-4227). TTY users call 877-486-2048.

- **General Medicare information:**
  - **Part A** is hospitalization coverage free to eligible Medicare beneficiaries.
  - **Part B** is medical coverage that requires a monthly premium (taken from your Social Security check or paid by personal check).
  - **Part C** (Medicare Advantage Plan) is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits and often includes prescription drug coverage. You must be enrolled in Medicare Part B and you may also be required to send a monthly premium to the insurance company.
  - **Part D** is prescription drug coverage that may require a monthly premium (taken from your Social Security check or paid by personal check).
  - **Medicare Supplement (Medigap) Plans** sold by private companies can help pay some of the health care costs Medicare doesn't cover, like copayments, coinsurance, and deductibles. Some Medigap policies also offer coverage for services that Medicare doesn't cover.

    You may purchase Part B, Part C, Part D or Medigap plans on the private market. If you choose to do so, you should cancel your state group health insurance plan. Remember, once you cancel, you cannot enroll at a later time.

- **You are eligible for Medicare (either at retirement or after retiring) and keeping state group health insurance:**

- **Coordinating medical coverage:** When Medicare Part A or Part B pays, your state group health insurance pays secondary. When Medicare does not pay, your state group health insurance pays primary for covered benefits and services (just like when you were an employee). Florida Blue administers the nationwide PPO secondary plan; Aetna, AvMed, and UnitedHealthcare administer the HMO secondary plans in their respective service areas.
    - **If you fail to enroll in Medicare Part B**: You will have significant out-of-pocket expenses for Part B eligible services because you will be required to pay the portion (approximately 80 percent) that Medicare would have paid. If you choose to continue your state group health insurance coverage once you're eligible for Medicare, elect your Medicare Part B coverage. Although Medicare does not require you to purchase Part B, it is in your financial interest to do so. This coverage provision also applies to Medicare-eligible dependents on your plan.
- **Creditable Coverage for Medicare Part D:** For prescription drug coverage, your state group health insurance pays primary for most prescription drugs. Covered medications, copays and the network remain the same as when you were an employee. If you are enrolled in the state group secondary health insurance, do **not** enroll in a separate Medicare Part D plan. The state's prescription drug coverage is as good as or better than Medicare Part D and is currently approved by Medicare as creditable coverage.
- **Medicare (Retiree) Advantage Plan:** Capital Health Plan offers this plan to state retirees in their respective HMO service area. To become a member, you must be enrolled in Medicare Parts A and B, complete Capital Health Plan's application and receive approval before your retiree health coverage becomes effective. Medicare Advantage Plans do not allow retroactive enrollment and claims can only be paid if you are approved for the plan. Medical and prescription drug coverage are included.
- **Enrolling in Medicare:** Once you are eligible for Medicare Part A and Part B due to age (65) or disability and no longer working, you should contact the Social Security Administration (SSA) about your Medicare benefits. Enrollment in Medicare is time sensitive and you may be subject to substantial financial penalties if you fail to meet federal deadlines. Contact your local SSA office three months before your 65th birthday: call 800-MEDICARE (800-633-4227), or visit www.Medicare.gov for more information. TTY users call 877-486-2048.
- **Enrolling in state group Medicare secondary coverage or a Medicare advantage plan:** the state offers three Medicare coverage tiers when you or a dependent is Medicare eligible:
    - Medicare I: a single policy for you
    - Medicare II: a family policy for you and your eligible dependents and at least one is eligible for Medicare
    - Medicare III: a family policy for you and one dependent and you are both Medicare eligible

- **You do not meet Medicare eligibility requirements:** If you have not worked enough quarters to be eligible for Medicare at age 65, call the Social Security Administration and request an ineligibility letter. Please send a copy of that letter immediately to People First to ensure your health insurance coverage continues without interruption. Mail or fax copies of Medicare documentation with your People First ID number to:

For online document submission, log in to your People First account at PeopleFirst.myflorida.com, select the "Submit" icon in the top right corner and follow the steps to send the completed form to the People First Service Center
Alternitively, you can mail the form to:
People First Service Center PO Box 6830
Tallahassee, FL 32314

Section F: Important reminders

- **Addresses:** Keep your mailing and notification email address up-to-date in People First to receive open enrollment materials and important notices timely.
- **Medicare card:** For proper enrollment and claims processing, send copies (yours and your dependent's) of Medicare ID cards to People First as soon as you receive them from the SSA.
- **Use the People First website:** To see your benefits information in People First, log in and go to Health & Insurance > M y Benefits. To see your monthly premium payments go to Health & Insurance > Benefit Premium History and select the month you want to see.
- **Authorization to Disclose Protected Health Information (PHI):** If you want to give People First or your insurance company permission to disclose PHI to an individual, you must submit an authorization form to each party. For example, if you want your spouse to be able to call People First to discuss your monthly premiums, you must send People First an authorization form (enclosed); otherwise, representatives will be unable to talk to your spouse per Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines. Call People First or your insurance company for more information.
- **For more information, including HMO service areas and annual premium changes:** Visit mybenefits.myflorida.com.
- **Waiver of premium for total disability:** the life insurance company may waive premiums if you become disabled while still actively employed. Call the life insurance company at 888-826-2756 for more information on the Waiver of Premium provisions.

If you have questions about your insurance benefits upon retirement, call us at 866-663-4735 or TTY 866-221-0268. We are open Monday through Friday, from 8 a.m. to 6 p.m. Eastern time.

Sincerely,
People First Service Center

Special Notice about the Medicare Part D Drug Program

January 1, 2018

Please read this notice carefully. It explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll in Medicare Part D.

Medicare prescription drug coverage (Medicare Part D) became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage.

All approved Medicare prescription drug plans must offer a minimum standard level of coverage set by Medicare. Some plans may offer more coverage than required. As such, premiums for Medicare Part D plans vary, so you should research all plans carefully.

The State of Florida Department of Management Services has determined that the prescription drug coverage offered by the State Employees' Health Insurance Program (State Health Program) is, on average, expected to pay out as much as or more than the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your State Health Program coverage, be aware that you and your dependents will be dropping your hospital, medical and prescription drug coverage. If you choose to drop your State Health Program coverage, you will not be able to re-enroll in the State Health Program.

If you enroll in a Medicare prescription drug plan and do not drop your State Health Program coverage, you and your eligible dependents will still be eligible for health and prescription drug benefits through the State Health Program. However, if you are enrolled in a state-sponsored HMO offering a Medicare Advantage Prescription Drug Plan, you may have to change to the State Employees' PPO Plan to get all of your current health and prescription drug benefits.

If you drop or lose your coverage with the State Health Program and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. Additionally, if you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage, and you may have to wait until the following Nov. to enroll.

Additional information about Medicare prescription drug plans is available from:

- www.medicare.gov
- Your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)
- (800) MEDICARE or (800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, payment assistance for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA). Contact your local SSA office, call 800-772-1213, or www.socialsecurity.gov for more information. TTY users call 800-325-0778.

For more information about this notice or your current prescription drug plan, call the People First Service Center at 866-663-4735.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium amount (a penalty).

SGI-12
11/15

Dependent Eligibility Certification Form

Department of MANAGEMENT SERVICES
Division of State Group Insurance

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-06
11/15

New Retiree Health and Life Insurance Election Form

Department of MANAGEMENT SERVICES
Division of State Group Insurance

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 Retiree Information - REQUIRED FIELDS*

People First ID* (0 _____)

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 Event Type - Please check (✓) appropriate box.

What type of event is this?

☐ Pension Plan Retirement ☐ Investment Plan ☐ Disability Retirement Plan ☐ Other Optional Retirement Plan

State Group Health Insurance - Please check (✓) your choice(s).

☐ I want to **continue** my current level of health insurance coverage as a retiree.

☐ I want to **change** my family health insurance coverage to individual coverage. I am not Medicare eligible. I understand that I must experience a Qualifying Status Change (QSC) event to go back to family coverage; otherwise, I can only make a change during Open Enrollment.
I no longer live in my HMO service area. **Change** my plan to: Plan Name _____.

☐ I want to **end** my state health insurance coverage. If I end my health coverage, I will not be allowed to join the plan at a later date as a retiree. **If you and/or your dependent(s) are eligible for Medicare[1], you may only select from these options:**

☐ Medicare I - An individual plan for you if you are eligible for Medicare Parts A and B due to age 65 or disability.

☐ Medicare II - A family plan for two or more people, if at least one family member is eligible for Medicare Parts A and B due to age 65 or disability.

☐ Medicare III - A family plan for only two people and both are eligible for Medicare Parts A and B due to age 65 or disability.

[1]State group health insurance plans pay claims secondary to Medicare, even if you do not enroll in Medicare.

New Retiree Health and Life Insurance Election Form

People First ID*

0							

Department of MANAGEMENT SERVICES
Division of State Group Insurance

SECTION D Dependent Enrollment (Attach additional page if necessary)

Complete all fields in the chart below and then check the appropriate column to **ENROLL**, to **CONTINUE** coverage for eligible dependents, or to **CANCEL** coverage for dependents. Go to mybenefits.myflorida.com for dependent eligibility requirements.

1 - Spouse 2 - Child 3 - Legal Guardianship 4 - Grandchild 5 - Legally Adopted Child 6 - Foster Child 7 - Stepchild 9 - Over-age Dependent

Name (Last, First, MI) Please Print	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender	Relation	Enroll	Continue	Cancel

SECTON E Basic Life Insurance Election

Choose one of the options below. These benefits and rates are subject to change:

☐ I elect $10,000 of basic life insurance coverage with a monthly premium of $19.33.

☐ I elect $2,500 of basic life insurance coverage with a monthly premium of $4.83.

☐ I want to **end** my basic life insurance coverage under the state group life insurance plan as a retiree. If I end my life coverage, I will not be allowed to join the plan at a later date as a retiree.

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SECTION F Method of Premium Payment

To complete your enrollment, you must submit the required premium for the first month of coverage to People First. You must submit a check, money order, or cashier's check to the payment address at the bottom of this page. All payments are due a month in advance for the next month's coverage. **After you pay your first month's premium, you have two payment options (check one):**

☐ I will submit premium payments to People First by the 10th day of each month for the following month's coverage.

☐ I authorize the State of Florida to deduct from my FRS monthly pension payment the amount necessary to pay the premiums for the coverage I have selected.

SECTION G Retiree and Dependent Certification

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.

I understand the options I am choosing and that my participation is subject to applicable rules in Chapter 60P, Florida Administrative Code. I understand that my enrollment in the State Health and Life Insurance Programs will be complete only if People First receives my first month's premium and this application within 60 days of my retirement. If checked above as my preferred payment method, I authorize the State of Florida to deduct from my FRS monthly pension payment the amount necessary to pay the premium for the coverage I have selected. If I do not receive a monthly retirement benefit or if it is not sufficient to pay the premium, I will submit the amount due by personal check, money order or cashier's check by the 10th day of each month for the following month's coverage. I understand that I may cancel my insurance coverage at any time but will not be allowed to join at a later date as a retiree. All other changes can only be made if I have a Qualifying Status Change event or during Open Enrollment. I must request changes within 60 calendar days of the Qualifying Status Change event.

Retiree Signature* _____ **Date*** _____

Mail this completed form to People First Service Center • PO Box 6830 • Tallahassee, FL 32314 or

For online document submission, log in to your People First account at PeopleFirst.myflorida.com, select the "Submit" icon in the top right corner and follow the steps to send the completed form to the People First Service Center

Mail payments to People First Service Center • PO Box 863477 • Orlando, FL 32886-3477

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.

Authorization for Release of Protected Health Information

People First and Chard Snyder, serving you on behalf of the State Group Insurance Program ("Program"), cannot use or disclose[1] protected health information (or the health information of your children or other people on whose behalf you can act) without the appropriate authorization. This means we are not permitted to discuss or provide to any person, including your spouse, any information concerning your health insurance, health care flexible spending account, or health savings account, as applicable.

To allow us to disclose your information to the person or organization of your choice, please complete the form below and return as directed on the last page of the form.

- If you wish to authorize us to discuss your protected health information with more than one person, you must complete a separate form for each person.
- If you wish to authorize us to discuss protected health information for your covered dependent(s) on whose behalf you can act, you must complete a separate form for each dependent.
- If your covered dependent(s) over the age of eighteen wishes to authorize us to discuss their protected health information, they must complete a separate form.
- If you have a valid medical power of attorney and you want to authorize him or her to receive your protected health information, you are not required to complete this form; however, you must send a copy of the valid medical power of attorney to provide authorization for disclosure.

Note: this form only authorizes People First and/or Chard Snyder to disclose your information. Your health plan, CVS/caremark, and healthcare provider each have separate authorization forms.

For assistance with completing this form, please call People First at 866-663-4735.

1. PERSON COMPLETING FORM		
First Name*	Last Name*	
People First ID Number*	Date of Birth (mm/dd/yyyy)*	
Primary Phone*	Secondary Phone	
Email Address		
Street Address*		
City*	State*	ZIP Code*

*required

2. PERSON WHOSE PROTECTED HEALTH INFORMATION MAY BE DISCLOSED (separate form required for each person)
☐ Self
☐ Dependent on whose behalf you may act
FIRST NAME _____ LAST NAME _____

[1] Except as permitted under federal law (HIPAA) and as described in the Program's privacy notice, available at myBenefits.myFlorida.com.

3. PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE/DISCUSS PROTECTED HEALTH INFORMATION			
Name	Phone		
Address	City	State	ZIP Code

Relationship to You

☐Spouse ☐Adult Child ☐Parent ☐Friend ☐Legal Representative

☐Other _____

Purpose:

4. INFORMATION TO BE RELEASED TO RECIPIENT NAMED IN #3 ABOVE

Check all that apply:

I hereby authorize **People First** to disclose protected health information recorded in the People First system for the person named in #2 above as indicated:

☐All account information recorded in the People First system

☐Enrollment information ☐Premium Payment information

☐Benefit information ☐Dependent information

Authorization to disclose protected health information expires:

☐ On the following date: _____

☐ Upon disenrollment from the Program.

I hereby authorize **Chard Snyder** to disclose the protected health information related to my flexible spending account (FSA) and/or my health savings account as indicated below. You MUST check the appropriate box:

☐ Healthcare FSA; and/or ☐ Health Savings Account

Authorization to disclose protected health information expires:

☐ On the following date: _____

☐ Upon disenrollment from the Program.

5. IMPORTANT INFORMATION ABOUT PARTICIPANT'S RIGHTS

☐ I have read and understand the following statements about my rights:

- This authorization is voluntary and I may refuse to sign this authorization.
- I am not required to sign this form to receive my health care benefits.
- The information used or disclosed pursuant to this authorization may be redisclosed by the recipient named in #3 above. I have the right to seek assurances from such recipient that he/she will not redisclose the information to any other party without my further authorization. Neither People First nor Chard Snyder will be held liable for any redisclosure of protected health information by such recipient.
- I may revoke this authorization at any time prior to its expiration date by notifying People First in writing, but the revocation will not have any effect on any actions that People First or Chard Snyder took before receiving the revocation notice.
- I understand this authorization will expire as stated above and I will need to complete a new form to allow individuals authorization to my protected health information.
- By authorizing Chard Snyder to disclose information related to my healthcare FSA and/or my health savings account, my records may include information regarding drug or alcohol use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.

AUTHORIZATION AND SIGNATURE	
Signature of Person Named in #1 Above*	Date*
Printed Name	

SUBMISSION
Keep a copy for your records and send the completed form to: People First Service Center PO Box 6830 Tallahassee, FL 32314 -OR- Fax to (800) 422-3128

*LEGAL REPRESENTATIVE
No additional documents are required, as long as the person signing this form is acting for himself or herself or has the authority to act on behalf of a dependent. If the person is unable to sign this form for any of the following reasons, the person's legal representative must provide one of the following and complete the information below: 1. If the person is deceased, the legal representative must provide documentation that he or she is the executor or administrator of the participant's estate. We may not rely on a durable power of attorney, advance directive, guardianship or conservatorship papers after the death of the person, as the papers are not valid after death. 2. If the person is incapacitated and, as a result, a legal representative needs to act on behalf of the person, submit this completed authorization form and include the legal documentation showing who the legal representative is. Legal documentation includes durable power of attorney, guardianship or conservatorship papers.

First Name of Person's Legal Representative	Last Name of Person's Legal Representative	
Primary Phone of Person's Legal Representative	Email Address of Person's Legal Representative	
Street Address of Person's Legal Representative		
City	State	ZIP Code