NEW RETIREE
HEALTH AND LIFE INSURANCE ELECTION FORM

Learn about plans, use the cost estimators and more at myflorida.com/mybenefits. 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* Date of Birth (MMDDYYYY)* Gender* Area Code Primary Phone Area Code Alternate Phone

First Name* Last Name* Suffix

Home Address Line 1*

Home Address Line 2

Home Country*

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

SECTION C  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 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 Medicare¹, 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.

¹State 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
PAGE 2 of 2

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 myflorida.com/mybenefits for dependent eligibility requirements.

<table>
<thead>
<tr>
<th>1 - Spouse</th>
<th>2 - Child</th>
<th>3 - Legal Guardianship</th>
<th>4 - Grandchild</th>
<th>5 - Legally Adopted Child</th>
<th>6 - Foster Child</th>
<th>7 - Stepchild</th>
<th>9 - Over-age Dependent</th>
</tr>
</thead>
</table>

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

SECTION 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 $29.65. I understand that the amount of life insurance shall be $10,000 and automatically includes a matching accidental death and dismemberment benefit.

☐ I elect $2,500 of basic life insurance coverage with a monthly premium of $7.41. I understand that the amount of life insurance shall be $2,500 and automatically includes a matching accidental death and dismemberment benefit.

☐ 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.

NOTE: Life insurance premiums may be waived if you are disabled before age 60. If you become disabled, call Minnesota Life at (888) 826-2756 for more information about the Waiver of Premium option.

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 fax to (800) 422-3128
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.

Revised 08/06/12