



# DIVISION OF STATE GROUP INSURANCE HEALTH INSURANCE ENROLLMENT FORM



Select Your Type of Enrollment:  New Hire  Qualifying Status Change  Open Enrollment  
PLEASE PRINT \* NOTE: If checked, Agency Personnel Office must complete QSC Section in Part 4.

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Name: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ SUNCOM: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Home County: \_\_\_\_\_ Code: \_\_\_\_\_

Work County: \_\_\_\_\_ Code: \_\_\_\_\_

### PART 1: STATE HEALTH INSURANCE

Please check your choices

Waive Health Insurance enrollment

Change my Health Insurance.

Enroll me in Health Insurance.

Cancel my Health Insurance.

#### Select a plan type:

State Employees PPO Plan (Blue Cross Blue Shield of Florida, Inc.)

Health Maintenance Organization (HMO).

HMO Plan Name: \_\_\_\_\_ Plan Number: \_\_\_\_\_

#### Indicate your coverage level:

Individual

Family

### PART 2: Add or Drop Dependents

List Your Eligible Dependents: You may **ADD** eligible dependents not currently covered & attach the required documentation as defined in the Benefits Guide and/or **DROP** ineligible dependents. (Attach an additional page if necessary.)

ADD	DROP	NAME (Last, First, MI) <i>Please Print</i>	SEX	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
				- -	/ /	
				- -	/ /	
				- -	/ /	
				- -	/ /	
				- -	/ /	

### PART 3: PLEASE READ: EMPLOYEE SIGNATURE REQUIRED

I have read the information on the back of this form and I authorize my employer to reduce my salary in accordance with the benefits I have selected. I understand my enrollment and/or changes will be effective the first of the month following a full payroll deduction and that my elections are IRREVOCABLE until the next open enrollment, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within 31 calendar days of the Qualifying Status Change.

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

### PART 4: AGENCY CERTIFICATION REQUIRED

Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Pay Plan: \_\_\_\_\_ SAMAS Org Code: \_\_\_\_\_

Coverage Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Coverage Code: \_\_\_\_\_ Plan Type: \_\_\_\_\_ Employment Status: \_\_\_\_\_

Agency Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Check if the employee is an 8, 9 or 10 month faculty member.

Work Phone: (\_\_\_\_) \_\_\_\_\_ SUNCOM: \_\_\_\_\_

\* QSC Code: \_\_\_\_\_ \*QSC Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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.
- If making no changes to your health insurance during the Open Enrollment period, **DO NOT** return this form to your Agency Personnel Office.
- Submit supporting documentation for dependent changes to your Agency Personnel Office.
- **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 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.
- To choose an HMO, refer to the HMO listing provided in your packet.
- Health plan participants should receive I.D. cards and plan information timely. If you do not receive your I.D. card in a timely manner, call the health plan you selected.
- If enrolling in the spouse program, **both** participants must complete the Spouse Program Enrollment Form **and** submit the required documentation to their Agency Personnel Offices.
- Pretax 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 pretax** your health premiums, you **must** complete a Pretax Premium Waiver Form available from your Agency Personnel Office.
- 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 calendar year.