Statement on the Collection and Use of Social Security Numbers

Human Resources

In accordance with the requirements of Florida law (Section 119.071, Florida Statutes), the University of West Florida collects social security numbers only if specifically authorized or required by law or if imperative for the performance of the University's duties and responsibilities. The University may collect social security numbers for some or all of the following purposes: identity tracking and management; billing and payments; credit worthiness; data collection; reconciliation and tracking; benefit processing; tax and scholarship reporting; financial aid processing; student health services, and reporting to authorized state and federal government agencies. Federal and state laws require us to protect social security numbers from disclosure to unauthorized parties. Students and employees are assigned UWF identification numbers to assist in tracking and protecting their personal information.

UWF Forms	Form Purpose	Purpose for SSN#	Statutory Authority	Mandated, Authorized or Business Imperative
FRS Certification Form	Eligibility to be employed	Applicant Identification	Section 119.071(5)(a)6.g, F.S.	Mandated
Level II Background Screening Request Form	Eligibility to be employed in a position of special trust	Applicant/employee identification	Section 119.071(4)(a)2.b., F. S.	Mandated
Verification of Employment Authorization Release	Employment verification	Employee identification	Section 119.071(5)(a)(2)(a)(II), F.S.	Business Imperative
Third Party Non-UWF Forms	**Purpose**	**Purpose of SSN#**	**Statutory Authority**	**Mandated, Authorized or Business Imperative**
Form I-9, Employment Eligibility Verification (US Department of Homeland Security)	Verify each new employee (both citizen and noncitizen) hired after Nov 6, 1986, is authorized to work in the United States.	Citizen and noncitizen identification	U.S. Dept. of Homeland Security, U.S. Citizenship and Immigration Services; Immigration Reform and Control Act of 1986, Pub. L. 99-603(8 USC 1324a)	Mandated
Form W-4, Employee's Withholding Allowance Certificate	Tax reporting	For employee identification	I.R.C. Section 6109	Mandated
Florida retirement contribution reports and forms (Florida Department of Revenue)	Administration of pension benefits	For employee identification	Section 119.071(6)(g), F.S.	Business Imperative
Worker's Compensation Amerisys forms on behalf of Risk Management, STARS reports of lost wages and First Report of Injury	For report and documentation of work-related injury and follow up	For employee identification	Section 440.185(2)(b), F.S.	Mandated
I.R.C. Section 403b,457b contribution reports (Internal Revenue Service)	Employee enrollment and claims	For employee identification	I.R.C. Section 6109	Mandated
State of Florida New Hire Report (Department of Revenue)	Administration of various programs: child support enforcement, Medicaid, unemployment compensation, Food Stamp, aid to disabled, etc.	New hire identification	Section 409.2576, F.S.	Mandated
State sponsored insurance enrollment forms and reports (group health, life, and dental coverage) (limited to dependents)	Administration of health benefits	Dependent identification	Section 119.071(6)(f), F.S.	Business Imperative
Agency for Workforce Innovation Unemployment Compensation forms	Verification of benefits eligibility	Employee identification and verification with Social Security Administration	Section 443.091(1)(g), F.S.	Mandated
FICA Alternative Plan Forms (OPS Retirement)	Selection of 401(a) Investment options and Beneficiaries	Reporting	(OBRA 90) IRC 3121(b)(7)(F).	Business Imperative

Group Life Insurance Evidence of Insurability

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
P.O. Box 14289 • Tallahassee, Florida 32317-4289 • Telephone 888-826-2756 • Fax 850-878-0048

EMPLOYER NAME: State of Florida **AGENCY:** **POLICY NUMBER: 33503**

EMPLOYEE INFORMATION (always complete for coverage that requires evidence of insurability)

First name	Middle initial	Last name	Daytime phone number	Evening phone number

Street address	City	State	Zip code

Date of birth	Social Security number	Annual earnings	Date of employment	Gender
				☐ Male ☐ Female

Email address

Total amount of optional insurance requested

☐ No Change ☐ 1x annual earnings ☐ 2x annual earnings ☐ 3x annual earnings
☐ 4x annual earnings ☐ 5x annual earnings ☐ 6x annual earnings ☐ 7x annual earnings

SPOUSE INFORMATION (only complete if spouse coverage requires evidence of insurability)

First name	Middle initial	Last name	Daytime phone number	Evening phone number

Date of birth	Email address	Gender
		☐ Male ☐ Female

Total amount of spouse insurance requested

☐ $15,000 ☐ $20,000

HEALTH QUESTIONS (always complete for coverage that requires evidence of insurability)

Employee		Spouse			Employee		Spouse		
Yes	No	Yes	No		Height	Weight	Height	Weight	Occupation
☐	☐	☐	☐	1. During the past three years, have you consulted a physician(s), medical doctor, or been hospitalized?					
☐	☐	☐	☐	2. Have you ever been diagnosed, or been treated by a licensed medical provider for any of the following: heart disorder, lung disorder, kidney disorder, liver disorder, nervous system disorder, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?					
☐	☐	☐	☐	3. Have you been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?					

If you answer "Yes" to any question, please provide additional information below or on a separate sheet of paper.

ADDITIONAL HEALTH INFORMATION (provide details for every "Yes" answer to the health questions, excluding information regarding treatment for HIV/AIDS/ARC)

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

FOR OFFICE USE ONLY:

Employee			Spouse		
Current in force	U/W applied for	Total elected	Current in force	U/W applied for	Total elected
$	$	$	$	$	$

PLEASE READ & SIGN NEXT PAGE & SEND ALL PAGES TO MINNESOTA LIFE

EMPLOYER NAME: State of Florida **POLICY NUMBER: 33503**

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Minnesota Life Insurance Company, (the Company), and its employees, reinsurers and representatives, except for information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

I also authorize any person(s), medical practitioner, institution, insurance company or MIB, Inc. to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, Inc. to give such information to any agency employed by the Company to collect and transmit such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

This protected health information is to be disclosed under this Authorization so the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand I am entitled to receive a copy of this Authorization. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to the Company's legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

CONSUMER PRIVACY NOTICE

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from MIB, Inc., a not-for-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies. If you apply to a MIB, Inc. member company for life or health insurance, or submit a benefits claim for benefits to a member company, MIB, Inc., upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB. Inc., files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send the Company a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

For further information about your file or your rights, you may contact:

Group Division Underwriting
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: (800) 872-2214

For information about MIB, Inc. you may contact:

MIB
50 Braintree Hill, Suite 400
Braintree, MA 02184-8734
Telephone: (866) 692-6901
Website: www.mib.com

I have read this Authorization and Consumer Privacy Notice and I understand I can have copies. The answers provided on this application are representations of the person signing below. To the best of my knowledge, the answers given are true and complete. It is understood that Minnesota Life Insurance Company shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I authorize my employer to withdraw premiums from my salary to pay for this coverage. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee name (please print)		Date of birth	
Employee signature X	Daytime phone number	Evening phone number	Date signed
Spouse name (please print) (only complete if coverage requires evidence of insurability)		Date of birth	
Spouse signature (only complete if coverage requires evidence of insurability) X	Daytime phone number	Evening phone number	Date signed

Securian Financial Group, Inc.

SECURIAN®

Fax

TO: Group Medical Underwriting

COMPANY: Minnesota Life
A Securian Company

PHONE: 888-826-2756

FAX: 850-878-0048

Securian Financial Group provides financial security for individuals and businesses through its subsidiaries including Minnesota Life Insurance Company, Advantus Capital Management, Securian Financial Services and Securian Trust Company.

FROM:

PHONE:

FAX:

DATE: 07/12/16

PAGES INCLUDING COVER:

STATUS: ☐ **URGENT** ☐ **FOR YOUR REVIEW** ☐ **REPLY ASAP** ☐ **PLEASE COMMENT**

Subject: Evidence of Insurability Form

In addition to completing the Evidence of Insurability form, you must also enroll for the coverage with PeopleFirst. You can do so by enrolling online at the PeopleFirst website - PeopleFirst.MyFlorida.com or by phone with the PeopleFirst Service Center at 1-866-663-4735. Once your enrollment is completed with PeopleFirst, the Evidence of Insurability form should be submitted to Minnesota Life.

If you prefer to mail the evidence of insurability form, please send it to the following address:

Mail To: Minnesota Life
PO Box 14289
Tallahassee, FL 32317-4289

400 Robert Street North
St. Paul, MN 55101-2098
www.securian.com