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	

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Spouse Program Election Form



Learn about plans, use the cost estin	nators and more at myflorida.com/my	ybenefits. For help,	call (866) 663-4735 or T	TY (866) 221-0268 weekdays	s, from 8 a.m. to 6 p.m. Eastern time.
SECTION A Primary Spouse (Policyholder) Information - REC	QUIRED FIELDS*			
People First ID*	Date of Birth (MMDDYYYY)* Ge	Gender* Ar	ea Code Primary Pho	one Area C	ode Alternate Phone
0		м		-	
First Name*		Last Name*			Suffix
Home Address Line 1*					
Home Address Line 2				Home County*	
City*		State*_ ZII	Code*	Country*	
Notification E-Mail Address					
Check this box if your mailing	address is the same as your home	ne address.			
Mailing Address Line 1*					
				_	
Mailing Address Line 2					
				_	
City*		State* ZII	Code*	Country*	
SECTION B Event Type - Pleas	se check (✓) appropriate box.				
What type of event is this?	pen Enrollment Qualifying St	Status Change (QSC) Event (see attached cl	nart)	
			Event:	,	Pate:

SECTION C Spouse Program Information

Preferred Provider Organization (PPO) plans allow you to visit doctors in and out of the Florida Blue network; however, your cost may be much greater if you select one out of network. Health Maintenance Organization (HMO) plans only provide coverage within the provider network, except for certain emergencies. You must live or work in the HMO service area county to be eligible for the HMO network. PPO and HMO plans both offer pharmacy benefits.

Health Investor Health Plans are high deductible plans with lower monthly premiums for Career Service employees. You may enroll in a Health Savings Account (HSA) and receive a monthly contribution from the state. Fill out the Tax-Favored Accounts form and open a HSA bank account at Tallahassee State Bank to be eligible for the HSA benefit.

If you and your spouse are active state employees, you are both eligible for health insurance coverage at a reduced monthly premium, provided you apply within 60 days of your qualifying event.



Spouse Program Election Form

People First ID*
SECTION C continued Spouse Program Information
To enroll, both spouses must complete and sign this form. One spouse must be designated "primary" and the other "secondary." The primary spouse is the policyholder. The secondary spouse and eligible dependents are covered under the primary spouse's coverage. Both spouses must enroll in the same health plan.
To cancel, the effective end date of participation in the Spouse Program shall be as of the first day the parties became ineligible to participate in the Spouse Program.
Both spouses must contact the Service Center within 60 days of becoming ineligible for the Spouse Program if one or both terminate state employment, retire, divorce, or in the event of death.
Note: In the event of divorce, covered dependent children are added to the primary spouse's plan, and the secondary spouse is enrolled in a separate family coverage policy. If there are no dependent children, each spouse is enrolled in individual coverage.
SECTION D State Group Health Insurance - Please check (✓) your choice(s).
Enter your requested effective date:
Standard PPO Plan Standard HMO - Print Plan Name Health Investor¹ PPO Plan HMO Health Investor¹ Plan - Print Plan Name
Out-of-pocket annual deductible amount is \$1,250 for individual coverage and \$2,500 for family coverage before anything is covered except some preventive care.
SECTION E Secondary Spouse Information - REQUIRED FIELDS* People First ID* 0
First Name* Last Name* Suffix
Home Address Line 1*
Home Address Line 2 Home County*
City* State* ZIP Code* Country*
Notification E-Mail Address

Spouse Program Election Form

												4		
People First ID* 0												•		
SECTION F Dependent Enrollment (Attach additional page	if ne	cess	ary))										
Complete all fields in the chart below and then check the appropriate of Go to myflorida.com/mybenefits for dependent eligibility requirements.	olumn	to E	NRC	LL,	to CO	ONTI	NUE	coverage for eligible dep	endents	s, or to (CANCE	L covera	age for o	dependents.
To complete the Relation column, use the number that describes your							_				_			
1 - Spouse 2 - Child 3 - Legal Guardianship 4 - Grandchild 5 Note: Secondary employee and any children enrolled will be covered under	_					6	- Fos	ster Child 7 - Stepchild	9 - O	ver-age	Depen	dent		
Name (Last, First, MI) Please Print					Numbe	er		Date of Birth (mm/dd/yyyy)	Gender	Relation	Enroll	Continue	Cancel	
				Ť			Π	, ,,,,,						
	\vdash		\sqcup	\perp	_	_								
SECTION G Employee Certification														
I hereby affirm and attest that the dependent(s) listed above meet the of eligibility or any supporting documentation is not provided upon requ				_			-	•		_		-		
I understand the options I am choosing and that my participation is sult in effect for the remainder of the calendar year and can only be chang Revenue Code and/or the Florida Administrative Code. I understand to canceling coverage, and adding or dropping dependents. I understan be processed if I send forms and/or applications to the insurance comevent. I authorize payroll deductions of the required contributions.	ed duri hat I m d that I	ing o nust r I mus	pen make st ser	enro all d	llmer chanç is ele	nt or i ges t ection	if I ha hrough n form	ave a Qualifying Status C gh People First. Allowab n directly to the People F	hange e le chang irst Serv	vent as es inclu ice Cen	defined de enro ter and	by the olling, che enrollm	Federal nanging ent char	Internal plans, nges cannot
Primary Employee Signature*								Date*						

Mail this completed form to People First Service Center • PO Box 6830 • Tallahassee, FL 32314 or fax to (800) 422-3128

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.

Date*

Secondary Employee Signature*

Dependent Eligibility Certification Form



This page must be completed before benefit changes will be processed.

If you cover dependents under *any* State Group Insurance plan, you **must** certify their eligibility 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 of the opposite sex to whom you are legally married. See Section 741.212(3), Florida Statutes.
- 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
 vear 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	

Qualifying Status Change (QSC) Event Chart

QSC		
Code	QSC Name	Documentation Requirement
1	Change in legal marital status (marriage, divorce or death).	Divorce decree, death certificate.
2	Change in the number of subscribers dependents (birth, adoption, placements, judgments decrees, court orders, death, dependent no longer meets eligibility.	Adoption papers, any official court ordered document, death certificate.
3	Commencement of employment or other change in employment that triggers eligibility (new hire, LWOP and return after one full calendar month, termination of spouse's employment if you were a covered dependent.	PAR
4	Termination or other change in employment status that causes loss of eligibility (death of subscriber).	Death certificate.
5	Change in residence or work location that triggers a loss of eligibility for subscriber or dependent.	PAR, recertification of dependent(s) eligibility.
6	Significant cost increase or decrease of at least \$20.00 (change in FTE, LWOP, FMLA, Optional life age banding, legislative mandates.	PAR
7	Significant reduction of coverage (with or without loss of coverage).	DSGI approval.
8	Gain or loss of other group coverage (military leave, Medicare, Medicaid, healthy kids (government subsidized insurance).	PAR, copy of Medicare card.
9	Other allowable changes see the QSC matrix.	www.myflorida.com/mybenefits

Revised 09.06.12