

## **Notification of Social Security Number Collection and Usage by Human Resources**

In compliance with Florida Statute 119.071(5), this document serves to notify you of the purpose for the collection and usage of your social security number by the University of West Florida (UWF).

UWF collects and uses your social security number only if specifically authorized by law to do so or it is imperative for the performance of its duties and responsibilities as prescribed by law. Specifically, UWF collects your social security number for the purpose of completing and processing:

- Federal Form I-9, Employment Eligibility Verification (US Department of Homeland Security)
- Federal forms W-4, W-2, 1099 (US Department of Treasury)
- Federal Social Security taxes (FICA)
- Unemployment reports (Florida Department of Revenue)
- Florida retirement contribution reports and forms (Florida Department of Revenue)
- Workers compensation claims (FCCRMS and Department of Labor)
- I.R.C. Section 403b and 457b contribution reports (Internal Revenue Service)
- State sponsored insurance enrollment forms and reports (group health, life, and dental coverage)
- Background Screening (background screening of finalists for the purpose of employment consideration)
- Verification of Employment (prior to 2000)
- Dual Employment and Compensation Request Form (State of Florida)
- State of Florida New Hire Report (Department of Revenue)
- Transcript Request

# FLORIDA RETIREMENT SYSTEM

## Insurance Payroll Authorization Form

AFLAC  
Name of Insurance Provider

Sandy VanBenthuisen  
Insurance Provider Contact Person

(850) 386-3100  
Insurance Provider Telephone No

The payee must authorize new insurance deductions OR the restart of a previously closed deduction. The payee is the person receiving the FRS pension payment.

PAYEE SSN: _____	DEDUCTION CODE NO: _____	003
	Deduction Amount: \$ _____	
PAYEE NAME: _____	DEDUCTION CODE NO: _____	

I hereby authorize the Division of Retirement to deduct my insurance premiums from my monthly Florida Retirement System (FRS) benefit check and make any subsequent premium charges as directed by my insurance provider. I understand that my insurance provider is responsible for notifying me of premium charges as they occur and for any refunds (if applicable). If I am changing insurance companies I will notify the existing company of the cancellation or changes.

Payee's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone No: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Member Retired: \_\_\_\_\_

Insurance Provider use only. Retirement will not use this information.