FLORIDA DEPARTMENT of management SERVICES
We serve those who serve Florida

People First
STATE OF FLORIDA HR

People First Service Center | P.O. box 6830 | Tallahassee, FL 32314 | Tel: 866-663-4735 | Fax: 800-422-3128 | TTY: 866-221-0268

Dear State of Florida Retiree:

Congratulations on your retirement! As a new retiree, you need to be aware of State Group Insurance benefit options available to you. Please read each section carefully.

Section A: Summary of options to continue your current coverage

- **Health**—continue through COBRA for up to 18 months or elect retiree coverage
- **Basic life**—choose either the $2,500 or the $10,000 benefit (optional life is not available)
- **Dental and vision**—continue through COBRA for up to 18 months
- **Other supplemental plans**—contact your insurance company about converting your policy or buying an individual plan
- **Health savings account**—make contributions until enrolled in Medicare, but the state will no longer make contributions
- **Healthcare flexible spending account**—continue through the grace period of the following plan year if you pay the balance and complete the form
- **Dependent care flexible spending account**—ends with your last employee payroll deduction, but you can file claims incurred before your termination date

Section B: Information you should receive in the mail

If you are enrolled in the plan at the time of your retirement, then you should receive two packets by mail:

1. **COBRA rights information packet:**
    - **Health:** Federal law (COBRA) provides that insured employees and their covered dependent(s) may continue employer group health coverage for up to 18 months from the date employment ends or until they become covered under another group plan, whichever is first. Take note of enrollment deadlines in the COBRA package.
    - **Supplemental dental and vision:** The enrollment forms in your COBRA information packet have information about your current state group dental and/or vision plans (if any). You can only continue your dental and/or vision plans under COBRA for up to 18 months.
2. **Retiree enrollment packet (enclosed with this letter)**:
    - **Your personalized benefits statement:** Shows your current insurance coverage with the state. Please carefully review this statement and the important messages.
    - **Dependent Eligibility Certification Form:** You must complete this form if you cover dependents.

Section C: When coverage ends

- **Your employee insurance plans** automatically end the last day of the month following your termination date; for example, if your termination date is June 7, your coverage ends July 31.
    - If your last pay warrant will not cover the remaining premium balance, please submit check, money order or cashier's check to the People First Service Center.
- **Flexible spending accounts** automatically end the day of your termination. Only expenses incurred before your last payroll deduction are eligible for reimbursement. File by April 15.
- **Retiree health and life and COBRA dental and vision** automatically cancel if you send no payment by the last day of the coverage month. *If your coverage cancels for <u>any</u> reason, you will not be allowed to join the State Group Insurance health and/or life plans at a later date as a retiree.*

Section D: To continue your coverage if you currently have insurance benefits

1. **Make smart choices:**
    - **You must make State Group health and life insurance elections through People First within 60 days of your employment termination. If you do not, you will not be able to enroll at a later time as a retiree.**
    - **New Retiree Health and Life Insurance Election Form:** Use to continue or end your coverage. You must enroll within 60 days of your last day of work if you are currently enrolled in health and/or life insurance. You must also send the appropriate premium payments to remain covered.
    - Review your enclosed benefits statement to see your coverage options. Upon retirement, you can change from family to individual coverage, but you can only change plans if you have an appropriate qualifying event, such as moving out of a Health Maintenance Organization (HMO) service area. You're allowed to make any changes to plans you are enrolled in during open enrollment.
    - Contact the insurance carriers directly to convert your supplemental pretax policies or to buy an individual plan. Go to mybenefits.myflorida.com for contact information.
    - Call People First at (866) 663-4735. TTY users call (866) 221-0268 for help.
    - If you and your spouse are both State of Florida retirees with no eligible dependents, think about changing your level of coverage from family to two individual policies. This may be cheaper than the family plan.
    - When your spouse is a State of Florida employee:
        - **Health insurance:** If you are listed as a dependent under your spouse's health plan, do nothing. If your spouse is listed as your dependent, you should both call People First to have your spouse enroll in employee coverage and add you as a dependent. As long as you maintain continuous coverage, you will be able to enroll in retiree health insurance later when your spouse retires or ends state employment.
        - **Life insurance:** Your spouse should enroll in spouse life coverage. This coverage provides a higher benefit at a lower monthly premium than retiree life insurance. As long as you maintain continuous coverage, you will be able to enroll in retiree life insurance later when your spouse retires or ends state employment.

2. **Complete the enclosed New Retiree Health and Life Insurance Election Form to continue coverage as a retiree.** If you call People First and make your choices over the phone, you don't need to complete the form. Mail and fax information are on the form.

3. **Pay the required premium payments for each month of coverage. You have two options to pay:**

   - Have the premium deducted on a post-tax basis each month from your Florida Retirement System (FRS) monthly pension benefit. Your benefit must be sufficient to cover the premium.
     - Call the Division of Retirement at (888) 377-7687 to find out when your monthly pension payment will begin; Tallahassee residents call 488-4742.
     - Then call People First to set up the deduction. You must send payments to People First until your deductions start.

     Call People First if you are a retiree under an optional retirement plan or if your FRS monthly pension payment, including the Health Insurance Subsidy, will not cover your monthly health and life insurance premium deductions. Be sure your mailing address is correct and People First will send you payment coupons.

   - Send a personal check, money order, or cashier's check. Write your People First ID number on your payment, made payable to Division of State Group Insurance and send it to:

     People First Service Center
     PO Box 863477
     Orlando, FL 32886-3477

   You can pay up to six months in advance, but you must pay by the 10th of the month for the next month's coverage; for example, payments for July coverage are due to People First by June 10. If your payment is not received by the 10th, your coverage will be suspended for the next month and you will not be eligible for services until the full payment is received. If your payment is not received by the last day of the month in suspension, your coverage will be cancelled and you will not be able to re-enroll.

4. **Submit your application for the Health Insurance Subsidy.** The health insurance subsidy is an employee benefit of the FRS. (Investment Plan members are eligible for the HIS benefit only if they meet certain requirements.) Retirees who carry qualified health insurance receive a monthly supplemental payment based on years of service. If you are an FRS pension plan retiree, the Division of Retirement Payroll Section will send the HIS-1 form to you in your retiree packet. If you are continuing your State Group Health Insurance as a retiree or if you are a covered dependent under your spouse's State Group Health Insurance plan, complete the HIS-1 form and send or fax it to:

   People First Service Center
   PO Box 6830
   Tallahassee, FL 32314

   Fax: (800) 422-3128

   People First will process this form to certify to FRS that you have State Group Health Insurance coverage and return it to the Division of Retirement. If your retiree health insurance coverage will be through a private vendor or Medicare, follow the instructions for submission on the HIS-1 form.

People First can only certify State Group Health Insurance coverage. Go to dms.myFlorida.com/Retirement to learn more.

5. **If you are enrolled in a healthcare flexible spending account and have money remaining in your FSA, you can continue your benefit under COBRA through the grace period** (March 15 of the following plan year). To avoid forfeiting your money, complete and submit the Continuing Your Healthcare FSA When Employment Ends form, located at mybenefits.myflorida.com in the Forms and Publications section. This form gives you the option of paying the balance of your account on a pretax basis from your sick or annual leave payout, or you can pay by personal check on a post- tax basis. Once you make the election, you will have until March 15 to incur claims and April 15 of the following plan year to file claims.

Section E: Medicare

For specific information about Medicare, including eligibility and coverage, visit www.medicare.gov or call 800-Medicare (800-633-4227). TTY users call (877) 486-2048.

- **General Medicare information:**
  - **Part A** is hospitalization coverage free to eligible Medicare beneficiaries.
  - **Part B** is medical coverage that requires a monthly premium (taken from your Social Security check or paid by personal check).
  - **Part C** (Medicare Advantage Plan) is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits and often includes prescription drug coverage. You must be enrolled in Medicare Part B and you may also be required to send a monthly premium to the insurance company.
  - **Part D** is prescription drug coverage that may require a monthly premium (taken from your Social Security check or paid by personal check).
  - **Medicare Supplement (Medigap) Plans** sold by private companies can help pay some of the health care costs Medicare doesn't cover, like copayments, coinsurance, and deductibles. Some Medigap policies also offer coverage for services that Medicare doesn't cover.

    You may purchase Part B, Part C, Part D or Medigap plans on the private market. If you choose to do so, you should cancel your state group health insurance plan. Remember, once you cancel, you cannot enroll at a later time.

- **You are eligible for Medicare (either at retirement or after retiring) and keeping state group health insurance:**
  - **Coordinating medical coverage:** When Medicare Part A or Part B pays, your state group health insurance pays secondary. When Medicare does not pay, your state group health insurance pays primary for covered benefits and services (just like when you were an employee). Florida Blue administers the nationwide PPO secondary plan; Aetna, AvMed, and UnitedHealthcare administer the HMO secondary plans in their respective service areas.
    - **If you fail to enroll in Medicare Part B**: You will have significant out-of-pocket expenses for Part B eligible services because you will be required to pay the portion (approximately 80 percent) that Medicare would have paid. If you choose to continue your state group health

insurance coverage once you're eligible for Medicare, elect your Medicare Part B coverage. Although Medicare does not require you to purchase Part B, it is in your financial interest to do so. This coverage provision also applies to Medicare-eligible dependents on your plan.

- **Creditable Coverage for Medicare Part D:** For prescription drug coverage, your state group health insurance pays primary for most prescription drugs. Covered medications, copays and the network remain the same as when you were an employee. If you are enrolled in the state group secondary health insurance, do **not** enroll in a separate Medicare Part D plan. The state's prescription drug coverage is as good as or better than Medicare Part D and is currently approved by Medicare as creditable coverage.
- **Medicare (Retiree) Advantage Plan:** Capital Health Plan and Florida Health Care Plans offer this plan to state retirees in their respective HMO service areas. To become a member, you must be enrolled in Medicare Parts A and B, complete the HMO's application and receive approval before your retiree health coverage becomes effective. Medicare Advantage Plans do not allow retroactive enrollment and claims can only be paid if you are approved for the plan. Medical and prescription drug coverage are included.
- **Enrolling in Medicare:** Once you are eligible for Medicare Part A and Part B due to age (65) or disability and no longer working, you should contact the Social Security Administration (SSA) about your Medicare benefits. Enrollment in Medicare is time sensitive and you may be subject to substantial financial penalties if you fail to meet federal deadlines. Contact your local SSA office three months before your 65th birthday: call 800-MEDICARE (800-633-4227), or visit www.Medicare.gov for more information. TTY users call (877) 486-2048.
- **Enrolling in state group Medicare secondary coverage or a Medicare advantage plan:** the state offers three Medicare coverage tiers when you or a dependent is Medicare eligible:
  - Medicare I: a single policy for you
  - Medicare II: a family policy for you and your eligible dependents and at least one is eligible for Medicare
  - Medicare III: a family policy for you and one dependent and you are both Medicare eligible

- **You do not meet Medicare eligibility requirements:** If you have not worked enough quarters to be eligible for Medicare at age 65, call the Social Security Administration and request an ineligibility letter. Please send a copy of that letter immediately to People First to ensure your health insurance coverage continues without interruption. Mail or fax copies of Medicare documentation with your People First ID number to:

  People First Service Center
  PO Box 6830
  Tallahassee, FL 32314

  Fax: (800) 422-3128

Section F: Important reminders

- **Addresses:** Keep your mailing and notification email address up-to-date in People First to receive open enrollment materials and important notices timely.
- **Medicare card:** For proper enrollment and claims processing, send copies (yours and your dependent's) of Medicare ID cards to People First as soon as you receive them from the SSA.
- **Use the People First website:** To see your benefits information in People First, log in and go to

Health & Insurance > My Benefits. To see your monthly premium payments go to Health & Insurance > Benefit Premium History and select the month you want to see.

- **Authorization to Disclose Protected Health Information (PHI):** If you want to give People First or your insurance company permission to disclose PHI to an individual, you must submit an authorization form to each party. For example, if you want your spouse to be able to call People First to discuss your monthly premiums, you must send People First an authorization form (enclosed); otherwise, representatives will be unable to talk to your spouse per Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines. Call People First or your insurance company for more information.
- **For more information, including HMO service areas and annual premium changes:** Visit mybenefits.myflorida.com.
- **Waiver of premium for total disability:** the life insurance company may waive premiums if you become disabled while still actively employed. Call the life insurance company at (888) 826-2756 for more information on the Waiver of Premium provisions.

If you have questions about your insurance benefits upon retirement, call us at (866) 663-4735 or TTY (866) 221-0268. We are open Monday through Friday, from 8 a.m. to 6 p.m. Eastern time.

Sincerely,
People First Service Center

SGI-12
11/15

Dependent Eligibility Certification Form

If you cover dependents under *any* State Group Insurance plan, you **must** certify their eligibility by completing this form 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 to whom you are legally married. The term "spouse" does not include common law marriage partners, registered domestic partners or other partners of relationships not defined as marriage under the law of the state or foreign county in which they were entered.
- 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 year 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**_____

SGI-06
11/15

New Retiree Health and Life Insurance Election Form

People First
STATE OF FLORIDA HR

Learn about plans, use the cost estimators and more at mybenefits.myflorida.com. 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* 0

Date of Birth (MMDDYYYY)*

Gender* M F

Area Code – Primary Phone

Area Code – Alternate Phone

First Name*

Last Name*

Suffix

Home Address Line 1*

Home Address Line 2

Home County*

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

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 no longer live in my HMO service area. **Change** my plan to: Plan Name _____.

☐ 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 Medicare[1], 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.

[1]State 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

People First ID*

0							

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 mybenefits.myflorida.com for dependent eligibility requirements.
1 - Spouse 2 - Child 3 - Legal Guardianship 4 - Grandchild 5 - Legally Adopted Child 6 - Foster Child 7 - Stepchild 9 - Over-age Dependent

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

SECTON 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 $19.33.

☐ I elect $2,500 of basic life insurance coverage with a monthly premium of $4.83.

☐ 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.

.

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.

SGI-01
11/15

Authorization to Use and/or Disclose Personal Health Information

The People First Service Center, on behalf of State Group Insurance Plan ("Plan"), cannot use or disclose your health information (or the health information of your children or other people on whose behalf you can act) for certain purposes without your authorization. This form is intended to meet the authorization requirement.

- **You must respond to each section, sign and date this form for the authorization to be valid.**

- To authorize the use and/or disclosure of any records or documents the Plan may have that were taken by a mental health professional, including a psychiatrist or a psychologist, during a counseling session, you must complete a form for the counseling session records or documents and a separate form for other health information.

- Under HIPAA, you have the right to authorize the release of all information or to describe and limit the information to be released.

Section A: Health Information to be Used or Disclosed.

- Describe in a specific and meaningful way the information to be disclosed. Example descriptions include medical records relating to your appendectomy, laboratory results, and medical records from [date] to [date], or the results of an MRI performed in [month] [year].

Section B: Purpose(s) for which Information will be Used or Disclosed.

- Describe each purpose for which the information will be used or released. If you initiate the authorization and do not wish to provide a statement of purposes, you may select "at my request."

Section C: Expiration.

- Specify when this authorization will expire. For example, you may state a specific date, a specific period of time following the date you signed this Authorization Form, or the resolution of the dispute for which you've requested assistance.

Signature Line.

- If you are authorizing the release of someone else's health information, then you must describe your authority to act for the individual.

- Complete and sign this form and send or fax it to:

People First Service Center
PO Box 6830
Tallahassee, FL 32314

Fax to (800) 422-3128

- For help, call (866) 663-4735 or TTY (866) 221-0268, Monday through Friday, from 8 a.m. to 6 p.m. Eastern time.

SGI-01
11/15

Authorization to Use and/or Disclose Personal Health Information

People First
STATE OF FLORIDA HR

I. Individual (Name and information of person whose personal health information is being disclosed.)

People First ID Number:

First Name:

Last Name:

Complete Mailing Address: _____

Date of Birth: ____/____/____ Area Code & Telephone Number: (____)_____

II. Authorization and Purpose:

I hereby authorize People First Service Center, on behalf of State Group Insurance Plan ("Plan"), to disclose the information as described in Sections A-C below. The health information is to be disclosed to or delivered to (as requested):

_____
Name

_____
Complete Mailing Address

_____
Street Address

(____)_____
Area Code & Telephone Number

Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one of the following boxes.

- ☐ All of my past, present or future health claims and/or medical records.
- ☐ All of my health information relating to Claim Number _____.
- ☐ Information regarding prescription drug coverage.
- ☐ My health information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).
- ☐ My health information regarding treatment for alcohol and/or substance abuse.
- ☐ My health information regarding behavioral health services, counseling notes or psychiatric or psychological care provided by _____(Name of individual provider or facility).
- ☐ Other (please specify). _____

Section B: Purpose(s) for Which Information will be Used or Disclosed.

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

- ☐ To facilitate the resolution of a claim dispute.
- ☐ As part of my application for leave under the Family and Medical Leave Act (FMLA) or state family leave laws.
- ☐ For a disability coverage determination.
- ☐ At my request.
- ☐ Other (please specify). _____

Authorization to Use and/or Disclose Personal Health Information

Section C: Expiration of Authorization.

Specify when the Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

- ☐ On the following date: _____
- ☐ Upon the passage of the following amount of time: _____
- ☐ Upon disenrollment from my State-sponsored health plan.
- ☐ Upon my return from FMLA leave.
- ☐ Other (please specify). _____

III. Your rights:

- You can revoke this Authorization at any time by submitting a written revocation to the address below.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information has been disclosed pursuant to this Authorization, neither the Plan nor People First has control over the use and distribution by recipient.
- The Plan may not condition Treatment, Payment, Enrollment or Eligibility for benefits on whether you sign the Authorization.
- If this Authorization is requested so the Plan can make an eligibility or enrollment determination, then the Individual may be ineligible for enrollment or benefits if you fail to sign this form. This applies to persons not yet enrolled in the Plan.
- We will provide you a copy of your signed Authorization Form upon request.

IV. Your Authorization:

This form must be signed by the Individual, parent of minor child or the personal representative. The personal representative includes persons with power of attorney, legal guardian, executor or administrator of an estate.

_____ _____

Signature of Individual or Personal Representative Date

If you are signing as a personal representative, attach a copy of your legal documents.

_____ _____

Personal Representative's Name (Print) Relationship to Individual

_____ _____ _____ _____

Personal Representative's Address City State Zip

(____)_____

Personal Representative's Telephone Number

Keep a copy for your records and send the completed form to the following address or fax number:

People First Service Center
PO Box 6830
Tallahassee, FL 32314

Fax to (800) 422-3128