

**Please read this page carefully. Signing the election form means you have read and agree to the following and understand the options you chose on the election form:**

- Review your current benefits and the available plans and options, and then select the benefit options most suited to your personal needs.
- Send required documentation to the People First Service Center (address below) when you add eligible dependents or drop ineligible dependents from your plans. You must provide documentation or risk losing coverage.
- You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received while your dependent was incorrectly listed as eligible.
- If you are dropping all of your dependents, you must change your coverage to individual.
- If you cancel your health insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event.
- To enroll in an HMO, you must work or live in the HMO service area.
- You should receive plan information and I.D. cards in a timely manner from the insurance company. If you do not, call the insurance company.
- You do not need to complete this health insurance election form to enroll in the spouse program. Instead, you and your spouse must complete the Spouse Program Election Form and submit the required documentation to the People First Service Center.
- Your elections will remain in effect for the remainder of the calendar year unless you experience a qualifying status change event, as defined by the Internal Revenue Code and/or the Florida Administrative Code.
- Your effective date of coverage will be the first of the month following receipt of this form and a full month's premium.
- Pretax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. If you do not wish to have your premiums deducted on a pretax basis, you must complete a Pretax Premium Waiver Form.
- Please mail or fax your completed and signed election form and Qualifying Status Change form, if applicable, to the People First Service Center:

People First Service Center  
PO Box 6830  
Tallahassee, FL 32314  
FAX: (904) 828-6092

- For help, call (866) 663-4735 or TTY (866) 221-0268, Monday through Friday, from 8:30 a.m. to 5:30 p.m. Eastern Time.
- Make elections online at <https://PeopleFirst.MyFlorida.com> and learn more about plans, use the cost estimator and find providers and insurance companies at [MyFlorida.com/MyBenefits](https://MyFlorida.com/MyBenefits).

Please note: Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.

Check Appropriate Box:

- New Hire   
  Open Enrollment   
  Qualifying Status Change Event  
**Note:** If checked, you must also complete and submit a Qualifying Status Change Event form.

**Employee Information - All Fields Required:**

People First ID:

First Name:

Last Name:

Complete Mailing Address: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      Male: \_\_\_\_\_      Female: \_\_\_\_\_

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

**PART 1: STATE HEALTH INSURANCE - Please check (✓) your choice.**

- WAIVE** my Health Insurance       **CHANGE** my Health Insurance  
 **ENROLL** me in Health Insurance       **CANCEL** my Health Insurance

**If you checked ENROLL or CHANGE, choose a plan type:**

The PPO plan has worldwide coverage; the HMO plans require you to live or work in the county they serve.

- Standard Preferred Provider Organization (PPO) Plan  
 Health Investor Health Plan PPO Plan (high deductible\* health plan)  
 Standard Health Maintenance Organization (HMO) Plan..... Plan Name: \_\_\_\_\_  
 Health Investor Health Plan HMO Plan (high deductible\* health plan)..... Plan Name: \_\_\_\_\_

**Indicate your Coverage Level:**

- Individual     Family

**Coverage Effective Date:**

(must be the 1st day of the month - refer to information page)

\* annual deductible amount is \$1250/Individual and \$2500/Family

**PART 2: ADD / DROP DEPENDENTS - Please Print (Attach additional page if necessary.)**

Check the appropriate column to **ADD** eligible dependents not currently covered and/or to **DROP** ineligible dependents.

To complete the Relation column, use the number that describes your dependent(s).

Spouse -1, Child -2, Legal Guardianship -3, Grandchild -4, Legally Adopted Child -5, Foster Child -6, Step Child -7, Unborn Child -8, Overage Dependent -9

Add	Drop	Name (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yyyy)	Male	Female	Relation
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

**PART 3: EMPLOYEE CERTIFICATION**

I have read and agree to the conditions listed in the Health Insurance Election Information page. I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next annual open enrollment period or if I have a qualifying status change event as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand I must request such changes within 31 calendar days of the qualifying event.

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

Send form to People First Service Center • PO Box 6830 • Tallahassee, FL 32314  
or Fax to (904) 828-6092