SPOUSE PROGRAM
2008 ENROLLMENT FORM
(Please Print)

Married couples who both work for the State are eligible to participate in the Spouse Program. Under this benefit, the State contribution for two full-time employees satisfies the required premiums and no payroll deductions will be withheld from either spouse's salary warrant.

Select your Enrollment Type: ☐ New Hire ☐ Open Enrollment ☐ Qualifying Status Change
Note: If checked, you must also complete and submit a Qualifying Status Change form.

EMPLOYEE A (primary) INFORMATION - Please Print

SSN: _____ **EEID:** 0 0 _____

Name: _____ **Agency Name:** _____

Complete Mailing Address: _____

Work Phone: ( ) _____ **Home Phone:** ( ) _____ **Sex (M/F):** ____ **Birth Date:** / /

Home County: _____ **Work County:** _____

Select Plan Type: ☐ **State PPO Standard Plan** ☐ **State PPO HIHP Plan**
☐ **HMO Standard Plan** ☐ **HMO HIHP Plan** **HMO Plan Name** _____

EMPLOYEE B (secondary) INFORMATION - Please Print

SSN: _____ **EEID:** 0 0 _____

Name: _____ **Agency Name:** _____

Complete Mailing Address: _____

Home County: _____ **Work County:** _____

ADD / DROP DEPENDENTS - Please Print (Attach additional page if necessary.)

You may: **ADD** eligible dependents not currently covered and/or **DROP** ineligible dependents.

***RELATIONSHIP:** Put the number that is next to the relationship, an example is Spouse-1 then you would put the 1 in the "Rel." column below.
Spouse - 1, Child - 2, Legal Guardianship - 3, Grandchild - 4, Legally Adopted Child - 5, Foster Child - 6, Step Child -7, Unborn Child - 8

NOTE: Employee B and any children enrolled will be covered under the PRIMARY employee (employee A) as indicated above.

Add	Drop	Name (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yyyy)	Sex M/F	*Rel.
☐	☐			/ /		
☐	☐			/ /		
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EMPLOYEE CERTIFICATION

I agree to notify the People First Service Center within thirty-one (31) days following my loss of eligibility for the Spouse Program. Loss of eligibility will occur when I divorce or if my spouse or I terminate employment, or otherwise becomes ineligible. I understand that failure to notify the Service Center within thirty-one (31) days following a loss of eligibility will result in cancellation of the Spouse Program and enrollment in family coverage of myself and any covered dependents, as appropriate ***(refer to conditions on the reverse side of this form)***. I also understand that I will be required to pay any expenses, including unpaid employee premium contributions and claims paid for myself or my covered dependents, during any period in which I am ineligible for coverage.

Employee A Signature: _____ **Date:** _____

Employee B Signature: _____ **Date:** _____

SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

COMPLETION OF THIS FORM MEANS THAT YOU HAVE READ AND AGREE TO COMPLY WITH THE FOLLOWING:

- Eligible Plan Participants must be active State employees.
- Under this benefit, health insurance is provided at no cost to the enrolled employees if both are full-time. If a part-time employee, the cost will be pro-rated.
- Review your current benefits and the available plans and options.
- Select the benefit options **most suited** to your personal needs.

ENROLLMENT PROCESS:

- A Spouse Program Enrollment Form must be requested from the People First Service Center:
  - website: https://peoplefirst.myflorida.com
  - toll-free: 1-866-ONE-HRFL (1-866-663-4735)
- Both spouses must complete, sign and date the Spouse Program Enrollment form.
  - One Spouse must be designated “primary” and the other “secondary”.
  - The Secondary Spouse and eligible Dependents will be covered under the Primary Spouse’s coverage.
- Eligible dependents must be listed in the Dependent Section of the form.
- Both spouses must enroll in the same health plan.
- Please **MAIL** or **FAX** your completed and signed enrollment form and Qualifying Status Change form, if applicable, to the People First Service Center at the address or fax number noted below.

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

SPOUSE PROGRAM PARTICIPATION TERMINATION:

- Both spouses must contact the Service Center within thirty-one (31) days of becoming ineligible for the Spouse Program for one of the following reasons:
  - One or both terminate employment
  - In the event of divorce or death
  - One or both retire
- If notification of ineligibility is not received within 31 days, the Spouse Program coverage will be stopped and remaining “eligible” spouse will be enrolled in family coverage covering the now “ineligible” spouse and dependent children, if applicable.

  NOTE: In the event of divorce, if there are dependent children also being covered, both spouses will be enrolled in family coverage. Otherwise they will each be enrolled in individual coverage.