

Sheriff



Larry Ashley, Okaloosa County Sheriff

1250 Eglin Parkway • Shalimar, Florida 32579-1234
Phone: (850) 651-7410 • Email: sheriff@sheriff-okaloosa.org

April 14, 2011
OCSO11CAD053901

Public Records Request: Retiree Insurance Benefits

From: Michael Barnes

On April 14, 2011 the agency received the following request for information. **The response is in bold.**

Sheriff Ashley: After the 04/12/2011 BCC Budget Workshop Meeting, I verbally expressed my concern about OCSO Post-Employment Benefits as reported in Note 14 of the recent Comprehensive Annual Financial Report, which covered fiscal year ending September 30, 2010. As we start the budget process, it is alarming in these challenging economic times that selected OCSO retirees are provided taxpayers-funded healthcare insurance.

In our conversation, you stated that the retirees participating for OCSO post-employment healthcare insurance benefit were being provided because it was a contract between previous Sheriffs and each recipient. You also stated that the eligibility for a retiree to participate in the post-employment benefit was the individual must have served 20 years with OCSO. The CAFR reports that the taxpayers are currently paying almost \$900,000 annually for 21 retirees and beneficiaries to receive post-employment healthcare insurance benefits. It appears that past years OCSO expenses were over \$1.4 million annually.

To understand the total picture of this benefit and the financial impact on the taxpayer's budget, please provide the following:

- a. The past written local policies that formally established the eligibility requirements or criteria that allowed all retired OCSO employees to participate in the post-employment healthcare insurance benefit.
There has been no written policy on this benefit. The practice utilized for participation was twenty years of active service with the agency. Sheriff Ashley suspended this program to new participants when he took office and the program is under review.
- b. The Name of the Current Recipients and the actual date each recipient started receiving the post-employment healthcare insurance benefit.
Current recipients and documents indicating enrolment date are indicated on the attached documents. Names and other identifying information has been redacted based on exemptions regarding retiree information in FSS 119.07(1)
- c. A copy of the executed contract between the Sheriff and each recipient receiving the post-employment healthcare insurance benefit.
No written contracts were found.
- d. A list of all OCSO retirees who are not participating, were not offered, or included in the post-employment insurance benefit.
There are no documents in regards to this request item.



The Okaloosa County Sheriff's Office is accredited by the
Commission for Florida Law Enforcement Accreditation.

"The Okaloosa County Sheriff's Office provides equal access and equal opportunity in employment and services and does not discriminate"

Retirees Health Insurance paid by SO	Date of Birth	Premium 2011	Premium 2012	Premium 2013	Premium 2014	Premium 2015	Premium 2016	Premium 2017	Premium 2018	Premium 2019	Premium 2020	Premium 2021	
		3,617	-	-	-	-	-	-	-	-	-	-	until September 1, 2011
		4,035	-	-	-	-	-	-	-	-	-	-	until October 1, 2011
		5,355	5,355	5,355	1,785	-	-	-	-	-	-	-	until April 1, 2014
		5,095	5,095	5,095	2,548	-	-	-	-	-	-	-	until July 1, 2014
		5,010	5,010	5,010	5,010	2,923	-	-	-	-	-	-	until August 1, 2015
		4,800	4,800	4,800	4,800	4,800	4,800	-	-	-	-	-	until January 1, 2017
		4,879	4,879	4,879	4,879	4,879	4,879	4,879	2,846	-	-	-	until August 1, 2018
		6,600	6,600	6,600	6,600	6,600	6,600	6,600	4,950	-	-	-	until October 1, 2018
		5,095	5,095	5,095	5,095	5,095	5,095	5,095	5,095	5,095	5,095	849	until March 1, 2021
		5,100	5,100	5,100	5,100	5,100	5,100	5,100	5,100	5,100	5,100	3,400	until September 1, 2021
		5,385	5,385	5,385	5,385	5,385	5,385	5,385	5,385	5,385	5,385	5,385	until January 1, 2034 ?
FORGIONE children		13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	until the children reach 26
Annual Premium		\$68,171	\$60,520	\$60,520	\$54,402	\$47,982	\$45,059	\$40,259	\$36,576	\$28,780	\$28,780	\$22,834	



HRH

HRH TPA Services
Administered by: Hunt Insurance Group, Inc.
P. O. Box 12969
Tallahassee, FL 32317
800-763-4868 FAX: 850-385-2124

Change Request Form

Subscriber Information			
Employee Last Name	First	Middle Initial	Group #:
[REDACTED]	[REDACTED]		OKA
Social Security Number	Employer Name	Job Location/Department	
[REDACTED]	OKALOOSA COUNTY SHERIFF'S OFFICE		

<input type="checkbox"/> Termination of Coverage			
Last Day Worked:	Date Coverage Terminated:	Reason for Termination:	Date Returned:
Effective Date of Change:	Eligible for COBRA: <input type="checkbox"/> Yes <input type="checkbox"/> No		

<input type="checkbox"/> COBRA Election of Coverage	Coverage Elected:
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<input checked="" type="checkbox"/> Retirement			
Last Day Worked:	Date Coverage Continued:	<input type="checkbox"/> Single <input checked="" type="checkbox"/> Other <input type="checkbox"/> Family	Date of Termination:
1/31/2008	2/1/2008	<i>Retiree + Spouse</i>	

<input type="checkbox"/> Changes			
Change Employee's Name To:	Change Job Location To:	Plan Change:	Other:
Reason:	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other:

<input type="checkbox"/> Address Change	
Change Employee's Address To:	
City, State, Zip Code:	

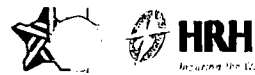
<input type="checkbox"/> Life Insurance Change		
Change Employee Class To:	Change Amount of Life Insurance To:	Effective Date:
Change Beneficiary To:	Relationship:	Effective Date:

<input type="checkbox"/> Dependent Change		
<input type="checkbox"/> Add Due To:	<input type="checkbox"/> Delete Due To:	DATE OF OCCURRENCE:
<input type="checkbox"/> Birth	<input type="checkbox"/> Divorce	Other Group Coverage:
<input type="checkbox"/> Adoption	<input type="checkbox"/> Death	Do you or your dependents have other insurance coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Marriage	<input type="checkbox"/> Retirement	If yes, who is covered and with what company?
<input type="checkbox"/> Student Verification	<input type="checkbox"/> Loss of Eligibility	
<input type="checkbox"/> Other	<input type="checkbox"/> Other	

First & Last Name	Social Security Number	Date of Birth	Relationship	Sex
	/ /			
	/ /			
	/ /			
	/ /			

*If new dependent has other coverage(s), please fill out a prior coverage affidavit form.

Anne P Smith *1-23-08* *Human Resource*



HRH TPA Services
 Administered by: Hunt Insurance Group, Inc.
 P. O. Box 12969
 Tallahassee, FL 32317
 800-763-4868 FAX: 850-385-2124

Change Request Form

Subscriber Information			
Employee Last Name [REDACTED]	First [REDACTED]	Middle Initial	Group #: OKA
Social Security Number [REDACTED]	Employer Name OKALOOSA COUNTY SHERIFF'S OFFICE	Job Location/Department	

<input type="checkbox"/> Termination of Coverage			
Last Day Worked:	Date Coverage Terminated:	Reason for Termination:	Date Returned:
Effective Date of Change:	Eligible for COBRA: <input type="checkbox"/> Yes <input type="checkbox"/> No		

COBRA Election of Coverage Coverage Elected:

<input checked="" type="checkbox"/> Retirement			
Last Day Worked: 6/27/2008	Date Coverage Continued: 6/28/2008	<input type="checkbox"/> Single <input checked="" type="checkbox"/> Other <input type="checkbox"/> Family <i>RETIREE + SPOUSE</i>	Date of Termination:

<input type="checkbox"/> Changes			
Change Employee's Name To:	Change Job Location To:	Plan Change:	Other:
Reason: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other:			

<input type="checkbox"/> Address Change	
Change Employee's Address To:	
City, State, Zip Code:	

<input type="checkbox"/> Life Insurance Change		
Change Employee Class To:	Change Amount of Life Insurance To:	Effective Date:
Change Beneficiary To:	Relationship:	Effective Date:

<input type="checkbox"/> Dependent Change		
<input type="checkbox"/> Add Due To: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Student Verification <input type="checkbox"/> Other	<input type="checkbox"/> Delete Due To: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Retirement <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Other	DATE OF OCCURRENCE: Other Group Coverage: Do you or your dependents have other insurance coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who is covered and with what company?

First & Last Name	Social Security Number	Date of Birth	Relationship	Sex
	/ /			
	/ /			
	/ /			
	/ /			

*If new dependent has other coverage(s), please fill out a prior coverage affidavit form.

Annie P. Smith *6/4/08*



BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Health & Financial Change Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name: Ocala County Sheriff's Office Group #: 65196 Division #: _____ Package #: _____
 Employee Name: (Last, First Name, M.I.) _____ Social Security #: _____ Effective Date of Coverage: _____ Date of Event: 1/31/2009

Section B: Coverage Change Information

Reason for Change: Adoption Death Leave of Absence/Layoff Moved from Service Area
 Open Enrollment Section 125 Marriage Birth
 Over-Aged Dependent Terminate Employment Return of Alternate Insurance Loss of Coverage
 Divorce Location _____ Employee # _____ Other _____
 Change Request Type: New Name: _____ New Physician Name/ID: _____
 New Address: _____ New Phone #: _____

Plan Coverage Type Requested: Add Health Delete Health Change Plan: Indicate Plan # _____
 Coverage Level Requested: Employee *Employee & Spouse *Employee & One Dependent *Employee & Children Family
 *When available

Dependent Change Complete Section D FSA Change Complete Section C Other Change: _____

Section C: Flexible Spending Account (FSA) Changes

Add Health Care FSA Add Dependent Care FSA
 I wish to Terminate and/or Stop Pay my FSA Health Care Program with a Final Payroll Deduction Date of: _____
 I wish to Change the Annualized Amount of my Health Care FSA to: \$ _____
 I wish to Terminate and/or Stop Pay my FSA Dependent Care Program with a Final Payroll Deduction Date of: _____
 I wish to Change the Annualized Amount of my Dependent Care FSA to: \$ _____
 Payroll Deduction Amount \$: _____ Effective Date: _____ Payroll Deduction Amount \$: _____ Effective Date: _____
 I wish to change my Payroll Frequency to: Weekly Bi-weekly Monthly Bi-monthly Other

Section D: Dependent Information Attach separate sheet, if additional space is needed, with dependent information, sign & date.

(A) Add (D) Delete (C) Change	Last Name: If different than employee First Name, M.I.	Social Security Number:	Birth Date:	Relation to You			Sex (M or F)	Check if Disabled	Physician Name/ID HMO only	Existing Patient (Y/N)	Dependent			Ethnicity optional Circle all that apply.					
				Spouse (S)	Child (C)	Other (O)*					You Support	Lives With You	is a Student	A) Asian/Pacific Islander	B) Black/African American	C) Caribbean Islander	H) Hispanic	N) Native American	W) White
D	[Redacted]	[Redacted]	[Redacted]	X				<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W
								<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W
								<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W
								<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W

* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

Section E: Other Health Insurance Information This section must be completed for claims processing and Prior Coverage Information

In addition to this policy, do you or your dependents have any other insurance coverage (including BCBSF plans) that will be in effect after this coverage begins? Yes No BCBSF Contract # _____ Medicare # _____ Pharmacy/Medicare D # _____
 Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage.
 Prior Health Carrier Name: _____ Contract #: _____ Effective Date: _____
 Prior Employee Hire Date: _____ Cancel Date: _____ List names of all family members that were covered, including yourself: _____

Section F: Change Authorization and/or FSA Participation

I have read, understand, and agree to the Change Authorization and/or Participation in the FSA Program Terms on the back of this form. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
 Employee Signature: _____ Date: _____
 Employer Signature: _____ Date: _____

Annex P Smith 1-14-09



HRH TPA Services
 Administered by: Hunt Insurance Group, Inc.
 P. O. Box 12969
 Tallahassee, FL 32317
 800-763-4868 FAX: 850-385-2124

Change Request Form

Subscriber Information			
Employee Last Name [REDACTED]	First [REDACTED]	Middle Initial	Group #: OKA
Social Security Number [REDACTED]	Employer Name OKALOOSA COUNTY SHERIFF'S OFFICE	Job Location/Department	

<input type="checkbox"/> Termination of Coverage			
Last Day Worked:	Date Coverage Terminated:	Reason for Termination:	Date Returned:
Effective Date of Change:	Eligible for COBRA: <input type="checkbox"/> Yes <input type="checkbox"/> No		

<input type="checkbox"/> COBRA Election of Coverage	Coverage Elected:
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<input checked="" type="checkbox"/> Retirement			
Last Day Worked: 9/19/2008	Date Coverage Continued: 9/20/2008	<input checked="" type="checkbox"/> Single <input type="checkbox"/> Other _____ <input type="checkbox"/> Family _____	Date of Termination:

<input type="checkbox"/> Changes			
Change Employee's Name To:	Change Job Location To:	Plan Change:	Other:
Reason: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other:			

<input type="checkbox"/> Address Change	
Change Employee's Address To:	
City, State, Zip Code:	

<input type="checkbox"/> Life Insurance Change		
Change Employee Class To:	Change Amount of Life Insurance To:	Effective Date:
Change Beneficiary To:	Relationship:	Effective Date:

<input type="checkbox"/> Dependent Change		
<input type="checkbox"/> Add Due To: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Student Verification <input type="checkbox"/> Other	<input type="checkbox"/> Delete Due To: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Retirement <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Other	DATE OF OCCURRENCE: Other Group Coverage: Do you or your dependents have other insurance coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who is covered and with what company?

First & Last Name	Social Security Number	Date of Birth	Relationship	Sex
	/ /			
	/ /			
	/ /			
	/ /			

*If new dependent has other coverage(s), please fill out a prior coverage affidavit form.

Ann P. Smith

7/7/08



HRH TPA Services
 Administered by: Hunt Insurance Group, Inc.
 P. O. Box 12969
 Tallahassee, FL 32317
 800-763-4868 FAX: 850-385-2124

Change Request Form

Subscriber Information			
Employee Last Name	First	Middle Initial	Group #: OKA
Social Security Number	Employer Name OKALOOSA COUNTY SHERIFF'S OFFICE	Job Location/Department	

<input type="checkbox"/> Termination of Coverage			
Last Day Worked:	Date Coverage Terminated:	Reason for Termination:	Date Returned:
Effective Date of Change:	Eligible for COBRA: <input type="checkbox"/> Yes <input type="checkbox"/> No		

<input type="checkbox"/> COBRA Election of Coverage	Coverage Elected:
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<input checked="" type="checkbox"/> Retirement			
Last Day Worked: 9/30/2007	Date Coverage Continued: 10/1/2007	<input checked="" type="checkbox"/> Single <input type="checkbox"/> Other <input type="checkbox"/> Family <i>Please change status to Retiree</i>	Date of Termination:

<input type="checkbox"/> Changes			
Change Employee's Name To:	Change Job Location To:	Plan Change:	Other:
Reason: <input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other:	

<input type="checkbox"/> Address Change	
Change Employee's Address To:	
City, State, Zip Code:	

<input type="checkbox"/> Life Insurance Change		
Change Employee Class To:	Change Amount of Life Insurance To:	Effective Date:
Change Beneficiary To:	Relationship:	Effective Date:

<input type="checkbox"/> Dependent Change		
<input type="checkbox"/> Add Due To:	<input type="checkbox"/> Delete Due To:	DATE OF OCCURRENCE:
<input type="checkbox"/> Birth	<input type="checkbox"/> Divorce	Other Group Coverage:
<input type="checkbox"/> Adoption	<input type="checkbox"/> Death	Do you or your dependents have other insurance coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Marriage	<input type="checkbox"/> Retirement	If yes, who is covered and with what company?
<input type="checkbox"/> Student Verification	<input type="checkbox"/> Loss of Eligibility	
<input type="checkbox"/> Other	<input type="checkbox"/> Other	

First & Last Name	Social Security Number	Date of Birth	Relationship	Sex
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			

*If new dependent has other coverage(s), please fill out a prior coverage affidavit form.

Please change status to Retiree. Thank you! Annie Smith 12/3/07

Amanda Cep



HRH

HRH TIA Services
Administered by: Hunt Insurance Group, Inc.
P. O. Box 12969
Tallahassee, FL 32317
800-763-4868 FAX: 850-385-2124

Change Request Form

Subscriber Information		
Employee Last Name [REDACTED]	First [REDACTED]	Middle Initial
Social Security Number [REDACTED]	Employer Name OKALOOSA COUNTY SHERIFF'S OFFICE	Group #: OKA
		Job Location/Department

<input type="checkbox"/> Termination of Coverage			
Last Day Worked: / /	Date Coverage Terminated:	Reason for Termination:	Date Returned:
Effective Date of Change:	Eligible for COBRA:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> COBRA Election of Coverage	Coverage Elected:
--	-------------------

<input checked="" type="checkbox"/> Retirement			
Last Day Worked: 12/31/2006	Date Coverage Continued: 1/1/2007	<input type="checkbox"/> Single <input type="checkbox"/> Family <input checked="" type="checkbox"/> Other <i>Retiree + Spouse</i>	Date of Termination:

<input type="checkbox"/> Changes			
Change Employee's Name To:	Change Job Location To:	Plan Change:	Other:
Reason: <input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other:	

<input type="checkbox"/> Address Change	
Change Employee's Address To:	
City, State, Zip Code:	

<input type="checkbox"/> Life Insurance Change		
Change Employee Class To:	Change Amount of Life Insurance To:	Effective Date:
Change Beneficiary To:	Relationship:	Effective Date:

<input type="checkbox"/> Dependent Change		
<input type="checkbox"/> Add Due To: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Student Verification <input type="checkbox"/> Other	<input type="checkbox"/> Delete Due To: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Retirement <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Other	DATE OF OCCURRENCE: Other Group Coverage: Do you or your dependents have other insurance coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who is covered and with what company?

First & Last Name	Social Security Number	Date of Birth	Relationship	Sex
	/ /			
	/ /			
	/ /			
	/ /			

*If new dependent has other coverage(s), please fill out a prior coverage affidavit form.

Annie P. Smith *H.R. Dept* *12/18/06*
1-5-07



HRH TPA Services
 Administered by: Hunt Insurance Group, Inc.
 P. O. Box 12969
 Tallahassee, FL 32317
 800-763-4868 FAX: 850-385-2124

Change Request Form

Subscriber Information			
Employee Last Name	First	Middle Initial	Group #:
[REDACTED]	[REDACTED]		OKA
Social Security Number	Employer Name	Job Location/Department	
[REDACTED]	OKALOOSA COUNTY SHERIFF'S OFFICE		

<input type="checkbox"/> Termination of Coverage			
Last Day Worked:	Date Coverage Terminated:	Reason for Termination:	Date Returned:
Effective Date of Change:	Eligible for COBRA: <input type="checkbox"/> Yes <input type="checkbox"/> No		

<input type="checkbox"/> COBRA Election of Coverage	Coverage Elected:
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<input checked="" type="checkbox"/> Retirement			
Last Day Worked:	Date Coverage Continued:	<input checked="" type="checkbox"/> Single <input type="checkbox"/> Other _____ <input type="checkbox"/> Family _____	Date of Termination:
6/30/2008	7/1/2008		

<input type="checkbox"/> Changes			
Change Employee's Name To:	Change Job Location To:	Plan Change:	Other:
Reason: <input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other:	

<input type="checkbox"/> Address Change	
Change Employee's Address To:	
City, State, Zip Code:	

<input type="checkbox"/> Life Insurance Change		
Change Employee Class To:	Change Amount of Life Insurance To:	Effective Date:
Change Beneficiary To:	Relationship:	Effective Date:

<input type="checkbox"/> Dependent Change		
<input type="checkbox"/> Add Due To:	<input type="checkbox"/> Delete Due To:	DATE OF OCCURRENCE:
<input type="checkbox"/> Birth	<input type="checkbox"/> Divorce	Other Group Coverage:
<input type="checkbox"/> Adoption	<input type="checkbox"/> Death	Do you or your dependents have other insurance coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Marriage	<input type="checkbox"/> Retirement	If yes, who is covered and with what company?
<input type="checkbox"/> Student Verification	<input type="checkbox"/> Loss of Eligibility	
<input type="checkbox"/> Other	<input type="checkbox"/> Other	

First & Last Name	Social Security Number	Date of Birth	Relationship	Sex
	/ /			
	/ /			
	/ /			
	/ /			

*If new dependent has other coverage(s), please fill out a prior coverage affidavit form.

Annie P. Smith *6/30/08* *H.R.*



BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

Health Financial Change Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name: OKALOOSA COUNTY SHERIFF'S OFFICE Group #: 65196 Division #: Package #:

Employee: [Redacted] Effective Date of Coverage: Date of Event: 9/30

Section B: Coverage Change Information

Reason for Change: [] Adoption [] Death [] Leave of Absence/Layoff [] Moved from Service Area [] Open Enrollment [] Section 125 [] Marriage [] Birth [] Over-Aged Dependent [] Terminate Employment [] Return of Alternate Insurance [] Loss of Coverage [] Divorce [] Location [] Employee # [] Other RETIRED [] New Name: [] New Address: [] New Physician Name/ID: [] New Phone #:

Plan Coverage Type Requested: [] Add Health [] Delete Health [] Change Plan: Indicate Plan #

Coverage Level Requested: [] Employee [] *Employee & Spouse [] *Employee & One Dependent [] *Employee & Children [] Family *When available

[] Dependent Change Complete Section D [] FSA Change Complete Section C [X] Other Change: CHANGE TO RETIREE STATUS

Section C: Flexible Spending Account (FSA) Changes

[] Add Health Care FSA [] Add Dependent Care FSA

[] I wish to Terminate and/or Stop Pay my FSA Health Care Program with a Final Payroll Deduction Date of: [] I wish to Terminate and/or Stop Pay my FSA Dependent Care Program with a Final Payroll Deduction Date of:

[] I wish to Change the Annualized Amount of my Health Care FSA to: \$ [] I wish to Change the Annualized Amount of my Dependent Care FSA to: \$

Payroll Deduction Amount \$: Effective Date: Payroll Deduction Amount \$: Effective Date:

I wish to change my Payroll Frequency to: [] Weekly [] Bi-weekly [] Monthly [] Bi-monthly [] Other

Section D: Dependent Information Attach separate sheet, if additional space is needed, with dependent information, sign & date.

Table with columns: (A) Add (D) Delete (C) Change, Last Name, Social Security Number, Birth Date, Relation to You, Sex, Check if Disabled, Physician Name/ID, Existing Patient, Dependent, Ethnicity. Includes rows for dependent information.

* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

Section E: Other Health Insurance Information This section must be completed for claims processing and Prior Coverage Information

In addition to this policy, do you or your dependents have any other insurance coverage (including BCBSF plans) that will be in effect after this coverage begins? [] Yes [] No BCBSF Contract # Medicare # Pharmacy/Medicare D #

Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage.

Prior Health Carrier Name: Contract #: Effective Date:

Prior Employee Hire Date: Cancel Date: List names of all family members that were covered, including yourself:

Section F: Change Authorization and/or FSA Participation

I have read, understand, and agree to the Change Authorization and/or Participation in the FSA Program Terms on the back of this form. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee Signature: Date:

Employer Signature: Annie P. Smith Date: 9/30/10

Deputy Forgione Killed in the Line of Duty July 22, 2008.



HRH TPA Services of Florida
 Administered by: Hunt Insurance Group, Inc.
 2324 Centerville Road
 Tallahassee, FL 32308
 850-385-3636 800-763-4868
 FAX: 850-385-2124

Health Coverage will continue per OCSO policy.

OFFICIAL USE ONLY
 Effective Date of Coverage _____
 Group Number _____
 Base Salary \$ _____

Employee Benefits Enrollment Application

Please Print

Date of Hire	Name of Employer OKALOOSA COUNTY SHERIFF	Occupation Spouse of Anthony Forgione	Social Security Number / /
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Last Name [REDACTED]	First Name [REDACTED]	M.I.	Date of Birth [REDACTED]	Gender Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>
--------------------------------	---------------------------------	-------------	------------------------------------	---

Street Address [REDACTED]	City/State [REDACTED]	Zip Code [REDACTED]
-------------------------------------	---------------------------------	-------------------------------

Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input checked="" type="checkbox"/>	Home Phone () -	Work Phone () -	County OKALOOSA
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If you wish to enroll your eligible dependents, complete the following:

- ◆ If dependent is a student age 19 or over, verification of full time status will be required from academic institution.
- ◆ If you are declining enrollment for health coverage for your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll your dependents in this plan, provided that you request enrollment within 30 days after the coverage terminates.
- ◆ If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Relationship	Last Name	First Name	MI	Social Security #	Date of Birth
Spouse				/ /	
Son <input type="checkbox"/> Daughter <input checked="" type="checkbox"/>	Forgione	[REDACTED]		/ /	[REDACTED]
Son <input type="checkbox"/> Daughter <input checked="" type="checkbox"/>	Forgione	[REDACTED]		/ /	[REDACTED]
Son <input type="checkbox"/> Daughter <input type="checkbox"/>				/ /	
Son <input type="checkbox"/> Daughter <input type="checkbox"/>				/ /	
Son <input type="checkbox"/> Daughter <input type="checkbox"/>				/ /	

OTHER GROUP COVERAGE Do you or your dependents have other insurance coverage? Yes No
 If YES, who is covered and with what company?

Name	Insurance Company Name & Address	Insurance Policy #

Coverage Requests	Employee Only	Employee & Spouse	Employee & Children	Family
Please check the coverages you are selecting for you and your dependents.	Health <input type="checkbox"/>	Health <input type="checkbox"/>	Health <input type="checkbox"/>	Health <input type="checkbox"/>
	Dental <input type="checkbox"/>	Dental <input type="checkbox"/>	Dental <input type="checkbox"/>	Dental <input type="checkbox"/>
	Vision <input type="checkbox"/>	Vision <input type="checkbox"/>	Vision <input type="checkbox"/>	Vision <input type="checkbox"/>
	Dependent Life <input type="checkbox"/>	Dep. Life \$	Dep. Life \$	Dep. Life \$
	Vol. Life \$			

BENEFICIARY (Life Insurance and AD&D)

PRIMARY:

Name:	Relationship:	%Share
Name:	Relationship:	%Share

CONTINGENT:

Name:	Relationship:	%Share
Name:	Relationship:	%Share

Authorization
 I hereby apply for the group coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for group coverage for which I am or may be eligible. I hereby authorize any person including physicians, hospitals, insurance companies and service organizations to release for review any information acquired by said persons in the course of, or in connection with my or my dependents examination or treatment for any purpose including peer review activities.

Jessica Forgione ^(AKA) 7/22/08
 Employee Signature Date Signed

Anna P. Smith 7/22/08
 Employer Representative Date Signed

NOTE: Attach Prior Coverage Affidavit or Certificate of Creditable Coverage from previous insurer, if applicable.

White Copy - HIG

Pink Copy - Employee

Yellow Copy - Employer