

Sheriff



Larry Ashley, Okaloosa County Sheriff

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Date: July 27, 2011
OCSO11CAD105437

Public Records Request: OCSO Health Insurance Coverage (Change Form 09302010)

From: Michael Barnes

On July 23, 2011 the OCSO received the following request for public records. The agency response is in **bold**.

Major Peacock: I respectfully request that the name of the person who made the attached change request to the OCSO health insurance coverage on September 30, 2010 be provided to me. The requested information does not violate any public records exemption whereby I am your agency to disclose the names or addresses in aggregate, compiled, or list form.

If OCSO is unable to satisfy my request, please provide me a written statement explaining with particularity the reasons for a conclusion by the agency that the records are exempt.

See attached document.



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"



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 Name: (Last, First Name, M.I.) YOUNG, MARK Social Security #: [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 Change Request Type: [] 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