Larry Ashley, *Okaloosa County Sheriff*

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

Date: July 7, 2011
OCSO11CAD094265

Public Records Request: OCSO Health Insurance Coverage (Change Form 06302008)

From: Michael Barnes

On June 30, 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 June 30, 2008 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.

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 #:
Wells	James		OKA

Social Security Number	Employer Name	Job Location/Department
[redacted]	OKALOOSA COUNTY SHERIFF'S OFFICE	

☐ **Termination of Coverage**

Last Day Worked:	Date Coverage Terminated:	Reason for Termination:	Date Returned:

Effective Date of Change:

Eligible for COBRA: ☐ Yes ☐ No

☐ **COBRA Election of Coverage** **Coverage Elected:**

☒ **Retirement**

Last Day Worked:	Date Coverage Continued:		Date of Termination:
6/30/2008	7/1/2008	☒ Single ☐ Other ______ ☐ Family ______	

☐ **Changes**

Change Employee's Name To:	Change Job Location To:	Plan Change:	Other:

Reason: ☐ Marriage ☐ Divorce ☐ Other:

☐ **Address Change**

Change Employee's Address To:

City, State, Zip Code:

☐ **Life Insurance Change**

Change Employee Class To:	Change Amount of Life Insurance To:	Effective Date:

Change Beneficiary To:	Relationship:	Effective Date:

☐ **Dependent Change**

☐ **Add Due To:**
- ☐ Birth
- ☐ Adoption
- ☐ Marriage
- ☐ Student Verification
- ☐ Other

☐ **Delete Due To:**
- ☐ Divorce
- ☐ Death
- ☐ Retirement
- ☐ Loss of Eligibility
- ☐ Other

DATE OF OCCURRENCE:
Other Group Coverage:
Do you or your dependents have other insurance coverage? **Yes** ☐ **No** ☐
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 6/30/08 H.R.