

Sheriff



Larry Ashley, Okaloosa County Sheriff

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Date: June 24, 2011
OCSO11CAD087367

Public Records Request: OCSO Health Insurance Coverage

From: Michael Barnes

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

Major Peacock: As discussed after the FWB City Council Meeting on June 14th, attached is a change request form for an employee requesting changes to OCSO health insurance coverage on July 7, 2008. This request was submitted while the individual was a full-time employee at OCSO.

As a public records request, I respectfully request that the name of the person who made the change request to the OCSO health insurance coverage on July 7, 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.



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"



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 Dyer	First Margaret	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