

# Sheriff



**Larry Ashley, Okaloosa County Sheriff**

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

Date: June 30, 2011  
OCSO11CAD090416

Public Records Request: OCSO Health Insurance Coverage (Change Form 06272008)

From: Michael Barnes

On June 28, 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 4, 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

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

<input type="checkbox"/> <b>Termination of Coverage</b>			
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"/> <b>COBRA Election of Coverage</b>	Coverage Elected:
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<input checked="" type="checkbox"/> <b>Retirement</b>			
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"/> <b>Changes</b>			
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"/> <b>Address Change</b>	
Change Employee's Address To:	
City, State, Zip Code:	

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

<input type="checkbox"/> <b>Dependent Change</b>		
<input type="checkbox"/> <b>Add Due To:</b> <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Student Verification <input type="checkbox"/> Other	<input type="checkbox"/> <b>Delete Due To:</b> <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Retirement <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Other	<b>DATE OF OCCURRENCE:</b> <b>Other Group Coverage:</b> 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*