Dependent Documentation Requirements

Dependent documentation is required for all dependents for the 2016 Plan Year.

Dependent Relationship	Documentation Requirements	
Spouse	Marriage Certificate	
Natural Child	Birth Certificate (must list employee as a parent) **Note:** birth registration, SS card or passport is not valid proof	
Stepchild	Birth Certificate (must list employee's spouse as a parent) and Marriage Certificate.	
Adopted Child	Court Documentation of adoption	
Legal Custody or Guardianship	Court documentation defining guardianship or legal custody. **Note:** Notarized affidavit is not acceptable documentation. Temporary custody does not constitute legal custody.	
Disabled Dependents Over Age 26	Social Security Disability Documentation. Disabled dependents are eligible only if covered by a School Board Healthcare plan or Flexible Benefits plan prior to the date of disability. Additionally, if coverage is terminated, it cannot be reinstated.	
Adult Child (between the age of 26–30)	• Affidavit of Eligibility • Birth certificate or Court Documents of Adoption/guardianship/legal custody • Proof of Florida Residence (Florida Driver License)	
Grandchildren For specific eligibility requirements, see each benefit's page.	**UNDER 18 MONTHS OLD** Birth Certificate (must list employee's child as a parent) **Note:** the parent must be a covered dependent; if not, same as Legal Custody or Guardianship	**OVER 18 MONTHS OLD** Legal Custody or Guardianship documentation

Dependent Eligibility Documentation

Print, complete and include this form with the required documentation.

Return To: School Mail: US Mail:
WL 9112 Office of Risk & Benefits Management
Suite 335 P.O. Box 12241, Miami, Florida 33101
Fax To: 1.305.995.1425

Employee (if applicable) Number _____

Social Security Number _____

Employee/Retiree/Participant Name _____

Important Information

- If not previously submitted, proof of eligibility must be on file for all listed dependents.
- You must submit proof of eligibility by the deadline. Otherwise, coverage may be terminated for any dependent whose eligibility has not been verified. Claims incurred will not be paid and any premiums deducted will not be automatically issued.
- If not previously submitted, you must provide your covered dependent's Social Security number.

DEPENDENT NAME (print clearly) Last Name First Name MI	BIRTH DATE	SOCIAL SECURITY #	RELATIONSHIP	GENDER	DOCUMENT PROOF INCLUDED (birth certificate, marriage certificate, etc.)

Employee/Retiree/Participant Signature_____ _____ Date _____

Domestic Partner Eligibility

Relationship	Documentation Requirements
Domestic Partner (Not married) A copy of the Domestic Partnership Affidavit is available on the following page of this online Benefits Guide.	Affidavit of Domestic Partnership and any two of the following, demonstrating a minimum of a year (12 consecutive months) partnership: • Joint mortgage or lease of residence • Joint ownership of a motor vehicle • Joint bank or investment account • Joint credit card or other financial responsibility • Will naming the partner as the beneficiary • Life Insurance policy naming the partner as the beneficiary • Assignment of durable power of attorney or healthcare proxy OR: Affidavit of Domestic Partnership and copy of registration under applicable law state or municipality
Children of Domestic Partner	Birth Certificate (must list domestic partner as a parent) and Domestic Partner documentation as defined above. **Note:** Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner with children" coverage.
Grandchildren of Domestic Partner	Birth Certificate (must list Domestic Partner's child as a parent) and children of Domestic Partner documentation as defined above. **Note:** Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner with children of a Domestic Partner" coverage. Legal Custody or Guardianship documentation
Domestic Partner Same Sex	A Domestic Partner of the same sex and legally married are covered on a tax-free basis with proper documentation (marriage certificate).

Important Information

Proof of eligibility must be provided for Domestic Partner and all listed Children or Grandchildren of Domestic Partner (Include this form with the required documentation and the completed notarized Affidavit).

Employee Number _____

Employee/Retiree/Participant Name _____

Social Security Number _____

PRINT AND RETURN BY U.S. MAIL TO:
Office of Risk & Benefits Management
P.O. Box 12241
Miami, Florida 33101

RETURN BY SCHOOL MAIL TO:
Work Location 9112, Suite 335
OR FAX TO: 1-305-995-1425

Indicate the relationship of your dependent on the form below.
DP = Domestic Partner **DC** = Child of Domestic Partner **DGC** = Grandchild of Domestic Partner

DEPENDENT NAME (print clearly) Last Name First Name MI	**BIRTH DATE**	**SOCIAL SECURITY #**	**RELATIONSHIP**	**GENDER**	**DOCUMENT PROOF INCLUDED** (birth certificate, joint mortgage, etc.)

Employee/Retiree/Participant Signature_____ _____ Date _____

Note: This is not an enrollment form, you must still complete your benefits enrollment and return it with both the dependent documentation and the notarized Domestic Partner Affidavit.

Affidavit of Domestic Partnership

The undersigned, being duly sworn, depose and declare as follows:

- We are each eighteen years of age or older and mentally competent.
- We are not related by blood in a manner that would bar marriage under the laws of the State of _____
- We have a close and committed personal relationship, and we are each other's sole domestic partner, not married to or partnered with any other spouse, spouse equivalent or domestic partner.
- **Note:** If you cover a Domestic Partner of the same sex and legally married, you can add your domestic partner and your deductions will be taken on a pre-tax basis. Additionally, you do not have to complete this Affidavit.
- For, at least, one year, we have shared the same regular and permanent residence in a committed relationship and intend to do so indefinitely.
- We have provided true and accurate required documentation, demonstrating a minimum of a year (12-consecutive months) of partnership.
- Each of us understands and agrees that in the event any of the statements set forth, herein, are not true, the insurance or healthcare coverage for which this Affidavit is being submitted may be rescinded and/or each of us shall jointly and severally be liable for any expenses incurred by the employer, insurer or healthcare entity.
- I understand that, per IRS Section 125, all deductions for employee-paid benefits will be taken on a post-tax basis.
- I understand that I must pay the tax liability on the monthly contribution (dependent subsidy) that the Board pays on my behalf.

_____ _____

Employee/Retiree/Participant Name (Print Name) Domestic Partner (Print Name)

_____ _____

Signature Signature

Sworn to before me this _____ day of_____ , 20 _____.

_____

NOTARY PUBLIC

Return To: School Mail:
WL 9112
Suite 335

US Mail:
Office of Risk & Benefits Management
P.O. Box 12241
Miami, Florida 33101

Fax To: 1-305-995-1425

Adult Child Notice

In order to continue the coverage for your currently enrolled Adult Child, you must re-submit the dependent eligibility documentation by the open enrollment deadline.

In order to continue coverage of your currently enrolled Adult Child, you must re-submit the dependent eligibility documentation by the December 2, 2015 enrollment deadline. The dependent eligibility documentations can be faxed to 1-305-995-1425 or sent via school mail to WL9112 Office of Risk and Benefits Management.

In accordance with the Patient Protection and Affordable Care Act (PPACA) Healthcare Reform, an employee can cover their dependent under the School Board's healthcare plan until the end of the calendar year the dependent reaches age 26. The dependent will be deemed an Adult Child the following calendar year. Under Florida law, a dependent adult child ages 26 – 30 may be considered an eligible dependent for the purpose of "health" insurance.

For medical coverage offered under the M-DCPS plan, you may add or continue to cover your Adult Child until the end of the calendar year in which the adult child reaches the age of 26-30, if the adult child:

- Is dependent upon you for support;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

In addition, the following dependent eligibility documents must be submitted with your completed enrollment form prior to the adult child dependent being added to your healthcare coverage:

- Affidavit of Eligibility
- Birth certificate or court documents of adoption/guardianship/legal custody
- Social Security number
- Drivers license number

Note: To continue to cover or add your adult child dependent, you must re-submit dependent eligibility documentation with your enrollment form. If dependent eligibility is not received, your current, covered adult child will be cancelled December 31, 2015.

Adult Dependent Healthcare Premiums

PER PAY RATE PER ADULT DEPENDENT CHILD			
Cigna HEALTHCARE	**10-Month**	**11-Month**	**12-Month**
Open Access Plus (OAP) 20	$327.60	$273.00	$252.00
Open Access Plus (OAP) 10	$358.80	$299.00	$276.00
LocalPlus Plan	$330.00	$275.00	$253.85

If you are covering other children, your adult child must be covered under the same healthcare plan, and the adult dependent premium is in addition to the under age 26 children rate. Adult child rates are not subsidized by the Board.

To add an Adult Child, you must request an Adult Dependent enrollment package. Call the Cigna Representative at 1-305-995-1273 , Monday through Friday, 7 a.m. to 8 p.m. An enrollment form and Affidavit of Eligibility will be mailed to your home address the following business day. Your completed form, affidavit, and dependent eligibility documentation must be received by the due date noted on the form.

Beyond Your Benefits

FBMC Privacy Notice - 4/14/03

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal-and sometimes, sensitive-information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. NOTE this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended.

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally vary depending on the products or services you request and may include:
   - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status, and spousal and beneficiary information.
   - Responses from you and others such as information relating to your employment and insurance coverage.
   - Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
   - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under Federal Law you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

II. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

II. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's recordkeeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder and the insurer:

1. **Contract Administrator.** FBMC Benefits Management, Inc. has been authorized by your employer to provide administrative services for your employer's insurance plans offered within your benefit program. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits to provide certain services, including, but not limited to: marketing; billing and collection of premiums; and processing insurance claims payments. FBMC is not the policyholder or the insurer.
2. **Policyholder.** This is the entity to whom the insurance policy has been issued; the employer is the policy holder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. **Insurer**. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

Taxable Benefits and the IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pre-tax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual medical expenses you incur, if these premiums were paid with pre-tax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than:
- 48 hours following a vaginal delivery; OR
- 96 hours following a cesarean section

Determination of when the hospital stay begins is based on the following:
For an in the hospital delivery:
- The stay begins at the time of the delivery.
- For multiple births, the stay begins at the time of the last delivery.

For a delivery outside the hospital (i.e. birthing center):
- The stay begins at the time of admission to the hospital.
- Requiring authorization for the stay is prohibited.
- If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:–
- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.
- These rules do not mandate hospital stay benefits on a plan that does not provide that coverage.
- The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

Creditable Coverage Disclosure Notice/Medicare Enrollees

Important Notice

Creditable Coverage Disclosure Notice for Active Employees and/or Their Dependents

Please read this notice carefully and keep it for your records.

Under the Medicare Modernization Act of 2003, a new Medicare-Approved Drug Plan (Part D) took effect as of January 1, 2006. This is your notice of creditable coverage.

- Your prescription drug coverage offered by Cigna Healthcare Plans, is, on average, as good or better as the standard Medicare prescription drug coverage.
- If you select one of the Cigna Healthcare Plans, you will not be penalized by Medicare if you decline to enroll in Medicare Part D at this time and decide to enroll in it at a later date. You will not have to pay the increased premium of at least one percent for each month that you did not elect to enroll in this plan after December 31, 2015 for an effective date of January 1, 2016.
- Creditable coverage means that the prescription drug coverage offered to you by the healthcare plan is, on average, as good as Medicare Part D coverage.
- Medicare enrollment in the Medicare Part D Prescription Drug Plan was from October 2015, through December 2015.

For more information refer to your "Medicare & You 2016" handbook provided to you by Medicare, or by logging in to **www.medicare.gov** or calling 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

When To Enroll In Medicare Parts A & B

You should enroll 60 days prior to turning 65. If not, you may experience a lapse in your coverage.

Enrollment in Medicare While Actively Working

Active Employees Eligible for Medicare Parts A & B:

- If you and/or your covered dependent are eligible for Medicare Parts A & B, you are provided the opportunity of enrolling in Medicare during the Special Enrollment Period.
- You do not need to enroll in Medicare while working and covered by a group healthcare plan through your employer. Please refer to your 2015 Medicare & You Book or by logging in to **www.medicare.gov.**
- However, if you do enroll in both Medicare Parts A & B, you can opt out of the School Board-sponsored healthcare plan (Cigna). In lieu of healthcare coverage, you will receive a monthly contribution of $100 paid through the payroll system based on your deduction schedule (subject to withholding and FICA). For additional information on how to enroll in healthcare, call the FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday - Friday, 7 a.m. - 8 p.m. ET.

Social Security Notice

THE SCHOOL BOARD OF MIAMI-DADE COUNTY

Statement on the Collection, Use or Release of Social Security Numbers of Employees and Others***

The School Board of Miami-Dade County is authorized to collect, use or release social security numbers (SSN) of employees, employee dependents, and other individuals*** for the following purposes, which are noted as either required or authorized by law to be collected. The collection of social security numbers is either specifically authorized by law or imperative for the performance of the District's duties and responsibilities as prescribed by law [Fla. Stat. §119.071(5) (a) 2 & 3].

1. **Employment eligibility, report to IRS, SSA, UC, and FAWI , including for W-4's and I-9's** [Required by federal statute and regulation 26 U.S.C. 6051 and 26 C.F.R. 31.6011(b)-2, 26 C.F.R. 301.6109-1 and 31.3402(f)(2)-1, and Fla. Stat. § 119.071(5) (a) 6]
2. **Receipts to employees for wages and Statements required in case of sick pay paid by third parties [**Required by federal statute 26 U.S.C. 6051 and Fla. Stat. § 119.071(5) (a) 6]
3. Verification of an alien's eligibility for employment, including I-9 [Authorized by 8 U.S.C. 1324 a(b) and 8 C.F.R. 274a.2]
4. **Income tax withholding (including for annuity and sick leave)/Payroll deductions on Form W-2** [Required by 26 U.S.C. 3402, 26 C.F.R. 31.6051-1 and Fla. Stat. § 119.071(5) (a) 6]
5. **Teacher retirement system benefits and contributions** [Authorized by Fla. Stat. § 238.01 et seq., including 238.07, and Fla. Stat. § 119.071(5) (a) 6]
6. **Retirement contributions required for enrollment in Florida Retirement System (FRS) Investment Plan, second election retirement plan enrollment, or for participation in and contributions to FRS** [Required by Fla. Admin. Code 19-11.010, 19-11.006 and 19-11.007 and Fla. Stat. § 119.071(5) (a) 2 & 6 or required by Fla. Stat. § 121.051 and 121.071 and Fla. Admin. Code 19-13.003 and Fla. Stat. § 119.071(5) (a) 2 & 6]
7. **Reports pertaining to deferred vested retirement programs** [Required by 26 C.F.R. 301.6057-1 and Fla. Stat. §119.071(5) (a) 6]
8. **Payments and plan relating to the retiree prescription drug subsidy under 42 C.F.R. § 423.34 and 42 C.F.R. § 423.886 [**Authorized by 42 C.F.R. 423.884 and Fla. Stat. § 119.071(5) (a) 6]
9. **Educator Certification or licensure application, renewal, or add-on, or non-employee registration for professional development for in-service points or incentive pay** [Required by Fla. Stat. §§ 1012.56, and 119.071(5) (a) 6, and/or authorized by Fla. Stat. §§ 1012.21and 119.071(5) (a) 6]
10. **Criminal history, Level 1 and level 2 background checks / Identifiers for processing fingerprints by Department of Law Enforcement/, if SSN is available** [Required by Fla. Admin. Code 11C-6.003 and Fla. Stat. § 119.071(5) (a) 6]
11. **Registration information regarding sexual predators and sexual offenders [**Authorized by Fla. Stat. § 943.04351 and required by Fla. Stat. § 119.071(5) (a) 2 & 6]
12. **Reports on staff required to be submitted to Florida Department of Education (DOE), including but not limited to Out-of-County/Out-of-State Verification of Highly Qualified** [Authorized and required by Fla. Stat. § 119.071(5) (a) 2 & 6 and/or EDGAR at 34 CFR 80.40(a) or Fla. Stat. § 1008.32]
13. **Social security contributions** [Required by Fla. Admin. Code 60S-3.010 and Fla. Stat. § 119.071(5) (a) 2 & 6]
14. **State directory of new hires (including for determining support obligations and eligibility for several federal and state programs)** [Required by federal law 42 U.S.C. 653a and Fla. Stat. § 409.2576 and Fla. Stat. § 119.071(5) (a)]
15. **Notice to Payor and Income Deduction notices for child support, or for alimony and child support** [Required by Fla. Stat. § 61.1301 (2)(e) and Fla. Stat. § 119.071(5) (a)]
16. **Child support enforcement** [Required by 45 C.F.R. 307.11 and Fla. Stat. § 61.13, 742.10 or 409.256.3 or 742.031]
17. **Garnishment payment pursuant to a Notice of Levy** [Required by Fla. Admin. Code 12E-1.028m and Fla. Stat. § 119.071(5) (a)]
18. **Request from depository for support payments** [Required by Fla. Stat. § 61.181 (3)(b) and Fla. Stat. § 119.071(5) (a)]
19. **Record of remuneration paid to employees** [Required by federal regulation 20 C.F.R. 404.1225, Fla. Admin. Code 60BB-2.032, and Fla. Stat. § 119.071(5) (a) 6]
20. **Unemployment benefits and short term compensation plan** [Required by Fla. Stat. Ch. 443, including 443.1116, and Fla. Stat. § 119.071(5)(a)6]
21. **Unemployment reports from District** [Required by Fla. Admin. Code 60BB-2.023 and Fla. Stat. § 119.071(5) (a) 6]
22. **Income information disclosure to HUD** [Required by federal regulation 24 C.F.R. 5.214 et seq. and Fla. Stat. § 119.071(5)(a)6]

Social Security Notice

23. **Vendors/Consultants that District reasonably believes would receive a 1099 form if a tax identification number is not provided Including for IRS form W-9.** [Required by 26 C.F.R. § 31.3406-0, 26 C.F.R. § 301.6109-1, and Fla. Stat. § 119.071(5) (a) 2 & 6
24. **Tort claims and tort notices of claim against the School Board** [Required by Fla. Stat. § 768.28 (6), and Fla. Stat. § 119.071(5) (a) 6]
25. **Reporting to and reports of worker's compensation injury or death, including for DWC-1** [Required by Fla. Stat. §440.185 and Fla. Admin. Code 69L-3.003 et seq. and Fla. Stat. § 119.071(5) (a) 6]
26. **Worker's compensation petitions for benefits and responses thereto** [Authorized by Fla. Admin. Code 60Q-6.103 and Fla. Stat. § 119.071(5) (a) 6]
27. **The disclosure of the social security number is for the purpose of the administration of retirement or health benefits for a District employee or his or her dependents** [Required by Fla. Stat. § 119.071(5)(a) 6]
28. **The disclosure of the social security number is for the purpose of the administration of a pension fund administered for the District employee's retirement fund, deferred compensation plan, or defined contribution plan** [Required by Fla. Stat. § 119.071(5)(a)6]
29. **Use of motor vehicle information from the Department of Motor Vehicles for the District to carry out its functions and to verify the accuracy of information submitted by agent or employee to District, including to prevent fraud, in connection with insurance investigations, and to verify a commercial driver's license** [Authorized allowed by federal law 18 U.S.C. 2721 et seq. and Fla. Stat. § 119.071(5) (a) 6]
30. **Authorization for direct deposit of funds by electronic or other medium to a payee's account** [Required by Fla. Admin. Code 6A-1.0012 and Fla. Stat. § 119.071(5) (a) 6]
31. **Identification of blood donors** [Authorized by 42 U.S.C. 405 (c)(2)(D)(i)]
32. **Employee's and former employee's request for report of exposure to radiation [**Authorized by 41 C.F.R. 50-204.33 and .3]
33. **Collection and/ or disclosure are imperative or necessary for the performance of the District's duties and responsibilities as prescribed by law, including but not limited for password identification to the District's network** [Authorized by Fla. Stat. § 119.071(5) (a) 6 and required by Fla. Stat. § 119.071(5) (a) 2]
34. **The disclosure of the social security number is expressly required by federal or state law or a court order** [Required by Fla. Stat. §§ 1012.56 and 119.071(5) (a) 6]
35. **The individual expressly consents in writing to the disclosure of his or her social security number** [Allowed by Fla. Stat. § 119.071(5) (a) 6]
36. **The disclosure of the social security number is made to prevent and combat terrorism to comply with the USA Patriot Act of 2001, Pub. L. No. 107-56, or Presidential Executive Order 13224** [Required by Fla. Stat. § 119.071(5) (a) 6]
37. **The disclosure of the social security number is made to a commercial entity for the permissible uses set forth in the federal Driver's Privacy Protection Act of 1994, 18 U.S.C. Sec. 2721 et seq.; the Fair Credit Reporting Act, 15 U.S.C. Sec. 1681 et seq.; or the Financial Services Modernization Act of 1999, 15 U.S.C. Sec. 6801 et seq., provided that the authorized commercial entity complies with the requirements of paragraph 5 in Fla. Stat. § 119.071** [Allowed by Fla. Stat. § 119.071(5)(a)6]
38. **The disclosure of the social security number is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State** [Required by Fla. Stat. § 119.071(5)(a)6]

****Note, this form states the reasons for collecting, using or releasing the social security numbers only of employees and individuals other than students, parents and volunteers. A separate written statement sets forth the reasons for collecting, using or releasing the social security numbers of students and parents, and a separate written statement exists for collecting, using or releasing the social security numbers of volunteers as part of the volunteer application.*

School Board Attorney's Office
New: October 1, 2009
Revised: April 12, 2010

Declination of Healthcare Coverage Affidavit

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided through Miami-Dade County Public Schools (M-DCPS).
2. I have been given an opportunity to apply within my eligibility period and I have elected to decline to participate in the group insurance plans that I am eligible to participate in.
3. I have other group or state-funded medical insurance currently in effect and it is not a School Board sponsored medical insurance.
4. I understand that if I desire to apply for medical insurance at a later date, I may enroll only during an annual enrollment period determined by M-DCPS or during a "special enrollment period" (Change in Status) following an IRS acceptable change in status event. For example, you may in the future, be able to enroll yourself or your dependents in a group medical plan through the School Board if you or your dependents lose coverage under an existing employer provided medical plan, provided that you request enrollment within 30 days after your other group product coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption (or placement for adoption), you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the event. In case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for cause or as a result of failure to pay any contributions toward the cost of coverage on a timely basis.

NOTE: Internal Revenue Service (IRS) guidelines state that the loss of insurance through an **individual** healthcare **plan does not** constitute a valid Change in Status event.

5. I understand that I will not be enrolled in a Board-Paid medical plan. I will receive Board-Paid Standard Short-Term Disability and will receive $100 per month, paid through the payroll system. (This may be subject to withholdings and FICA.)
6. I understand that I must provide proof of other group healthcare coverage. Otherwise, I understand that I will be auto-assigned Cigna LocalPlus Plan (employee-only) coverage.

I have read, understand and agree to comply with the requirements stated above.
Additionally, proof of other group or state funded healthcare plan coverage is being submitted with this Affidavit.

_____	_____
Print Name	Employee Number
_____	_____
Signature	Date

This Affidavit must be submitted with proof of other group or state-funded healthcare coverage, even if previously submitted.
Please fax this affidavit and proof of other group healthcare coverage to 305.995.1425.