ORANGE COUNTY SHERIFF'S OFFICE

HEALTH INSURANCE SUBSIDY CERTIFICATION FORM

For Retirees with insurance coverage not administered by P & A

Retiree SSN (last 4 digits): _____ Retiree Name: _____

(Print full legal name)

Phone number: _____ Email: _____

SPOUSE OF ORANGE COUNTY SHERIFF'S OFFICE EMPLOYEE (Complete if applicable)

☐ I am covered as a spouse of an active Orange County Sheriff's Office employee (see eligible types of insurance plans below)

Name of employee:_____ EID:_____

ELIGIBLE TYPES OF INSURANCE FOR DOCUMENTATION OF THE COST

Coverage can be with any company or coverage through any employer. The employee or the employee's spouse or other family member may pay for the single or family insurance to cover the retiree. We will need something showing coverage for 2026 and how much it costs.

Check the following insurance options that you are providing proof of coverage and documentation of cost:

☐ Health ☐ Cancer ☐ Accident ☐ Disability ☐ Dental ☐ Vision ☐ Military/Tricare ☐ Medicare

Indicate the frequency of the payment: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Other

Total monthly cost for all eligible premiums: $_____ If your total OCSO HIS is greater than your insurance charge, the OCSO HIS will be capped at your total premiums.

PLEASE NOTE:

- **It is your responsibility to update Benefits with any changes to your: bank account, beneficiaries, mailing address, phone number and email address.**
- **Documentation of proof of coverage AND proof of costs must be emailed to our group email below and received no later than August 31st 2026.**
- **There will be no retroactive payments.**

I affirm that the information and documentation that I have provided is accurate and factual.

Signature: _____ **Date:** _____

ELECTRONIC NOTIFICATIONS ACKNOWLEDGEMENT

I understand all communications regarding retiree information, including but not limited to, Health Insurance Subsidy, benefits, HIPAA notifications, and open enrollment information will be sent to me electronically at the email provided below. Retiree is responsible for updating contact information with OCSO.

Email address_____

Signature: _____ **Date:** _____

Please submit completed form to SO-Benefits@ocsofl.com