

Notification of Social Security Number Collection and Usage by Human Resources

In compliance with Florida Statute 119.071(5), this document serves to notify you of the purpose for the collection and usage of your social security number by the University of West Florida (UWF).

UWF collects and uses your social security number only if specifically authorized by law to do so or it is imperative for the performance of its duties and responsibilities as prescribed by law. Specifically, UWF collects your social security number for the purpose of completing and processing:

- Federal Form I-9, Employment Eligibility Verification (US Department of Homeland Security)
- Federal forms W-4, W-2, 1099 (US Department of Treasury)
- Federal Social Security taxes (FICA)
- Unemployment reports (Florida Department of Revenue)
- Florida retirement contribution reports and forms (Florida Department of Revenue)
- Workers compensation claims (FCCRMS and Department of Labor)
- I.R.C. Section 403b and 457b contribution reports (Internal Revenue Service)
- State sponsored insurance enrollment forms and reports (group health, life, and dental coverage)
- Background Screening (background screening of finalists for the purpose of employment consideration)
- Verification of Employment (prior to 2000)
- Dual Employment and Compensation Request Form (State of Florida)
- State of Florida New Hire Report (Department of Revenue)
- Transcript Request

REQUEST FOR CHANGE

American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters, Columbus, Georgia 31999
For information call Toll-Free 1-800-99-AFLAC (1-800-992-3522)

Policy/Contract No.(s) _____

Name of Member Shown On Policy/Contract _____

Member's Social Security Number: _____

Current Address of Member _____

City _____ State _____ Zip _____

If Payment is paid thru Deduction please enter
Employer or Account Name _____

TYPE OF CONTRACT	<input type="checkbox"/> Cancer Ins.	<input type="checkbox"/> Hospital Intensive Care Ins.	<input type="checkbox"/> Medicare Supplement
	<input type="checkbox"/> LifeCare®	<input type="checkbox"/> Advanced Life	

Associate's Signature and Writing Number _____
Licensed Resident Associate

Please make the following changes to my Policy / Contract:

<input type="checkbox"/>	ACCOUNT TRANSFERS	Transfer From _____ (Employer or Account Name and Number) To _____ (Employer or Account Name and Number) Amount Remitted \$ _____ Months _____ Effective Date of Transfer _____
<input type="checkbox"/>	NAME CHANGE ONLY	Name Shown On Policy / Contract _____ Change Name To: _____ Reason _____ Effective Date of Name change _____
<input type="checkbox"/>	DELETIONS ONLY	Person to be Deleted _____ Relationship _____ Address _____ Phone No. _____ Birthday of Person to be Deleted _____ Effective Date of Deletion _____ Reason _____ (Date of death / marriage/ no longer dependent)
<input type="checkbox"/>	ADDITIONS ONLY	New Policy / Contract Holders Full Name _____ Birthdate of new Policy / Contract Holder _____ Type of Coverage now desired <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single-Parent Family Person(s) To Be Added: Full Name Date of Birth Relationship Reasons for Additions _____ Effective Date of Additions _____ Type of Coverage now desired <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single-Parent Family

IMPORTANT! READ BEFORE SIGNING: To the best of my knowledge and belief, no one to be added to my cancer policy has ever been diagnosed as having cancer, no one to be added to my hospital intensive care policy has ever been treated for or diagnosed for heart attack or any abnormality of the heart.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Signature: _____ Date: _____