

## **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

# Notice of Claim



Return this claim form and itemized hospital bill (UB92) to:  
 Alta Health & Life Insurance Company  
 P.O. Box 2568  
 Jacksonville, FL 32203-2568  
 Phone: 1-(800) 888-5256

FOR OFFICE USE ONLY	
PLAN	_____
EFF. DATE	_____/_____/_____
PTD	_____
INT	_____

## FLORIDA

- 30/20 PLAN     365+ PLAN  
 PPP PLAN     PRE-TAX SUPP./SIS HEALTH PLAN

### HELP SPEED YOUR CLAIM BY

#### Following these easy steps

1. Complete the "Notice of Claim" claim form.  
(Please answer all questions and sign it.)
2. When you have completed the claim form return it to the address shown above along with your ITEMIZED BILLS (UB92).

#### Please remember ...

- To be sure to submit a claim form for each separate illness or injury.
- To submit separate claim forms and bills for yourself and each of your dependents who have claims.

Employee's Statement	1. Employee's name _____	Phone No. ( ) _____	Employee Social Security No. _____
	2. Employee's Mailing Address Street _____	City _____	State _____ Zip Code _____
	3. Insured's employment:		
	Department name _____		
	Are your premium payments being made by: 1) Payroll deduction <input type="checkbox"/> 2) Personal check <input type="checkbox"/>		
	Are you a retired employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	4. This claim is for:		Dependent Social Security No. _____
	<input type="checkbox"/> Employee <input type="checkbox"/> Child Name _____		
	<input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child Date of birth of employee ____/____/____		Date of birth of patient ____/____/____
	5. If step-child, does this child reside with you?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. If patient is a child or step-child over 19 years old.			
Does this child reside with you?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this child wholly dependent on you for support and maintenance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this child attend school as a full-time or part-time student?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name and address of school _____			
7. Is this claim being filed under Workers' Compensation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Has insured's name changed since policy was issued?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, give name on date policy was issued _____			
9. Name of hospital _____			
Address _____			
Date of admission ____/____/____		Phone ( ) _____	

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, or employer to release information to Alta as is required to properly pay all benefits, if any, due me, my spouse, or parent for this claim.

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

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature X \_\_\_\_\_ X \_\_\_\_\_  
 Signature Patient (or if minor, parent)

Fully complete this form then ATTACH A COPY OF THE HOSPITAL'S ITEMIZED BILL INCLUDING DIAGNOSIS CODE TO THIS FORM and send both to the address shown above.