

CITY OF JACKSONVILLE



CITY HALL, ST. JAMES BUILDING
117 WEST DUVAL STREET
JACKSONVILLE, FLORIDA 32202

CLAIM FOR BENEFITS UNDER FLORIDA STATUTE § 112.1816

Name: _____

Date: _____

Employee ID No.: _____

Job Title: _____

I am a:

- ☐ Current employee.
- ☐ Former employee currently covered by City of Jacksonville's health insurance plan.
- ☐ Former employee not currently covered by City of Jacksonville's health insurance plan.

If a current employee:

- ☐ I have applied for worker's compensation benefits regarding my cancer diagnosis/treatment
- ☐ I have NOT applied for worker's compensation benefits regarding my cancer diagnosis/treatment

If a former employee:

- Date of separation: _____
- Type of separation:
 - ☐ Termination

☐ Resignation

☐ Retirement

I hereby request the following benefit(s), pursuant to Florida Statute 112.1816: (check all that currently apply)

☐ \$25,000.00 one-time payout

☐ Reimbursement of expenses

INSTRUCTIONS:

Please note that your claim for benefits **cannot** be processed without the following additional documentation. Please submit all documents together, in a single packet, to Mary Diperna and Carolina Teran-Oceguera, either in person, or via email, to MDiperna@coj.net , carolinato@coj.net. All forms are available at <https://www.jacksonville.gov/departments/employee-services/employee-information/employee-information.aspx>

Necessary paperwork for each benefit type sought:

- \$25k payout
 - Letter of Diagnosis
 - Affidavit
 - Medical Certification
- Reimbursement
 - Letter of Diagnosis
 - Affidavit
 - Medical Certification
 - EOBs and receipts to support each reimbursement you are seeking