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.coj.net/departments/employee-services/employee-information/employee-information.aspx

Necessary paperwork for each benefit type sought:

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