



# SUPPLEMENTAL ACCIDENT/DISABILITY INSURANCE 2009 ENROLLMENT FORM



Select your enrollment type:  New Hire  Open Enrollment  Qualifying Status Change  
 Note: If checked, you must complete & submit a QSC change form

SSN: \_\_\_\_\_ EEID: \_\_\_\_\_

Name: \_\_\_\_\_ Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_ DOB: \_\_\_\_\_

### COLONIAL DISABILITY COVERAGE - PLAN CODE 5020

Elimination Period Acc/Sick	Age Bands	Benefit Period (Months)	Monthly Disability Benefit (Includes Wellness Rider)											
			To ENROLL, place an E in the box next to the monthly premium for the Plan and Coverage level you want. To STOP coverage, place an S in the box next to the monthly premium amount you want to stop.											
			\$500	E/S	\$1,000	E/S	\$1,500	E/S	\$2,000	E/S	\$2,500	E/S	\$3,000	E/S
0/7	17-49	3	\$19.25		\$36.75		\$54.25		\$71.75		\$89.25		\$106.75	
7/7	17-49	3	\$17.50		\$33.25		\$49.00		\$64.75		\$80.50		\$96.25	
0/14	17-49	3	\$14.50		\$27.25		\$40.00		\$52.75		\$65.50		\$78.25	
14/14	17-49	3	\$13.00		\$24.25		\$35.50		\$46.75		\$58.00		\$69.25	
0/7	50-69	3	\$22.00		\$42.25		\$62.50		\$82.75		\$103.00		\$123.25	
7/7	50-69	3	\$20.75		\$39.75		\$58.75		\$77.75		\$96.75		\$115.75	
0/14	50-69	3	\$17.00		\$32.25		\$47.50		\$62.75		\$78.00		\$93.25	
14/14	50-69	3	\$15.50		\$29.25		\$43.00		\$56.75		\$70.50		\$84.25	
0/7	17-49	6	\$24.50		\$47.25		\$70.00		\$92.75		\$115.50		\$138.25	
7/7	17-49	6	\$21.75		\$41.75		\$61.75		\$81.75		\$101.75		\$121.75	
0/14	17-49	6	\$19.50		\$37.25		\$55.00		\$72.75		\$90.50		\$108.25	
14/14	17-49	6	\$16.75		\$31.75		\$46.75		\$61.75		\$76.75		\$91.75	
0/30	17-49	6	\$16.00		\$30.25		\$44.50		\$58.75		\$73.00		\$87.25	
30/30	17-49	6	\$12.25		\$22.75		\$33.25		\$43.75		\$54.25		\$64.75	
0/7	50-69	6	\$30.00		\$58.25		\$86.50		\$114.75		\$143.00		\$171.25	
7/7	50-69	6	\$28.25		\$54.75		\$81.25		\$107.75		\$134.25		\$160.75	
0/14	50-69	6	\$23.75		\$45.75		\$67.75		\$89.75		\$111.75		\$133.75	
14/14	50-69	6	\$21.50		\$41.25		\$61.00		\$80.75		\$100.50		\$120.25	
0/30	50-69	6	\$20.50		\$39.25		\$58.00		\$76.75		\$95.50		\$114.25	
30/30	50-69	6	\$16.50		\$31.25		\$46.00		\$60.75		\$75.50		\$90.25	
0/7	17-49	12	\$33.00		\$64.25		\$95.50		\$126.75		\$158.00		\$189.25	
7/7	17-49	12	\$29.25		\$56.75		\$84.25		\$111.75		\$139.25		\$166.75	
0/14	17-49	12	\$25.75		\$49.75		\$73.75		\$97.75		\$121.75		\$145.75	
14/14	17-49	12	\$21.50		\$41.25		\$61.00		\$80.75		\$100.50		\$120.25	
0/30	17-49	12	\$19.75		\$37.75		\$55.75		\$73.75		\$91.75		\$109.75	
30/30	17-49	12	\$16.00		\$30.25		\$44.50		\$58.75		\$73.00		\$87.25	
0/7	50-69	12	\$39.25		\$76.75		\$114.25		\$151.75		\$189.25		\$226.75	
7/7	50-69	12	\$36.00		\$70.25		\$104.50		\$138.75		\$173.00		\$207.25	
0/14	50-69	12	\$31.50		\$61.25		\$91.00		\$120.75		\$150.50		\$180.25	
14/14	50-69	12	\$27.00		\$52.25		\$77.50		\$102.75		\$128.00		\$153.25	
0/30	50-69	12	\$24.50		\$47.25		\$70.00		\$92.75		\$115.50		\$138.25	
30/30	50-69	12	\$20.75		\$39.75		\$58.75		\$77.75		\$96.75		\$115.75	

### COLONIAL ACCIDENT COVERAGE - PLAN CODE 5002

	MONTHLY RATE	Enroll	Stop
Employee Only	\$18.00		
Employee + Spouse	\$24.00		
Employee + Child(ren)	\$30.00		
Employee + Family	\$36.00		

Spouse and dependent information is needed for Employee + Spouse and Employee + Family Plans.  
Please see page 2 and list your dependent information.

**I WISH TO STOP MY COLONIAL ACCIDENT COVERAGE (CODE 5000)** Please check \_\_\_\_\_

**I WISH TO STOP MY COLONIAL ACCIDENT/DISABILITY COVERAGE (CODE 5010)** Please check \_\_\_\_\_

**EMPLOYEE CERTIFICATION**  
 I have read and agree to the conditions listed in the Supplemental Insurance Information Section (found on the back of this form). Enrollment may be subject to the underwriting requirements of the carrier. I authorize my employer to reduce my salary in accordance with the benefits I have selected. I understand that my elections are IRREVOCABLE, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within thirty-one (31) calendar days of the Qualifying Status Change.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SEE REVERSE SIDE FOR ADDITIONAL INFORMATION**



**SUPPLEMENTAL ACCIDENT/DISABILITY INSURANCE  
2009 ENROLLMENT FORM  
PAGE 2 - DEPENDENT INFORMATION FOR ACCIDENT PLANS**



SSN: \_\_\_\_\_ EEID: \_\_\_\_\_

Name: \_\_\_\_\_ Agency Name: \_\_\_\_\_

**ADD / DROP DEPENDENT - Please print (Attach additional page if necessary.)**  
**You may: ADD eligible dependents not currently covered and/or DROP ineligible dependents.**

\*RELATIONSHIP: Put the number that is next to the relationship. An example is Spouse - 1 then you would put the 1 in the "Rel". Column below.  
 Spouse - 1, Child - 2, Legal Guardianship - 3, Grandchild - 4, Legally Adopted Child - 5, foster Child - 6, Step Child - 7, Unborn Child - 8



Add / Drop	Name (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yyyy)	Sex M/F	*Rel.
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**– SUPPLEMENTAL INSURANCE INFORMATION SECTION –**

COMPLETION OF THE SUPPLEMENTAL ENROLLMENT FORM MEANS THAT YOU HAVE READ AND AGREE TO COMPLY WITH THE FOLLOWING:

- Depending on the monthly benefit you select, you are guaranteed to be issued a coverage amount at 66 2/3 of your income, up to \$3,000 a month. Be sure you pick a monthly benefit amount less than or equal to 66 2/3 of your monthly income.
- To enroll in the supplemental Accident and/or Disability plans, you must enroll through People First either with this enrollment form or by enrolling online. In addition, you must meet with a Colonial agent to complete the enrollment process. See the list of agents in the Colonial brochure located on People First under the Benefit Materials tab.
- **Sending this form and/or the company's policy application directly to the insurance company does not mean you are enrolled - you must enroll through People First by this form or online.**
- Disability insurance benefits are paid at different times depending on whether you have an accident or you are sick, as defined by the policy. This time frame is called an "elimination period," which means this is the number of days you must wait before benefits start. For example, the elimination period "0/14" means the accident benefit starts immediately (zero days) and the sickness benefit starts 14 consecutive days after you become ill (on the 15<sup>th</sup> day).
- The enrollment form (or go online) must be used to enroll in or change coverage. **No changes will be accepted by e-mail or letter.**
- Review your current benefits and the available plans and options.
- Enrolling in a supplemental insurance plan or changing options automatically stops other coverage you currently have. If you want to **stop your current coverage**, you must place an "S" for Stop in the box provided for that plan and coverage level on the front of this form. Only complete lower section on the front of this form if you wish to stop plans currently not offered.
- If you cancel or do not enroll in supplemental insurance, **you will not be able to enroll again until the next annual open enrollment period, unless you experience a Qualifying Status Change.**
- Supplemental premiums are deducted on a pre-tax basis.
- Please ensure that your enrollment selections are in effect. **Check your payroll warrants to be sure the correct deductions are taken.** Call the People First Service Center immediately if these deductions are not correct.
- **I understand my enrollment and/or changes will be effective the first of the month following a full payroll deduction. I also understand my elections are IRREVOCABLE until the next annual open enrollment period, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within thirty-one (31) calendar days of the Qualifying Status Change.**

Please **MAIL** or **FAX** your completed and signed enrollment form and Qualified Status Change form, if applicable, to the People First Service Center at the address or fax number noted below.

People First Service Center  
Post Office Box 6830  
Tallahassee, FL 32314  
**FAX: (904) 828-6092**

**DO NOT SIGN THE SUPPLEMENTAL ENROLLMENT FORM UNLESS YOU HAVE A CLEAR UNDERSTANDING OF THE OPTIONS YOU SELECTED.**

The telephone numbers for the Supplemental Insurance Companies are available:

1. in the Supplemental Brochures and in the Benefits Guide
2. on the People First Web site @ <https://peoplefirst.myflorida.com>
3. by calling a Benefits Specialist at (866) 663-4735