



SUPPLEMENTAL CANCER / INTENSIVE CARE INSURANCE 2009 ENROLLMENT FORM (Please Print)



Select your Enrollment Type:

New Hire Open Enrollment

Qualifying Status Change

Note: If checked, you must also complete and submit a Qualifying Status Change form.

SSN:

EEID: 0 0

Name: _____

Agency Name: _____

Complete Mailing Address: _____

Work Phone: () _____ Home Phone: () _____ Sex (M/F): _____ Birth Date: / /

PART 1: TO ENROLL: Place an E in only ONE of the Cancer Plans and/or the Hospital Intensive Care Plan, then Check () ONE RESPECTIVE COVERAGE LEVEL.

NOTE: You may only enroll in one Cancer Plan and/or Hospital Intensive Care Plan. Enrollment in multiple plans is not permitted.

TO STOP COVERAGE: Place an S in the appropriate CANCER PLAN box.

(Premiums listed are monthly, divide by two for bi-weekly amounts)

Plan Name	Benefit Plan Code	Employee	Employee + Children	Employee + Family
COLONIAL				
<input type="checkbox"/> Cancer	6600	<input type="checkbox"/> \$10.94	<input type="checkbox"/>	<input type="checkbox"/> \$18.18
<input type="checkbox"/> Cancer / Intensive Care	7500	<input type="checkbox"/> \$13.96	<input type="checkbox"/>	<input type="checkbox"/> \$24.48
AFLAC Cancer				
<input type="checkbox"/> PCI Level 1	6500	<input type="checkbox"/> \$18.70	<input type="checkbox"/> \$21.70	<input type="checkbox"/> \$30.50
<input type="checkbox"/> PCI Level 1 + SDR	6501	<input type="checkbox"/> \$19.70	<input type="checkbox"/> \$23.20	<input type="checkbox"/> \$32.50
<input type="checkbox"/> PCI Level 1 + BBR	6502	<input type="checkbox"/> \$20.50	<input type="checkbox"/> \$24.40	<input type="checkbox"/> \$34.40
<input type="checkbox"/> PCI Level 1 + Both	6503	<input type="checkbox"/> \$21.50	<input type="checkbox"/> \$25.90	<input type="checkbox"/> \$36.40
<input type="checkbox"/> PCI Level 3	6510	<input type="checkbox"/> \$33.50	<input type="checkbox"/> \$40.20	<input type="checkbox"/> \$55.90
<input type="checkbox"/> PCI Level 3 + SDR	6511	<input type="checkbox"/> \$34.50	<input type="checkbox"/> \$41.70	<input type="checkbox"/> \$57.90
<input type="checkbox"/> PCI Level 3 + BBR	6512	<input type="checkbox"/> \$36.50	<input type="checkbox"/> \$44.70	<input type="checkbox"/> \$62.40
<input type="checkbox"/> PCI Level 3 + Both	6513	<input type="checkbox"/> \$37.50	<input type="checkbox"/> \$46.20	<input type="checkbox"/> \$64.40
<input type="checkbox"/> AFLAC Hospital Intensive Care	7000	<input type="checkbox"/> \$8.70	<input type="checkbox"/>	<input type="checkbox"/> \$16.64

PART 2: STOP OLD POLICIES. Enter the plan codes of policies not listed above that you no longer wish to carry. For assistance call the People First Service Center.

Plan Code Plan Code Plan Code Plan Code

PART 3: ADD / DROP DEPENDENTS - 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.
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					

PART 4: 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 INSURANCE INFORMATION SECTION –

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

- Review your current benefits and the available plans and options.
- The enrollment form must be used to enroll in or change coverages. **No changes will be accepted by e-mail or letter.**
- Enrolling in a supplemental insurance plan, or changing options, does not automatically stop other coverages you currently have. If you want to **stop your existing coverage**, you must place an “S” in the box provided for that Plan on the front of this form (Part 1). Only complete Part 2 on the front of this form if you wish to stop plans currently not offered.
- The Supplemental Enrollment Form **must** be submitted to the People First Service Center. **Enrollment changes will not occur if forms and/or applications and the Supplemental Company Application are submitted directly to the supplemental insurance company.**
- 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.
- It is your responsibility to ensure that your enrollment selections are in effect. **Check your payroll warrants to ensure that your deductions properly reflect your selections.** Contact 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 website @ <https://peoplefirst.myflorida.com>
- 3) by calling a Benefits Specialist at 1 (866) ONE-HRFL (1-866-663-4735)