DEPARTMENT OF MANAGEMENT SERVICES

SUPPLEMENTAL ACCIDENT INSURANCE 2012 ELECTION FORM

(Please Print)

People First STATE OF FLORIDA HR

The terms and conditions of your participation are contained in your Certificate of Coverage or Plan Document.

Check Appropriate Box: ☐ New Hire ☐ Open Enrollment ☐ Qualifying Status Change (QSC) Event (see attached chart)

QSC Code: _____

QSC Name: _____

QSC Date: _____

Employee Information - All Fields Required:

People First ID: 0 0 | | | | | | |

First Name: | | | | | | | | | | | | | | | | | | | | |

Last Name: | | | | | | | | | | | | | | | | | | | | |

Complete Mailing Address: _____

Birth Date: ____/____/_____ Male: _____ Female: _____

Work Phone: (_____)_____ Home Phone: (_____)_____

PART 1: COLONIAL ACCIDENT COVERAGE - PLAN CODE 5002

Coverage Level	Monthly Cost	Enroll	Cancel	Coverage Level	Monthly Cost	Enroll	Cancel
Employee Only	$18.00			Employee + Child(ren)	$30.00		
Employee + Spouse	$24.00			Employee + Family	$36.00		

PART 2: To **CANCEL** closed plans, enter the plan code(s) of the plans not listed in Part 1 that you no longer wish to carry. You will not be able to re-enroll. Refer to your most recent benefits statement or your policy for the correct plan code. For help, call the People First Service Center at (866) 663-4735.

Plan Code: | | | | | Plan Code: | | | | | Plan Code: | | | | |

PART 3: ADD / DROP DEPENDENTS - Please print (Attach additional page if necessary.)

Check the appropriate column to **ADD** eligible dependents not currently covered and/or to **DROP** ineligible dependents

To complete the Relation column, use the number that describes your dependent(s):

Spouse - 1, Child - 2, Legal Guardianship - 3, Grandchild - 4, Legally Adopted Child - 5, Foster Child - 6, Stepchild - 7, Over-age Dependent - 9

Add	Drop	Name (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yyyy)	Male	Female	Relation

PART 4: EMPLOYEE CERTIFICATION

I have read and agree to the conditions listed in the Supplemental Accident Insurance Election Information page. Enrollment may be subject to the underwriting requirements of the carrier. I authorize deductions of the required contributions. I understand that my elections can only be changed during open enrollment or if I have a Qualifying Status Change event as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within 31 calendar days of the Qualifying Status Change event.

Employee Signature: _____ **Date:** _____

Mail form to People First Service Center • PO Box 6830 • Tallahassee, FL 32314
or Fax to (800) 422-3128