



**SUPPLEMENTAL
CANCER INTENSIVE CARE INSURANCE
2012 ELECTION FORM
(Please Print)**



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:

First Name:

Last Name:

Complete Mailing Address: _____

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

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

PART 1: To **ENROLL**, check the box next to the monthly premium for the plan and coverage level you want. If you choose an Aflac plan, you must submit a separate application to Aflac.
To **CANCEL** coverage, check the box next to the monthly premium and coverage level you want to cancel.

Plan Name	Benefit Plan Code	Employee			Employee + Child(ren)			Employee + Family		
		Cost	Enroll	Cancel	Cost	Enroll	Cancel	Cost	Enroll	Cancel
Aflac Cancer PCI Level 1	6500	\$18.70			\$21.70			\$30.50		
PCI Level 1 + SDR	6501	\$19.70			\$23.20			\$32.50		
PCI Level 1 + BBR	6502	\$20.50			\$24.40			\$34.40		
PCI Level 1 + Both	6503	\$21.50			\$25.90			\$36.40		
PCI Level 3	6510	\$33.50			\$40.20			\$55.90		
PCI Level 3 + SDR	6511	\$34.50			\$41.70			\$57.90		
PCI Level 3 + BBR	6512	\$36.50			\$44.70			\$62.40		
PCI Level 3 + Both	6513	\$37.50			\$46.20			\$64.40		
Colonial Life Cancer	6601	\$12.50			N/A			\$20.90		

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 Cancer 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**