

SUPPLEMENTAL ACCIDENT AND DISABILITY INSURANCE ELECTION INFORMATION



Please read this page carefully. Signing the election form means you have read and agree to the following and understand the options you chose on the election form:

- Review your current benefits and the available plans and options, and then select the benefit options most suited to your personal needs.
- Enrolling in a pretax accident and disability plan or changing coverage levels will automatically stop other pretax accident and disability plan coverage. If you only want to drop your existing coverage, you must check the box next to the plan name and coverage level you want to drop. Only complete Part 2 if you wish to drop old plans not listed in Part 1.
- Send required documentation to the People First Service Center (address below) when you add eligible dependents or drop ineligible dependents from your plans. You must provide documentation or risk losing coverage.
- You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received while your dependent was incorrectly listed as eligible.
- If you are dropping all of your dependents, you must change your coverage to individual.
- You must send election forms directly to the People First Service Center. Enrollment changes cannot be processed if forms and/or applications are sent to the supplemental insurance company.
- If you cancel your accident and disability insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event.
- Your elections will remain in effect for the remainder of the calendar year unless you experience a
 qualifying status change event, as defined by the Internal Revenue Code and/or the Florida Administrative
 Code.
- Your effective date of coverage will be the first of the month following receipt of this form and a full month's premium.
- Pretax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. If you do not wish to have your premiums deducted on a pretax basis, you must complete a Pretax Premium Waiver Form.
- Mail or fax your completed and signed election form and Qualifying Status Change form, if applicable, directly to the People First Service Center (forms sent to the insurance company cannot be processed):

People First Service Center PO Box 6830 Tallahassee, FL 32314

FAX: (904) 828-6092

- For help, call (866) 663-4735 or TTY (866) 221-0268, Monday through Friday, from 8:30 a.m. to 5:30 p.m.
 Eastern Time.
- Make elections online at https://PeopleFirst.MyFlorida.com and learn more about plans, use the cost estimator and find providers and insurance companies at MyFlorida.com/MyBenefits.

Please note: Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.



SUPPLEMENTAL ACCIDENT/DISABILITY INSURANCE 2010 ELECTION FORM (Please Print)



Check Appropriate Box:				Ne	ew Hire	е		Ope	n En	rollmei	nt	Qualifying Statue Change Event Note: If checked, you must complete and submit a Qualifying Status
Employee Information	- All Fields	Require	ed:									Change Event form.
People First ID: 0	0 0											
First Name:												
Last Name:												
Complete Mailing Address	ss:											
Birth Date:/					Male	e:				Femal	le:	
Work Phone: ()					Hom	ne Ph	one:	-	()		

COLONIAL DISABILITY COVERAGE - PLAN CODE 5020

Monthly Disability Benefit

To ADD, check the box next to the monthly premium for the plan and coverage level you want. To DROP coverage, check the box next to the monthly premium and coverage level you want to drop.

	To DROP coveraç		ox next to the	montniy	premiur	n and cover	age ievei	you war	it to arop.		
Elimination Period Accident/Sick	Age Bands	Benefit Period Months	\$500	/Month		\$1,00	0/Month		\$1,50		
				Add	Drop		Add	Drop		Add	Drop
0/7	17-49	3	\$17.50			\$35.00			\$52.50		
7/7	17-49	3	\$15.75			\$31.50			\$47.25		
0/14	17-49	3	\$12.75			\$25.50			\$38.25		
14/14	17-49	3	\$11.25			\$22.50			\$33.75		
0/7	50-69	3	\$20.25			\$40.50			\$60.75		
7/7	50-69	3	\$19.00			\$38.00			\$57.00		
0/14	50-69	3	\$15.25			\$30.50			\$45.75		
14/14	50-69	3	\$13.75			\$27.50			\$41.25		
0/7	17-49	6	\$22.75			\$45.50			\$68.25		
7/7	17-49	6	\$20.00			\$40.00			\$60.00		
0/14	17-49	6	\$17.75			\$35.50			\$53.25		
14/14	17-49	6	\$15.00			\$30.00			\$45.00		
0/30	17-49	6	\$14.25			\$28.50			\$42.75		
30/30	17-49	6	\$10.50			\$21.00			\$31.50		
0/7	50-69	6	\$28.25			\$56.50			\$84.75		
7/7	50-69	6	\$26.50			\$53.00			\$79.50		
0/14	50-69	6	\$22.00			\$44.00			\$66.00		
14/14	50-69	6	\$19.75			\$39.50			\$59.25		
0/30	50-69	6	\$18.75			\$37.50			\$56.25		
30/30	50-69	6	\$14.75			\$29.50			\$44.25		
0/7	17-49	12	\$31.25			\$62.50			\$93.75		
7/7	17-49	12	\$27.50			\$55.00			\$82.50		
0/14	17-49	12	\$24.00			\$48.00			\$72.00		
14/14	17-49	12	\$19.75			\$39.50			\$59.25		
0/30	17-49	12	\$18.00			\$36.00			\$54.00		
30/30	17-49	12	\$14.25			\$28.50			\$42.75		
0/7	50-69	12	\$37.50			\$75.00			\$112.50		
7/7	50-69	12	\$34.25			\$68.50			\$102.75		
0/14	50-69	12	\$29.75			\$59.50			\$89.25		
14/14	50-69	12	\$25.25			\$50.50			\$75.75		
0/30	50-69	12	\$22.75			\$45.50			\$68.25		
30/30	50-69	12	\$19.00			\$38.00			\$57.00		

SUPPLEMENTAL ACCIDENT/DISABILITY INSURANCE 2010 ELECTION FORM PAGE 2 of 3

People First ID:	0	0									
First Name:											
Last Name											

COLONIAL DISABILITY COVERAGE - PLAN CODE 5020 (Continued)

Monthly Disability Benefit

To ADD, check the box next to the monthly premium for the plan <u>and</u> coverage level you want. To DROP coverage, check the box next to the monthly premium amount you want to drop.

Elimination Period Accident/Sick	Age Bands	Benefit Period Months	\$2,00	0/Month		\$2,50	0/Month		\$3,000/Month			
				Add	Drop		Add	Drop		Add	Dro	
0/7	17-49	3	\$70.00			\$87.50			\$105.00		<u> </u>	
7/7	17-49	3	\$63.00			\$78.75			\$94.50			
0/14	17-49	3	\$51.00			\$63.75			\$76.50			
14/14	17-49	3	\$45.00			\$56.25			\$67.50		 	
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0/7	50-69	3	\$81.00	T		\$101.25	T		\$121.50			
7/7	50-69	3	\$76.00			\$95.00			\$114.00			
0/14	50-69	3	\$61.00			\$76.25			\$91.50			
14/14	50-69	3	\$55.00			\$68.75			\$82.50			
								<u> </u>				
0/7	17-49	6	\$91.00			\$113.75			\$136.50			
7/7	17-49	6	\$80.00			\$100.00			\$120.00			
0/14	17-49	6	\$71.00			\$88.75			\$106.50			
14/14	17-49	6	\$60.00			\$75.00			\$90.00			
0/30	17-49	6	\$57.00			\$71.25			\$85.50			
30/30	17-49	6	\$42.00			\$52.50			\$63.00			
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0/7	50-69	6	\$113.00			\$141.25			\$169.50			
7/7	50-69	6	\$106.00			\$132.50			\$159.00			
0/14	50-69	6	\$88.00			\$110.00			\$132.00			
14/14	50-69	6	\$79.00			\$98.75			\$118.50			
0/30	50-69	6	\$75.00			\$93.75			\$112.50			
30/30	50-69	6	\$59.00			\$73.75			\$88.50			
0/7	17-49	12	\$125.00			\$156.25			\$187.50			
7/7	17-49	12	\$110.00			\$137.50			\$165.00			
0/14	17-49	12	\$96.00			\$120.00			\$144.00			
14/14	17-49	12	\$79.00			\$98.75			\$118.50			
0/30	17-49	12	\$72.00			\$90.00			\$108.00			
30/30	17-49	12	\$57.00			\$71.25			\$85.50			
0/7	50-69	12	\$150.00			\$187.50			\$225.00			
7/7	50-69	12	\$137.00			\$171.25			\$205.50			
0/14	50-69	12	\$119.00			\$148.75			\$178.50			
14/14	50-69	12	\$101.00			\$126.25			\$151.50			
0/30	50-69	12	\$91.00			\$113.75			\$136.50			
30/30	50-69	12	\$76.00		İ	\$95.00			\$114.00			

COLONIAL ACCIDENT COVERAGE - PLAN CODE 5002														
Coverage Level Monthly Cost Add Drop Coverage Level Monthly Cost														
Employee Only	\$18.00			Employee + Child(ren)	\$30.00									
Employee + Spouse	\$24.00			Employee + Family	\$36.00									

If you are enrolling in a plan that covers dependents, you must complete the required information on page 3 of this form.

SUPPLEMENTAL ACCIDENT/DISABILITY INSURANCE 2010 ELECTION FORM PAGE 3 of 3

People	First ID:	0	0							l																
First Na	ame:																									
Last Na	ame:																									
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															ī											
COI	LONIAL	ACCI	DEN	NT C	OV	/ER	AG	E -	PLA	N C	OD	E 5	000					CO	LOI	NIA	L A	/CC	CIDENT/DISABILITY -	PLAN (ODE 5	5010
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	P	lans 5	000 a	nd 50	010 a	are o	old (c	lose	d) pl	ans. `	You	may	/ kee	ро	r can	cel	the p	olan,	but i	if yo	u ca	ance	l, you cannot re-enroll at a	ater date.		
ADD /	DROP D	EPE	NDE	NT	- Pi	leas	se p	rint	t (At	tach	ad	dit	iona	al p	oago	e if	nec	cess	sarv	/.)						
							_		•											•	RO	P ir	neligible dependents.			
To com	plete the	Relat	ion c	olun	nn, '	use	the	nun	nber	that	des	crib	es y	ou/	r de	pen	iden	t(s).								
Spouse	-1, Child -	2, Leg	al Gu	ardia	ansh	ıip -3	3, Gr	ando	child	-4, Le	gall	y Ac	dopte	ed C	Child	-5,	Fost	er Ch	nild -	-6, S	tep	Chi	ld -7, Unborn Child -8, Ove	rage Dep	endent -	9
Add	d Drop Name (Last, First, MI)									Social Security Number									Date of Birth (mm/dd/yyyy)	Male	Female	Relation				
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elections	s can only	be cha	anged	d dur	ring t	the n	next a	annu	ıal op	pen er	nroll	mer	nt pe	riod	or if	f I ha	ave a	a qua	alifyii	ng st	tatu	ıs ch	nange event as defined by	he Federa	al Interna	
Revenue	e Code an	d/or th	e Flo	rida .	Adm	inist	trativ	e Co	ode.	I und	lerst	and	that	l m	ust r	requ	est :	such	cha	nges	s wi	thin	31 calendar days of the qu	alifying e	rent.	
Emplo	yee Signa	ature:																					Date:			_
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or Fax to (904) 828-6092