



# SUPPLEMENTAL HOSPITAL INSURANCE

(Alta 8000 – 8020 Plans)  
2008 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.

SS#:

EEID:  0  0

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

Complete Mailing Address: \_\_\_\_\_

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

**TO ENROLL:** Place an "E" (enroll) in one Hospital Plan, then Check (✓) ONE RESPECTIVE COVERAGE LEVEL

**PART 1:** **NOTE:** You may only enroll in one Hospital Plan. Enrollment in multiple plans is not permitted.

Premiums listed are monthly, divide by 2 for bi-weekly amounts.

**TO STOP COVERAGE:** Place an "S" in the appropriate HOSPITAL PLAN box.

**Alta PPP Plan**  
**Plan Code 8000**

**Alta 30/20 Plan**  
**Plan Code 8010**

**Alta SIS Plan**  
**Plan Code 8020**

01 Employee

20 Family

01 Employee

20 Family

01 Employee

20 Family

Age	Single	Family	Age	Single	Family	Age	Single	Family	Age	Single	Family	Age	Single	Family	Age	Single	Family
18	\$17.76	\$38.64	49	\$33.40	\$70.74	18	\$29.10	\$63.76	49	\$54.68	\$116.76	18	\$18.02	\$39.22	49	\$33.88	\$71.80
19	\$17.80	\$38.90	50	\$34.62	\$72.86	19	\$29.14	\$64.22	50	\$56.68	\$120.26	19	\$18.06	\$39.50	50	\$35.12	\$73.96
20	\$17.80	\$38.82	51	\$35.84	\$74.96	20	\$29.14	\$64.62	51	\$58.68	\$123.72	20	\$18.06	\$39.74	51	\$36.36	\$76.08
21	\$17.90	\$39.56	52	\$36.80	\$76.50	21	\$29.28	\$65.30	52	\$60.24	\$126.26	21	\$18.14	\$40.16	52	\$37.32	\$77.64
22	\$17.98	\$39.98	53	\$37.68	\$77.86	22	\$29.44	\$66.00	53	\$61.68	\$128.50	22	\$18.24	\$40.58	53	\$38.22	\$79.02
23	\$18.08	\$40.40	54	\$38.68	\$79.42	23	\$29.60	\$66.70	54	\$63.30	\$131.10	23	\$18.34	\$41.02	54	\$39.22	\$80.62
24	\$18.18	\$40.84	55	\$39.96	\$81.58	24	\$29.74	\$67.40	55	\$65.40	\$134.66	24	\$18.42	\$41.44	55	\$40.52	\$82.80
25	\$18.42	\$41.62	56	\$41.22	\$83.68	25	\$30.16	\$68.70	56	\$67.46	\$138.10	25	\$18.68	\$42.24	56	\$41.80	\$84.94
26	\$18.80	\$42.72	57	\$42.22	\$85.24	26	\$30.80	\$70.52	57	\$69.12	\$140.70	26	\$19.08	\$43.36	57	\$42.82	\$86.52
27	\$19.18	\$43.82	58	\$43.24	\$86.84	27	\$31.42	\$72.32	58	\$70.78	\$143.32	27	\$19.46	\$44.48	58	\$43.86	\$88.14
28	\$19.58	\$44.92	59	\$44.20	\$88.26	28	\$32.04	\$74.16	59	\$72.34	\$145.70	28	\$19.84	\$45.60	59	\$44.82	\$89.60
29	\$20.10	\$46.40	60	\$45.42	\$90.22	29	\$32.92	\$76.58	60	\$74.34	\$148.90	29	\$20.40	\$47.10	60	\$46.06	\$91.58
30	\$20.62	\$47.82	61	\$46.62	\$92.14	30	\$33.74	\$78.92	61	\$76.30	\$152.06	30	\$20.90	\$48.54	61	\$47.28	\$93.52
31	\$21.16	\$49.34	62	\$47.68	\$93.74	31	\$34.64	\$81.44	62	\$78.04	\$154.72	31	\$21.46	\$50.08	62	\$48.36	\$95.16
32	\$21.70	\$50.84	63	\$48.26	\$94.40	32	\$35.52	\$83.90	63	\$78.98	\$155.82	32	\$22.00	\$51.60	63	\$48.94	\$95.82
33	\$22.16	\$52.20	64	\$48.88	\$95.16	33	\$36.28	\$86.14	64	\$80.02	\$157.06	33	\$22.48	\$52.98	64	\$49.58	\$96.58
34	\$22.62	\$53.54	65	\$49.82	\$96.48	34	\$37.04	\$88.38	65	\$81.54	\$159.26	34	\$22.94	\$54.36	65	\$50.52	\$97.94
35	\$23.16	\$54.56	66	\$50.74	\$98.04	35	\$37.92	\$90.04	66	\$83.06	\$161.80	35	\$23.50	\$55.38	66	\$51.46	\$99.50
36	\$23.74	\$55.40	67	\$51.68	\$99.84	36	\$38.86	\$91.44	67	\$84.60	\$164.80	36	\$24.08	\$56.24	67	\$52.42	\$101.34
37	\$24.18	\$55.96	68	\$52.66	\$101.76	37	\$39.58	\$92.38	68	\$86.22	\$167.94	37	\$24.52	\$56.80	68	\$53.42	\$103.28
38	\$24.66	\$56.58	69	\$53.64	\$103.60	38	\$40.36	\$93.40	69	\$87.78	\$171.02	38	\$25.00	\$57.44	69	\$54.40	\$105.16
39	\$25.24	\$57.46				39	\$41.32	\$94.84				39	\$25.60	\$58.32	70	\$55.40	\$107.12
40	\$25.98	\$58.68				40	\$42.54	\$96.84				40	\$26.36	\$59.56	71	\$56.40	\$109.04
41	\$26.66	\$59.70				41	\$43.62	\$98.56				41	\$27.02	\$60.60	72	\$57.44	\$111.06
42	\$27.28	\$60.66				42	\$44.66	\$100.12				42	\$27.68	\$61.58	73	\$58.48	\$113.08
43	\$28.00	\$61.80				43	\$45.84	\$102.00				43	\$28.40	\$62.74	74	\$59.54	\$115.12
44	\$28.80	\$63.10				44	\$47.14	\$104.14				44	\$29.20	\$64.04	75	\$60.64	\$117.24
45	\$29.88	\$65.00				45	\$48.92	\$107.28				45	\$30.30	\$65.98	76	\$61.74	\$119.40
46	\$30.98	\$66.94				46	\$50.72	\$110.48				46	\$31.42	\$67.94	77	\$62.88	\$121.58
47	\$31.80	\$68.22				47	\$52.04	\$112.60				47	\$32.24	\$69.24	78	\$64.06	\$123.84
48	\$32.56	\$69.40				48	\$53.30	\$114.54				48	\$33.02	\$70.44	79	\$65.20	\$126.06

**SEE NEXT PAGE FOR ADDITIONAL PLAN OPTIONS**  
**SEE PAGE 3 FOR DEPENDENT ENROLLMENT INFORMATION**  
**SEE PAGE 4 FOR ADDITIONAL ENROLLMENT INFORMATION**



# SUPPLEMENTAL HOSPITAL INSURANCE

(Alta 8030 -- 8040 & PALIC Plans)  
2008 ENROLLMENT FORM  
(Please Print)



Select Your Enrollment Type:  New Hire

Open Enrollment

Qualifying Status Change

SS#:

EEID:  0  0

**NOTE:** If checked, you must also complete and submit a Qualifying Status Change Form.

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

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

Complete Mailing Address: \_\_\_\_\_

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

**TO ENROLL:** Place an "E" (enroll) in one Hospital Plan, then Check (✓) ONE RESPECTIVE COVERAGE LEVEL

**PART 1:** **NOTE:** You may only enroll in one Hospital Plan. Enrollment in multiple plans is not permitted.

Premiums listed are monthly, divide by 2 for bi-weekly amounts.

**TO STOP COVERAGE:** Place an "S" in the appropriate HOSPITAL PLAN box.

**Alta 365 Plus \$100/Per Day Plan**  
**Plan Code 8030**  
 01 Employee  20 Family

**Alta 365 Plus \$200/Per Day Plan**  
**Plan Code 8040**  
 01 Employee  20 Family

**Philadelphia American Plan**

Age	Single	Family	Age	Single	Family	Age	Single	Family	Age	Single	Family	Philadelphia American Plan \$100/Per Day			
18	\$5.32	\$12.36	49	\$10.02	\$22.64	18	\$11.04	\$25.64	49	\$20.76	\$46.94	Plan Code	Employee	Employee + 1	Employee + 2 Or More
19	\$5.34	\$12.46	50	\$10.38	\$23.32	19	\$11.06	\$25.82	50	\$21.52	\$48.34				
20	\$5.34	\$12.54	51	\$10.76	\$24.00	20	\$11.06	\$25.98	51	\$22.28	\$49.74	8060	<input type="checkbox"/> \$9.58	<input type="checkbox"/> \$19.20	<input type="checkbox"/> \$25.18
21	\$5.36	\$12.66	52	\$11.04	\$24.48	21	\$11.12	\$26.26	52	\$22.88	\$50.76				
22	\$5.40	\$12.80	53	\$11.30	\$24.92	22	\$11.18	\$26.54	53	\$23.42	\$51.66				
23	\$5.42	\$12.94	54	\$11.60	\$25.42	23	\$11.24	\$26.82	54	\$24.04	\$52.70				
24	\$5.44	\$13.06	55	\$11.98	\$26.12	24	\$11.30	\$27.10	55	\$24.84	\$54.14				
25	\$5.52	\$13.32	56	\$12.36	\$26.78	25	\$11.44	\$27.62	56	\$25.62	\$55.52				
26	\$5.64	\$13.68	57	\$12.66	\$27.28	26	\$11.68	\$28.36	57	\$26.24	\$56.58	Plan Code	Employee	Employee + 1	Employee + 2 Or More
27	\$5.76	\$14.02	58	\$12.98	\$27.80	27	\$11.92	\$29.08	58	\$26.88	\$57.62				
28	\$5.86	\$14.38	59	\$13.26	\$28.26	28	\$12.16	\$29.82	59	\$27.46	\$58.58	8070	<input type="checkbox"/> \$20.36	<input type="checkbox"/> \$40.60	<input type="checkbox"/> \$53.52
29	\$6.02	\$14.84	60	\$13.62	\$28.88	29	\$12.50	\$30.78	60	\$28.22	\$59.86				
30	\$6.18	\$15.30	61	\$13.98	\$29.50	30	\$12.82	\$31.74	61	\$28.98	\$61.14				
31	\$6.34	\$15.80	62	\$14.30	\$30.00	31	\$13.16	\$32.74	62	\$29.64	\$62.22				
32	\$6.50	\$16.28	63	\$14.48	\$30.22	32	\$13.48	\$33.74	63	\$30.00	\$62.64				
33	\$6.64	\$16.70	64	\$14.66	\$30.46	33	\$13.78	\$34.64	64	\$30.38	\$63.14	Plan Code	Employee	Employee + 1	Employee + 2 Or More
34	\$6.78	\$17.14	65	\$14.94	\$30.88	34	\$14.06	\$35.54	65	\$30.96	\$64.04				
35	\$6.94	\$17.46	66	\$15.22	\$31.38	35	\$14.40	\$36.20	66	\$31.54	\$65.06	8080	<input type="checkbox"/> \$12.92	<input type="checkbox"/> \$25.86	<input type="checkbox"/> \$32.72
36	\$7.12	\$17.74	67	\$15.50	\$31.96	36	\$14.76	\$36.76	67	\$32.12	\$66.26				
37	\$7.26	\$17.92	68	\$15.80	\$32.58	37	\$15.04	\$37.14	68	\$32.74	\$67.52				
38	\$7.40	\$18.12	69	\$16.08	\$33.16	38	\$15.32	\$37.56	69	\$33.34	\$68.76				
39	\$7.58	\$18.40	70	\$16.38	\$33.78	39	\$15.68	\$38.12	70	\$33.96	\$70.04				
40	\$7.80	\$18.78	71	\$16.68	\$34.40	40	\$16.16	\$38.94	71	\$34.56	\$71.30				
41	\$8.00	\$19.12	72	\$17.00	\$35.02	41	\$16.56	\$39.62	72	\$35.20	\$72.60				
42	\$8.18	\$19.42	73	\$17.30	\$35.66	42	\$16.96	\$40.26	73	\$35.84	\$73.94				
43	\$8.40	\$19.78	74	\$17.62	\$36.30	43	\$17.40	\$41.02	74	\$36.50	\$75.28				
44	\$8.64	\$20.20	75	\$17.94	\$36.98	44	\$17.90	\$41.88	75	\$37.16	\$76.64				
45	\$8.96	\$20.80	76	\$18.26	\$37.66	45	\$18.58	\$43.14	76	\$37.84	\$78.06				
46	\$9.30	\$21.42	77	\$18.60	\$38.34	46	\$19.26	\$44.42	77	\$38.54	\$79.50				
47	\$9.54	\$21.84	78	\$18.94	\$39.06	47	\$19.76	\$45.28	78	\$39.26	\$80.98				
48	\$9.76	\$22.22	79	\$19.28	\$39.76	48	\$20.24	\$46.06	79	\$39.96	\$82.42				

**PART 2:** To **STOP OLD POLICIES:** Enter the plan codes of the policies not listed above that you no longer wish to carry. For assistance, call the People First Service Center at 1-866-663-4735.

Plan Code:     Plan Code:     Plan Code:     Plan Code:

**SEE PREVIOUS PAGE FOR ADDITIONAL PLAN OPTIONS**  
**SEE PAGE 3 FOR DEPENDENT ENROLLMENT INFORMATION**  
**SEE PAGE 4 FOR ADDITIONAL ENROLLMENT INFORMATION**



**SUPPLEMENTAL HOSPITAL INSURANCE**  
*Dependent Information & Employee Signature*  
**2008 ENROLLMENT FORM**  
 (Please Print)



**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 No.									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"/>													
<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). 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 Charge.

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

Date: \_\_\_\_\_

**SEE NEXT PAGE FOR ADDITIONAL ENROLLMENT INFORMATION**  
**SEE PAGE 1 & 2 FOR ENROLLMENT OPTIONS**

- 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, will automatically stop other Hospital Plan coverage you previously elected. If you only 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 (Page 1 or 2). Only complete Part 2 (Page 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 **Qualifying** 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)