



SUPPLEMENTAL CANCER / INTENSIVE CARE INSURANCE 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.

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.**

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

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.

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