



SUPPLEMENTAL ACCIDENT / DISABILITY 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 either ACCIDENT PROTECTION or ACCIDENT / DISABILITY PLAN and then Check (✓) ONE RESPECTIVE COVERAGE LEVEL.
TO STOP COVERAGE: Place an **S** in the appropriate ACCIDENT / DISABILITY PLAN box.

<input type="checkbox"/> Colonial Accident Protection Plan (plan code 5000)	<input type="checkbox"/> Colonial Accident / Disability Plan (plan code 5010)
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee, Spouse, + Dependents	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee, Spouse, + Dependents
<input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Children	<input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Children

IF ENROLLING IN ACCIDENT / DISABILITY INSURANCE, THE COLONIAL AGENT MUST COMPLETE THE FOLLOWING SECTION:

Agent #: _____ Initials: _____ Employee Initials: _____ Total Monthly Premium:\$ _____

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

– 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 Accident/Disability 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). Only complete Part 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)