SUPPLEMENTAL HOSPITAL INSURANCE
2009 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: ____/____/____

PART 1:

TO **ENROLL:** Place an "**E**" (enroll) in a Hospital Plan box, then check (✓) ONE COVERAGE LEVEL.
TO **STOP** COVERAGE: Place an "**S**" in the appropriate HOSPITAL PLAN box.

Important: You may enroll in the Alta 8000 Plan **or** the Alta 8010 plan. Enrollment in both plans is not permitted. In addition, you may enroll in **one** of the following Alta plans: 8020, 8030 or 8040.

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

☐ **Alta PPP Plan Plan Code 8000**						☐ **Alta 30/20 Plan Plan Code 8010**					
☐ 01 Employee			☐ 20 Family			☐ 01 Employee			☐ 20 Family		
Age	Single	Family	Age	Single	Family	Age	Single	Family	Age	Single	Family
18	$14.58	$34.18	49	$33.88	$76.60	18	$23.94	$56.40	49	$58.08	$130.16
19	$14.60	$34.36	50	$35.54	$79.66	19	$23.94	$56.88	50	$60.82	$135.20
20	$14.62	$34.38	51	$37.22	$82.74	20	$24.08	$57.66	51	$63.00	$138.92
21	$14.78	$35.52	52	$38.56	$85.02	21	$24.26	$58.50	52	$65.02	$142.20
22	$14.84	$35.80	53	$39.78	$87.02	22	$24.42	$59.32	53	$67.30	$146.04
23	$14.94	$36.30	54	$41.18	$89.38	23	$24.58	$60.16	54	$70.28	$151.36
24	$15.04	$36.80	55	$43.02	$92.62	24	$25.04	$61.70	55	$73.26	$156.56
25	$15.32	$37.76	56	$44.84	$95.80	25	$25.74	$63.90	56	$75.66	$160.50
26	$15.74	$39.10	57	$46.30	$98.22	26	$26.44	$66.08	57	$78.10	$164.48
27	$16.18	$40.44	58	$47.80	$100.66	27	$27.14	$68.32	58	$80.42	$168.12
28	$16.62	$41.80	59	$49.22	$102.88	28	$28.14	$71.32	59	$83.38	$173.08
29	$17.22	$43.64	60	$51.02	$105.92	29	$29.10	$74.24	60	$86.34	$178.00
30	$17.80	$45.44	61	$52.84	$108.92	30	$30.12	$77.40	61	$88.96	$182.16
31	$18.44	$47.36	62	$54.44	$111.48	31	$31.14	$80.56	62	$90.42	$183.88
32	$19.06	$49.30	63	$55.34	$112.52	32	$32.04	$83.44	63	$91.98	$185.82
33	$19.60	$51.06	64	$56.28	$113.72	33	$32.92	$86.32	64	$94.32	$189.30
34	$20.14	$52.82	65	$57.72	$115.86	34	$33.98	$88.50	65	$96.68	$193.36
35	$20.80	$54.16	66	$59.16	$118.34	35	$35.10	$90.34	66	$99.06	$198.14
36	$21.48	$55.28	67	$60.62	$121.26	36	$36.00	$91.58	67	$101.60	$203.20
37	$22.02	$56.04	68	$62.18	$124.36	37	$36.94	$92.92	68	$104.08	$208.16
38	$22.60	$56.86	69	$63.70	$127.38	38	$38.12	$94.84	69	$106.66	$213.34
39	$23.32	$58.04				39	$39.62	$97.54			
40	$24.24	$59.68				40	$40.96	$99.82			
41	$25.06	$61.10				41	$42.28	$101.96			
42	$25.86	$62.40				42	$43.76	$104.52			
43	$26.78	$63.96				43	$45.42	$107.46			
44	$27.80	$65.76				44	$47.72	$111.80			
45	$29.20	$68.42				45	$50.08	$116.26			
46	$30.64	$71.16				46	$51.84	$119.24			
47	$31.72	$72.96				47	$53.50	$122.00			
48	$32.74	$74.66				48	$55.36	$125.16			

SEE NEXT PAGE FOR ADDITIONAL PLAN OPTIONS

SEE PAGE 4 FOR DEPENDENT ENROLLMENT INFORMATION

SEE PAGE 5 FOR ADDITIONAL ENROLLMENT INFORMATION

SUPPLEMENTAL HOSPITAL INSURANCE
2009 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: ___/___/___

PART 1:

TO **ENROLL:** Place an "**E**" (enroll) in a Hospital Plan box, then check (✓) ONE COVERAGE LEVEL.
TO **STOP** COVERAGE: Place an "**S**' in the appropriate HOSPITAL PLAN box.

Important: You may enroll in the Alta 8000 Plan **or** the Alta 8010 plan. Enrollment in both plans is not permitted. In addition, you may enroll in **one** of the following Alta plans: 8020, 8030 or 8040.

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

☐ **Alta SIS Plan Plan Code 8020**

☐ 01 Employee			☐ 20 Family		
Age	**Single**	**Family**	**Age**	**Single**	**Family**
18	$14.52	$34.20	49	$35.22	$78.94
19	$14.52	$34.48	50	$36.88	$82.00
20	$14.60	$34.96	51	$38.20	$84.24
21	$14.70	$35.48	52	$39.42	$86.24
22	$14.80	$35.98	53	$40.82	$88.58
23	$14.90	$36.48	54	$42.62	$91.80
24	$15.18	$37.42	55	$44.42	$94.94
25	$15.62	$38.74	56	$45.88	$97.34
26	$16.04	$40.08	57	$47.36	$99.76
27	$16.46	$41.44	58	$48.76	$101.96
28	$17.06	$43.26	59	$50.56	$104.96
29	$17.64	$45.02	60	$52.36	$107.94
30	$18.26	$46.94	61	$53.96	$110.48
31	$18.88	$48.86	62	$54.84	$111.52
32	$19.42	$50.60	63	$55.78	$112.70
33	$19.96	$52.34	64	$57.20	$114.82
34	$20.60	$53.68	65	$58.64	$117.26
35	$21.28	$54.80	66	$60.08	$120.16
36	$21.82	$55.54	67	$61.62	$123.24
37	$22.40	$56.36	68	$63.12	$126.24
38	$23.12	$57.52	69	$64.68	$129.38
39	$24.02	$59.16	70	$66.24	$132.50
40	$24.84	$60.54	71	$67.88	$135.76
41	$25.64	$61.84	72	$69.54	$139.08
42	$26.54	$63.38	73	$71.22	$142.44
43	$27.56	$65.16	74	$72.96	$145.92
44	$28.94	$67.80	75	$74.76	$149.52
45	$30.38	$70.52	76	$76.60	$153.18
46	$31.44	$72.32	77	$78.50	$157.00
47	$32.44	$73.98	78	$80.38	$160.76
48	$33.58	$75.90	79	$80.38	$160.76

☐ **Alta 365 Plus $100/Per Day Plan Plan Code 8030**

☐ 01 Employee			☐ 20 Family		
Age	**Single**	**Family**	**Age**	**Single**	**Family**
18	$3.42	$8.06	49	$8.30	$18.60
19	$3.42	$8.12	50	$8.70	$19.32
20	$3.44	$8.24	51	$9.00	$19.86
21	$3.46	$8.36	52	$9.30	$20.32
22	$3.48	$8.48	53	$9.62	$20.88
23	$3.52	$8.60	54	$10.04	$21.64
24	$3.58	$8.82	55	$10.46	$22.38
25	$3.68	$9.14	56	$10.82	$22.94
26	$3.78	$9.44	57	$11.16	$23.52
27	$3.88	$9.76	58	$11.50	$24.04
28	$4.02	$10.20	59	$11.92	$24.74
29	$4.16	$10.62	60	$12.34	$25.44
30	$4.30	$11.06	61	$12.72	$26.04
31	$4.44	$11.52	62	$12.92	$26.28
32	$4.58	$11.90	63	$13.14	$26.56
33	$4.70	$12.32	64	$13.48	$27.06
34	$4.86	$12.64	65	$13.82	$27.64
35	$5.02	$12.90	66	$14.16	$28.32
36	$5.14	$13.08	67	$14.52	$29.04
37	$5.28	$13.28	68	$14.88	$29.76
38	$5.44	$13.56	69	$15.24	$30.50
39	$5.66	$13.94	70	$15.62	$31.24
40	$5.86	$14.26	71	$16.00	$32.00
41	$6.04	$14.58	72	$16.38	$32.78
42	$6.26	$14.94	73	$16.78	$33.58
43	$6.50	$15.36	74	$17.20	$34.40
44	$6.82	$15.98	75	$17.62	$35.24
45	$7.16	$16.62	76	$18.06	$36.10
46	$7.40	$17.04	77	$18.50	$37.00
47	$7.64	$17.44	78	$18.94	$37.90
48	$7.92	$17.88	79	$18.94	$37.90

☐ **Alta 365 Plus $200/Per Day Plan Plan Code 8040**

☐ 01 Employee			☐ 20 Family		
Age	**Single**	**Family**	**Age**	**Single**	**Family**
18	$7.56	$17.80	49	$18.34	$41.10
19	$7.56	$17.96	50	$19.20	$42.70
20	$7.60	$18.20	51	$19.90	$43.86
21	$7.66	$18.46	52	$20.52	$44.90
22	$7.70	$18.72	53	$21.24	$46.12
23	$7.76	$19.00	54	$22.20	$47.80
24	$7.90	$19.48	55	$23.12	$49.44
25	$8.12	$20.18	56	$23.88	$50.68
26	$8.34	$20.86	57	$24.66	$51.94
27	$8.56	$21.58	58	$25.40	$53.08
28	$8.88	$22.52	59	$26.32	$54.66
29	$9.18	$23.44	60	$27.26	$56.20
30	$9.50	$24.44	61	$28.10	$57.52
31	$9.82	$25.44	62	$28.54	$58.06
32	$10.12	$26.34	63	$29.04	$58.68
33	$10.40	$27.24	64	$29.78	$59.78
34	$10.72	$27.94	65	$30.52	$61.06
35	$11.08	$28.52	66	$31.28	$62.56
36	$11.36	$28.92	67	$32.08	$64.16
37	$11.66	$29.34	68	$32.86	$65.74
38	$12.04	$29.94	69	$33.68	$67.36
39	$12.50	$30.80	70	$34.48	$68.98
40	$12.94	$31.52	71	$35.34	$70.68
41	$13.34	$32.20	72	$36.20	$72.42
42	$13.82	$33.00	73	$37.08	$74.16
43	$14.34	$33.92	74	$37.98	$75.98
44	$15.06	$35.30	75	$38.92	$77.84
45	$15.82	$36.72	76	$39.88	$79.76
46	$16.36	$37.66	77	$40.86	$81.74
47	$16.90	$38.52	78	$41.84	$83.70
48	$17.48	$39.52	79	$41.84	$83.70

SEE NEXT PAGE FOR ADDITIONAL PLAN OPTIONS

SEE PAGE 4 FOR DEPENDENT ENROLLMENT INFORMATION

SEE PAGE 5 FOR ADDITIONAL ENROLLMENT INFORMATION

SUPPLEMENTAL HOSPITAL INSURANCE
2009 ENROLLMENT FORM
(Please Print)

PART 1:	TO **ENROLL:** Place an "**E**" (enroll) in a Hospital Plan box, then check (✓) ONE COVERAGE LEVEL. TO **STOP** COVERAGE: Place an "**S**' in the appropriate HOSPITAL PLAN box. **Important:** You may enroll in any of the 3 Philadelpia Amer. Plans: 8060, 8070 and 8080. Multiple enrollments are permitted.	Premiums listed are monthly; divide by 2 for bi-weekly amounts.

☐ **Philadelphia American Plan $100/Per Day Plan Code 8060**		☐ **Philadelphia American Plan $200/Per Day Plan Code 8070**		☐ **Philadelphia American Plan $100/Per Day/ECR Plan Code 8080**	
Enrollment	**Cost**	**Enrollment**	**Cost**	**Enrollment**	**Cost**
☐ 01 Employee	**$9.58**	☐ 01 Employee	**$20.36**	☐ 01 Employee	**$12.92**
☐ 01 Employee + 1 Dependent	**$19.20**	☐ 01 Employee + 1 Dependent	**$40.60**	☐ 01 Employee + 1 Dependent	**$25.86**
☐ 01 Employee + 2 or more Dependents	**$25.18**	☐ 01 Employee + 2 or more Dependents	**$53.52**	☐ 01 Employee + 2 or more Dependents	**$32.72**

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: ☐☐☐☐

SEE PAGE 4 FOR DEPENDENT ENROLLMENT INFORMATION

SEE PAGE 5 FOR ADDITIONAL ENROLLMENT INFORMATION

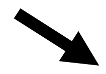
SUPPLEMENTAL HOSPITAL INSURANCE 2009 ENROLLMENT FORM

(Please Print)

PART 3: ADD OR 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



Plan Code	Add	Drop	NAME (Last, First, MI)	Social Security No.									Date of Birth (mm/dd/yyyy)	Sex M /F	*Rel.
	☐	☐													
	☐	☐													
	☐	☐													
	☐	☐													
	☐	☐													
	☐	☐													
	☐	☐													
	☐	☐													
	☐	☐													

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 **cannot be changed** 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.

Employee Signature: ______________________________ **Date:** ____________________

SEE NEXT PAGE FOR ADDITIONAL ENROLLMENT INFORMATION

SEE PAGE 1, 2 & 3 FOR ENROLLMENT OPTIONS

SUPPLEMENTAL HOSPITAL INSURANCE
2009 ENROLLMENT FORM
(Please Print)

– 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 coverage. **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 3) 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 CANNOT BE CHANGED 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 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)