

DIVISION OF STATE GROUP INSURANCE
 SUPPLEMENTAL HOSPITAL INSURANCE
 ENROLLMENT FORM



Select Your Type of Enrollment: New Hire Qualifying Status Change Open Enrollment

* NOTE: If checked, Agency Personnel Office must complete QSC Section in Part 3.

PLEASE PRINT

Social Security Number: _____ - _____ - _____ Name: _____ SUNCOM: _____

Address: _____ Work Phone: (_____) _____

Home Phone: (_____) _____ Date of Birth: ____/____/____ Sex: _____

PART 1: SELECT ONLY ONE COVERAGE LEVEL
 (Premiums listed are monthly, divide by 2 for biweekly amounts.)

Supplemental Hospital Insurance	Company Code	Product Code	Option Code	In the box, place an E for ENROLLING or an S for STOPPING		
				Coverage Level		
ALTA				Employee Only (01)	Employee + Family (20)	
30/20	005	101	050	<input type="checkbox"/> \$68.48	<input type="checkbox"/> \$123.26	
PPP	005	101	051	<input type="checkbox"/> \$41.62	<input type="checkbox"/> \$72.46	
S.I.S.	005	101	052	<input type="checkbox"/> \$45.24	<input type="checkbox"/> \$79.02	
365+ /\$100 per day	005	101	053	<input type="checkbox"/> \$22.66	<input type="checkbox"/> \$51.12	
PHILADELPHIA AMERICAN				Employee Only (01)	Employee + One Dependent (02)	Employee + Two or More Dependents (03)
\$100 per day	010	101	101	<input type="checkbox"/> \$ 9.58	<input type="checkbox"/> \$19.20	<input type="checkbox"/> \$25.18
\$200 per day	010	101	102	<input type="checkbox"/> \$20.36	<input type="checkbox"/> \$40.60	<input type="checkbox"/> \$53.52
\$100 per day/ECR	010	101	111	<input type="checkbox"/> \$12.92	<input type="checkbox"/> \$25.86	<input type="checkbox"/> \$32.72

PART 2: EMPLOYEE CERTIFICATION

I have read the information on the back of this form and I authorize my employer to reduce my salary in accordance with the benefits I have selected. **I understand my enrollment and/or changes will be effective the first of the month following a full payroll deduction, and 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 31 calendar days of the Qualifying Status Change.**

Employee Signature: _____ Date: _____

PART 3: AGENCY CERTIFICATION

Hire Date: ____/____/____ Pay Plan: _____ SAMAS Org Code: _____

Coverage Effective Date: ____/____/____ Employment Status: _____

Agency Signature: _____ Date: _____

Work Phone: (_____) _____ SUNCOM: _____

Check if the employee is an 8, 9 or 10 month faculty member.

* QSC Code: _____ * QSC Date: ____/____/____

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.
- If making no changes to your supplemental insurance, **DO NOT** return this form to your Agency Personnel Office.
- The enrollment **form** must be used to enroll in or change coverages. **No changes will be accepted by phone, e-mail or letter.**
- Enrolling in a supplemental insurance plan, or changing options, does not automatically stop other coverages you currently have. **To stop an existing coverage** you must place an “S” in the box provided for that coverage on the Supplemental Enrollment Form.
- The Supplemental Enrollment Form **must** be submitted to your Agency Personnel Office. **Enrollment changes will not occur if forms and/or applications and the Supplemental Company Application are submitted directly to the supplemental insurance company.**
- Submit verifying documentation for dependents to your Agency Personnel Office.
- You must drop any ineligible dependents. To do so, you must complete a supplemental company application or change form.
- 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 automatically deducted on a pretax 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 your Agency Personnel Office 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, and that my elections are IRREVOCABLE until the next 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 31 calendar days of the Qualifying Status Change.**
- Please give your completed and signed enrollment form to your Agency Personnel Office. **DONOTSIGNTHE SUPPLEMENTALENROLLMENTFORMUNLESSYOUHAVEACLEARUNDERSTANDINGOFTHEOPTIONSYOU SELECTED.** The telephone numbers for the Supplemental Insurance Companies are shown in the Supplemental Brochures and in the Benefits Guide.