

# DIVISION OF STATE GROUP INSURANCE SUPPLEMENTAL INSURANCE ENROLLMENT FORM



Select Your Type of Enrollment:  **New Hire**  **Qualifying Status Change**  **Open Enrollment**  **Stop Old Policy**  
\* NOTE: If checked, Agency Personnel Office must complete QSC Section in Part 4.  
 Company Code \_\_\_\_\_  
 Option Code \_\_\_\_\_

**PLEASE PRINT**

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Name: \_\_\_\_\_ SUNCOM: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

**PART 1: SELECT ONLY ONE CANCER AND INTENSIVE CARE PLAN AND COVERAGE LEVEL.**

(Premiums listed are monthly, divide by 2 for biweekly amounts.)

	Company Code	Product Code	Option Code	Coverage Level		
				Employee Only(01)	Employee+Children(11)	Employee+Family(20)
<small>In the box, place an <b>E</b> for ENROLLING or an <b>S</b> for STOPPING</small>						
<b>AFLAC Cancer</b>						
PCI Level 1	015	102	141	<input type="checkbox"/> \$18.70	<input type="checkbox"/> \$21.70	<input type="checkbox"/> \$30.50
PCI Level 1 + SDR	015	102	142	<input type="checkbox"/> \$19.70	<input type="checkbox"/> \$23.20	<input type="checkbox"/> \$32.50
PCI Level 1 + BBR	015	102	143	<input type="checkbox"/> \$20.50	<input type="checkbox"/> \$24.40	<input type="checkbox"/> \$34.40
PCI Level 1 + Both	015	102	144	<input type="checkbox"/> \$21.50	<input type="checkbox"/> \$25.90	<input type="checkbox"/> \$36.40
PCI Level 3	015	102	145	<input type="checkbox"/> \$33.50	<input type="checkbox"/> \$40.20	<input type="checkbox"/> \$55.90
PCI Level 3 + SDR	015	102	146	<input type="checkbox"/> \$34.50	<input type="checkbox"/> \$41.70	<input type="checkbox"/> \$57.90
PCI Level 3 + BBR	015	102	147	<input type="checkbox"/> \$36.50	<input type="checkbox"/> \$44.70	<input type="checkbox"/> \$62.40
PCI Level 3 + Both	015	102	148	<input type="checkbox"/> \$37.50	<input type="checkbox"/> \$46.20	<input type="checkbox"/> \$64.40
				<b>Employee Only(01)</b>		<b>Employee +Family(20)</b>
<b>AFLAC Hospital Intensive Care</b>	015	102	191	<input type="checkbox"/> \$8.70		<input type="checkbox"/> \$16.64
<b>COLONIAL</b>						
Cancer	035	102	352	<input type="checkbox"/> \$10.94		<input type="checkbox"/> \$18.18
Cancer and Intensive Care	035	102	353	<input type="checkbox"/> \$13.96		<input type="checkbox"/> \$24.48

**PART 2: CHECK ONLY ONE ACCIDENT/DISABILITY INSURANCE PLAN AND COVERAGE LEVEL.**

In the box, place an **E** for ENROLLING or an **S** for STOPPING

<p>_____ <b>ACCIDENT PROTECTION PLAN</b> <sup>035</sup>  <small>Product Code 105 • Option Code 350</small></p> <p><input type="checkbox"/> Employee Only <sup>01</sup>      <input type="checkbox"/> Employee + Spouse <sup>10</sup>  <input type="checkbox"/> Employee, Spouse <sup>12</sup> + Dependents      <input type="checkbox"/> Spouse + Dependents <sup>16</sup>  <input type="checkbox"/> Employee + Children <sup>11</sup></p>	<p>_____ <b>ACCIDENT / DISABILITY PLAN</b> <sup>035</sup>  <small>Product Code 105 • Option Code 351</small></p> <p><input type="checkbox"/> Employee Only <sup>01</sup>      <input type="checkbox"/> Employee + Spouse <sup>10</sup>  <input type="checkbox"/> Employee, Spouse <sup>12</sup> + Dependents      <input type="checkbox"/> Spouse + Dependents <sup>16</sup>  <input type="checkbox"/> Employee + Children <sup>11</sup></p>
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**IF ENROLLING IN ACCIDENT/DISABILITY INSURANCE, THE COLONIAL AGENT MUST COMPLETE THE FOLLOWING SECTION**

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

**PART 3: EMPLOYEE CERTIFICATION**

I have read and agree to the conditions listed in the Supplemental Insurance Information Section. 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 4: AGENCY CERTIFICATION**

Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Pay Plan: \_\_\_\_\_ SAMAS Org. Code: \_\_\_\_\_

Coverage Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employment Status: \_\_\_\_\_  Check if the employee is an 8, 9 or 10 month faculty member.

Agency Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ SUNCOM: \_\_\_\_\_

**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.**
- 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 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.**
- In the case of supplemental policies which require underwriting approval, the effective date of coverage shall be the first day of the month initially requested, following approval or in which a full month’s premium can be deducted.
- Please give your completed and signed enrollment form to your Agency Personnel Office. **DONOT 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 shown in the Supplemental Brochures and in the Benefits Guide.**

