

Enrollment Form



Please mail completed form to:

Department of Corrections, Attn: Post-tax Benefits Coordinator - DC/Personnel , 501 South Calhoun St., Tallahassee, FL 32399 or fax to 850-488-7534

Take Control. Enroll Today.

1. Personal Information All sections must be completed. Optional information is noted. Please print clearly.

First Name Middle Initial Last Name

Street Address

City State ZIP Code

Best Phone Number to Reach Me: *(circle one)* Daytime, Evenings, Mobile Email Address

Social Security Number Employer/Association Affiliation *(if applicable)*

Date of Birth *MM/DD/YYYY* Gender *M/F* Date of Hire *MM/DD/YYYY*

2. Coverage and Family Information

Please check the level of coverage.

UltimateAdvisor
 Cancel my participation in the plan
 Individual \$7.81 Bi-weekly
Date of cancellation: _____
 Family \$9.99 Bi-weekly

	First Name	Last Name	Gender M/F	Date of Birth MM/DD/YYYY
Spouse/Domestic Partner				
Child(ren)				

3. Authorization

By signing below, I am requesting enrollment or cancellation in the legal plan indicated above. I understand that the change in coverage will not become effective until the date assigned by the underwriter of the plan. I authorize my employer to deduct or cancel deductions for the cost of the plan as shown above, and as may be modified or adjusted, from my wages or salary.

Enrollee Signature Date

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For assistance in completing this enrollment form, call 800-247-4184.