

# Group Term Life Insurance Program

*For Full-Time Employees  
of the State of Florida*



**200% Bonus Benefit**  
**Accidental Death and  
Dismemberment Benefit**

**\$20,000 Life Insurance  
Protection on Your Spouse**

**\$5,000 Life Insurance Protection  
on Your Eligible Child(ren)**

*Enhancements at **No Additional Cost**  
To You.*



## Consortium of Participating Departments and Agencies:

Agency for Health Care Administration  
Department of Business and  
Professional Regulation  
Department of Children & Families  
Department of Corrections  
Department of Elder Affairs  
Department of Environmental Protection  
Department of Health  
Department of Juvenile Justice  
Department of Management Services  
Department of Revenue  
Department of State  
Department of Transportation  
Department of Veteran's Affairs  
Division of Administrative Hearings  
Florida Parole Commission  
Office of the Auditor General  
State Board of Administration

**Plan Underwritten By**  
**Alta Health & Life Insurance Company**

*Now part of CIGNA  
Administrative offices; Jacksonville, Florida*

CAPITAL INSURANCE AGENCY, INC.



## TO ALL FULL-TIME EMPLOYEES:

Your department has made available to you an outstanding benefit of an affordable GROUP TERM LIFE INSURANCE PLAN. Premiums are conveniently payroll deducted on a post-tax Miscellaneous Deduction Code #262. Since 1960, this Plan has paid out millions in benefits to state employees' loved ones.

The financial soundness of this Plan has allowed the following benefit enhancements:

- a 200% Bonus to be added to the Basic Coverage
- \$20,000 life insurance protection on your spouse
- Employee Accidental Death and Dismemberment Benefit
- \$5,000 life insurance protection on your eligible child(ren)

*All at no extra charge to you.*

### ACTIVE AT WORK PROVISION:

For enrolled employees actively at work, life insurance coverage becomes effective the day following the end of the payroll period in which the first deduction is made. However, if you are both: (a) not actively at work on the date your employee insurance would become effective, and (b) disabled or under a physician's care because of the sickness or injury, such insurance will not become effective until the date you resume full-time active work with your employer. Likewise, any increase in insurance coverage would be deferred until such date as you resume full-time active work with your employer.

### WAIVER OF PREMIUM:

If, while insured and under age 60, you become totally disabled from an injury or sickness which prevents you from engaging in any work for at least nine consecutive months, you can apply for Waiver of Premium benefits by obtaining the Premium Waiver application from a Capital Insurance representative and submitting it to Alta within nine to twelve months after your last day at work (premiums must be paid for the first twelve months of disability or until the Premium Waiver is approved, whichever is first.) Alta will send a letter annually requesting a doctor's statement verifying the continuation of your disability. This continuance of insurance will terminate on the earliest of (a) cessation of disability, (b) failure to submit the required proof of continued disability, or (c) failure to submit to the annual examination by a physician, at which time the employee is entitled to the Conversion Privilege.

### CONVERSION PRIVILEGE:

Upon termination of employment, all insured employees have the option of converting this Group Term Life Insurance Plan to an individual Whole Life Plan issued by Connecticut General Life Insurance Company. It cannot be converted to another term insurance plan. This conversion must be requested within 31 days of your termination by calling ALTA's Home Office at 1-800-663-1589 ext 729 8906, in order for the conversion policy to be issued without evidence of insurability.

### BENEFICIARY:

The amount of your Group Term Life Insurance Plan will be paid to the beneficiary of your designation in the event of your death from any cause at any time while insured under this Plan. You name the beneficiary, which may be changed at any time, by completing a new Application/Change Form, dating it, and filing it in your employee file in your Department's Personnel Office.

### POLICY PROVISIONS:

**Misstatement of Age or Sex:** If the age or sex of an insured has not been stated correctly, the insured's correct age or sex will be used to adjust the benefits and premiums accordingly.

**Incontestability:** The validity of this group policy will not be contested, except for non-payment of premium, after it has been continuously in force for two years from the effective date.

**Renewability:** The group policy will be renewed on the policy anniversary date. However, the Company may terminate the policy if the number of insured employees or if the percentage of the number of insured persons of all eligible employees falls below required amounts specified by the policy.

**Termination of Insurance:** Your Group Term Life Insurance Plan will terminate on the earliest of: (a) the date this group policy terminates; or (b) the last day for which your premium has been paid; or (c) the date you enter into full-time military, naval, or air service; or (d) termination of membership in a class eligible for insurance under the Policy; or (e) the date you are no longer Actively at Work, as defined by the Policy, with the Employer.

# Benefits of Your ALTA GROUP TERM LIFE PLAN

**This plan provides \$20,000 Life Insurance on your spouse and \$5,000 life insurance on all eligible dependent children at no additional cost.**

*Eligible dependents include the employee's spouse and all unmarried children to age 25 if they (1) depend on the employee for support, and (2) live with the employee or are classified as a full-time or part-time student.*

## **Accidental Death, Dismemberment and Loss of Sight Insurance**

These benefits are payable for any of the following losses incurred by you as a result of and within 365 days of an injury occurring on or off the job. Payment will be made regardless of any other benefits provided by the Plan.

### **Benefits Payable for Loss of:**

Life.....	}	The full amount of Insurance for which the employee is covered
Both hands or both feet.....		
Sight of both eyes.....		
One hand and one foot.....		
One hand and sight of one eye.....		
One foot and sight of one eye.....		
One hand or one foot.....	}	One-half the full amount of Insurance for which the employee is covered.
Sight of one eye.....		

Not more than the Full Amount of Insurance will be paid for all losses sustained as the result of one accident, but benefits paid on account of one loss will not prevent further payment for losses resulting from subsequent accidents. These benefits are not payable for loss caused by war or riot or under certain other circumstances described in your Policy Booklet.

## **DIRECTIONS FOR ENROLLING IN YOUR ALTA GROUP TERM LIFE PLAN**

**NOTE:** No Physical examination or other evidence of insurability is required of an employee if enrollment is made within the first 60 days of employment.

1. Complete the Enrollment Application/Change Form.
2. Be sure to designate a primary beneficiary.
3. Separate the completed application (page 5) from the brochure at the perforation line.
4. Submit the application to your Personnel Office.
5. Personnel will start your deduction on Code #262 and **file the Enrollment Application form in your personnel employee file.**
6. This coverage shall take effect on the day following the end of the pay period in which the first deduction is made. (see Active At Work Provision)

### **If Enrollment does not Occur:**

(a) within the first 60 days of employment,

*Or*

(b) during an open enrollment period, then the employee must complete a Health Statement form satisfactory to Alta Health & Life Insurance Company (Alta). This form can be obtained from a Capital Insurance Agency representative or online at [www.capitalins.com](http://www.capitalins.com). Both the company application and the Health Statement must be submitted together to the Company for approval. Once approved, Alta will request Personnel to start the payroll deduction.



## HOW TO FIGURE YOUR LIFE INSURANCE COVERAGE

The amount of your life insurance coverage in force at any time depends on **your age, your annual salary, and the Bonus Coverage (currently 200%)**. The amount of your Life Insurance coverage will change with any changes in your salary or when your age changes or with any changes in the percentage of Bonus Coverage.

<b>EXAMPLE: 30-Year Old with Annual Salary of \$30,000</b>	<b>\$30,000</b>	<b>x 1.60</b>	<b>= \$48,000</b>	<b>x 3.0</b>	<b>=\$144,000.00</b>
	Annual Salary	Age Factor	Basic Life Coverage	200% Bonus	Total Life Insurance Coverage

<b>YOUR FIGURES:</b>	\$	x	= \$	x 3.0	=\$
	Annual Salary	Age Factor	Basic Life Coverage	200% Bonus	Total Life Insurance Coverage

### TABLE OF FACTORS CHART

Age	Factor	Age	Factor	Age	Factor	Age	Factor
20 or less	2.00	32	1.52	45	1.00	58	0.48
21	1.96	33	1.48	46	0.96	59	0.44
22	1.92	34	1.44	47	0.92	60	0.40
23	1.88	35	1.40	48	0.88	61	0.36
24	1.84	36	1.36	49	0.84	62	0.32
25	1.80	37	1.32	50	0.80	63	0.28
26	1.76	38	1.28	51	0.76	64	0.24
27	1.72	39	1.24	52	0.72	65	0.20
28	1.68	40	1.20	53	0.68	66	0.16
29	1.64	41	1.16	54	0.64	67	0.12
30	1.60	42	1.12	55	0.60	68	0.08
31	1.56	43	1.08	56	0.56	69+	0.04
		44	1.04	57	0.52		

*This Plan provides a minimum of \$20,000 Total Life Insurance Coverage regardless of the employee's age factor.*

## HOW TO FIGURE YOUR PREMIUM

**Your premium is three fourths of 1% (.0075) of your biweekly or monthly salary.**

Your premium will change when your salary changes. This change is done in the Personnel Office.

Use the space below to calculate your premium.

<b>BIWEEKLY EXAMPLE:</b>	<b>\$1,000.00</b>	<b>x .0075</b>	<b>= \$7.50</b>
	Biweekly Salary	Premium Percentage	Biweekly Premium

<b>MONTHLY EXAMPLE:</b>	<b>\$2,000.00</b>	<b>x .0075</b>	<b>= \$15.00</b>
	Monthly Salary	Premium Percentage	Monthly Premium

<b>YOUR PREMIUM:</b>	\$	x .0075	=\$
	Biweekly or Monthly Salary	Premium Percentage	Biweekly/Monthly Premium

**NOTE:** Record your calculated premium, coverage amount and beneficiary designations in this space and retain a copy with your insurance records.

\_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 DATE COVERAGE AMOUNT PREMIUM AMOUNT

PRIMARY BENEFICIARY(IES) RELATIONSHIP

PRIMARY BENEFICIARY(IES) RELATIONSHIP

CONTINGENT BENEFICIARY RELATIONSHIP

# ALTA HEALTH & LIFE INSURANCE COMPANY, NOW PART OF CIGNA LIFE INSURANCE PLAN ENROLLMENT APPLICATION/CHANGE FORM FOR STATE OF FLORIDA PARTICIPATING AGENCIES

- Agency for Health Care Administration, #781019
- Department of Revenue, #780112
- Division of Administrative Hearings, #763851
- Department of State, #749952
- Department of Children & Families, #749932
- Department of Transportation, #780172
- Department of Corrections, #749902
- Department of Veteran's Affairs, #780102
- Department of Elder Affairs, #781018
- Florida Parole Commission, #749992
- Department of Environmental Protection, #749922
- Office of the Auditor General, #749872
- Department of Health, #781020
- State Board of Administration, #749942
- Department of Juvenile Justice, #780122
- Department of Business and Professional Regulation, #713736
- Department of Management Services, #749852

## TO ALL FULL-TIME EMPLOYEES

This is your opportunity to enroll in an excellent, low-cost Group Term Life Insurance Plan sponsored by your Department.

- If you **ELECT TO HAVE COVERAGE**, complete and sign the **APPLICATION** (Section I).
- If you desire to make a **policy change** (beneficiary or name), complete and sign the **POLICY CHANGE (Section II)**,
- All employees must return this form promptly to the Personnel Office in order to obtain coverage.

**Attention: THIS FORM MUST REMAIN IN THE EMPLOYEE'S PERSONNEL FILE. DO NOT MAIL IT TO THE COMPANY.**

### I. APPLICATION FOR GROUP TERM LIFE INSURANCE COVERAGE

EMPLOYEE NAME	DOB	SSN
EMPLOYEE HOME ADDRESS		
EMPLOYEE ID#	DEPT	DATE OF HIRE
COUNTY	WORK PHONE	
BENEFICIARY NAME(S)	DOB	RELATIONSHIP
BENEFICIARY NAME(S)	DOB	RELATIONSHIP
CONTINGENT BENEFICIARY NAME	DOB	RELATIONSHIP

I hereby apply for the amount of Group Term Life Insurance for which I am eligible under my employer's Group Insurance Plan.  
I authorize deductions from my earnings in the amount required to cover my premiums.

EMPLOYEE SIGNATURE	DATE
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### II. POLICY CHANGE ONLY

EMPLOYEE NAME	DOB	SSN
EMPLOYEE HOME ADDRESS		
EMPLOYEE ID#	DEPT	WORK PHONE
<input type="radio"/> BENEFICIARY CHANGE		
CHANGE PRIMARY BENEFICIARY TO: LAST NAME	FIRST NAME	RELATIONSHIP
CHANGE CONTINGENT BENEFICIARY TO: LAST NAME	FIRST NAME	RELATIONSHIP

<input type="radio"/> NAME CHANGE		
CHANGE MY NAME FROM	TO	
EMPLOYEE SIGNATURE	DATE	

### III. BENEFICIARY DESIGNATION

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request. If you need assistance, contact your benefits administrator at (800) 888-5256 or your own legal counsel.

### IV. FOR PERSONNEL USE ONLY PLEASE FILE IN EMPLOYEE'S PERSONNEL FILE. DO NOT MAIL TO COMPANY

				<b>262</b>	
<b>Samas Code</b>	<b>District/div Code</b>	<b>Effective Date of Insurance</b>	<b>Deduction Amount</b>	<b>Deduction Code</b>	<b>Date Processed/Initial</b>



# CAPITAL INSURANCE AGENCY, INC.

appreciates the opportunity  
to provide for the insurance needs of  
State of Florida employees.

*“We’re Here  
To Help You!”*

We have regional offices  
located across the state  
in addition to our fully  
licensed home office staff  
to service state employees.  
Contact your nearest  
Regional Office for  
questions, forms  
or assistance.

## CAPITAL INSURANCE AGENCY, INC.

*“We’re Here To Help You!”*

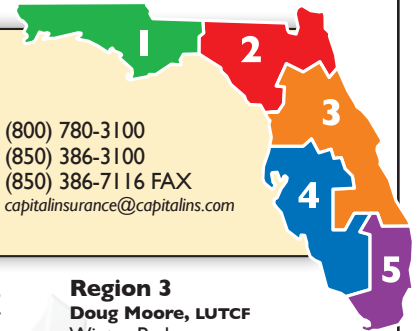
Contact the Capital Insurance Agency  
Regional Office in your area for assistance.

### Home Office

1425 E. Piedmont Dr.  
Suite 301  
Tallahassee, FL 32308

P.O. Box 15949  
Tallahassee, FL  
32317-5949

(800) 780-3100  
(850) 386-3100  
(850) 386-7116 FAX  
[capitalinsurance@capitalins.com](mailto:capitalinsurance@capitalins.com)



### Regional Locations

#### Region 1

**Robert W. ‘Buck’ Miller, LUTCF, CLU**  
Tallahassee  
(850) 671-2029  
(800) 226-9808  
(850) 671-2149 fax  
[northwestregion@capitalins.com](mailto:northwestregion@capitalins.com)

#### Region 2

**David L. Corbin, LUTCF, CLF**  
Tallahassee  
(850) 942-2323  
(800) 881-1871  
(850) 942-2360 fax  
[northeastregion@capitalins.com](mailto:northeastregion@capitalins.com)

Jacksonville  
(904) 731-9800  
(800) 940-9800  
(904) 731-4293 fax  
[northeastregionjax@capitalins.com](mailto:northeastregionjax@capitalins.com)

#### Region 3

**Doug Moore, LUTCF**  
Winter Park  
(407) 673-1254  
(800) 416-1618  
(407) 673-1255 fax  
[centralregion@capitalins.com](mailto:centralregion@capitalins.com)

#### Region 4

**David K. Mobley**  
Brandon  
(813) 839-8800  
(800) 940-2048  
(813) 839-8860 fax  
[southcentralregion@capitalins.com](mailto:southcentralregion@capitalins.com)

#### Region 5

**Mariam Spaulding, LUTCF**  
Coral Springs  
(954) 341-8705  
(800) 940-5656  
(954) 341-5311 fax  
[southflregion@capitalins.com](mailto:southflregion@capitalins.com)

[www.capitalins.com](http://www.capitalins.com)

*This Plan Marketed and Serviced By  
Capital Insurance Agency, Inc.*