HOW TO ENROLL

Rev. 04/09

Eligible employees* can enroll:

- Within the first 60 days of employment (as a new hire with the State or upon transferring to a participating agency).
- During an annual open enrollment period.
- By submitting a Statement of Health together with the application to Alta for approval.

Send the completed application to P.O. Box 15949, Tallahassee, Florida, 32317 for processing.

The deduction will be made on Miscellaneous Deduction Code **#300.**

Contact your Capital Insurance Agency, Inc. representative for additional information or assistance in enrolling.

*All active, permanent employees under age 70 who work 30+ hours per week in a participating State of Florida agency.

HOW TO FILE A CLAIM

Obtain a claim form from your local Capital Insurance Agency office.

Complete all parts of the claim form. Your attending physician and employer must complete the form to certify your disability.

Mail the claim form to the address listed on the claim form:

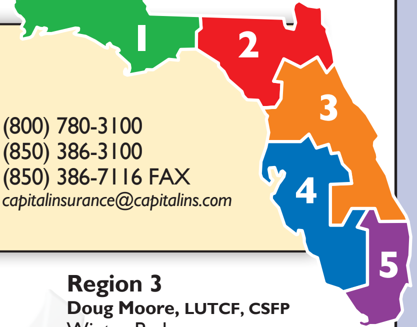
Alta Health & Life Insurance Company
c/o CIGNA Group Disability Department
P.O. Box 22328
Pittsburgh, PA 15222

Claim status inquiries should be directed to Alta at **1.800.888.5256**.

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

Regional Locations

Region 1
Robert W. 'Buck' Miller, LUTCF, CLU
Tallahassee
(850) 671-2029
(800) 226-9808
(850) 671-2149 fax
northwestregion@capitalins.com

Region 2
David L. Corbin, LUTCF, CLF, CSFP
Tallahassee
(850) 942-2323
(800) 881-1871
(850) 942-2360 fax
northeastregion@capitalins.com
Jacksonville
(904) 731-9800
(800) 940-9800
(904) 731-4293 fax
northeastregionjax@capitalins.com

Region 3
Doug Moore, LUTCF, CSFP
Winter Park
(407) 673-1254
(800) 416-1618
(407) 673-1255 fax
centralregion@capitalins.com

Region 4
David K. Mobley
Brandon
(813) 654-8663
(800) 940-2048
(813) 655-6629 fax
southcentralregion@capitalins.com

Region 5
Mariam Spaulding, LUTCF, CSFP
Coral Springs
(954) 341-8705
(800) 940-5656
(954) 341-5311 fax
southflregion@capitalins.com

www.capitalins.com

Plan Underwritten By
Alta Health & Life Insurance Company
A Subsidiary of Great-West Healthcare,
now part of CIGNA
Administrative Office: Jacksonville, FL

This Plan Marketed and Serviced by Capital Insurance Agency, Inc.

ALTA

VOLUNTARY LONG TERM DISABILITY ENROLLMENT FORM

Group Name **STATE OF FLORIDA**

GRAY BOXES ARE FOR OFFICE USE ONLY: | Application # | Insurance Effective Date Month/Day/Year

INSTRUCTIONS FOR FORM COMPLETION: Please type or print. Do not write in gray shaded areas.

1. Employee ID#	2. Social Security Number	3. Agency or Department	
4. Employee's Name Last	First	Middle Initial	
5. Mailing Address Street	City	State	Zip
6. Home Phone Number ( )	7. Work Phone Number ( )	8. Date of Birth	9. Sex ❒ Male ❒ Female
10. Employment Address (work location) Street City Zip		11. Full-Time Employment Date	12. Hours Worked Weekly
13. Do you have any other sources of income? ❒ YES ❒ NO	14. Annual Salary $	15. Group Coverage Desired 2 3 4 5	16. ❒ New Enrollee ❒ Upgrade/Downgrade · 17. Occupation or Title

EMPLOYEE must complete sections 1 -18. Note: Eligible class of employees - all active full-time employees of the sponsoring employer who are under age 70.

If you answered YES to Q.13 above, benefits will coordinate with all other sources of income and will reduce your ALTA benefit amount.

18. I hereby apply to Alta Health & Life Insurance Company for Disability Salary Continuation Insurance. I understand that the Company may decline to accept this application if it is not completed during the enrollment periods predetermined by the Company and the Sponsoring Employer. I further understand that, if accepted, my coverage will take effect (if actively at work) on the day following the end of the payroll period in which the first payroll deduction is made. I also certify that I am an Employee of the Sponsoring Employer in an Eligible Class (as specified above), and authorize my Employer to deduct from my earnings an amount sufficient to pay the premium for this insurance.
I hereby acknowledge that I have received the outline of coverage (brochure) describing insurance for which I am now applying.

Payroll Deduction Authorization

Licensed Resident Agent:
David M. Moore, CLU, ChFC, President, Capital Insurance Agency, Inc.

Signature ____________ Date ____________ (04/09)

Deduction Code **300** | Action Processed Date/Initial | Dept./Div. Code | Pay Period of First Deduction | Dist No. | Amount of Deduction

SEND THE COMPLETED APPLICATION TO: CAPITAL INSURANCE AGENCY, INC., P.O. BOX 15949 TALLAHASSEE, FL 32317-5949