

# ALTA LIFE INSURANCE PLAN ENROLLMENT APPLICATION/CHANGE FORM FOR STATE OF FLORIDA PARTICIPATING AGENCIES:

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

## 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 \_\_\_\_\_ Work Phone \_\_\_\_\_

Beneficiary Name \_\_\_\_\_ 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 \_\_\_\_\_

### II. POLICY CHANGE ONLY

Employee Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Employee Home Address \_\_\_\_\_

Employee ID# \_\_\_\_\_ Dept \_\_\_\_\_ Work Phone \_\_\_\_\_

\_\_\_ BENEFICIARY CHANGE

Change primary beneficiary to: \_\_\_\_\_  
Last Name First Name Relationship

Change contingent beneficiary to: \_\_\_\_\_  
Last Name First Name Relationship

\_\_\_ 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

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Samas Code	District/div Code	Effective Date of insurance	Deduction Amount	Deduction Code	Date Processed/Initial