

Serviced and Marketed
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Agency Inc.



Group Term Life Insurance

Open Enrollment Ends May 31, 2011

Conditional Guaranteed Issue Monthly Rate Chart

Age	80,000		30,000	
	Employee	Spouse	Employee	Spouse
Under 25	\$ 8.00	\$ 1.80		
25-29	\$ 8.00	\$ 1.80		
30-34	\$ 9.60	\$ 2.40		
35-39	\$ 12.00	\$ 3.30		
40-44	\$ 16.80	\$ 5.10		
45-49	\$ 25.60	\$ 8.40		
50-54	\$ 40.80	\$ 14.10		
55-59	\$ 64.00	\$ 22.80		
60-64	\$ 83.20	\$ 30.00		
65-69	\$ 131.20	\$ 48.00		
70-74	\$ 230.40	\$ 85.20		
75+	\$ 389.60	\$ 144.90		

Dependent Child Coverage -
\$.60 per month for 10,000

Plan Highlights

- Payroll deductible (Code 0208)
- Conditional guaranteed issue*
- Employees eligible up to \$300,000*
- Your spouse eligible up to \$150,000*
- Your dependent children eligible up to \$10,000*
- Convertible upon separation from employment
- Waiver of premium and accelerated benefit included

Please review your enrollment information for additional details, benefits and limitations.

Post Tax Benefits Office Contact Information

Kristen Mitchell
Office of Workforce Management
Post Office Box 10410
Tallahassee, Florida 32302
Phone: (866) 305-6004
Fax : (850) 488-4621
Email: emploben@dor.state.fl.us

For more information contact Kristen Mitchell, your Post Tax Benefits Coordinator

* Coverage amounts elected over \$80,000 (employee) or \$30,000 (spouse) require further evidence of good health that is satisfactory to The Hartford before the excess coverage can become effective. All employees, and their spouse if electing coverage, must complete the Simplified Medical Underwriting (SMU) form during the enrollment. Voluntary coverage will be approved, or additional information will be requested based on each individual's responses. Employees must qualify to receive coverage on their spouse and/or dependent child(ren).



Income Protection

Supplemental Life and AD&D Insurance

Benefit Fact Sheet for:

Florida Department of Revenue

Eligibility	You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.
Coverage Effective Date	Coverage goes into effect subject to the terms and conditions of the policy. In no case will newly elected benefits become effective sooner than 6/1/2011 or on the date of hire. You must be Actively at Work with your employer on the day your coverage takes effect.
Enrollment Period	4/1/2011 through 5/31/2011
Benefit Amount	<p>You can purchase Supplemental Life and AD&D Insurance in increments of \$10,000.</p> <p>The maximum amount you can purchase cannot be more than the lesser of 5 times your annual Salary or \$300,000. Annual Salary is as defined in The Hartford's contract with your employer.</p>
AD&D Coverage	<p>AD&D provides benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The insurance pays:</p> <ul style="list-style-type: none"> • 100% of the amount of coverage you purchase in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia. • 75% for paraplegia or triplegia (paralysis of three limbs). • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand or uniplegia. <p>Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.</p>
Guaranteed Issue Amount	If you are electing new or increasing your existing coverage you must complete the Simplified Medical Underwriting (SMU) Form during this enrollment. Coverage will be approved, or additional information will be requested based on your responses. If you elect a new amount that exceeds the guaranteed issue amount of \$80,000, you will need to provide additional evidence of good health that is satisfactory to The Hartford before the excess can become effective.

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Benefit Reductions	50% at age 70. All coverage cancels at retirement.
Spouse Supplemental Life Insurance	<p>If you elect Supplemental Life and AD&D Insurance for yourself, you may choose to purchase Spouse Supplemental Life Insurance in increments of \$5,000, to a maximum of \$150,000.</p> <p>Coverage cannot exceed 50% of the amount of your Employee Voluntary/Supplemental Life Insurance coverage. You may not elect coverage for your Spouse if they are an active member of the armed forces of any country or international authority, or is already covered as an Employee under this policy.</p> <p>If you are electing new or increasing your current Spouse Supplemental Life Insurance, your Spouse must complete the Simplified Medical Underwriting (SMU) Form during this enrollment. Coverage will be approved, or additional information will be requested based on their responses. If you elect an amount that exceeds the guaranteed issue amount of \$30,000, your Spouse will need to provide additional evidence of good health that is satisfactory to The Hartford before the excess can become effective.</p>
Child(ren) Supplemental Life Insurance	<p>If you elect Supplemental Life and AD&D Insurance for yourself - You may choose to purchase Child(ren) Supplemental Life Insurance coverage in increments of \$2,000 to a maximum of \$10,000 for each Child— <i>no medical information is required</i>. You may not elect coverage for your Child if your Child is an active member of the armed forces of any country or international authority.</p> <ul style="list-style-type: none"> • Child(ren) must be unmarried and are covered from 15 days to 19 years old or 25 years if they are a full-time student or meet certain other conditions. • Unmarried child(ren) over age 19 may be covered if they are disabled and primarily dependent upon the Employee for financial support. • Child(ren) from 15 days to 6 months are limited to a reduced benefit of \$100.
Conversion	You have the option of converting your group Life coverage to your own individual policy (policies).
Living Benefits Option	If you are diagnosed as having a terminal illness with a 12 month life expectancy, the Living Benefits Option allows you to receive an accelerated payment of a portion of your life Insurance. The option is available to individuals with at least \$10,000 in group coverage from The Hartford and is subject to a maximum age limit of 60. You may request a minimum accelerated payment of \$3,000 up to a maximum of 80% of your coverage not to exceed \$300,000. Funds are paid directly to you, with no policy restrictions on how you use them. The remaining benefit is then payable to your beneficiary.
Waiver of Premium	This provision applies if you become totally disabled before 60 and your disability lasts for at least 9 months. You must provide proof of your condition within one year of your last day of work and once we approve, your coverage will continue without payment of premium up to Social Security Normal Retirement Age, as long as you remain totally disabled. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates. Payment of premium is required until waiver is approved by The Hartford.

Limitations and Exclusions

As is standard with most term life Insurance plans, death by suicide is covered only after the employee has been insured for two years. Therefore, if death results from suicide, no benefit will be payable for any Life coverage that became effective within two years of the date of death.

Other exclusions may apply depending upon your coverage. Refer to your policy.

This Benefit Fact Sheet is an overview of the Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your Insurance coverage. In the event of any difference between the Benefit Fact Sheet and the Insurance policy, the terms of the Insurance policy apply.

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Florida Department of Revenue
Enrollment Period 4/1/2011 - 5/31/2011
Rev 03/08



Income Protection Benefits

Florida Department of Revenue
Benefits Enrollment Form

Information About You

Name:	Social Security Number:
Date of Birth:	Employee ID Number:
Annual Salary:	Date of Hire:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer’s contract.*
- **Step 2:** Please **sign, date and return** this form to FLORIDA DEPARTMENT OF REVENUE, OFFICE OF WORKFORCE MANAGEMENT, PO BOX 10410, TALLAHASSEE, FLORIDA, 32302

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Supplemental Life and AD&D Insurance

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1000	0.1000	0.1200	0.1500	0.2100	0.3200	0.5100	0.8000	1.0400	1.6400	2.8800	4.8700

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Life and AD\&D Benefit Amount}}{\div \$1,000} = \text{Rate} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- I elect to **enroll** for \$_____ of Life and AD&D coverage.
- I elect to **change** my current Life and AD&D coverage to \$_____.
- I elect to **cancel** my current Life and AD&D coverage.

Spouse Supplemental Life Insurance

Costs are based on your Spouse’s age.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0600	0.0600	0.0800	0.1100	0.1700	0.2800	0.4700	0.7600	1.0000	1.6000	2.8400	4.8300

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Life Benefit Amount}}{\div \$1,000} = \text{Rate} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- I elect to **enroll** for \$_____ of Life coverage.
- I elect to **change** my current Life coverage to \$_____.
- I elect to **cancel** my current Life coverage.

First Name	Last Name	Gender	Date of Birth	Date of Marriage

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**Expertise without equal.
Benefits without burden.™**

Name: _____

Child(ren) Supplemental Life Insurance

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Life Benefit Amount}}{\$1,000} = \frac{\text{Rate}}{\$0.0600} = \text{My Monthly Cost}$$

- I elect to **enroll** for \$_____ of Life coverage.
- I elect to **change** my current Life coverage to \$_____.
- I elect to **cancel** my current Life coverage.

Total Monthly cost of all coverage elected (Employee + Spouse + Child) \$_____

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life insurance coverage described in the Benefit Highlight Sheets and offered through Florida Department of Revenue.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

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Name: _____

Florida Department of Revenue



Supplemental Life Simplified Medical Underwriting Application

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Please answer the following questions by checking yes or no in the designated box. Upon completion, please sign and return this form along with your enrollment application in a sealed envelope to:

FLORIDA DEPARTMENT OF REVENUE
CARLTON BUILDING, ROOM 343M
501 S. CALHOUN STREET
TALLAHASSEE, FLORIDA 32399-0100

During the past 5 years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition; cancer; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? **(For residents of Florida, Maine, Minnesota, North Carolina and Vermont please see second page for your state specific question.)**

Employee Yes No Spouse Yes No

During the past 5 years, have you (or anyone proposed for coverage) been declined for any life insurance coverage?

Employee Yes No Spouse Yes No

NOTICE

Hereby certify that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. This information may be used by the Hartford Life and Accident Insurance Company for plan administration purposes to decide if the person(s) is/are eligible for coverage.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

EMPLOYEE'S SIGNATURE DATE SIGNED SPOUSE'S SIGNATURE **(Required)** DATE SIGNED
(Required) Relationship: _____ **only if applying for Life Coverage)** Relationship: _____
or Legal representative to Applicant or Legal representative to Spouse

For residents of the following states, please read the specific statutory language and respond on the first page:

Florida:

During the past 5 years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition; cancer; chronic/recurrent respiratory disease; diabetes; kidney or liver disease? Has anyone proposed for coverage ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?

Maine:

During the past 5 years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition; cancer; chronic/recurrent respiratory disease; diabetes, kidney or liver disease; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? **(In response to this question, you are not required to disclose whether you have been tested for HIV if you have not developed symptoms of the disease AIDS or ARC in response to this question.)**

Minnesota:

During the past 5 years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition; cancer; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? NOTE: YOU NEED NOT DISCLOSE AN HIV (AIDS VIRUS) TEST WHICH WAS ADMINISTERED: (1) TO A CRIMINAL OFFENDER OR CRIMINAL VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE; (2) TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; (3) TO EMERGENCY MEDICAL PERSONNEL WHO WERE TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES.

North Carolina:

During the past 5 years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition; cancer; chronic/recurrent respiratory disease; diabetes, kidney or liver disease; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

“AIDS-Related Complex (ARC)” is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. “Disorder of the Immune System” includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave’s Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Vermont:

During the past 5 years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition; cancer; chronic/recurrent respiratory disease; diabetes; kidney or liver disease? Have you been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a licensed medical physician?