

Please complete this enrollment form and return it to the address listed below so that your enrollment decision can be verified. Premiums will be automatically payroll-deducted.

Department of Transportation  
 Post Tax Benefits Office  
 605 Suwannee Street, MS 50  
 Tallahassee, Florida 32399-0450

If you are eligible and do not enroll within the first 31 days of employment or during an open enrollment period, you will not have another opportunity to enroll until the next enrollment period.

**The Florida Department of Transportation**  
 Group Long Term Income Protection Plan Enrollment Request

People First ID #: \_\_\_\_\_

Social Security Number - -	Name (last, first, middle initial)	<input type="checkbox"/> New	<input type="checkbox"/> Change
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Date of Hire / /	Bi-Weekly Salary \$

I REQUEST COVERAGE under the Long Term Income Protection Plan through my employer's group insurance contract, as now or hereafter applicable to me, and authorize the appropriate deductions from my wages for the option I have selected below.

**Option 1**                       **Option 2**                       **Option 3**  
*(90-Day Elimination Period)*                      *(180-Day Elimination Period)*                      *(360-Day Elimination Period)*

I REQUEST TO CHANGE my existing coverage from Option # \_\_\_\_\_ to Option # \_\_\_\_\_ of the Long Term Income Plan through my employer's group insurance contract, as now or hereafter applicable to me, and authorize the appropriate deductions from my wages. I understand that by doing so, all provisions, limitations and exclusions of the *new* plan will apply.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Shaded area to be completed by employer**

Payroll Unit #

Date of First Deduction  
/ /

Bi-Weekly Deduction  
\$

Inter-Dept. #

#434