Group Benefits from The Hartford

# Income Protection Benefits

**Florida Department of Transportation**
**Benefits Enrollment Form**

## Information About You

| **Name:** | **Social Security Number:** |
|---|---|
| **Date of Birth:** | **Date of Hire:** |
| **Bi-weekly Salary:** | **People First ID Number:** |

## Instructions

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

- **Step 1:** Please **enter and/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 Enrollment Form along with the Simplified Medical Underwriting Application to the address on the reverse side of this Enrollment Form by 9/30/2010.

## Voluntary Long Term Disability Insurance

You have the opportunity to enroll in Voluntary Long Term Disability Insurance. Voluntary Long Term Disability Insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been Disabled for a predetermined waiting period, known as the elimination period, of **90, 180 or 365 days**. This plan provides you with income protection to replace up to 60% of your Earnings, to a maximum monthly benefit of $5,000. If you are electing coverage for the first time and are a late entrant or if you are electing to decrease your existing elimination period (i.e. changing from Option 3 to Option 2) you must provide evidence of insurability by completing 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 are currently enrolled, evidence of insurability is not required to maintain your current coverage.

Use the rate chart and calculation line below to determine your bi-weekly cost for this coverage.*

I elect to **enroll** in the Voluntary **LTD:**

☐ **Option 1** Plan **(90 day elimination period)**

| **Your Age** | Under 40 | 40-49 | 50+ |
|---|---|---|---|
| **Your Rate** | $.0055 | $.0082 | $.0110 |

☐ **Option 2 Plan (180 day elimination period)**

| **Your Age** | Under 40 | 40-49 | 50+ |
|---|---|---|---|
| **Your Rate** | $.0046 | $.0069 | $.0092 |

☐ **Option 3** Plan **(365 day elimination period)**

| **Your Age** | Under 40 | 40-49 | 50+ |
|---|---|---|---|
| **Your Rate** | $.0040 | $.0059 | $.0079 |

I elect to **change my option** in the Voluntary **LTD to:**

☐ **Option 1** Plan **(90 day elimination period)**

| **Your Age** | Under 40 | 40-49 | 50+ |
|---|---|---|---|
| **Your Rate** | $.0055 | $.0082 | $.0110 |

☐ **Option 2 Plan (180 day elimination period)**

| **Your Age** | Under 40 | 40-49 | 50+ |
|---|---|---|---|
| **Your Rate** | $.0046 | $.0069 | $.0092 |

☐ **Option 3** Plan **(365 day elimination period)**

| **Your Age** | Under 40 | 40-49 | 50+ |
|---|---|---|---|
| **Your Rate** | $.0040 | $.0059 | $.0079 |

1. Enter your bi-weekly salary: $____________________
2. Enter your **Rate** from the chart above: ____________________
3. Multiply (1) by (2). This is your bi-weekly cost: $____________________*

*Once a year your deductions will be adjusted if there has been a change from one age bracket to the next, or if your bi-weekly pay has changed.

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## Confirmation

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

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 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 (Miscellaneous Deduction Code 0434).

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 ______________________________

**PLEASE SIGN AND RETURN THIS SIMPLIFIED MEDICAL UNDERWRITING FORM ALONG WITH YOUR COMPLETED ENROLLMENT APPLICATION TO:**

POST TAX BENEFITS OFFICE
DEPARTMENT OF TRANSPORTATION
605 SUWANNEE STREET, MS 50
TALLAHASSEE, FLORIDA 32399-0450

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