



Critical Illness Insurance Coverage for employees of the Florida Department of Children and Families.

Help combat the costs of fighting life threatening diseases

Why critical illness coverage is important

- 80 million American adults (one in three) have one or more types of cardiovascular disease.

— American Heart Association

Critical Illness Advantage is Kanawha Insurance Company Policy 8011. Benefits outlined in this brochure are supplemental and not intended to cover all medical expenses. Not all benefits will be available in all states and benefits may vary by state. For complete information, refer to the policy documents.

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• Critical Illness Advantage is insurance that helps protect you, your family and your assets in the event of a critical illness. It offers valuable peace of mind from the rising costs of specialized healthcare, which may not be covered by ordinary health insurance.

• Benefits are paid directly to you upon diagnosis and can assist in covering a variety of expenses associated with a critical illness: out-of-pocket medical care costs, home healthcare, travel to and from treatment facilities, loss of income due to your or your family members' absences from work, child care, and other expenses.

• Base benefits of critical illness

- › Vascular coverage – Heart attack, transplant as a result of heart failure or stroke
- › Benefits are also available for Other Critical Illnesses, such as transplant (other than heart), coma, severe burns, and Occupational HIV to name a few
- › Benefit amounts for employees are up to \$20,000, \$10,000 for a spouse, and \$5,000 for each eligible child

• Your plan will also include these valuable benefits

- › Health Screening Benefit – Pays \$150 for an annual health screening for each covered family member
- › Loss of work – The employee's premium will be waived in the event of authorized strike, lockout, layoff, or job elimination (maximum six-month benefit per occurrence, with a lifetime maximum of 12 months' waiver). Available through age 55.

• Enrollment is easy

• There are only a few questions to answer; and premiums are paid through payroll deduction helping to provide you with the insurance protection you need.

• How to enroll

1. Download the Enrollment Form and Payroll Authorization.
2. Complete all highlighted areas on both forms.
3. Mail to: Capital Insurance Agency, Inc.
P.O. Box 15949
Tallahassee, Florida 32317
Attn: Tina Phelps

• Please feel free to contact a Capital Representative in your area with questions. You will be contacted by a Capital Representative regarding your deductions before they begin.

• Presented by

CAPITAL INSURANCE AGENCY, INC.

HUMANA
Specialty Benefits

Rates for Critical Illness

Bi-weekly premiums include Loss of Work* and \$150 Health Screening Benefit.

Age	Employee				Spouse			
	Non-tobacco user		Tobacco user		Non-tobacco user		Tobacco user	
Benefit:	\$10,000	\$20,000	\$10,000	\$20,000	\$5,000	\$10,000	\$5,000	\$10,000
18-29	\$3.80	\$5.23	\$4.31	\$6.25	\$2.16	\$2.92	\$2.43	\$3.47
30-39	\$4.68	\$6.98	\$6.20	\$10.03	\$2.64	\$3.88	\$3.54	\$5.69
40-49	\$6.15	\$9.94	\$9.48	\$16.58	\$3.47	\$5.55	\$5.29	\$9.20
50-55	\$8.69	\$15.02	\$14.78	\$27.20	\$4.88	\$8.36	\$8.20	\$15.01
56-59	\$8.09	\$13.82	\$13.77	\$25.17	\$4.88	\$8.36	\$8.20	\$15.01
60-64	\$10.40	\$18.43	\$17.69	\$33.02	\$6.20	\$10.99	\$10.51	\$19.63
65-69	\$11.28	\$20.18	\$19.08	\$35.78	\$6.73	\$12.06	\$11.41	\$21.42

Children rates

Bi-weekly premiums include Loss of Work* and \$150 Health Screening Benefit.

Age	Children
Benefit:	\$5,000
0-24	\$1.64

Child premiums are based on maximum of 50% of employee benefit or \$5,000.

*For employee age above 55, Loss of Work is not available

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
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
Winter Park
(407) 673-1254
(800) 416-1618
(407) 673-1255 fax
centralregion@capitalins.com

Region 4
David K. Mobley
Tampa
(813) 839-8800
(800) 940-2048
(813) 839-8860 fax
southcentralregion@capitalins.com

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

www.capitalins.com

CRITICAL ILLNESS INSURANCE

Employee Spouse Child(ren)

Has any Proposed Insured used any form of tobacco in the last 12 months?.....	Employee		Spouse	
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Base Plan Vascular Cancer Other Critical Illnesses

Base Benefit **Benefit Amount** \$, **Total Modal Premium** \$.

Optional Benefits Health Screening

	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you Actively at work?.....	<input type="radio"/>	<input type="radio"/>								
2. Will this coverage replace a critical illness policy or certificate of insurance paid for, by, or through your employer?.....	<input type="radio"/>	<input type="radio"/>								

Evidence of Insurability: Complete Only if Proposed Insured is a Late Enrollee

3. Has the Proposed Insured been performing their normal duties at work, home, or school on a full-time basis and not having missed more than 5 consecutive days in the last 12 months due to illness or injury, except for normal pregnancy?.....	<input type="radio"/>	<input type="radio"/>								
4. Has any Proposed Insured tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In the 6 months prior to the application date, has any Proposed Insured been hospitalized as an inpatient or outpatient, or missed more than 5 consecutive days of work due to an illness or injury, except for normal pregnancy?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Within the past 5 years, has any Proposed Insured been diagnosed with or treated for:										
A) Vascular: Heart disease, including angina; heart attack; congestive heart failure; heart bypass; cerebrovascular disease, including Transient Ischemic Attack (TIA); stroke (blockages or hemorrhage); diabetes; or blood pressure readings above the normal range which have not been controlled with medication?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) Cancer: Cancer, including melanoma; leukemia; malignant tumors; or skin cancers?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) Other: Drug abuse or alcohol abuse; disease of the liver, kidney or digestive system; disease or disorder of the lung; diabetes; diseases of the nervous system, including Parkinson's, MS and cerebral palsy; or any disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing, or speech?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. To the best of your knowledge and belief, have any 2 of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:										
A) Vascular: Heart attack, heart disease or stroke?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) Cancer: Cancer?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) Other: Kidney disease or diabetes?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Payroll Deduction Authorization
For

Capital Insurance Agency, Inc.

Department of _____

Location _____

Employee Name _____

Social Security # _____

People First Employee ID # _____

You are hereby requested and authorized to deduct the amount of the premium from my wage each pay period and to transmit it to Capital Insurance Agency, Tallahassee, Florida, in payment of the premium under the policy(ies).

Said deduction shall commence as of _____ and continue each pay period thereafter until (A) termination of my employment, or (B) completion of the premium paying period as provided in the policy, or (C) written notice by me of the cancellation of this order stating when thereafter cancellation shall be effective, or (D) termination of this salary savings system.

I understand that amounts to be deducted may be subject to change without written authorization from me. In the event that my policy involves renewable term insurance, I understand that my premiums may increase on the policy anniversary date and will be changed without written authorization from me. _____ (initials)

Signature of Employee _____



Date _____

Witness _____

Policy Register

Policy No.	Effective Date	Description	Monthly / Biweekly Premium	

For Official Use Only

Dist No.	Dept. / Div. Code	Eff. Date of Deduction	Deduction Code	Total Monthly / Biweekly Deduction	Action Processed Date / Initial
			285		