

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
ENROLLMENT FORM FOR THE HYATT LEGAL PLANS

Last Name: _____ First Name: _____ M.I: _____

Social Security Number: _____ People First ID Number: _____ Home Zip Code: _____

Date of Hire: _____ Work Location: _____

I wish to ACCEPT enrollment into the HYATT LEGAL PLANS and authorize, now or hereafter, the appropriate deductions be taken from my wages for this Plan. I understand my enrollment in the HYATT LEGAL PLANS is effective for one full year, and cannot be canceled during that period.

Employee's Signature (Required for Processing): _____ Date: _____

PLEASE RETURN TO YOUR POST TAX BENEFITS COORDINATOR

PREMIUM TO BE DEDUCTED: \$7.62 - BIWEEKLY

HYATT LEGAL PLANS

MISC. DEDUCT. CODE: 257
