How To Enroll

Eligible Employees: All active, permanent employees under age 70 who work 30+ hours per week in a participating State of Florida agency.

Complete an enrollment form by one of the following four options:

- Online at https://capitalins.com/enroll-ltd
- Fax to 850-386-7116
- Send completed application to:
  Capital Insurance Agency, Inc.
  P.O. Box 15949, Tallahassee, Florida 32317-5949
- Contact your Capital Insurance Agency, Inc. representative for additional information or assistance in enrolling.

The deduction will be made on Post Tax Miscellaneous Deduction Code **#0300.**

How to File a Claim

1. Obtain a claim form from your local Capital Insurance Agency office.
2. Complete all parts of the claim form. Your attending physician and employer must complete the form to certify your disability.
3. Mail the claim form to:
   Cigna Group Insurance | P.O. Box 16491 | Pittsburgh, PA 15242-0791
4. Claim status inquiries should be directed to Cigna at **1.800.238.2125**.

Plan Underwritten by Life Insurance Company of North America (LINA), a Cigna Company.
Administrative Office: Jacksonville, FL

Help Protect Your Income!

Cigna

Cigna

VOLUNTARY LONG TERM DISABILITY ENROLLMENT FORM

Group Name **STATE OF FLORIDA**

GRAY BOXES ARE FOR OFFICE USE ONLY: | Application # | Insurance Effective Date Month/Day/Year

1. People First Employee ID# | 2. Social Security Number | 3. Agency and County of Work Location

4. Employee's Name Last First Middle Initial | 5. ❑ New Enrollee or ❑ Group Coverage Change

6. Mailing Address Street City State Zip

7. Cell Phone Number ( ) | 8. Work Phone Number ( ) | 9. Date of Birth | 10. Sex ❑ Male ❑ Female

11. Employment Address (work location) Street City Zip | 12. Full-Time Employment Date | 13. Hours Worked Weekly

14. Annual Salary $ | 15. Do you have any other sources of income? ❑ YES ❑ NO | 16. Group Coverage Desired II III IV | 17. ❑ Group V SMS/SES | 18. OPS ❑ Yes ❑ No | 19. Occupation or Title

If you answered YES to Q.15 above, benefits will coordinate with other sources of income and will reduce your Cigna benefit amount.

20. I hereby apply to Life Insurance Company of North America (LINA), a Cigna Company, for Disability Salary Continuation Insurance. I understand that the Company may decline to accept this application if it is not completed during the enrollment periods predetermined by the Company and the Sponsoring Employer. I further understand that, if accepted, my coverage will take effect (if actively at work) on the day following the end of the payroll period in which the first payroll deduction is made. I also certify that I am an Employee of the Sponsoring Employer in an Eligible Class (as specified above), and authorize my Employer to deduct from my earnings an amount sufficient to pay the premium for this insurance, including Age Band changes. I hereby acknowledge that I have received the outline of coverage (brochure) describing insurance for which I am now applying.

Licensed Resident Agent: Douglas Moore, LUTCF, CSFP
President & CEO, Capital Insurance Agency, Inc.

Employee's Signature Date

Employee's Personal E-mail

Agent Name

Region 1 2 3

(08/19)

Caution: 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.

Caution: EMPLOYEE must complete sections 1 - 20. Please print or type.

NOTE: Eligible class of employees - all active full-time employees of the sponsoring employer who are under age 70.

Payroll Deduction Authorization

Deduction Code **0300**

Dept/Div. Code

Amount of Deduction