SUPPLEMENTAL CANCER / INTENSIVE CARE INSURANCE
2008 ENROLLMENT FORM
(Please Print)

Select your Enrollment Type: ☐ New Hire ☐ Open Enrollment ☐ Qualifying Status Change
Note: If checked, you must also complete and submit a Qualifying Status Change form.

SSN: _____ **EEID:** 0 0 _____

Name: _____ **Agency Name:** _____

Complete Mailing Address: _____

Work Phone: ( ) _____ **Home Phone:** ( ) _____ **Sex (M/F):** ____ **Birth Date:** ____/____/____

PART 1: TO ENROLL: Place an E in only ONE of the Cancer Plans and/or the Hospital Intensive Care Plan, then Check (☐) ONE RESPECTIVE COVERAGE LEVEL.
NOTE: You may only enroll in one Cancer Plan and/or Hospital Intensive Care Plan. Enrollment in multiple plans is not permitted.
TO STOP COVERAGE: Place an S in the appropriate CANCER PLAN box.

(Premiums listed are monthly, divide by two for bi-weekly amounts)

	Plan Name	Benefit Plan Code	Employee	Employee + Children	Employee + Family
	COLONIAL				
☐	Cancer	6600	☐ $10.94		☐ $18.18
☐	Cancer / Intensive Care	7500	☐ $13.96		☐ $24.48
	AFLAC Cancer				
☐	PCI Level 1	6500	☐ $18.70	☐ $21.70	☐ $30.50
☐	PCI Level 1 + SDR	6501	☐ $19.70	☐ $23.20	☐ $32.50
☐	PCI Level 1 + BBR	6502	☐ $20.50	☐ $24.40	☐ $34.40
☐	PCI Level 1 + Both	6503	☐ $21.50	☐ $25.90	☐ $36.40
☐	PCI Level 3	6510	☐ $33.50	☐ $40.20	☐ $55.90
☐	PCI Level 3 + SDR	6511	☐ $34.50	☐ $41.70	☐ $57.90
☐	PCI Level 3 + BBR	6512	☐ $36.50	☐ $44.70	☐ $62.40
☐	PCI Level 3 + Both	6513	☐ $37.50	☐ $46.20	☐ $64.40
☐	**AFLAC Hospital Intensive Care**	7000	☐ $8.70		☐ $16.64

PART 2: STOP OLD POLICIES. Enter the plan codes of policies not listed above that you no longer wish to carry. For assistance call the People First Service Center.

Plan Code _____ Plan Code _____ Plan Code _____ Plan Code _____

PART 3: ADD / DROP DEPENDENTS - Please Print (Attach additional page if necessary.)

You may: **ADD** eligible dependents not currently covered and/or **DROP** ineligible dependents.

***RELATIONSHIP:** Put the number that is next to the relationship, an example is Spouse-1 then you would put the 1 in the "Rel." column below.
Spouse - 1, Child - 2, Legal Guardianship - 3, Grandchild - 4, Legally Adopted Child - 5, Foster Child - 6, Step Child -7, Unborn Child - 8

Add	Drop	Name (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yyyy)	Sex M/F	*Rel.
☐	☐			/ /		
☐	☐			/ /		
☐	☐			/ /		
☐	☐			/ /		
☐	☐			/ /		

PART 4: EMPLOYEE CERTIFICATION

I have read and agree to the conditions listed in the Supplemental Insurance Information Section (found on the back of this form). Enrollment may be subject to the underwriting requirements of the carrier. I authorize my employer to reduce my salary in accordance with the benefits I have selected. I understand that my elections are IRREVOCABLE, unless I have a Qualifying Status Change as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must request such changes within thirty-one (31) calendar days of the Qualifying Status Change.

Employee Signature: _____ **Date:** _____

SEE REVERSE SIDE FOR ADDITIONAL INFORMATION