

Eligible employees\* can enroll:

- Within the first 60 days of employment (as a new hire with the State or upon transferring to a participating agency).
- During an annual open enrollment period.
- By submitting a Statement of Health together with the application to Alta for approval.

Send the completed application to P.O. Box 15949, Tallahassee, Florida, 32317 for processing.

The deduction will be made on Miscellaneous Deduction Code **#300**.

Contact your Capital Insurance Agency, Inc. representative for additional information or assistance in enrolling.

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

**HOW TO FILE A CLAIM**

Obtain a claim form from your local Capital Insurance Agency office.

Complete all parts of the claim form. Your attending physician and employer must complete the form to certify your disability.

Mail the claim form to the address listed on the claim form:

**Alta Health & Life Insurance Company**  
**c/o CIGNA Group Disability Department**  
**P.O. Box 22328**  
**Pittsburgh, PA 15222**

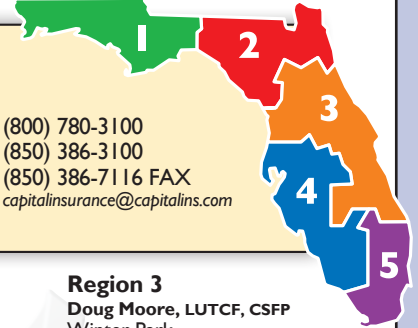
Claim status inquiries should be directed to Alta at **1.800.888.5256**.



Plan Underwritten By  
 Alta Health & Life Insurance Company  
 A Subsidiary of Great-West Healthcare,  
 now part of CIGNA  
 Administrative Office: Jacksonville, FL

**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

(800) 780-3100  
 (850) 386-3100  
 (850) 386-7116 FAX  
 capitalinsurance@capitalins.com

P.O. Box 15949  
 Tallahassee, FL  
 32317-5949

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

**Region 4**

**David K. Mobley**  
 Brandon  
 (813) 654-8663  
 (800) 940-2048  
 (813) 655-6629 fax  
 southcentralregion@capitalins.com

**Region 5**

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

**www.capitalins.com**



This Plan Marketed and Serviced by  
 Capital Insurance Agency, Inc.



**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. Employee ID#

2. Social Security Number

3. Agency or Department

INSTRUCTIONS  
 FOR FORM  
 COMPLETION  
 Please type  
 or print.  
 Do not write  
 in gray  
 shaded areas.

4. Employee's Name Last First Middle Initial

5. Mailing Address Street City State Zip

6. Home Phone Number ( ) 7. Work Phone Number ( ) 8. Date of Birth 9. Sex  Male  Female

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

13. Do you have any other sources of income?  YES  NO 14. Annual Salary \$ 15. Group Coverage Desired 2 3 4 5 16.  New Enrollee  Upgrade/Downgrade 17. Occupation or Title

**If you answered YES to Q.13 above, benefits will coordinate with all other sources of income and will reduce your ALTA benefit amount.**

18. I hereby apply to Alta Health & Life Insurance 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. I hereby acknowledge that I have received the outline of coverage (brochure) describing insurance for which I am now applying.

Payroll Deduction  
 Authorization

Licensed Resident Agent:  
 David M. Moore, CLU, ChFC, President, Capital Insurance Agency, Inc.

Signature

Date

(04/09)

Deduction Code  
**300**  
 Action Processed  
 Date/Initial

Dept./Div. Code  
 Pay Period of First Deduction

Dist. No.  
 Amount of Deduction