

Disability Income Protection

*For Full-Time Employees
of the State of Florida*



**How long can you go
without a paycheck
and still pay your bills?**

Participating Departments and Agencies:

Agency for Workforce Innovation
Department of Community Affairs
Department of Elder Affairs
Department of Environmental Protection
Department of Highway Safety & Motor Vehicles
Department of Revenue
Department of State
Division of Administrative Hearings
Justice Administrative Commission
Parole Commission
Office of the Governor
Public Service Commission
State Board of Administration

For Monthly Employees of the State of Florida

The Alta Disability Income Protection Plan gives you the ability to protect your income – and your family’s lifestyle – in the event you were unable to work due to an accident or sickness.

This Plan is offered only to State of Florida employees and pays in addition to annual leave and sick leave benefits. It offers you the ability to choose a plan that fits your financial situation and is an important part of your employee benefits package. Review the chart on the facing page and determine the group for which you are eligible per your salary, or you may select a lower group for a shorter elimination period.

— POLICY PROVISIONS —

Definition of Total Disability: Total disability or totally disabled is defined by your policy as a disability caused by an injury or sickness disabling a person to the extent the individual is unable to perform the material and substantial duties of *his/her occupation* for a period of two continuous years (after the elimination period), and after that, must be unable to perform the duties of *any occupation*.

Pre-Existing Conditions: If you have received **medical treatment, consultations, or taken prescribed medications three months prior** to your effective date of coverage, that condition will not be covered until you have been insured for twelve consecutive months.

Effective Date of Coverage: The effective date of coverage will be the day following the end of the pay period in which the first deduction is made. An employee must be actively at work on this day.

Coordination of Benefits: This Plan will provide benefits at **60%** of your Basic Monthly Earnings or the Maximum Monthly Benefit, whichever is less. Your Basic Monthly Benefit integrates with and **shall be reduced by all amounts payable**, either periodically or in a lump sum, **from Social Security, PIP income, disability retirement benefits, or any other disability income or retirement plans of your current employer or any prior employer.** Workers’ Compensation claims, where benefits are being received for the same condition, are excluded from this coverage. This Plan **does not integrate with, but does pay in addition to, sick leave, annual leave, and/or sick leave benefits.**

Waiver of Premium: Insureds must pay premiums during the elimination period. Premium payments are then discontinued until you return to work and the premium deduction resumes (Code #300). Premium payments should be forwarded to your Personnel Office, who will in turn forward them to Alta.

Elimination Period: The number of consecutive days of total disability before the insured is eligible for benefits.

Group Changes: Any employee eligible for groups 3 or 4 may choose a lower group when enrolling or may downgrade coverage only during the open enrollment period. Any upgrade in coverage (increasing group) is made by completing a new application and a Health Statement or during the annual open enrollment period. Any employee who becomes eligible for a higher group due to an increase in salary or SES/SMS status, may upgrade within 60 days of that promotion without a health statement or during the open enrollment. All enrollments and changes require the employee to be actively at work on the effective date.

Recurrent Disability: After a period of Total Disability ends, the insured may become disabled again. This later disability will be considered a continuation of the earlier disability if it is due to the same or related causes, and is separated by the same or less period of time as the elimination period. If the later disability is unrelated to the first, or if the separation time is more than the elimination period, it shall be considered a new disability. In such case, a new elimination period would apply.

Limitations & Exclusions: This Plan has a 24-month Mental and Nervous Limitation. This Plan does not cover any loss caused by war or any act of war, or any loss suffered while in the active military service, or any disability resulting from self-inflicted injury or Workers’ Compensation. (Also refer to Pre-existing Conditions).

Continuation of Benefits: This Plan ends upon termination of employment with the State of Florida or with the transferring to another state agency that does not participate in this Plan.

This brochure is for illustration purposes only. Refer to your group certificate upon enrolling for complete details, limitations and exclusions.

If your income is necessary, **DISABILITY INCOME PROTECTION IS ESSENTIAL.**

***BENEFIT PERIOD:**

Sickness, Up to 2 Years

Accident, Up to 5 Years

Group II: Salary Range Up to \$24,999 (Previously Groups I & II)		Group III: Salary Range \$25,000 - \$29,999		Group IV: Salary Range: \$30,000 and Above		Group V: Eligibility: Any state employee currently covered under State Statutes 110.205 (Select Exempt; Senior Management) or elected officials ; or similar classification or designations made by individual agencies and/or otherwise eligible for the state sponsored disability income and life insurance programs.	
60% of Basic Salary up to: \$800 Monthly Benefit †		60% of Basic Salary up to: \$1200 Monthly Benefit †		60% of Basic Salary up to: \$2000 Monthly Benefit †		60% of Basic Salary up to: \$3000 Monthly Benefit †	
15-DAY ELIMINATION • SICKNESS		60-DAY ELIMINATION • SICKNESS		75-DAY ELIMINATION • SICKNESS		ONE YEAR ELIMINATION	
7-DAY ELIMINATION • ACCIDENT		30-DAY ELIMINATION • ACCIDENT		45-DAY ELIMINATION • ACCIDENT			
Age	Monthly Rates	Age	Monthly Rates	Age	Monthly Rates	Age	Monthly Rates
Under 30	\$10.73	Under 30	\$ 9.43	Under 30	\$11.27	Under 30	\$1.63
30 – 34	\$11.92	30 – 34	\$11.70	30 – 34	\$13.65	30 – 34	\$2.17
35 – 39	\$13.43	35 – 39	\$15.17	35 – 39	\$17.77	35 – 39	\$3.25
40 – 44	\$16.03	40 – 44	\$16.79	40 – 44	\$19.61	40 – 44	\$5.42
45 – 49	\$20.15	45 – 49	\$19.93	45 – 49	\$23.18	45 – 49	\$8.23
50 – 54	\$24.05	50 – 54	\$25.57	50 – 54	\$29.90	50 – 54	\$13.11
55 – 59	\$29.03	55 – 59	\$31.42	55 – 59	\$36.83	55 – 59	\$17.33
60 – 69*	\$40.08	60 – 69*	\$37.48	60 – 69*	\$43.33	60 – 69*	\$26.00

Premium changes will occur on five year birthdays between the ages of 30 and 60.

† Monthly benefits are integrated with SS, PIP and other employer-sponsored plans.

**5 years or to age 65. Whichever First occurs.

*** Payout Benefit Periods for Certain Ages**

Age at Disability	“Your Occupation” Accident or Sickness Benefit Period	“Any Occupation” for Accident Only Benefit Period	Total Benefit Period Sickness /Accident
61 or younger	24 months	36 months	24 months / 60 months**
62	24 months	18 months	24 months / 42 months
63	24 months	12 months	24 months / 36 months
64	24 months	6 months	24 months / 30 months
65	24 months	N/A	24 months / 24 months
66	21 months	N/A	21 months / 21 months
67	18 months	N/A	18 months / 18 months
68	15 months	N/A	15 months / 15 months
69 or older	12 months	N/A	12 months / 12 months

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

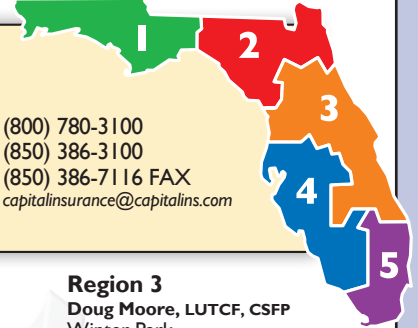
Claim status inquiries should be directed to Alta at **1.800.888.5256**.



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	
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 <input type="checkbox"/> Male <input type="checkbox"/> Female		10. Employment Address (work location) Street City State Zip			
11. Full-Time Employment Date		12. Hours Worked Weekly			
13. Do you have any other sources of income? <input type="checkbox"/> YES <input type="checkbox"/> NO		14. Annual Salary \$		15. Group Coverage Desired 2 3 4 5	
16. <input type="checkbox"/> New Enrollee <input type="checkbox"/> 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
 Amount of Deduction
 Dist. No.