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 Health Care Administration
Agency for Persons with Disabilities
Department of Business & Professional Regulation
Department of Children & Families
Department of Corrections
Department of Health
Department of Juvenile Justice
Department of Law Enforcement
Department of Management Services
Department of Veterans' Affairs
Florida Fish & Wildlife Conservation Commission
Southwood Shared Resource Center

CAPITAL INSURANCE AGENCY, INC.

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

For Bi-Weekly Employees of the State of Florida

The CIGNA Disability Income Protection Plan is a fully-insured disability policy that can help protect your income — and your family's lifestyle — in the event you are unable to work due to a covered 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 that you are eligible for based on your salary, or you may select a lower group for a shorter elimination period and lower benefit amount.

POLICY PROVISIONS

Definition of Total Disability: Total disability or totally disabled is defined by the insurance 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 the Insured has received **medical treatment, consultations, diagnostic test(s) or taken prescribed medications three months prior** to the effective date of coverage, that condition will not be covered until the Insured has been insured for twelve (12) 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. The proposed Insured must be actively at work on this day.

Coordination of Benefits: This Plan provides a **Basic Monthly Benefit** of **60%** of an Insured's Basic Monthly Earnings or the Maximum Monthly Benefit, whichever is less. The **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, V.A. disability and retirement, or disability retirement benefits, or any other disability income, or retirement plans of the Insured's 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 pays in addition to, sick leave, annual leave, and/or sick leave benefits.**

Elimination Period: The number of consecutive days of total disability before the Insured is eligible for benefits. Premium is due during the Elimination Period. Any premium payments not payroll deducted should be sent to Capital Insurance Agency, Inc., P.O. Box 15949, Tallahassee, Florida 32317 ATTN: Group Department.

Waiver of Premium: Once the Insured begins receiving the Monthly Disability Benefit, premium can be waived until the Insured returns to work or the payable Monthly Disability Benefit ends, whichever occurs first. To discontinue payroll deductions the Insured can send a cancellation request to the Personnel Office. Please note that upon returning to work the Insured will be responsible for restarting the premium payroll deduction (Code #0300) to ensure no break in coverage.

Recurrent Disability: A disability which is contributed to by the same cause(s) or is the result of the same cause(s) of a prior disability for which a monthly benefit was payable. (1) If during the Elimination Period of a Disability the Insured attempts to return to work, and works longer than two (2) weeks, a new Elimination Period is required. (2) After the payable Monthly Disability Benefit ends, if the same or related disability recurs within six (6) months of the Insured's return to work, no new Elimination Period is required. If the separation period is longer than six (6) months, a new Elimination Period will then apply.

Limitations & Exclusions: This Plan has a 24-month Mental and Nervous, and Alcoholism and Drug Addiction or Abuse 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).

Group Changes: Any employee eligible for groups 3 or 4 may choose a lower group when enrolling or may downgrade coverage 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 Insured who becomes eligible for a higher/lower group due to a change in salary or SES/SMS status may upgrade/downgrade within 60 days of that event with a new application or during the open enrollment. All enrollments and changes require the employee/Insured to be actively at work on the effective date.

When Coverage Ends: An insured's coverage will end on the earliest of the following dates: the date an Insured terminates employment or transfers to a non-participating state agency; the day after the end of the period for which premiums are paid; the date the Policy is terminated; the date benefits end for failure to comply with the terms and conditions of the Policy. The Employer or the Insurance Company may cancel the policy as of any Premium Due Date by giving 45 days advance written notice.

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	**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.
	(You have the option to choose a Group lower than your Salary Range but not higher than your current earnings.)		
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	Group II Bi-Weekly Rates	Group III Bi-Weekly Rates	Group IV Bi-Weekly Rates	Group V Bi-Weekly Rates
Under 30	$4.95	$4.35	$5.20	$0.75
30 – 34	$5.50	$5.40	$6.30	$1.00
35 – 39	$6.20	$7.00	$8.20	$1.50
40 – 44	$7.40	$7.75	$9.05	$2.50
45 – 49	$9.30	$9.20	$10.70	$3.80
50 – 54	$11.10	$11.80	$13.80	$6.05
55 – 59	$13.40	$14.50	$17.00	$8.00
60 – 69*	$18.50	$17.30	$20.00	$12.00

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.

* 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

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

HOW TO ENROLL

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 CIGNA for approval.

Send the completed application to:
Capital Insurance Agency, Inc.
P.O. Box 15949
Tallahassee, Florida 32317-5949

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

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:
CIGNA Group Disability Dept.
P.O. Box 22328
Pittsburgh, PA 15222-0328

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

Plan Underwritten by:
Life Insurance Company of North America (LINA), a CIGNA Company
(previously underwritten by Alta Health & Life Insurance Company)
Administrative Office: Jacksonville, FL

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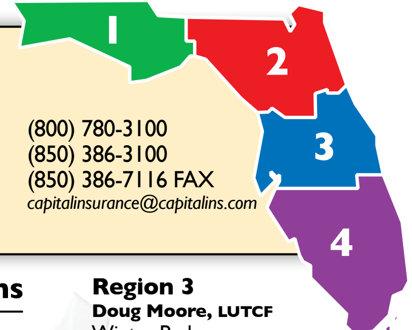
CAPITAL INSURANCE AGENCY, INC.

"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

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

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

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

Tampa
(813) 839-8800
(800) 940-2048
(813) 839-8860 fax
southcentralregion@capitalins.com

Region 4
Mariam Spaulding, LUTCF
Coral Springs
(954) 341-8705
(800) 940-5656
(954) 341-5311 fax
southflregion@capitalins.com

www.capitalins.com

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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 and County	
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 CIGNA benefit amount.

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.

EMPLOYEE must complete sections 1 - 18. Please print or type.

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

18. I hereby apply to Life Insurance Company of North America, 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.
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, Chairman of the Board, Capital Insurance Agency, Inc.

Signature ______________ Date ______________ (07/11)

Deduction Code **300** | Action Processed Date/Initial | Dept./Div. Code | Pay Period of First Deduction | Amount of Deduction | Dist No.

SEND THE COMPLETED APPLICATION TO: CAPITAL INSURANCE AGENCY, INC., P.O. BOX 15949 TALLAHASSEE, FL 32317-5949