

ALTA LIFE INSURANCE PLAN ENROLLMENT APPLICATION/CHANGE FORM FOR STATE OF FLORIDA PARTICIPATING AGENCIES:

- Agency for Health Care Administration, #781019
- Department of Revenue, #780112
- Division of Administrative Hearings, #763851
- Department of State, #749952
- Department of Children & Families, #749932
- Department of Transportation, #780172
- Department of Corrections, #749902
- Department of Veteran's Affairs, #780102
- Department of Elder Affairs, #781018
- Florida Parole Commission, #749992
- Department of Environmental Protection, #749922
- Office of the Auditor General, #749872
- Department of Health, #781020
- State Board of Administration, #749942
- Department of Juvenile Justice, #780122
- Department of Business and Professional Regulation, #713736
- Department of Management Services, #749852

TO ALL FULL-TIME EMPLOYEES

This is your opportunity to enroll in an excellent, low-cost Group Term Life Insurance Plan sponsored by your Department.

- If you **ELECT TO HAVE COVERAGE**, complete and sign the **APPLICATION** (Section I).
- If you desire to make a **policy change** (beneficiary or name), complete and sign the **POLICY CHANGE** (Section II),
- All employees must return this form promptly to the Personnel Office in order to obtain coverage.

Attention: THIS FORM MUST REMAIN IN THE EMPLOYEE'S PERSONNEL FILE. DO NOT MAIL IT TO THE COMPANY.

I. APPLICATION FOR GROUP TERM LIFE INSURANCE COVERAGE

Employee Name _____ DOB _____ SSN _____

Employee Home Address _____

Employee ID# _____ Dept _____ Work Phone _____

Beneficiary Name _____ DOB _____ Relationship _____

Contingent Beneficiary Name _____ DOB _____ Relationship _____

I hereby apply for the amount of Group Term Life Insurance for which I am eligible under my employer's Group Insurance Plan.
I authorize deductions from my earnings in the amount required to cover my premiums.

EMPLOYEE SIGNATURE _____ DATE _____

II. POLICY CHANGE ONLY

Employee Name _____ DOB _____ SSN _____

Employee Home Address _____

Employee ID# _____ Dept _____ Work Phone _____

___ BENEFICIARY CHANGE

Change primary beneficiary to: _____

Last Name	First Name	Relationship
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Change contingent beneficiary to: _____

Last Name	First Name	Relationship
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___ NAME CHANGE

Change my name from _____ to _____

EMPLOYEE SIGNATURE _____ DATE _____

III. BENEFICIARY DESIGNATION

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request. If you need assistance, contact your benefits administrator at (800) 888-5256 or your own legal counsel.

IV. FOR PERSONNEL USE ONLY

PLEASE FILE IN EMPLOYEE'S PERSONNEL FILE. DO NOT MAIL TO COMPANY