The Florida Department of Children and Families & Agency for Persons with Disabilities For the Hyatt Legal Plans

Last Name: ______________________ First Name: ______________________ M.I: ________

Social Security Number: ______________ People First ID Number: ______________ Home Zip Code: ____________

Date of Hire: ______________ Work Location: ______________________________

I wish to Accept *enrollment into the* Hyatt Legal Plans *and authorize, now or hereafter, the appropriate deductions be taken from my wages for this Plan. I understand my enrollment in the* Hyatt Legal Plans *is effective for one full year, and cannot be canceled during that period.*

Employee's Signature (*Required for Processing*): ______________________________ *Date:* ______________

Please Return To Your Post Tax Benefits Coordinator

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premium to Be Deducted: $8.20 | Hyatt Legal Plans | Misc. Deduct. Code: 257