HOW TO ENROLL

CAPITAL INSURANCE AGENCY, INC.

"We're Here To Help You!"

Contact the Capital Insurance Agency Regional Office in your area for assistance.

HOW TO ENROLL

- Enroll during the ANNUAL OPEN ENROLLMENT PERIOD or as a NEW EMPLOYEE (within the first 60 days of employment).
- Complete all parts of your ALTA Supplemental Hospital application (see below), sign and date, then return to the Capital Insurance Agency Office nearest you.
- **Alta's application is in addition to the Official State Enrollment form. To obtain the OFFICIAL State Enrollment Form, you may contact the People First Service Center, toll free 866-663-4735, or access their web site at https: //peoplefirst.myflorida.com.**

NOTE: Enrollment will not be complete unless both forms are completed and returned to the appropriate place.

HOW TO FILE A CLAIM

1. Obtain a copy of your itemized hospital bill with a diagnosis.
2. Check the bill to make sure all charges are correct.
3. Use " Notice of Claim" Form included with your policy, or obtain a form from www.capitalins.com (State of Florida Employees only- Hospital Supplements- Alta 'Notice of Claim')
4. Complete all parts of the "Notice of Claim" Form. Claim(s) must be submitted no later than 12 months from the date of occurrence.
5. Mail the itemized hospital bill and "Notice of Claim" Form to:

   Alta Health & Life Insurance Company
   P.O. Box 2568
   Jacksonville, Florida 32203-2568

For verification of Alta Coverage and claim information, call Alta Customer Service in Jacksonville, Florida 1-800-888-5256.

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
bonniecook@capitalins.com

Regional Locations

Region 1
Robert W. 'Buck' Miller, LUTCF, CLU
Tallahassee
(850) 671-2029
(800) 226-9808
(850) 671-2149 fax
cinsurance37@comcast.net

Region 2
David L. Corbin, LUTCF, CLF
Tallahassee
(850) 942-2323
(800) 881-1871
(850) 942-2360 fax
jcorbin0831@electro-net.com
Jacksonville
(904) 731-9800
(800) 940-9800
(904) 731-4293 fax
capitalinsura980@bellsouth.net

Region 3
Tami Van Syckle, LUTCF
Orlando
(407) 384-9982
(800) 416-1618
(407) 384-9985 fax
Tvansyckle8@cs.com

Region 4
Carol Pasciuta-Whitaker, FLMI
Brandon
(813) 654-8663
(800) 940-2048
(813) 655-6629 fax
capital.brandon@verizon.net

Region 5
Mariam Spaulding, LUTCF
Coral Springs
(954) 341-8705
(800) 940-5656
(954) 341-5311 fax
capita9690@aol.com

www.capitalins.com

THIS FORM MUST BE COMPLETED WITH THE STATE SUPPLEMENTAL INSURANCE ENROLLMENT FORM AND TURNED IN TO YOUR PERSONNEL OFFICE.

DETACH AND RETURN COMPLETED APPLICATION TO P.O. BOX 15949, TALLAHASSEE, FL 32317-5949

SUPPLEMENTAL HOSPITAL EXPENSE INSURANCE APPLICATION AND CHANGE OF COVERAGE FORM

Employee ID # ____________________

Proposed Insured (Last, First, MI)	Date Employed	Date of Birth	Sex	Social Security Number

Address (Street, City, County, State, Zip)	Telephone # ( )	Marital Status	Spouse's Birthdate

ENROLLMENT: (Check desired coverage)

- ❑ 30/20 Medical Supplement
- ❑ Preferred Provider Plus
- ❑ State Insurance Supplement
- ❑ 365 Plus Hospital Indemnity
- ❑ $100 Daily Option I
- ❑ $200 Daily Option II
- ❑ $300 Daily Option III

Change of Coverage
From Present Coverage ____________________

To Desired Coverage ____________________

Sponsoring Employer (State Agency or Department by whom you are employed)

Do you have any eligible Dependants ❑ YES ❑ NO

Do you wish to insure your Eligible Dependents? ❑ YES ❑ NO

I hereby apply to Alta for Supplemental Hospital Expense Insurance. I understand that Alta may decline to accept this application if it is not completed during the enrollment periods that have been predetermined by Alta and the Sponsoring Employer. I further understand that if accepted, my coverage will take effect on the day following the end of the month during which two biweekly or one monthly deduction was made. I understand that my elections are IRREVOCABLE unless I experience a QSC as defined by the Internal Revenue Code and Rule 60P 6.006 FAC Florida Administrative Code (F.A.C.). I hereby certify that I am an Employee of the Sponsoring Employer in an Eligible Class (as specified above), and authorize my Employer to reduce my salary by an amount sufficient to pay the premium for the insurance. I hereby acknowledge that I have received the Outline of Coverage which describes the insurance that I am applying for.

Licensed Resident Agent: David M. Moore, CLU, ChFC, President
Capital Insurance Agency, Inc.,
License #731120

DATE ____________ SIGNATURE OF PROPOSED INSURED ____________________

FOR AGENCY OR DEPARTMENT USE ONLY	DIST. NO.	DEPT./DIV CODE	REDUCTION CODE 101	COMPANY CODE 005	AMT. OF REDUCTION	DATE OF 1ST DEDUCT.	ACTION PROCESSED DATE INITIAL

HOME OFFICE USE ONLY	POLICY NUMBER	ISSUE MO.	DAY	PLAN NO.	INSURED'S AGE	SPOUSE'S AGE	ALLOTMENT NO.	DEPT. NO.	NO. OF DED	PRE. AMT	PREM MODE MONTHLY

APPLICANT: To obtain coverage, please complete this application, detach and return completed application to **P.O. Box 15949, Tallahassee, FLorida 32317-5949**

CONSENT NOTICE: By completing and signing this application, you are consenting to the disclosure of your Social Security Number by your Employer to Alta for use in conjuction with this policy for as long as it remains in force.

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