2019

RETIREMENT BENEFITS PACKET

STATE OF FLORIDA & UNIVERSITY EMPLOYEES

Capital Insurance Agency, Inc.

RETIREMENT INFORMATION

CONTINUING YOUR INSURANCE THROUGH RETIREMENT PAY:

CODE 102: Cancer/Hospital Intensive Care

- Code will change from 102 to Retirement Code 003 (forms attached)
- CONTACT 800-780-3100

CODE 219: Accident

- CONTACT 800-443-3036

CODE 101: 30/20 | PPP | 365+ | SIS

- SIS, 30/20, PPP – must be less than 65 years of age to keep plan
- CONTACT 800-888-5256 for the necessary forms
  or contact Star Goldner directly at 904-306-5556

CODE 300: Long Term Disability

- *NO CONTINUATION OF COVERAGE (see attached brochure)*

CODE 262: Group Term Life

- CONTACT 800-888-5256

CODE 103: Dental

- Must contact People First to go to Direct Pay
- CONTACT 866-663-4735

CODE 103: Dental

- Must go to Direct Pay
- CONTACT 844-222-9104

RETIREMENT INFORMATION *CONTINUED*

Humana

CODE 103: **Dental**

- Network Plus Prepaid and Preferred Plus DPPO Plans – Direct Pay
    - CONTACT 800-943-6880
- Select 15 Prepaid and Schedule B Plans – Direct Pay
    - CONTACT 866-879-3630

CODE 107: **Vision**

- Must go to Direct Pay
- CONTACT 800-939-5369

CODE 285: **Life**

- American National
- Lincoln Financial/Jefferson Pilot/Kentucky Central
- Loyal American (Founders/American Defender)
- Code will change from 285 to Retirement Code 018 (form attached)
- CONTACT 800-780-3100

Capital Insurance Agency, Inc.

"We're Here to Help You!"

Toll Free: 800-780-3100

Local: 850-386-3100

www.capitalins.com | info@capitalins.com

1425 Piedmont Drive E, Ste. 301 • Tallahassee, Florida 32308 | P.O. Box 15949 • Tallahassee, FL 32317

Can I Keep My Benefits?

Insurance Benefits that are Portable if You Leave or Retire

CODE	COVERAGE TYPE	PORTABLE?	DEDUCTION ELLIGIBLE?	CHANGES IN BENEFITS?	CHANGE IN PREMIUMS?
102	AFLAC Cancer/ICU	✓	✓	✗	✗
219	AFLAC Accident	✓	✓	✗	✗
101	CIGNA 30/20, PPP *(Age < 65 years)*	✓	✓	✗	✗
101	CIGNA 365+	✓	✓	Can Keep for 18 Months	✗
101	CIGNA SIS *(Age < 65 years)*	✓	✓	✗	✗
300	CIGNA Disability	✗	✗	N/A	N/A
262	CIGNA Group Term Life	✓	✗	Convert to Whole Life	Increase
103	CIGNA Dental	✓	✗	Not for 1st 18 Months	Increases After 18 Months
103	HUMANA Dental	✓	✗	✗	✗
107	HUMANA Vision	✓	✗	✗	✗
103	MetLife Dental	✓	✗	✗	✗
285	LIFE	✓	✓	✗	✗
285	Long Term Care	✓	✓	✗	✗

Questions or concerns?

We're Here to Help You!

Toll Free: 800-780-3100
Local: 850-386-3100
www.capitalins.com
P.O. Box 15949 · Tallahassee, FL 32317

Capital Insurance Agency, Inc.

Can I Keep My Benefits?

Insurance Benefits that are Portable if You Leave or Retire

UNIVERSITY EMPLOYEES

CODE	COVERAGE TYPE	PORTABLE?	DEDUCTION ELLIGIBLE?	CHANGES IN BENEFITS?	CHANGE IN PREMIUMS?
102	AFLAC Cancer/ICU	✓	✓	✗	✗
101	CIGNA 30/20, PPP *(Age < 65 years)*	✓	✓	✗	✗
101	CIGNA 365+	✓	✓	Can Keep for 18 Months	✗
101	CIGNA SIS *(Age < 65 years)*	✓	✓	✗	✗
103	CIGNA Dental	✓	✗	Not for 1st 18 Months	Increases After 18 Months
107	HUMANA Vision	✓	✗	✗	✗
285	LIFE	✓	✓	✗	✗

• CODE 285/LIFE MAY OR MAY NOT BE AVAILABLE AT YOUR UNIVERSITY.

Questions or concerns?

We're Here to Help You!

Toll Free: 800-780-3100
Local: 850-386-3100
www.capitalins.com
P.O. Box 15949 · Tallahassee, FL 32317

Capital Insurance Agency, Inc.

Rev. 3/06
INS DOC

FLORIDA RETIREMENT SYSTEM
Insurance Payroll Authorization Form

AFLAC
Name of Insurance Provider

Samantha Norton / Benefits Specialist
Insurance Provider Contact Person

850-386-3100
Insurance Provider Telephone Number

The payee must authorize new insurance deductions OR the restart of a previously closed deduction. The payee is the person receiving the FRS pension payment.

PAYEE SSN: ____________ **DEDUCTION CODE NO:** **003**

Deduction Amount: $ ________

PAYEE NAME: ____________ **DEDUCTION CODE NO:** ____________

I hereby authorize the Division of Retirement to deduct my insurance premiums from my monthly Florida Retirement System (FRS) benefit check and make any subsequent premium charges as directed by my insurance provider. I understand that my insurance provider is responsible for notifying me of premium charges as they occur and for any refunds (if applicable). If I am changing insurance companies I will notify the existing company of the cancellation or changes.

Payee's Signature: ____________________

Address: ____________________

Date: ____________ Telephone No: (____) ____________

Date of Birth: ____________ Date Member Retired: ____________

Insurance Provider use only. Retirement will not use this information.

REQUEST FOR CHANGE

American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters, Columbus, Georgia 31999
For information call Toll-Free 1-800-99-AFLAC (1-800-992-3522)

Policy/Contract No.(s) ____________________ ____________________ ____________________

Name of Member Shown On Policy/Contract ____

Member's Social Security Number: ____

Current Address of Member ____

City ____________________ State ______________ Zip ______________

If Payment is paid thru Deduction please enter
Employer or Account Name ____

TYPE OF CONTRACT	☐ **Cancer Ins.**	☐ **Hospital Intensive Care Ins.**	☐ **Medicare Supplement**
	☐ **LifeCare®**	☐ **Advanced Life**	

Associate's Signature and Writing Number ____
Licensed Resident Associate

Please make the following changes to my Policy / Contract:

☐ **ACCOUNT TRANSFERS**

Transfer From ____
(Employer or Account Name and Number)

To ____
(Employer or Account Name and Number)

Amount Remitted $_________ Months________ Effective Date of Transfer____________

☐ **NAME CHANGE ONLY**

Name Shown On Policy / Contract ______________________________

Change Name To: ______________________________

Reason ________________ Effective Date of Name change ________________

☐ **DELETIONS ONLY**

Person to be Deleted ________________ Relationship ________________

Address ______________________________ Phone No. ______________

Birthday of Person to be Deleted ______________________________

Effective Date of Deletion ________________ Reason ______________

(Date of death / marriage/ no longer dependent)

New Policy / Contract Holders Full Name ______________________________

Birthdate of new Policy / Contract Holder ______________________________

Type of Coverage now desired ☐ Individual ☐ Family ☐ Single-Parent Family

☐ **ADDITIONS ONLY**

Person(s) To Be Added:

Full Name	Date of Birth	Relationship

Reasons for Additions ______________________________

Effective Date of Additions ______________________________

Type of Coverage now desired ☐ Individual ☐ Family ☐ Single-Parent Family

IMPORTANT! READ BEFORE SIGNING: To the best of my knowledge and belief, no one to be added to my cancer policy has ever been diagnosed as having cancer, no one to be added to my hospital intensive care policy has ever been treated for or diagnosed for heart attack or any abnormality of the heart.

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.

Signature: ______________________________ Date: ______________

Form A-3596 6-96FL A3596FL.1

Rev. 01/18

INS DOC

FLORIDA RETIREMENT SYSTEM PENSION PLAN

Insurance Payroll Deduction Authorization Form

CAPITAL ADMINISTRATIVE SERVICES

Approved Deduction Name

SHAREE ROSS
Retiree Contact Person

1 (800) 780-3100
Retiree Contact Person's Telephone No

The payee must authorize new insurance deductions OR the restart of a previously closed deduction. The payee is the person receiving the FRS pension payment.

PAYEE SSN: ____________________

DEDUCTION CODE: **018 (LIFE)**

PAYEE NAME: ____________________

DEDUCTION AMOUNT: ____________________

I hereby authorize the Division of Retirement to deduct my insurance premiums from my monthly Florida Retirement System (FRS) benefit check and make any subsequent premium changes as directed by my insurance provider. I understand that my insurance provider is responsible for notifying me of premium changes as they occur and for any refunds (if applicable). If I am changing insurance companies I will notify the existing company of the cancellation or changes.

Payee's Signature: ____
Signature required if no premium deduction (for above deduction code) from previous month's pension payment.

Address: ____

Date: ____________________________ Telephone No: ________________________

Date of Birth: __________________________ Date Member Retired: __________________

Insurance office use only. The Division of Retirement will not use this information.

Insurance provider staff must fax or mail a completed authorization form for all new deductions (or restarted deductions) to the Division of Retirement.

MAIL: Capital Admin. Services, Inc. P.O. Box 15769 Tallahassee, Fl. 32317

FAX: 850-385-8126