

STATE OF FLORIDA

HYATT LEGAL PLANS ENROLLMENT FORM

Please complete and return this form to your Post Tax Benefits Coordinator

Name (please print): _____
Last First M.I.

Mailing Address: _____
(please list the address that you would like to receive your Hyatt Legal Plans information)

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Employee ID#: _____

Date of Hire: ____/____/____ Contact #: (____) _____

State Agency:

- | | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Agency for Persons with Disabilities (APD) | <input type="checkbox"/> | Department of Economic Opportunities (DEO) |
| <input type="checkbox"/> | Agency for State Technology (AST) | <input type="checkbox"/> | Department of Revenue (DOR) |
| <input type="checkbox"/> | Department of Children and Families (DCF) | <input type="checkbox"/> | Department of Transportation (DOT) |
| <input type="checkbox"/> | Department of Agriculture (DACS) | | |

Authorization

I wish to ACCEPT enrollment in the Hyatt Legal Plan and authorize, now or hereafter, the appropriate deductions to be taken from my wages for this plan. I understand my enrollment is effective for one full year, and cannot be cancelled until the next open enrollment period.

Employee's Signature: _____ Date: _____
Required for processing

Miscellaneous Deduction Code - 0257

Monthly Premium: \$17.25

Bi-Weekly Premium: \$7.96

Smart. Simple. Affordable.®

Hyatt Legal Plans

A MetLife Company