

2021

**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
- HD205 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

Can I Keep My Benefits?

Insurance Benefits that are Portable if You Leave or Retire

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

Questions or concerns?

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P.O. Box 15949 • Tallahassee, FL 32317



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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 <i>(Age < 65 years)</i>	✓	✓	✗	✗
101	CIGNA 365+	✓	✓	Can Keep for 18 Months	✗
101	CIGNA SIS <i>(Age < 65 years)</i>	✓	✓	✗	✗
103	CIGNA Dental	✓	✗	Not for 1 st 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?

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Capital Insurance
Agency, Inc.

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	<input type="checkbox"/> Cancer Ins.	<input type="checkbox"/> Hospital Intensive Care Ins.	<input type="checkbox"/> Medicare Supplement
	<input type="checkbox"/> LifeCare®	<input type="checkbox"/> Advanced Life	

Associate's Signature and Writing Number _____

Licensed Resident Associate

Please make the following changes to my Policy / Contract:

<input type="checkbox"/>	ACCOUNT TRANSFERS	Transfer From _____ (Employer or Account Name and Number) To _____ (Employer or Account Name and Number) Amount Remitted \$ _____ Months _____ Effective Date of Transfer _____
<input type="checkbox"/>	NAME CHANGE ONLY	Name Shown On Policy / Contract _____ Change Name To: _____ Reason _____ Effective Date of Name change _____
<input type="checkbox"/>	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 _____
<input type="checkbox"/>	ADDITIONS ONLY	Type of Coverage now desired <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single-Parent Family Person(s) To Be Added: Full Name Date of Birth Relationship _____ _____ Reasons for Additions _____ Effective Date of Additions _____ Type of Coverage now desired <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> 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: _____

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: 850-701-2028