



Select One: Enroll
 Change
 Cancel

Benefits Election Form

Group Name: State of Florida/Post-Tax

Please complete the following information:				
Social Security No.	Last Name	First	Middle	Date of Birth
Home Address		Home Phone		Gender
City	State	ZIP Code	Business Phone	People First Emp ID#
List All Your Eligible Dependents That Are To Be Covered				
First	MI	Last	Sex	Birth Date
Spouse:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:			M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Effective Date	Deduction Code	Group Number	Your E-mail Address	Agent Number 1206037FL

PLEASE CHECK YOUR CHOICE	<input type="checkbox"/> VisionCare Plan
Employee Only	<input type="checkbox"/> \$3.48 (Bi-Weekly) <input type="checkbox"/> \$6.96 (Monthly)
Employee + Family	<input type="checkbox"/> \$8.94 (Bi-Weekly) <input type="checkbox"/> \$17.88 (Monthly)

I wish to enroll in/or cancel the plan indicated above as offered through my employer. I understand that if I enroll during an open enrollment period, my enrollment in the CompBenefits VisionCare Plan is effective for one full year, and cannot be cancelled during that period. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X _____ Date: _____