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# Disability Income Protection

For Full-Time Employees  
of the State of Florida



## Participating Departments and Agencies:

Department of Economic  
Opportunity

Department of Elder Affairs

Department of Environmental  
Protection

Department of Highway Safety  
& Motor Vehicles

Department of Revenue

Department of State

Division of Administrative  
Hearings

The Florida Lottery

Justice Administrative  
Commission

Florida Commission on  
Offender Review

Office of the Governor

Public Service Commission

State Board of Administration

State Courts

*How long can  
you go without a  
paycheck and still  
pay your bills?*

**For Monthly Employees of  
the State of Florida**



**Capital Insurance  
Agency, Inc.**

*This Plan Marketed and Serviced by  
Capital Insurance Agency, Inc.*

**The Cigna Disability Income Protection Plan** is a fully-insured disability policy that can help protect your income — and your family’s lifestyle — in the event you are unable to work due to a covered accident or sickness.

This Plan is offered only to State of Florida full-time employees in participating agencies and pays in addition to annual leave and sick leave benefits. It offers you the ability to choose a plan that fits your financial situation and is an important part of your employee benefits package. Review the chart on page 7 and determine the group that you are eligible for based on your salary, or you may select a lower group for a shorter elimination period and lower benefit amount.

# Policy Provisions

This is a brief description of coverage available under the policy issued by Life Insurance Company of North America (LINA), a Cigna Company, insuring eligible employees of the State of Florida. This is not the insurance contract. Terms and conditions of coverage are set forth in the group insurance contract.

## Definition of Disability

Disabled is defined by the insurance policy as a disability caused by an injury or sickness disabling a person to the extent the individual is unable to perform the material and substantial duties of his/her occupation for a period of two continuous years (after the elimination period), and after that, must be unable to perform the duties of any occupation.

## Active Service

The Insured must be performing his/her regular occupation on a full-time basis (at least 30+ hours per week).

## Pre-Existing Conditions

If the Insured has **incurred expenses, received medical treatment, consultations, diagnostic test(s) or taken prescribed medications three months prior** to the effective date of coverage, that condition will not be covered until after the Insured has been covered under the plan for 12 months while performing their regular occupation on a full-time basis.

## Effective Date of Coverage

The effective date of coverage will be the day following the end of the pay period in which the first deduction is made. The proposed Insured must be actively at work on this day.

## Survivor Benefit

If a claimant dies and has been receiving benefits under the plan for 3 continuous months their survivor will receive an additional 3 months of benefit payments in one lump sum.

## Coordination of Benefits

This Plan provides a **Basic Monthly Benefit of 60%** of an Insured's Basic Monthly Earnings or the Maximum Monthly Benefit, whichever is less. **Benefits will be reduced by other sources of income**, whether received periodically or in a lump sum, **from (1) Social Security Disability and/or Retirement benefits (or assumed receipt of benefits for self or dependents); (2) Employer (State of Florida) funded retirement benefits; (3) Workers' Compensation, Occupational Disease and Unemployment Compensation benefit; (4) Automobile no-fault benefits for wage loss; (5) Damages from third parties on account of Wage Loss or loss of Earning Capacity; (6) Other group or franchise disability insurance benefits; (7) other government programs based on employment with the Employer (State of Florida).**

This Plan **does not integrate with, but pays in addition to, sick leave and/or annual leave.**

## Elimination Period

The number of continuous days of disability before the Insured is eligible for benefits (on an approved disability). Premium is due during the Elimination Period. Any premium payments not payroll deducted should be made payable to: **C.A.S.** Mail payments to: Capital Administrative Services, Inc., Attn: Premium Accounting Dept., P.O. Box 15769, Tallahassee, Florida 32317. **(Please note deduction code 0300 on the payment.)**



## Waiver of Premium

Once the Insured begins receiving the Monthly Disability Benefit, premium can be waived until the Insured returns to work or the payable Monthly Disability Benefit ends, whichever occurs first. To discontinue payroll deductions the Insured can send a cancellation request to the Personnel Office. Please note that upon returning to work the Insured will be responsible for restarting the premium payroll deduction (Code #0300) to ensure no break in coverage.

## Limitations

This Plan has a 24-month lifetime limit for Mental and Nervous, and Alcoholism and Drug Addiction or Abuse.

## Exclusions

This Plan does not cover any loss caused by war or any act of war, or any loss suffered while in the active military service, or any disability resulting from self-inflicted injury, active participation in a riot, commission of a felony, or while incarcerated. (Also, refer to Pre-existing Conditions).

## Group Changes

Any employee eligible for groups 3, 4 or 5 may choose a lower group when enrolling or may downgrade coverage during the open enrollment period. Any Insured who becomes eligible for a higher/lower group due to a change in salary or SES/SMS status may upgrade/downgrade within 60 days of that event with a new application or during the open enrollment. All enrollments and changes require the Employee/Insured to be actively at work on the effective date.

## When Coverage Ends

An Insured's coverage will end on the earliest of the following dates: the date an Insured terminates employment; the day after the end of the period for which premiums are paid; the date the Policy is terminated; the date benefits end for failure to comply with the terms and conditions of the Policy. The Employer or the Insurance Company may cancel the policy as of any Premium Due Date by giving 45 days advance written notice.

*This brochure is for illustration purposes only. Refer to your group certificate upon enrolling for complete details, limitations and exclusions.*

## DAY-ONE VALUE-ADDED PROGRAMS

# Cigna Healthy Rewards<sup>®</sup>

*helping people stay healthy*

- Weight Management and Nutrition
- Vision and Hearing Care
- Tobacco Cessation
- Alternative Medicine
- Mind/Body
- Fitness
- Vitamins, Health and Wellness Products

UP TO 60% DISCOUNTS ON HEALTH AND WELLNESS SERVICES

*Some Healthy Rewards are not available in all states. A discount program is NOT insurance, and the customer must pay the entire discounted charge.*

Go to [www.Cigna.com/rewards](http://www.Cigna.com/rewards) (Password: savings) ■ Or call 1.800.258.3312.

## Cigna's Identity Theft Program: Resolving identity theft issues

Valuable help when employees need it the most

- Review credit information to determine if identity theft occurred
- Provide identity theft resolution kit and an affidavit for credit bureaus and creditors
- Help with reporting an identity theft to credit reporting agencies
- Assist with cancellation and replacement of lost or stolen credit cards and documents
- Provide education on how to identify and avoid identity theft
- Help with emergency travel arrangements, translation services, and message relay

Call 1.888.226.4567.

Please indicate that you are a member of Cigna Identity Theft, Group # 57.

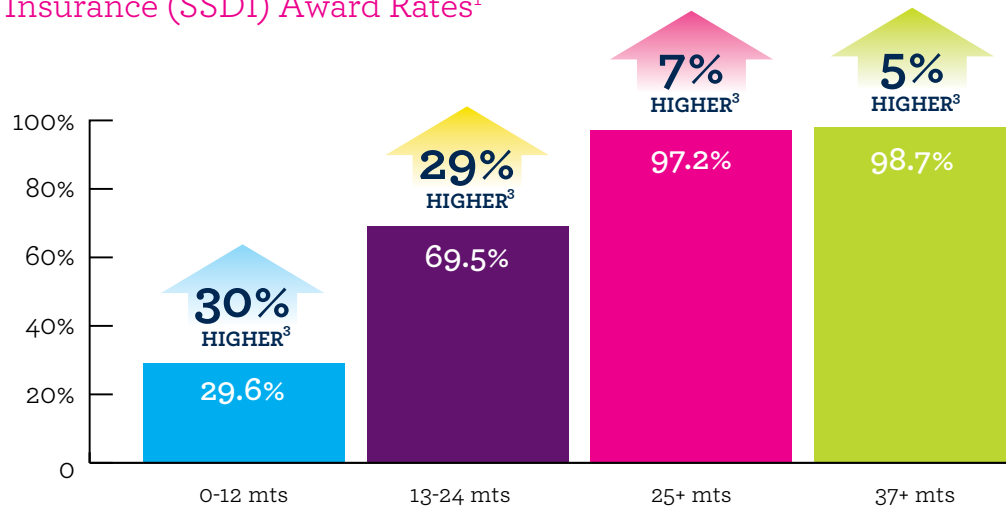
## Cigna Will Preparation: Planning for the Future

- Simple, self-service online tools
- Last will and testament
- Living will
- Health care power of attorney
- Financial power of attorney
- Estate planning information
- Medical authorization for minors
- Online life and disability planning kits
- Funeral Planning Services – new!

Visit [www.CignaWillCenter.com](http://www.CignaWillCenter.com) to find out more.

## Advocacy Program Helps Employees Obtain Social Security Disability Insurance Benefits

### Cigna's Social Security Disability Insurance (SSDI) Award Rates<sup>1</sup>



- Experienced advocates help eligible employees navigate complex SSDI application and award process
- Earlier approvals

**84%**

*satisfied with claim managers help pursuing Social Security disability benefits—exceeding industry average<sup>2</sup>*

**79%**

*satisfied with claim managers help explaining the Social Security disability benefits application process—exceeding industry average<sup>2</sup>*

<sup>1</sup> For employees identified as likely eligible for SSDI benefits and referred for SSDI claim application assistance, 2009;

<sup>2</sup> JHA claimant satisfaction research, 2009;

<sup>3</sup> Cigna SSDI award rates vs. industry average—ING-Re Group Disability Claims Management Benchmarking Survey, Cigna internal analysis, 2009



# Disability Income Protection *Is Essential*

**BENEFIT PERIOD:** Sickness Up to 2 Years<sup>†</sup>; Accident Up to 5 Years<sup>†</sup>

DEDUCTION CODE 0300

GROUP II Salary Range: Up to \$24,999		GROUP III* Salary Range: \$25,000 - \$29,999		GROUP IV* Salary Range: \$30,000 and Above		GROUP V* Eligibility: Any state employee currently covered under <b>State Statutes 110.205 (Select Exempt; Senior Management) or elected officials</b> , or similar classification or designations made by individual agencies and/or otherwise eligible for the state sponsored disability income and life insurance programs.	
60% OF BASIC SALARY UP TO: \$800 MONTHLY BENEFIT <sup>†</sup>		60% OF BASIC SALARY UP TO: \$1200 MONTHLY BENEFIT <sup>†</sup>		60% OF BASIC SALARY UP TO: \$2000 MONTHLY BENEFIT <sup>†</sup>		60% OF BASIC SALARY UP TO: \$3000 MONTHLY BENEFIT <sup>†</sup>	
15-DAY ELIMINATION: SICKNESS		60-DAY ELIMINATION: SICKNESS		75-DAY ELIMINATION: SICKNESS		ONE YEAR ELIMINATION: SICKNESS AND/OR ACCIDENT	
7-DAY ELIMINATION: ACCIDENT		30-DAY ELIMINATION: ACCIDENT		45-DAY ELIMINATION: ACCIDENT			
AGE BAND	MONTHLY RATES**	AGE BAND	MONTHLY RATES**	AGE BAND	MONTHLY RATES**	AGE BAND	MONTHLY RATES**
Under 30	\$10.73	Under 30	\$9.43	Under 30	\$11.27	Under 30	\$1.63
30 - 34	\$11.92	30 - 34	\$11.70	30 - 34	\$13.65	30 - 34	\$2.17
35 - 39	\$13.43	35 - 39	\$15.17	35 - 39	\$17.77	35 - 39	\$3.25
40 - 44	\$16.03	40 - 44	\$16.79	40 - 44	\$19.61	40 - 44	\$5.42
45 - 49	\$20.15	45 - 49	\$19.93	45 - 49	\$23.18	45 - 49	\$8.23
50 - 54	\$24.05	50 - 54	\$25.57	50 - 54	\$29.90	50 - 54	\$13.11
55 - 59	\$29.03	55 - 59	\$31.42	55 - 59	\$36.83	55 - 59	\$17.33
60 - 69 <sup>‡</sup>	\$40.08	60 - 69 <sup>‡</sup>	\$37.48	60 - 69 <sup>‡</sup>	\$43.33	60 - 69 <sup>‡</sup>	\$26.00

\*\*Initial premium is based on your age at issue; premium changes will occur on five year birthdays between the ages of 30 and 60.

PAYOUT BENEFIT PERIODS FOR CERTAIN AGES			
AGE AT DISABILITY	"YOUR OCCUPATION" ACCIDENT OR SICKNESS BENEFIT PERIOD	"ANY OCCUPATION" FOR ACCIDENT ONLY EXTENDED BENEFIT PERIOD	TOTAL BENEFIT PERIOD SICKNESS /ACCIDENT
61 or younger	24 months	36 months	24 months / 60 months <sup>‡</sup>
62	24 months	18 months	24 months / 42 months
63	24 months	12 months	24 months / 36 months
64	24 months	6 months	24 months / 30 months
65	24 months	N/A	24 months / 24 months
66	21 months	N/A	21 months / 21 months
67	18 months	N/A	18 months / 18 months
68	15 months	N/A	15 months / 15 months
69 or older	12 months	N/A	12 months / 12 months

\* Groups III, IV or V have the option to choose a Group lower than your Salary Range but not higher than your current earnings.

<sup>†</sup> Monthly benefits are integrated with SS Disability and/or Retirement benefits (or assumed receipt of benefits for self or dependents), Employer (State of Florida) funded retirement benefits, Workers' Compensation, Occupational Disease and Unemployment Compensation, Automobile no-fault benefits for wage loss, damages from third parties on account of Wage Loss or loss of Earnings Capacity, Other group or franchise disability insurance, other government programs based on employment with the Employer (State of Florida).

<sup>‡</sup> 5 years or to age 65. Whichever occurs first.

# How To Enroll

Eligible Employees: All active, permanent employees under age 70 who work 30+ hours per week in a participating State of Florida agency.

Complete an enrollment form by one of the following four options:

- Online at [www.capitalins.com/enroll\\_ltd.php](http://www.capitalins.com/enroll_ltd.php)
- Fax to 850-701-2028
- Send completed application to:  
Capital Insurance Agency, Inc.  
P.O. Box 15949, Tallahassee, Florida 32317-5949
- Contact your Capital Insurance Agency, Inc. representative for additional information or assistance in enrolling.

The deduction will be made on Post Tax Miscellaneous Deduction Code #0300.

# How to File a Claim

1. Obtain a claim form from your local Capital Insurance Agency office.
2. Complete all parts of the claim form. Your attending physician and employer must complete the form to certify your disability.
3. Mail the claim form to:  
Cigna Group Insurance | P.O. Box 16491 | Pittsburgh, PA 15242-0791
4. Claim status inquiries should be directed to Cigna at **1.800.238.2125**.

Plan Underwritten by Life Insurance Company of North America (LINA), a Cigna Company.  
Administrative Office: Jacksonville, FL

## CAPITAL INSURANCE AGENCY, INC.

"We're Here To Help You!"

Contact Capital Insurance Agency

### 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  
FAX (850) 386-7116

[groupdepartment@capitalins.com](mailto:groupdepartment@capitalins.com)



### REGIONAL LOCATIONS

#### REGION 1

**Robert E. 'Ed' Miller**  
**Regional Director**  
2236 Capital Circle NE,  
Suite 104  
Tallahassee, FL 32308

#### REGION 2

**David F. Spivey Jr., MDRT®**  
**Regional Director**  
1537 Dale Mabry  
Highway, Suite 102  
Lutz, FL 33548

#### REGION 3

**Mariam Spaulding, LUTCF**  
**Regional Director**  
5491 University Dr.,  
Suite 103  
Coral Springs, FL 33067

[www.capitalins.com](http://www.capitalins.com)

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#848440G REV. 7/18



### VOLUNTARY LONG TERM DISABILITY ENROLLMENT FORM

Group Name **STATE OF FLORIDA**

**GRAY BOXES ARE FOR OFFICE USE ONLY:**

Application #

Insurance Effective Date  
Month/Day/Year

1. Employee ID#		2. Social Security Number		3. Agency and County	
4. Employee's Name Last		First		Middle Initial	
5. Mailing Address Street		City		State Zip	
6. Home Phone Number ( )		7. Work Phone Number ( )		8. Date of Birth	
9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		10. Employment Address (work location) Street City Zip		11. Full-Time Employment Date	
12. Hours Worked Weekly		13. Annual Salary \$		14. Do you have any other sources of income? <input type="checkbox"/> YES <input type="checkbox"/> NO	
15. Group Coverage Desired II III IV		16. <input type="checkbox"/> Group V SMS/SES		17. OPS <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Occupation or Title					

**If you answered YES to Q.14 above, benefits will coordinate with other sources of income and will reduce your Cigna benefit amount.**

19. I hereby apply to Life Insurance Company of North America (LINA), a Cigna Company, for Disability Salary Continuation Insurance. I understand that the Company may decline to accept this application if it is not completed during the enrollment periods predetermined by the Company and the Sponsoring Employer. I further understand that, if accepted, my coverage will take effect (if actively at work) on the day following the end of the payroll period in which the first payroll deduction is made. I also certify that I am an Employee of the Sponsoring Employer in an Eligible Class (as specified above), and authorize my Employer to deduct from my earnings an amount sufficient to pay the premium for this insurance, including Age Band changes. I hereby acknowledge that I have received the outline of coverage (brochure) describing insurance for which I am now applying.

Licensed Resident Agent: David M. Moore, CLU, ChFC,  
Chairman of the Board, Capital Insurance Agency, Inc.  
Signature \_\_\_\_\_ Date \_\_\_\_\_  
E-mail \_\_\_\_\_ (07/18)

**Caution:** 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.

**Caution:** EMPLOYEE must complete sections 1 - 19. Please print or type.

NOTE: Eligible class of employees - all active full-time employees of the sponsoring employer who are under age 70.

Payroll Deduction Authorization

Deduction Code **0300**

Dept./Div. Code

Amount of Deduction