2025

RETIREMENT BENEFITS PACKET

STATE OF FLORIDA & UNIVERSITY EMPLOYEES

Capital Insurance Agency, Inc.

"We're Here to Help You!"

RETIREMENT INFORMATION

CONTINUING YOUR INSURANCE THROUGH RETIREMENT PAY:

CODE 102 & 219: **Cancer | Hospital Intensive Care | Aflac Suite (ACC, STD, CC, WL)**

- **Continue coverage through Retirement Deduction:**
  - Complete Aflac Retirement Deduction Authorization (RDA) Form and Aflac Change Form (included in packet)
- **OR continue coverage through Direct Pay:**
  - Complete Aflac Change Form (included in packet)

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

- SIS, 30/20, PPP – must be less than 65 years of age to keep plan
- Contact Star Goldner directly at 904-306-5556
- Coverage continuation options: Retirement Deduction or Direct Pay

CODE 300: **Long Term Disability**

- *NO CONTINUATION OF COVERAGE*

CODE 262: **Group Term Life**

- Contact Star Goldner directly at 904-306-5556
- Convert to individual policy to continue coverage through Direct Pay

CODE 103: Dental

- Contact People First at 866-663-4735 to continue coverage through COBRA

RETIREMENT INFORMATION
CONTINUED

Humana.

CODE 103: **Dental**

- Contact People First at 866-663-4735 to continue coverage through COBRA

CODE 107: **Vision**

- Contact People First at 866-663-4735 to continue coverage through COBRA

Protective

Loyal American Life Insurance Company

CODE 285: **Life | American National Life Insurance | Protective Life | Loyal American Life Insurance Company (Founders/American Defender)**

- **Continue coverage through Retirement Deduction:**
  - Complete CAS Retirement Deduction Authorization (RDA) Form (included in packet)
- **OR continue coverage through Direct Pay:**
  - Complete Bank Draft (PAC) Form (included in packet)

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

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 ELIGIBLE?	CHANGES IN BENEFITS?	CHANGE IN PREMIUMS?
102	Aflac Cancer/ICU	✓	✓	None	None
219	Aflac Suite (ACC, STD, CC, Whole Life)	✓	✓	None	None
101	Cigna 30/20, PPP *(Age < 65 years)*	✓	✓	None	None
101	Cigna 365+	✓	✓	Can Keep for 18 Months	None
101	Cigna SIS *(Age < 65 years)*	✓	✓	None	None
300	LINA (Capital) Disability	None	None	N/A	N/A
262	LINA Group Term Life	✓	None	Convert to Whole Life	Increase
103	Cigna Dental	✓	None	Not for 1st 18 Months	Increases After 18 Months
103	Humana Dental	✓	None	None	None
107	Humana Vision	✓	None	None	None
285	Life Insurance	✓	✓	None	None

Questions or concerns?

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UNIVERSITY EMPLOYEES

CODE	COVERAGE TYPE	PORTABLE?	DEDUCTION ELIGIBLE?	CHANGES IN BENEFITS?	CHANGE IN PREMIUMS?
102	Aflac Cancer/ICU	✓	✓	None	None
101	Cigna 30/20, PPP *(Age < 65 years)*	✓	✓	None	None
101	Cigna 365+	✓	✓	Can Keep for 18 Months	None
101	Cigna SIS *(Age < 65 years)*	✓	✓	None	None
103	Cigna Dental	✓	None	Not for 1st 18 Months	Increases After 18 Months
107	Humana Vision	✓	None	None	None

Questions or concerns?

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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
(herein referred to as Aflac)
ATTENTION: POLICYHOLDER SERVICES (PHS)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information call toll-free 1.800.99.AFLAC (1.800.992.3522)
Toll-Free Fax: 1.800.448.8922

❑ **Pre-tax** ❑ **After-tax**

Name of Policyholder/Certificateholder _____ SSN _____
Last Name First Name MI Suffix

Policy/Certificate Number _____ Policy/Certificate Type _____ Date of Birth _____

Policyholder's/Certificateholder's E-Mail Address _____

Associate/Agent's Signature _____ Writing Number _____
Licensed Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY/CERTIFICATE.

❑ **ADDRESS CHANGE ONLY**

New Address of Policyholder/Certificateholder _____
Street Apt. No.

City _____ State _____ ZIP _____ Telephone No. _____

Former Address of Policyholder/Certificateholder _____
Street Apt. No.

City _____ State _____ ZIP _____

❑ **NAME CHANGE ONLY**

Name Shown on Policy/Certificate _____
Last Name First Name MI Suffix

Change Name To _____
Last Name First Name MI Suffix

Reason ❑ Marriage ❑ Divorce ❑ Death ❑ Request

Billing Name _____
(If policy/certificate is on payroll/association)

Draftee/Cardholder Name _____
(If policy/certificate is on bank draft/credit card)

Effective Date of Change _____

❑ **GENDER IDENTITY CHANGE/REASSIGNMENT ONLY**

PLEASE NOTE: Changing the gender/sex from the gender/sex you selected at the time of application may impact the premium you will be charged for this policy/certificate.

Change the gender of: ☐ Insured ☐ Spouse

Gender requested: ☐ Male ☐ Female

Date of gender change (surgery) _____

Please provide one of the following:
☐ Court Order
☐ New/modified Birth Certificate
☐ Physician Letter

❑ **TRANSFERS TO PAYROLL/UNION/ASSOCIATION BILLING ONLY**

Transfer From _____ _____
Account Name Account Number

Transfer To _____ _____
Account Name Account Number

Department No. _____ Employee/Member No. _____

Amount Remitted $_____ Months _____

Billing Name _____
Last Name First Name MI Suffix

Effective Date of Transfer _____

❑ **TRANSFERS TO DIRECT BILLING ONLY**

❑ Bill at Home ❑ Bank Draft ❑ Credit Card

Transfer From _____ Effective Date of Transfer _____

Direct Billing Mode (select one) ❑ Monthly (Bank Draft/Credit Card Only) ❑ Quarterly ❑ Semiannual ❑ Annual

Amount Remitted $_____ Months _____

When would you like your premiums deducted?_____ (Please choose any day 1-28.)

❑ **I choose to pay by electronic draft.**

Account Holder's Name _____

Account Holder's Address _____

City _____ State_____ ZIP _____

Transit/ABA Number _____

Account Number _____ ❑ Checking ❑ Savings

❑ **I choose to pay by credit or debit card (only Visa, MasterCard, and American Express are accepted).**

Card Holder's Name _____

Card Holder's Address_____City _____ State____ZIP_____

Card Number _____ Expiration Date _____

Confirmation

I authorize Aflac to initiate debit entries or charges electronically to my account indicated above, and I authorize the institution named above to debit or charge same to such account. I authorize Aflac to continue to initiate debit entries or charges to the account beyond the expiration date of the card and automatically update card information as necessary to continue initiating debit entries or charges. This authorization remains effective and in full force until Aflac and the institution receive written notification from me of its termination in such time and in such manner to afford Aflac and the institution a reasonable opportunity to act on it.

Account Holder/Card Holder's Signature _____Date _____
(If different from Policyholder/Certificateholder/Applicant)

Policyholder's/Certificateholder's/Applicant's Signature _____ Date _____

❑ **DELETIONS ONLY**

Person to be Deleted _____
Last Name First Name MI Suffix

Gender ❑ Male ❑ Female Relationship ❑ Insured ❑ Spouse ❑ Dependent

Address of person being deleted _____

Reason for Deletion ❑ Divorce/Annulment/Dissolution of Domestic Partnership*
❑ Death ❑ Dependent attaining age ❑ Request

Date of Divorce*/Death/Request or Date of birth of dependent attaining age _____

New Policyholder's/Certificateholder's Full Name _____
Last Name First Name MI Suffix

Gender ❑ Male ❑ Female Birth Date of New Policyholder/Certificateholder _____

Billing Name (only applicable if policy/certificate on payroll/association) _____
Last Name First Name MI Suffix

New Coverage Desired ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured-Spouse Only

***Please attach a copy of the divorce decree, court order verifying annulment, or order dissolving the domestic partnership. Failure to attach documentation may prevent Aflac from processing the deletion and/or issuing a refund of premium.**

❑ BENEFICIARY INFORMATION

PLEASE NOTE: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.

If you reside in a community property state, are married, and designate a person other than your spouse as the primary beneficiary, your spouse may have rights to the death benefit of the policy/certificate under state law even if you choose not to name them as your beneficiary. We recommend submitting documentation signed by your spouse consenting to your beneficiary designation and waiving any right to proceeds payable under the policy/certificate. If you are unsure whether these laws apply to you, consult with your legal or tax advisor to determine whether submission of such documentation is necessary. Unless Aflac has been notified of a community or marital property interest in the policy/certificate, Aflac will presume that no such interest exists and disclaims any responsibility for determining the applicability of community property laws or the validity of the beneficiary designation. However, if your spouse claims a community property interest in the proceeds, it may delay in the payment of proceeds under the policy/certificate. By signing this form, you agree to indemnify and hold Aflac harmless from the consequences of making the designation requested in this form.

Effective Date of Change _____

Change the Primary Beneficiary(ies) from: (If no beneficiary previously named, please put N/A in the space below.)

(1) Name _____ (2) Name _____
Last Name First Name MI Suffix Last Name First Name MI Suffix

(3) Name _____ (4) Name _____
Last Name First Name MI Suffix Last Name First Name MI Suffix

To the following new Primary Beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

(2) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(3) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

---

(4) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

Change the Contingent Beneficiary(ies) from: (If no beneficiary previously named, please put N/A in the space below.)

(1) Name _____ (2) Name _____
Last Name First Name MI Suffix Last Name First Name MI Suffix

(3) Name _____ (4) Name _____
Last Name First Name MI Suffix Last Name First Name MI Suffix

To the following new Contingent Beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

---

(2) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

---

(3) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ -_____ -_____

Date of Birth _____ Relationship to Insured _____

(4) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ -_____ -_____

Date of Birth _____ Relationship to Insured _____

❑ **OCCUPATION CLASS CHANGE ONLY**

Please note that all occupation class changes are subject to review and approval.

Class ❑ A ❑ B ❑ C ❑ D ❑ E

Type of Business _____

Job Duties _____

Job Title _____

❑ **RIDER DELETIONS ONLY**

❑ Delete optional benefit rider(s) titled _____

_____

❑ **ACCIDENT/DISABILITY DOWNGRADES ONLY**

❑ (a) – Decrease the monthly benefit amount under the policy/certificate from $_____ to $_____

❑ (b) – Increase the policy/certificate elimination period from _____ days to _____ days.

❑ (c) – Decrease the maximum benefit period under the policy/certificate from _____ to _____

❑ (d) – Decrease the monthly benefit amount under the _____ rider from $_____ to $_____

❑ **CANCER RIDER DOWNGRADES ONLY**

❑ (a) – Decrease the benefit amount under the Initial Diagnosis Benefit Rider from $_____ to $_____

❑ (b) – Decrease the benefit amount under the Cancer Screening and Annual Care Benefit Rider from $_____ to $_____

For downgrades:

- I have reviewed the benefits and premium of the insurance policy/certificate and/or rider(s) that I am changing and agree to the following:
  - I understand the impact that the premium for this coverage has on my paycheck/income;
  - I understand the impact that the total Aflac premium for this coverage and any other Aflac coverage has on my paycheck/income and believe it to be appropriate for me; and
  - I have considered all of my existing health insurance coverage, with Aflac and/or with other carriers, and believe this change in coverage is appropriate for my insurance needs. I further understand that I can contact Aflac and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

Policyholder's/Certificateholder's Signature _____ Date _____

Rev. 01/18

INS DOC

FLORIDA RETIREMENT SYSTEM PENSION PLAN

Insurance Payroll Deduction Authorization Form

CAPITAL ADMINISTRATIVE SERVICES

Approved Deduction Name

PREMIUM ACCOUNTING — 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