New! Florida College System

Allstate Benefits - Medical GAP Plan

Group Indemnity Medical (GIM1)

Benefits increase 5% per year for the first 5 years at no additional charge!

Designed to complement existing major medical insurance and help provide first dollar benefits to fill the gap between what your current major medical coverage pays and what your out-of-pocket expense is.

Choice of:	☐ **"Low" Plan GIM1**	☐ **"High" Plan GIM1**
Available to:	All Employees (and families)	All Employees (and families)
Issue Age	Employee's Age 18+	Employee's Age 18+
Initial Hospital Confinement Benefit	**$250** - Once per year per insured (excluding pregnancy and birth)[2]	**$500** - Once per year per insured (excluding pregnancy and birth)[2]
Daily Hospital Confinement Benefit	**$100/day** (180 days max) (including pregnancy and birth)	**$200/day** (180 days max) (including pregnancy and birth)
Hospital Intensive Care Benefit	**$100/day** (60 days max)	**$200/day** (60 days max)
Surgery	Benefit pays from **$20-$500** Depending on the specific surgery	Benefit pays from **$20-$500** Depending on the specific surgery
Anesthesia Benefit	**25% of surgical benefit paid** (pays for anesthesia received by covered person during covered surgical procedure)	**25% of surgical benefit paid** (pays for anesthesia received by covered person during covered surgical procedure)
Inpatient Physician's Benefit	**$25/day** (while receiving DHC benefit)	**$25/day** (while receiving DHC benefit)
Emergency Accident Benefit	**$250/day** (max. 2 times/person/year)	**$500/day** (max. 2 times/person/year)
At-Home Nursing Benefit	**$50/day** (max. 30 days in 60 days after hospitalization)	**$100/day** (max. 30 days in 60 days after hospitalization)
Ambulance	**$150/day** (double for Air Ambulance; max. 3 times/person.year)	**$300/day** (double for Air Ambulance; max. 3 times/person.year)
Non-Local Transportation	**$150/day** (max. 3 times/person/year)	**$300/day** (max. 3 times/person/year)
Outpatient Physician's Benefit	**$25/day** (5 times/person, 10 max. for EE+1; 15 max. for Family)	**$50/day** (5 times/person, 10 max. for EE+1; 15 max. for Family)
EyeMed Vision Discount Program	Discount Program - ID Card provided	Discount Program - ID Card provided
Pre-Existing Exclusion	12/12 Month Pre-X clause* Otherwise Coverage begins immediately	12/12 Month Pre-X clause* Otherwise Coverage begins immediately
Maternity Benefits	10 Month* Wait	10 Months* Wait

Semi-Monthly (24) Premium	☐ **"Low" Plan GIM1**	☐ **"High" Plan GIM1**
Employee Only	**$9.68**	**$15.85**
Employee & Spouse	**$16.61**	**$28.40**
Employee & Child(ren)	**$14.64**	**$24.97**
Family	**$21.20**	**$36.78**

**waived if replacing current Hospital Indemnity Plan*

[1] *payable for each day of continuous hospital confinement; not paid for any day the First Day Hospital Confinement Benefit is paid*

[2] *payable for each day of continuous hospital intensive care unit confinement; pays in addition to the First Day Hospital Confinement Benefit and Daily Hospital Confinement*

Allstate Benefits - Medical GAP Plans

For enrollment - claims assistance contact:
Custom Benefit Services 800-809-8161

EyeMed Vision Discount Benefit – This no cost benefit offers employees $5 off eye examinations and averages 40% off a complete pair of glasses. Additional discounts for Lasik are available. Underwritten by Fidelity Security Life Insurance Company (FSL). www.eyemedvisioncare.com (ACCESS Network).

Terms of coverage - Family Plan coverage may include employee/member, spouse (Domestic Partner), and dependent children as defined in the policy. Individual and Spouse coverage includes employee/member and spouse. Individual and Children coverage includes employee/member and eligible children as defined in the policy.

Effective Date - The effective date of coverage will be the policy date assigned by the Home Office and shown on the certificate specification page, not the application date.

Pre-Existing Condition Limitation - Allstate Benefits does not pay for any loss during the first 12 months of coverage due to a pre-existing condition. A Pre-Existing Condition is a disease or physical condition for which: medical treatment, consultation, care or services were received, including diagnostic measures, drugs or medicines were taken or prescribed, over the counter medications were taken or treatment recommendations were followed in the 12 months just prior to the covered person's effective date of coverage or the date an increase in benefits would otherwise be effective; or symptoms existed within the 12 month period prior to the covered person's effective date of coverage or the date an increase in benefits would otherwise be effective.

Policy Limitations and Exclusions - Allstate Benefits does not pay benefits caused by or resulting from (directly or indirectly): 1. Injury or sickness incurred prior to the covered person's effective date of coverage subject to the Pre-Existing Condition Limitation provision and Incontestability provision, if applicable (Does not apply if waiving pre-existing conditions); or 2. Any act of war whether or not declared, participation in a riot, insurrection or rebellion; or 3. Suicide, or any attempt at suicide, whether sane or insane; or 4. Injury incurred while engaging in an illegal occupation or committing or attempting to commit an assault or felony; or 5. Dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an injury; or (b) correct a disorder of normal bodily function; or 6. Intentionally self-inflicted injuries; or 7. Confinement that begins before the covered person's effective date of coverage; or 8. The reversal of a tubal ligation or vasectomy; or 9. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law; or 10. Participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or 11. A newborn child's routine nursing or routine well baby care during the initial confinement in a hospital; or 12. Driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway; or 13. Childbirth occurring within the first 10 months of the covered person's effective date of coverage (complications are covered to the same extent as a sickness (Does not apply if Maternity Hospitalization is elected); or 14. mental or nervous disorders (according to plan design); or 15. alcoholism, drug addiction or dependence upon any controlled substance (according to plan design).

Termination of Coverage - The insured employee's/member's coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which any required premium payments were made; or the last day the insured employee/member is in active employment, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision in the policy; or the date the insured employee/member is no longer in an eligible class; or the date the insured employee's/member's class is no longer eligible; or our discovery of fraud or material misrepresentation in the presentation of a claim under this policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. Coverage for your child will end on the issue day of the month that follows when the insured employee/member dies or the child reaches age 26 or otherwise does not meet the requirements of an eligible dependent.

Portability - If your coverage terminates for reasons other than non-payment of premium, or if coverage of a spouse terminates due to divorce or your death, or if coverage of a child terminates due to the child reaching age 26, the covered person will be eligible for portability coverage. This means the covered person may continue the same benefits you had under the group policy, subject to the conditions defined in the policy, as long as premiums are paid directly to American Heritage Life Insurance Company. Portability coverage is not available if the group policy is terminated, and portability coverage ends upon termination of the group policy.

Coverage Subject to Policy - Coverage under the certificate is subject in every way to the terms of the policy that is issued to the policyholder. The group policy may at any time be amended or discontinued by agreement between Allstate Benefits and the policyholder. The certificate holder's consent is not required for this. Nor is Allstate Benefits required to give the certificate holder prior notice.

The policy and riders are Limited Benefit Insurance which provides supplemental benefits as defined in the policy and riders. The policy and riders are not a Medicare Supplement Policy. If eligible for Medicare, review the Medicare Supplement Buyer's Guide, available from Allstate Benefits. This illustration highlights some features of the policy and riders but is not the insurance contract. Only the actual policy and rider provisions control. The policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company.

Allstate Benefits

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

For AHL Home Office use only ☑ New Certificate ☐ Change/Increase Certificate # _____

Group No.	Account	Location	Dep Code	Smoker	Issue State	Effective Date
18471			☐E S☐ ☐C F☐	EE Y or N SP Y or N	FL	1/1/2015

GENERAL INFORMATION

Employee's (Certificateholder) Name (Last, First, M.I.) *			☐ M ☐ F	Social Security Number *
Residence Address *		City *	State *	Zip *
Date of Birth *	Phone Number *	Email *		
Employer/Association/Union COLLEGE OF CENTRAL FLORIDA	Date Hired *	Occupation *		Plant Or Division N/A
Primary Beneficiary's Full Name and Address * (address not required)		City	State	Zip / Relationship *
Phone Number *	Date of Birth (if available)	Social Security Number (if available)		
Contingent Beneficiary's Full Name and Address (if desired)		City	State	Zip / Relationship
Phone Number	Date of Birth	Social Security Number (if available)		

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number
		Employee			
		Spouse			

Are you changing existing coverage due to a qualifying event such as marriage, birth, or adoption?

Indemnity Medical ☐ Yes ☑ No

If "Yes", please complete the following: Qualifying Event New Coverage - Initial Enrollment - N/A

Date of Qualifying Event N/A Current Certificate Number(s) N/A

Do you currently have the following individual coverage with American Heritage Life Insurance Company (AHL)?

Hospital Indemnity ☐ Yes ☑ No

If you answered "Yes" to the coverage, please enter the Policy Number. New Coverage - Initial Enrollment - N/A

Do you wish to terminate this coverage? ☐ Yes ☑ No If "Yes", please enter effective date of termination. N/A

ENROLLMENT FORM

SELECTION OF COVERAGE

(Answer Yes or No and complete for each coverage selected)

Indemnity Medical I ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☒ Yes ☐ No	☐ Low Plan ☐ High Plan	Total Mode Premium $_____

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance, including all documents accompanying my certificate(s) of insurance. If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my certificate and accompanying documents at: www.allstatebenefits.com/mybenefits.

☐ Yes ☑ No

By checking the "Yes" box, I elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) of insurance, to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive instructions at the last email address I have provided on how to receive correspondence at: www.allstatebenefits.com/mybenefits.

☐ Yes ☑ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my certificate(s) of insurance, free of charge, by calling toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

ACCEPTANCE/AUTHORIZATION: I hereby request all coverage(s) checked "yes" above for which I am or may become eligible under the group coverages issued by AHL. I **AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **EFFECTIVE DATE:** I understand that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment form is signed. **WAIVER/DECLINATION**: I understand that if I refuse any coverage for which I am eligible (by checking "no" above), satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

FRAUD NOTICE: 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.

Date Signed _____ Employee's Signature _____