GABOR
Lowest Rates
Available
In Florida’s
Pretax Program

SAVE! SAVE! SAVE!

GABOR 1-2-3 PLAN
A pre-tax hospital supplemental insurance plan for employees of the State of Florida

Offices Located In
Tallahassee 850-894-9611
Boca Raton 561-395-7969
Gainesville 352-372-1802
Jacksonville 904-396-6992
Orlando 407-277-0246
Pensacola 850-478-1649
Tampa 813-631-8000
Miami 305-559-9332

Licensed salaried representatives to serve you at all office locations
Applicant:

Social Security No.

Date of Birth:

Month: ___ Day: ___ Year: ___

Job Title: ___ State Agency: ___

Office Address:

Company Code 010 - Product Code 101

Select one from this column:

[ ] Employee Only
   (Cov Code 01)

[ ] Employee & One Dependent
   (Cov Code 02)

[ ] Employee & Two or More Dependents
   (Cov Code 03)

Select one from this column:

[ ] $100.00 Daily
   (Cov Code 101)

[ ] $200.00 Daily
   (Cov Code 102)

[ ] $100.00 Daily w/ ECR
   (Cov Code 111)

9 month employee

12 month employee

Monthly Premium $.

Dependents to be covered under the Hospital Income Insurance:

(Spouse, children only. See Question 12 for relationship and age. D.O.B)

The Hospital Income Insurance has a pre-existing condition limitation and if I, or any covered dependents, have received medical treatment or consultation, had medical care or services including diagnostic measures or prescribed drugs or medications within the 90 days prior to the start of this insurance, there will be no coverage for any of these or related conditions until 90 days after the effective date.

If I am insured under the “Employee and Two or More” premium category, any newborn children will be covered automatically at birth, provided I notify the Company within 31 days of date of birth. If I am insured under the “Employee Only” or the “Employee and One Dependent”, I must notify the Company and complete a Pre-Tax Qualified Status Change Form and begin paying the required rate within 31 days of the birth; otherwise, there will be no coverage for the newborn child.

I have read the brochure outlining coverage and completed the State of Florida Enrollment Angle of Information Form and understand the election may not be changed, modified or modified unless I experience a Qualifying Status change or until an Open Enrollment Period.

Date of Application: __________________________ Policy Effective Date: __________________________

Date Employed: __________________________ Agent: __________________________

Signature of Applicant: __________________________

PLEASE FULLY COMPLETE AND SIGN THE APPLICATION FOR HOSPITAL INSURANCE AND MAIL IT TO YOUR PERSONNEL OFFICE ALONG WITH THE STATE OF FLORIDA SUPPLEMENTAL INSURANCE ENROLLMENT FORM

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<th>$100/Day</th>
<th>$200/Day</th>
<th>$100/Day/ECR</th>
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<td>Employee and Two or More Dependents</td>
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