

Fax: 305-355-2324 ■ JHSFieldOffice@fbmc.com

PLEASE WRITE IN ALL CAPITAL LETTERS

2024 JACKSON HEALTH SYSTEM

Benefit Selection Form for Flexible Benefits, Group Medical, Dental, and Vision Plans

SECTION 1: EMPLOYEE INFORMATION																								
LAST NAME	FI	FIRST NAME							MI SS#					T				T						
ADDRESS [STREET,								Z	ZIP				HOME PH	IONE/	CELLPHO	NE	1							
EMAIL ADDRESS	AL SALARY															FOR	OFFICE USE ONLY							
								- -							□ No	EFFE	ECTIVE DATE:							
BIRTH DATE		RIED DATE HIRED ENROLLMENT STA						TATUS (CHECK ONE) DLLMENT								PAYR	OLL							
□ PENALL □ PENALL □ PENALL □ SUPERSEDE □ CHANGE IN STATUS □ NON- BINARY □ SINGLE □ OPEN ENROLLMENT □ APPEAL □ SUPERSEDE □ CHANGE IN STATUS													DATE	EFFECTIVE Date:										
SECTION	2: [□ Waive Vision																						
01011011	Dental I st-Tax □\$						TAL □ Pretax □ Post-Tax																	
(Please mark one box only.) JACKSON				KSON SI	ELECT	JACKSON POS			┦╹					- Standard -				- Enric						
Bi-weekly rates for:		FIRST HMO	HMO PLAN [•]			PLAN ⁻					Emp		DHM0 oyee Only 🗆 \$0								PP0			
Employee Only Employee & Child(ren) †		□ \$0.00 □ \$105.00	□ \$57.75 □ \$197.41			□ \$173.25 □ \$440.46				Employ			lependent 2 \$2						□ \$2.54 □ \$7.89		□ \$4.90 □ \$27.70			
Employee & Spouse /		□ \$120.00	□ \$232.50			\$530.87			Employee &				Family 🗆 \$6.8						□ \$16	.09 🗆 \$	□ \$55.32			
Domestic Partner Employee & Family		□ \$160.00	□ \$330.72			\$917.68			VISION Pret										SE	P	PREMIER			
LITIPIOYEE & Lat					_					Employee & One						Dependent* 🛛 🗆			\$1.91 \$3.83		□ \$4.59 □ \$9.87			
		□ JACKSON RID	CK RENFL	11: \$45		Depo	endents Onl							Employee				□ \$7.03			□ \$19.06			
SECTION 3: EMPLOYEE & DEPENDENT INFORMATION (YOU MUST LIST A PRIMARY CARE PHYSICIAN (PCP #) BELOW, IF SELECTING MEDICAL COVERAGE FOR YOU AND YOUR DEPENDENTS)																								
													ver	age Des	sired				DOB	PCP #	Cheo	ck Or	ne*	
Relationship	M/F/N	Last Nam	1e/First i	vame		Socia	Security Nu	umber	✓ ¹	MEDICA	L DENTAL	VISIO	N	HOSPITAL NDEMNIT	ACCID INSURA	ENT NCE	CONSTANT CREDIT	М	1M/DD/YY		DP	CDP	AC	
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* IF ENROLLING A DOMESTIC PARTNER, CHILD OF A DOMESTIC PARTNER OR ADULT CHILD(REN) PLEASE SELECT THE APPROPRIATE BOX. ** PLEASE CHECK MARK () ANY DEPENDENT WHO RESIDES OUTSIDE MIAMI-DADE, BROWARD, OR PALM BEACH AREA.</td <td></td>																								
	SECTION 4: FLEXIBLE SPENDING ACCOUNTS [*] YOU MUST COMPLETE THIS SECTION IF YOU WISH TO PARTICIPATE IN EITHER OR BOTH SPENDING ACCOUNTS FOR 2024.															24.								
		his amount each pa					-				Covera	0					.D(REN)(AC) BE C PARTNER (CE			30 YEARS OF PER IS INCLUDED	\$			
		his amount each pa DE YOUR BENEFITS REFE					ending Acco	unt.		Cance	l Covera	ge		THE PLAN.	D(ILIN) OF T	DOMEOT	o minici (oc	51).	UNITION		\$			
CECTION	5. DO		רסנות			al _ II	timata Ad	lvico	~				nlv	¢6 20		EE ,	Family	¢Q	2 1 0	□ Cance	1			
															÷									
Group Hospital Indemnity* Low Medium High Cancel Coverage Group Accident Coverage Low Plan Cancel Coverage																1 2								
Employee Only Employee & Spouse Employee & Child(ren) Employee & Family Employee Only Employee & Spouse Employee & Child(ren) Employee & Family														\$										
				CTING DE	PENDENT GUV	ENAGE.		† OPTI	ON ALSO	ASE PROVIDE DEPENDENT INFORMATION IN SECTION TWO IF ELECTING DEPENDENT COVERAGE. 1 ALSO APPLIES TO ADULT CHILD(RENI)(AC) BETWEEN 26 THROUGH 30 YEARS OF AGE AND/OR CHILD(REN) OF A DOMESTIC (COP) "SMARTSHOPPER IS INCLUDED IN THE PLAN.														
Group Critical Illness*						Employee & Family								AN.						\$ 				
□ \$10k □ \$15k □ \$20k □ \$25k □ \$30k □ Cancel Ocenture ID Commander □ Emolovee Only \$4.85							Family \$10.3	TUDa	Dacco 🗆 Non Tobbacco											\$ \$				
										DE DEPENDENT INFORMATION IN SECTION TWO IF ELECTING DEPENDENT COVERAGE.														
Pet Assure 🗆 \$3.69 PETplus 🗆 Single Pet \$2.08 🗋 Multiple Pet \$3.92 Pet Assure/PETplus 🗅 Single Pet \$5.77 🗌 Multiple Pet \$7.61 🗠 Cancel Coverage																								
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Health Consumer/Fertility & Family Planning □ Employee/Family \$7.00 □ Cancel \$ SECTION 6: DISABILITY INCOME PROTECTION* (Employee Coverage Only)																								
SECTION 6: DISABILITY INCOME PROTECTION [*] (Employee Coverage Only) A. I elect the following coverage for 2024 (If you are currently enrolled in this benefit, do not answer the questions in B.)																								
														Add			Canoo	l Coverag						
Short-Term Disability						□ Buy-Up Plan (For Companies 150, 200, 300,								10,000)	□ Add □ Cancel Coverage							\$		
	Long-Term Disability Option I Option II Cancel Coverage \$																							
1. Have you b	peen activ	ely working on a fu	II-time ba	asis, or	if part time	, at leas	t 30 hours a				90 days ((exclud	ding	vacatio	n days)		I YES		□ NO					
		oitalized (in-patient)					□ N0																	
		ide your Benefits Refe																						
		list additional chi r dependents cov									f yes, pl	امعدم ر	ovn	lain										
-		stic Partner and c									r yes, pi □ YES			NO										
IMPORTANT				,		-							_		be cover	ed unti	the end o	of the	calender	/ear in which t	he child	reach	es the	
 I certify that the infor I hereby authorize m 	y employer	plied in this application is to reduce my gross sala duction indicated above	ry before Fe	ederal inco	ome and Socia	al Securit	/ taxes are calcu	llated	aq •lu	ge of 26. nderstan	d that if a d	lepender	nt ha	s a differe	nt last nar	ne tha	n mine, leg	jal do	ocuments e	evidencing de	pendent	status	must	
 I understand the cor income after reduct 	tribution to	my Social Security accou	unt may be r	reduced s	ince contribut	tions will I			m •la	ake the c gree for r	lependent nyself and	ineligible covered	e for I men	coverage nbers of m	and prem y family t	iums a o be b	re not refu	ındab e ber	ole. nefits, ded	to supply doc uctibles, copa				
 Income after reduction. Inderstand that the funds in one Flexible Spending Account cannot be used to reimburse expenses covered by another account. Inderstand that expenses for which I am reimbursed cannot be claimed on my income tax returns, nor are they eligible Inderstand that expenses for which I am reimbursed cannot be claimed on my income tax returns, nor are they eligible 											elect.													
for coverage under any other insurance plan. I understand that the amount of salary reduction will include the items specified above and will continue in effect through-												ony of the thir	d degree	e. F.S.										
of the plan year.		nployment or file an appr employer and FBMC Ber	-	-	-				ar	nd my IRS	eligible de	ependen	nts; 2) I will exh	aust all ot	her so	urces of rei	imbu	rsement, ir	y employer's p ncluding those ursement throu	provide	d und	er my	
Iunderstand and agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from my failure to sign or accurately complete this Selection Form. Employer's plans before seeking reimbursement from my FSA; 3] will not seek reimbursement through source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.												- 9-1 ariy												
EMPLOYEE SIGN	IATURE																DA	TE						

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