

Fax: 305-355-2324

PLEASE WRITE IN ALL CAPITAL LETTERS

2024 JACKSON HEALTH SYSTEM

PART-TIME (B5) Benefit Selection Form for Flexible Benefits, **Group Medical, Dental, and Vision Plans**

SECTION 1: EMPLOYEE INFORMATION																						
LAST NAME FIRST NAME										MI		SS#										
ADDRESS [STREET, CITY, STATE]											Z	ΙP			HOME PH	ONE/CELLPH(ONE					
EMAIL ADDRESS ANNUAL SALI								ARY					WORK L	OCATION			F	R OFFICI	E USE (ONLY		
										_										DATE:		
									IROLLMENT STATUS (CHECK ONE) ☐ OPEN ENROLLMENT ☐ APPEAL ☐ SUPERSEDE ☐ CHANGE IN STATUS PAY EEE										ROLL			
		☐ PEMALE ☐ NON- ☐ SINGLE ☐ DATE OF QUALIFYING EVENT													E	EFFECTIVE DATE:						
SECTION 2:																						
MEDICAL Pretax Post-Tax \$50 Non-Wellness Surcharge DENTAL Pretax Post-Tax																						
(Please mark one box only.)			JACKSON JACKSON SELEC				JACKSON POS				DENIAL DIE					Standar	d -	-	Enriche			
Bi-weekly rates for:			FIRST HMO HMO PLAN			N^	PLAN*			-					DHMO PPO y □ \$0.00 □ \$0.			DHM		PPO		
Employee Only Employee & Child(ren) †			□ \$25.00 □ \$107.75 □ \$155.00 □ \$272.41			□ \$273.25 □ \$565.46			Employee (Employee & One Depen				* I			□ \$0.00 □ \$2 □ \$17.05 □ \$7						
Employee & Child(len) Employee & Spouse / Domestic Partner Employee & Family			□ \$195.00 □ \$332.50				\$680.87				Employee &						\$38.15	□ \$1		\$55.32		
			D #000.00 D #455.70				\$1,092.68			۷					Post-Tax			BASE		PREMI		
			□ \$260.00 □ \$455.72												Emplo One De	oyee Only ependent*		\$1.91 \$3.83		□ \$4.5 □ \$9.8		
□ JACKSON RIDER BENEFIT: \$45 Dependents Only Employee & One Dependent* Employee & Family* □ \$7.03 □											\$19.0	6										
			LOYEE & D														AC) BETWEEN INCLUDED IN	26 THROUGH 30	YEARS OF AG	E AND/OR C	HILD(RE	N) OF A
`			IYSICIAN (PCP #) BELOW,			AL COVERAGE F			,			DOW			age Desi		INGLODED IN	DOB	PCP i	# Che	eck O	ne*
Relationship	M/F/N	١	Last Nam	e/Fir:	st Name		Socia	al Securi	ity Number	√ "	MEDICAL	DENTAL	VISIO	4 II	HOSPITAL NDEMNITY	ACCIDENT INSURANCE	CONSTANT CREDIT	MM/DD/Y	′	DP	CDP	AC
																				+		
* IE ENDOL I INO A DO	IMECTIC D	ADTN	IED CUII D OE A DOMEO	TIC DAI	OTNIED OD ADI	II T CUII D/DEN	I) DI EACE	CELECT T	UE ADDD∩DDIAT	E DUA	** DI EAC	ב רעברע ו	MADIZ (IN DEDENIDEI	NIT WILL DECI	DEG ULITOIN	MIAMI DADE	DDUMADU	OD DAI M	DEVUN	ADEA
* 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.																						
SECTION 4: FLEXIBLE SPENDING ACCOUNTS* YOU MUST COMPLETE THIS SECTION IF YOU WISH TO PARTICIPATE IN EITHER OR BOTH SPENDING ACCOUNTS FOR 2024. □ I elect to contribute this amount each pay period to my Healthcare Spending Account. □ Cancel Coverage \$																						
			s amount each pay								□ Can											
			YOUR BENEFITS REFE		-	•							9 -							\$		
SECTION	5: P()S	T-TAX PRO	DU	CTS AF	RAG Lega	al - U	Itimat	e Advisoı			Emplo	yee O	nly	\$6.20	□ EE ·	+ Family	\$8.18	□ Car	ncel \$		
					AF	RAG Lega	al - U	Itimat	e Advisoı	Plu	is 🗆	Emplo	yee C	nly	\$8.34	□ EE ·	+ Family	\$11.00	□ Car	ncel \$		
Group Hosp					dium □ Hi				Gr	oup	Accid	ent Co	overa	ige	Low	Plan □ Hi	gh Plan 🗆	Cancel Cove	erage	s \$		
			ee & Spouse ☐ Ei FORMATION IN SECTION					& Family	1 -		,		,			, ,	, ,	☐ Employ EPENDENT C		ly \int_{0}^{Φ}		
Group Critical Illness*								ASE PROVIDE DEPENDENT INFORMATION IN SECTION TWO IF ELECTING DEPENDENT COVERAGE.														
□ Employee Only □ Employee & Spouse □ Employee & Child(ren) □ Employee & Fa □ \$10k □ \$15k □ \$20k □ \$25k □ \$30k						& Family											\$					
Ocenture ID Commander									☐ Cancel Coverage									\$				
Ocenture Co	nstan	tCr	edit \square Emplo	yee O	nly \$5.31	□ EE +	Spouse	\$10.62	2 *PLEASE PROV	DE DEF	PENDENT IN	FORMATIO	N IN SEC	TION	TWO IF ELECT	ING DEPENDE	NT COVERAGE	. □ Can	cel Cover	age \$		
Pet Assure	□ \$3.6	9	PETplus 🗆 Si	ngle F	Pet \$2.08	☐ Multip	le Pet	\$3.92	Pet Assu	re/P	ETplus	s \square Si	ngle P	et \$	5.77 🗆	Multiple F	Pet \$7.61	☐ Cano	el Cover	age \$		
Pet Assure \$\text{ \$\text{ \$\text{9}}} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \																						
SECTION 6: DISABILITY INCOME PROTECTION* (Employee Coverage Only)																						
			erage for 2024 (If						•	-		ons in B	5.)									
Short-Term D	isabilit	у	☐ Option	ıl	□ Opti	on II		3 Buy-l	Jp Plan (F	or Co	ompani	es 150	, 200	30	0,350)	□ Ad	d	□ Canc	el Covei	age g	<u> </u>	
Long-Term Disability													<u>`</u>									
B. To add coverage you must answer the following questions, unless this is your first eligibility period. 1. Have you been actively working on a full-time basis, or if part time, at least 30 hours a week for the past 90 days (excluding vacation days) YES NO																						
2. Have you been hospitalized (in-patient) in the past 12 months? YES NO																						
_		•	your Benefits Refer		•																	
☐ Check her	e if you	ı lis	t additional chil	dren	on a sepa	ırate shee	t. Stap	ole shee	et to your S	elect	ion For	rm.										
-			lependents cove									yes, pl	ease (expl	lain							
Is your Spouse/Domestic Partner and or child(ren) employed by JHS and eligible for benefits?																						
IMPORTANT										• I un	derstand t	hat all de	penden	t chile	dren may be	e covered ur	ntil the end o	f the calender	year in wh	ch the chi	d reach	nes the

- I certify that the information supplied in this application is true to the best of my knowledge.
 I hereby authorize my employer to reduce my gross salary before Federal income and Social Security taxes are calculated by the total amount of salary reduction indicated above in the selections made in Section 1, 3 & 5.
 I understand the contribution to my Social Security account may be reduced since contributions will be based on my income after reduction.
 I understand that the funds in one Flexible Spending Account cannot be used to reimburse expenses covered by another

- I understand that the funds in one Flexible Spending Account Cannot be claimed on my income tax returns, nor are they eligible 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 throughout 2024, unless I terminate employment or file an approved Change in Status, through the FBMC Office, before the end of the plan year.

 I understand 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.

- age of 26.

 I understand that if a dependent has a different last name than mine, legal documents evidencing dependent status must be submitted to the group plans within 30 days of the coverage effective date. Failure to supply documentation may make the dependent ineligible for coverage and premiums are not refundable.

 I agree for myself and covered members of my family to be bound by the benefits, deductibles, copayments, exclusions, limitations, and other items of the Contracts, Agreements, and Plan Documents.

 I hereby authorize my employer to deduct from my pay any premiums for the benefits I elect.

 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. F.S. Section 817234(l)(b).

 I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents; 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plans before seeking reimbursement from my FSA; 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	DATE