

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: EN	IPLOYEE INF	ORM	ATIO	N																	
LAST NAME							FIRST NAME					MI	SS#									
ADDRESS [STREET, CITY, STATE]												ZIP				HOME PHO	NE/CELLPH	ONE				
EMAIL ADDRESS ANNUAL SALARY							WORK LOC	ATION											OR OFFI	CE USE	ONLY	
									Total Rewards Menu Option: ☐ Yes ☐ No													
BIRTH DATE		EMPLOYEE ID #			☐ MARRIE	D/	ATE HIRED	E	NROLLMENT STATUS (CHECK ONE)													
FEMALE   MAP					SINGLE	-				□ OPEN ENRULLMENT □ APPEAL □ SUPERSEDE □ CHANGE IN STATUS FFF								PAYROLL FFECTIV PATE:	E			
DINART DI																						
SECTION 2: Waive Medical Waive Dental Waive Vision																						
(Plassa mark one ho	MEDICAL   Pretax   Post-Tax   \$50 Non-Wellness Surcharge   DENTAL   Pretax   Post-Tax   Post-Tax																					
Bi-weekly rates		JACKSON FIRST HMO					JACKSON POS PLAN <sup>*</sup>						DH	- Stan MO		- PP0	DHM	Enriche 0	nea - PPO			
Employee Only		\$0.00	□ \$57.75				\$173.25				Emplo	yee Only	/ 0	\$0.00		\$0.00			□ \$4.90			
	Employee & Child(ren) † 🗆 \$105		□ \$197.41						Employee & One Dep Employee &								□ \$7 □ \$1		□ \$27.70 □ \$55.32			
Employee & Spo Domestic Partne		□ \$120.00		\$232.50			\$530.87										BASE		PREMIEF			
Employee & Fan	nily	□ \$160.00	□ \$	330.72		\$917.68												\$1.91		□ \$4.59		
☐ JACKSON RI			ER BENEF	IT: \$45		De	/					oyee & One Depende			□ \$3.83				\$9.87			
Employee & Family													J0									
SECTION	3: EM	PLOYEE & D	)EPEN	IDEN	T INFO	)RN	IATION			IF S							(PCP #) I YOUR DE		NTS)			
Relationship M/F/		Last Name/First Name				Soc	ocial Security Nur		√"		DENTAL I		rage Des			CONICTANIT	DOB	PCP #		neck (		
	,.,					000		111001	<u> </u>	MEDICAL	DENTAL	VISION	HOSPITAL INDEMNIT	/ INSURA	ANCE	CREDIT	MM/DD/Y	Y	DF	CDI	P AC	
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		his amount each pa						nt			Coverage Coverage		GE AND/OR CHI				WEEN 26 THROUG P). *SMARTSH	H 30 YEARS OF OPPER IS INCL	. ⊢	\$		
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SECTION	J. PU	SI-IAX FNU	וטטעו				Ultimate Ad			_			y \$8.34	-			\$11.00	□ Ca		\$ \$		
Group Hosp	ital Ind	emnity* 🗆 low	□ Mediu					_			_ ' '								1001	Φ		
Group Hospital Indemnity*																						
Group Critic			N I WU IF ELE	:CTING DE	PENDENT COV	/EKAGE.												OVERAGE.	$\dashv$	\$		
☐ Employee Only	☐ Empl	oyee & Spouse 🗆 E		& Child(r	en) 🗆 Em	ployee	e & Family	PARTNER												Φ.		
□\$10k □\$15k □\$20k □\$25k□\$30k □Cancel <b>Ocenture ID Commander</b> □ Employee Only \$4.85 □ EE + Fam						+ Family \$10.38		Tobacco □ Non Tobbacco □ Cancel Coverage									\$					
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Ocenture Co		<del> </del>				-	se* \$10.62 *PLEAS										l	cel Cove				
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 \$																						
Health Consumer/Fertility & Family Planning ☐ Employee/Family \$7.00 ☐ Cancel \$												\$										
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.)																						
Short-Term Disability												\$										
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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?																						
*Please refer to pages inside your Benefits Reference Guide for fee information.																						
☐ Check her	e if you	list additional chi	ldren on	a sepa	ırate shee	t. Sta	iple sheet to y	our S	elect	tion Fo	rm.											
Are you or any of your dependents covered under any other medical plan?   YES   NO If yes, please explain.																						
ls your Spouse/Domestic Partner and or child(ren) employed by JHS and eligible for benefits? ☐ YES ☐ NO																						
IMPORTANT  I certify that the info	rmation sup	plied in this application is	s true to the	best of m	y knowledge.					derstand	that all dep	endent ch	ildren may	be cover	ed until 1	the end of	the calende	r year in wl	ich the c	hild rea	ches 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 Hexible Spending Account cannot be used to reimburse expenses covered by another account.
   I understand that expenses for which I am reimbursed 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 817:234(fl(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	ATE