

SECTION 1: RETIREE INFORMATION										PLEASE WRITE IN ALL CAPITAL LETTERS									
LAST NAME					FIRST NAME					MI		SS#							
ADDRESS (STREET, CITY, STATE)										ZIP									
EMAIL ADDRESS										HOME PHONE									
BIRTH DATE					<input type="checkbox"/> MALE <input type="checkbox"/> MARRIED <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE		CELLPHONE					EFFECTIVE DATE (MM/DD/YYYY)							

SECTION 2: INSTRUCTIONS RETIREE: NOTE THAT ALL CANCELLATIONS ARE IRREVOCABLE. PLEASE REMEMBER TO COMPLETE THE DEPENDENT INFORMATION SECTION IF YOU HAVE COVERAGE THAT INCLUDES DEPENDENTS. IF YOU CANCEL A BENEFIT, YOU CANNOT ELECT IT AT A LATER DATE.

SECTION 3: RETIREE MEDICAL	MEDICAL RATES		
(Please mark one box only)			
<input type="checkbox"/> CANCEL MEDICAL <input type="checkbox"/> NOT ENROLLED MONTHLY RATES FOR:	JACKSON FIRST HMO	JACKSON SELECT HMO PLAN	JACKSON POS PLAN
Retiree Only	<input type="checkbox"/> \$804.37	<input type="checkbox"/> \$847.61	<input type="checkbox"/> \$1,903.05
Retiree & Spouse/DP Under 65	<input type="checkbox"/> \$1,688.33	<input type="checkbox"/> \$1,779.02	<input type="checkbox"/> \$3,623.00
Retiree & Child(ren)†	<input type="checkbox"/> \$1,563.78	<input type="checkbox"/> \$1,647.84	<input type="checkbox"/> \$3,320.33
Retiree & Spouse/DP Under 65, plus Child(ren)†	<input type="checkbox"/> \$2,058.98	<input type="checkbox"/> \$2,169.64	<input type="checkbox"/> \$4,917.78
Retiree Under 65 & Spouse/DP Over 65 on Medicare - High HMO No Rx	N/A	<input type="checkbox"/> \$1,452.15	<input type="checkbox"/> \$2,507.59
Retiree Under 65 & Spouse/DP Over 65 on Medicare - High HMO	N/A	<input type="checkbox"/> \$2,238.40	<input type="checkbox"/> \$3,293.84
Retiree Under 65 + Child(ren) & Spouse Over 65 on Medicare w/High HMO No Rx	N/A	<input type="checkbox"/> \$2,252.38	N/A
Retiree Under 65 + Child(ren) & Spouse Over 65 on Medicare w/High HMO	N/A	<input type="checkbox"/> \$3,038.63	N/A

† Option also applies to Adult Children (AC) between 26 through 30 years of age, children of a Domestic Partner and/or eligible dependents.

SECTION 4: RETIREE DENTAL	- Standard -		- Enriched -	
(Please mark one box only)				
<input type="checkbox"/> CANCEL DENTAL <input type="checkbox"/> NOT ENROLLED MONTHLY RATES FOR:	Delta DHMO*	Delta PPO	Delta DHMO*	Delta PPO
Retiree Only	<input type="checkbox"/> \$9.97	<input type="checkbox"/> \$38.88	<input type="checkbox"/> \$18.15	<input type="checkbox"/> \$50.90
Retiree & One Dependent	<input type="checkbox"/> \$16.48	<input type="checkbox"/> \$76.92	<input type="checkbox"/> \$30.07	<input type="checkbox"/> \$100.63
Retiree & Family	<input type="checkbox"/> \$25.17	<input type="checkbox"/> \$123.98	<input type="checkbox"/> \$47.81	<input type="checkbox"/> \$162.27

*Delta DHMO Plans are not available outside Florida. NOTE: Dental coverage is not provided to Adult Children (AC).

SECTION 5: RETIREE VISION	BASE PLAN	PREMIER PLAN
(Please mark one box only)		
<input type="checkbox"/> CANCEL VISION <input type="checkbox"/> NOT ENROLLED MONTHLY RATES FOR:	<input type="checkbox"/>	<input type="checkbox"/>
Retiree Only	<input type="checkbox"/> \$4.14	<input type="checkbox"/> \$9.95
Retiree & One Dependent	<input type="checkbox"/> \$8.30	<input type="checkbox"/> \$21.39
Retiree & Family	<input type="checkbox"/> \$15.23	<input type="checkbox"/> \$41.29

SECTION 6: RETIREE & DEPENDENT INFORMATION

Relationship	M/F	Last Name/First Name	Social Security Number	✓**	Coverage Desired				Date of Birth MM/DD/YYYY	Check One*	
					Medical	Dental	Vision	Constant Credit		DP/CDP	AC
				<input type="checkbox"/>							
				<input type="checkbox"/>							
				<input type="checkbox"/>							
				<input type="checkbox"/>							

* If enrolling a Domestic Partner, Child of a Domestic Partner or Adult Child(ren), please select the appropriate box. NOTE: You may only continue or cancel dependent coverage. You may not add new dependents.
 ** Please check mark (✓) dependent who resides outside Miami-Dade, Broward, and Palm Beach.

SECTION 7: LIFE INSURANCE AND VOLUNTARY PRODUCTS (Monthly Rates)

Life Insurance Elect Life Insurance Decline Life Insurance NOTE: Life Insurance coverage is reduced when you reach age 65. The coverage options are \$15,000 or \$20,000.

\$ _____ x .00017 = \$ _____ **Base Annual Salary Monthly Premium Life Insurance.**

ARAG Legal - UltimateAdvisor	<input type="checkbox"/> Retiree Only \$13.43	<input type="checkbox"/> Retiree + Family \$17.73	<input type="checkbox"/> Cancel
ARAG Legal - UltimateAdvisor Plus	<input type="checkbox"/> Retiree Only \$18.07	<input type="checkbox"/> Retiree + Family \$23.84	<input type="checkbox"/> Cancel
Ocenture ConstantCredit	<input type="checkbox"/> Retiree Only \$11.50	<input type="checkbox"/> Retiree + Spouse \$23.00	<input type="checkbox"/> Cancel
Ocenture ID Commander	<input type="checkbox"/> Retiree Only \$10.50	<input type="checkbox"/> Retiree + Family \$22.50	<input type="checkbox"/> Cancel
Pet Assure	<input type="checkbox"/> \$8.00	PetPlus <input type="checkbox"/> Single Pet \$4.50 <input type="checkbox"/> Multiple Pet \$8.50	<input type="checkbox"/> Cancel
Pet Assure/PetPlus	<input type="checkbox"/> Single Pet \$12.50 <input type="checkbox"/> Multiple Pet \$16.50		

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. I understand and agree that JHS and FBMC Benefits Management, Inc. will be held harmless from any liability resulting from either my participation in any of the benefits herein or my failure to sign or accurately complete this enrollment form. F.S. Section 817.234 (1) (b)

RETIREE SIGNATURE	DATE
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