

PLEASE WRITE IN ALL CAPITAL LETTERS

SECTION 1: EMPLOYEE INFORMATION

Form fields for employee information including Last Name, First Name, MI, SS#, Address, Email Address, Annual Salary, Work Location, Birth Date, Lawson Employee #, and Enrollment Status.

SECTION 2:

Form for selecting benefit options: Medical (JACKSON FIRST HMO, JACKSON SELECT HMO PLAN, JACKSON POS PLAN), Dental (Standard - DHMO, PPO, Enriched - DHMO, PPO), and Vision (BASE, PREMIER).

SECTION 3: EMPLOYEE & DEPENDENT INFORMATION

Table for listing dependents with columns for Relationship, M/F/N, Last Name/First Name, Social Security Number, and Coverage Desired (Medical, Dental, Vision, Hospital Indemnity, Accident Insurance, Constant Credit).

SECTION 4: FLEXIBLE SPENDING ACCOUNTS\* YOU MUST COMPLETE THIS SECTION IF YOU WISH TO PARTICIPATE IN EITHER OR BOTH SPENDING ACCOUNTS FOR 2025.

Form for selecting Flexible Spending Accounts: Healthcare Spending Account and Dependent Care Spending Account.

SECTION 5: POST-TAX PRODUCTS

Form for selecting post-tax products: ARAG Legal - Ultimate Advisor, ARAG Legal - Ultimate Advisor Plus, Group Hospital Indemnity, Group Accident Coverage, Group Critical Illness, Ocenture ID Commander, Ocenture ConstantCredit, Pet Assure, and Health Consumer/Fertility & Family Planning.

SECTION 6: DISABILITY INCOME PROTECTION\* (Employee Coverage Only)

Form for selecting Disability Income Protection coverage for 2024, including questions about active work status and hospitalization.

IMPORTANT: I certify that the information supplied in this application is true to the best of my knowledge. I understand that all dependent children may be covered until the end of the calendar year in which the child reaches the age of 26.

EMPLOYEE SIGNATURE and DATE fields.