

## **2025 JACKSON HEALTH SYSTEM**

PART-TIME (B5) Benefit Selection Form for Flexible Benefits,

Fax: 305-355-2324
PLEASE WRITE IN ALL CAPITAL LETTERS

Group Medical, Dental, and Vision Plans

SECTION	SECTION 1: EMPLOYEE INFORMATION																					
LAST NAME					FIRST NAME						MI	MI SS#										
ADDRESS [STREET, CITY, STATE]											ZIP				ŀ	IOME PHO	NE/CELLPH	IONE				
EMAIL ADDRESS						ANNUAL S		21/				1	WORK L									
EMAIL ADDRESS	11					WURK L	UCATION						ICE USE	-								
BIRTH DATE		LAWSON EMPLOYEE #			DATE HIRED		ENR	ROLLME	NT STA	ATUS (CH	ECK ONE)								EFFECTIVE DATE:			
					_   □ OF				OPEN ENROLLMENT							CHANG	e in statu	5	PAYROL Effecti Date:			
SECTION		Waive Vision																				
(Please mark one bo	ox only.)	JACKSON JACKSON SELECT			I \$50 Non-Wellness Surcharge JACKSON POS			DENTAL □ Pretax □ Post-Tax Standar									· Enrich	ed -				
Bi-weekly rates for: Employee Only		FIRST HMO	HMO PL	AN'	PLAN <sup>*</sup>			Employe				DHMO			PPO		DHMO		PP0			
Employee only Employee & Child(ren) <sup>†</sup> Employee & Spouse / Domestic Partner Employee & Family		□ \$155.00	□ \$282.28		\$587.48			Employee & One De				pendent		□ \$2.93 [		\$17.05			□ \$27			
		□ \$195.00	□ \$344.13		□ \$707.41			Employee &				<u> </u>				\$38.15	□ \$ <sup>-</sup> BASE	16.09			5.32 EMIER	
		□ \$260.00	□ \$472.26		□ \$1,138.		VISION Pre				etax □ Post-1 Er		-Tax Employee Only			\$1.91				9		
		□ JACKSON RIDE	ER BENEFIT: \$45	s Only					Employee & One De Employee &			ependent*			\$3.83 \$7.03				7			
SECTION 3: EMPLOYEE & DEPENDENT INFORMATION       1 option also applies to adult child(ren)(ac) Between 26 through 30 years of age and/or child(ren) of a																						
(YOU MUST LIST A PR	RIMARY CAR	PHYSICIAN (PCP #) BELOW	, IF SELECTING MEDIC	AL COVERAGE F	OR YOU AND YOUR D	DEPENDENTS)					STIC PARTN	IER (C	(CDP). *SMARTSHOPPER I age Desired					PCP		Check One*		
Relationship	M/F/N	Last Nam	e/First Name		Social Secur	ity Numbe	er 🗸	/ MEI	DICAL	DENTAL		HO	SPITAL	ACCIDENT		) NSTANT CREDIT	MM/DD/Y			P CDF		
																				_		
								4												_		
* IF ENROLLING A DO	)MESTIC PA	RTNER, CHILD OF A DOMES	STIC PARTNER OR AD	JLT CHILD(REN)	) PLEASE SELECT T	HE APPROPR	IATE B	 30X. ** I	PLEASE	E CHECK N	/ARK (✓) /	 Any (	) Depender	NT WHO RES	SIDES	OUTSIDE	MIAMI-DAD	E, BROWAR	D, OR PA	LM BEAC'	H AREA.	
SECTION	<u>⊿</u> ∙ FI	EXIBLE SPEI		COUNT	S* YOU MUS	ST COMPLE	TF T	THIS SE	CTIO	N IF YOI	U WISH T	T0 P	ARTICIE	PATE IN FI	THF	R OR BC	TH SPFNI	DING AC	COUNT	S FOR 2	025	
		this amount each pa								cel Cov										\$	0201	
													\$									
SECTION	5: PO	ST-TAX PRO			al - Ultimat al - Ultimat			Due				-								\$		
Group Hosp	ital Ind	lemnity* 🗆 Low				1					-						Cancel Cov			\$		
Employee Only	y 🗆 Emp	Ioyee & Spouse DE	mployee & Child(	ren) 🗆 Em	ployee & Family		1 Emp	ployee	Only	🗆 Emp	loyee & S	Spou	se 🗆 E	Employee	& CI	nild(ren)	EPENDENT (	/ee & Fan		\$		
Group Critic							LLING	0211101				/						01210102		\$		
		loyee & Spouse □ E : □ \$25k □ \$30k	mployee & Child(	ren) 🗆 Emp	ployee & Family	,														\$		
Ocenture ID Commander         Employee Only \$4.85         EE + Family \$10.38         Cancel Coverage										\$												
Ocenture Co	onstant	Credit 🗆 Emplo	oyee Only \$5.31	🗆 EE + S	Spouse <sup>*</sup> \$10.62	2 *PLEASE PR	OVIDE	DEPEND	ent inf	ORMATION	N IN SECTIO	IN TW	0 IF ELECT	ING DEPEND	ENT (	COVERAGE.	□ Car	icel Cove	erage	\$		
Pet Assure	□ \$3.69	PETplus 🗆 Si	ingle Pet \$2.08	□ Multip	le Pet \$3.92	Pet Ass	ure	PET	plus	S 🗆 Si	ngle Pet	\$5.	77 🗆	Multiple	Pet	\$7.61	🗆 Can	cel Cove	rage	\$		
Health Consumer/Fertility & Family Planning       Employee/Family \$7.00       Cancel       \$         SECTION 6: DISABILITY INCOME PROTECTION* (Employee Coverage Only)       (Employee Coverage Only)       (Employee Coverage Only)       (Employee Coverage Only)														\$								
		SABILITY IN overage for 2024 (If				•	-				)											
Short-Term D					Buy-l							300	350)		ht		🗆 Cano	cel Cove	erane	\$		
Long-Term D	,	Option				<u>op : iaii (</u>		00111	paine		, 200, 0		(000)				□ Cano		-	\$		
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																					
		side your Benefits Refer				NO																
	□ Check here if you list additional children on a separate sheet. Staple sheet to your Selection Form.																					
-	Are you or any of your dependents covered under any other medical plan? □ YES □ N0 If yes, please explain																					
IS YOUR SPOUS	se/Dome	suc Partner and o	n crilla(ren) en	iipioyed by	7 JHS and eli	yot sidiy				□ YES			-				4h		61.1 · ·	- le 71 - ć	ala a st	
<ul> <li>I certify that the info</li> <li>I hereby authorize n</li> </ul>	ny employe	plied in this application is to reduce my gross salar	y before Federal inc	ome and Socia		e calculated	•	age of I unders	26. stand th	hat if a de	pendent h	nas a	different	last name f	han i	nine, lega	the calende	s evidencii	ng deper	ident stat	us must	
	ntribution to	eduction indicated above my Social Security accou				on my		make t	he dep	pendent i	neligible fo	or cov	verage ar	d premium	s are	not refun			-			
income after reduction. • I agree for myself and covered members of my family to be bound by the benefits, deductibles, copayment initiations, and other items of the Contracts, Agreements, and Pian Documents. • I agrees for myself and covered members of my family to be bound by the benefits, deductibles, copayment initiations, and other items of the Contracts, Agreements, and Pian 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 cla																						
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- Section 817.234(1)(b).										e third d	egree. F.	S.										
of the plan year. I understand and agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand and agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand and agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand and agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from I understand I under												nder my										
EMPLOYEE SIG	NATURE						_								_	DAT	E					