

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 [*] | | | Employe | | | | DHMO | | | PPO | | DHMO | | PP0 | | | |
| Employee only Employee & Child(ren) [†] 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 | □ \$ ⁻ 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 [*] \$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 | |
| I certify that the info I hereby authorize n | 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 | | | | | | | | | | |
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| EMPLOYEE SIG | NATURE | | | | | | _ | | | | | | | | _ | DAT | E | | | | | |