Jackson HEALTH SYSTEM

Email: JHSFieldOffice@FBMC.com or Fax: 305-355-2324

2027 JACKSON HEALTH SYSTEM
Voluntary Product Selection Form
January 1, 2027 - December 31, 2027

PLEASE WRITE IN ALL CAPITAL LETTERS

SECTION 1: EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	SS#

ADDRESS [STREET, CITY, STATE]	ZIP	HOME PHONE/CELLPHONE

EMAIL ADDRESS	ANNUAL SALARY	WORK LOCATION

FOR OFFICE USE ONLY
EFFECTIVE DATE:
PAYROLL EFFECTIVE DATE:

BIRTH DATE	☐ MALE ☐ FEMALE ☐ NON-BINARY	☐ MARRIED ☐ SINGLE	DATE HIRED	LAWSON EMPLOYEE #	BADGE ID #

SECTION 2: ARAG LEGAL (Please mark one box only)

Ultimate Advisor	☐ Employee Only $6.20	☐ EE + Family $8.18	☐ Add ☐ Change ☐ Cancel
Ultimate Advisor Plus	☐ Employee Only $8.34	☐ EE + Family $11.00	☐ Add ☐ Change ☐ Cancel

SECTION 3: OCENTURE PRODUCTS

Ocenture ID Commander

☐ Employee Only $4.85 ☐ EE + Family $10.38

☐ Add ☐ Change ☐ Cancel

Ocenture ConstantCredit

☐ Employee Only $5.31 ☐ EE + Spouse* $10.62

*Please provide dependent information in Section two if electing dependent coverage.

☐ Add ☐ Change ☐ Cancel

SECTION 4: PET BENEFITS

Pet Assure ☐ $3.69 **PETplus** ☐ Single Pet $2.08 ☐ Multiple Pet $3.92

Pet Assure/PetPlus ☐ Single Pet $5.77 ☐ Multiple Pet $7.61

☐ Add ☐ Change ☐ Cancel

SECTION 5: EMPLOYEE INFORMATION

Health Consumer/Fertility & Family Planning ☐ Employee/Family $7.00 ☐ Cancel

House Staff Group ☐ Enroll ☐ Cancel

SECTION 6: EMPLOYEE & DEPENDENT INFORMATION

Relationship	M/F/N	Last Name/First Name	SSN	Coverage Desired		Date of Birth
				ID COMMANDER	CONSTANT CREDIT	MM/DD/YYYY

IMPORTANT

- The salary deduction amount specified on this form will continue in effect until I discontinue or modify my Agreement for a subsequent Plan Year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT MY EMPLOYER, UNION AND FBMC BENEFITS MANAGEMENT, INC., THE PLAN CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN THE ABOVE PLAN OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Employer or Employer's designee to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.
- State laws require agencies that are required to collect employee Social Security numbers (SSN) to disclose the purpose for collecting the SSN. Jackson Health System (JHS) is allowed to collect SSN's when specially authorized by law to do so, or when the collection is imperative for the performance of the District's duties and responsibilities. Pursuant to Federal and State Laws, JHS is collecting your Social Security number for the purpose processing employee and dependent benefits; this collection is Mandatory. If you do not provide us your SSN, JHS cannot process your application/request. JHS will not disclose your SSN to anyone outside of JHS except as authorized by law.
- 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 (1) (b) (2004) I understand that by signing below, I agree to the information above.

SECTION 6: SIGN

EMPLOYEE SIGNATURE	DATE

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