Jackson
HEALTH SYSTEM

PO Box 1878, Tallahassee FL 32302-1878, Fax: 850-514-5803

JACKSON HEALTH SYSTEM
Change In Status Election Form

PLEASE WRITE IN ALL CAPITAL LETTERS

NAME: LAST	FIRST	MI	SOCIAL SECURITY #

LAWSON EMPLOYEE NUMBER	ADDRESS (STREET / PO BOX)

CITY	STATE	ZIP	DAYTIME PHONE
			( )

Please indicate the type of qualifying event incurred (check and date all that apply.)

Event Date	Qualifying Events	Documentation Required
_____	Marriage	Marriage certificate
_____	Domestic Partnership	Certificate of Domestic Partnership
_____	Birth	Birth certificate (when it becomes available)
_____	Adoption	Finalized adoption agreement or letter from placement agency with date of placement
_____	Medicare	Copy of Medicare card showing effective date or letter of entitlement
_____	Medicaid	Copy of Medicaid card or letter of entitlement
_____	Deceased Dependent	Death certificate
_____	Employee begins or ends Unpaid Leave	Letter of explanation from employer with effective date or end date of unpaid leave.
_____	Dependent not eligible (marriage, age, loss of dependent status)	Letter of explanation from Employer or insurance company listing plan type (Medical/Dental) with cancellation date of coverage
_____	Spouse begins or ends Employment	Letter from employer with loss of coverage eligibility and termination date or date of full-time employment, date of insurance (spouse).
_____	Spouse begins or ends Unpaid Leave	Letter of explanation from employer with effective date or end date of unpaid leave.
_____	Divorce	Divorce decree
_____	Change from benefits eligible to non-benefits eligible (spouse, dependent)	Letter of explanation from employer w/ date of loss of coverage eligibility or the effective date of insurance. Must specify benefits terminated.
_____	Change from non-benefits eligible to benefits eligible (spouse, dependent)	Letter from employer with gain of coverage eligibility and effective date of insurance.
_____	Other	_____ _____

This is to certify that on _____ , 20____ I incurred the events indicated above and therefore wish to modify my benefits and salary reduction amounts as indicated. **I understand that the change(s) requested must be consistent with the change in status event and that I must provide documentation of all events.**

Employee Signature	Date

Completed form and all available documentation must be received within 30 days of the change in status. Submit the Change in Status form and documentation to:

Jackson Health System
Employee Service Center
Main Campus, PPW #L-109B
7:30 a.m. - 5 p.m.

OFFICE USE ONLY

Approved _____ Complete_____
Effective date _____ Payroll date _____
Pending documentation _____
_____
Denied _____
_____
Notes _____

Jackson
HEALTH SYSTEM

PO Box 1878, Tallahassee FL 32302-1878
Fax: 850-514-5803

2020 JACKSON HEALTH SYSTEM

Benefit Selection Form for Flexible Benefits, Group Medical, Dental, and Vision Plans

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	WORK PHONE	ANNUAL SALARY	WORK LOCATION/COMPANY CODE

FOR OFFICE USE ONLY
EFFECTIVE DATE:
PAYROLL EFFECTIVE DATE:

BIRTH DATE	LAWSON EMPLOYEE #	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE	DATE HIRED	ENROLLMENT STATUS (CHECK ONE)
					☐ OPEN ENROLLMENT ☐ APPEAL ☐ SUPERSEDE ☐ CHANGE IN STATUS DATE OF QUALIFYING EVENT __ __/ __ __/ __ __ __ __

SECTION 2: ☐ Waive Medical ☐ Waive Dental ☐ Waive Vision

MEDICAL ☐ Pretax ☐ Post-Tax ☐ $50 Non-Wellness Surcharge

(Please mark one box only.)

Bi-weekly rates for:	JACKSON FIRST HMO	JACKSON SELECT HMO PLAN*	JACKSON POS PLAN*
Employee Only	☐ $0.00	☐ $16.54	☐ $110.25
Employee & Child(ren) †	☐ $105.00	☐ $155.38	☐ $346.68
Employee & Spouse / Domestic Partner	☐ $120.00	☐ $183.00	☐ $417.84
Employee & Family	☐ $160.00	☐ $260.31	☐ $722.30

† OPTION ALSO APPLIES TO ADULT CHILD(REN)(AC) BETWEEN 26 THROUGH 30 YEARS OF AGE AND/OR CHILD(REN) OF A DOMESTIC PARTNER (CDP).
*SMARTSHOPPER IS INCLUDED IN THE PLAN.

DENTAL ☐ Pretax ☐ Post-Tax

	- Standard -		- Enriched -	
	DHMO	PPO	DHMO	PPO
Employee Only	☐ $0.00	☐ $0.00	☐ $2.10	☐ $4.45
Employee & One Dependent	☐ $2.42	☐ $14.09	☐ $6.52	☐ $22.89
Employee & Family	☐ $5.64	☐ $31.53	☐ $13.10	☐ $45.72

VISION ☐ Pretax ☐ Post-Tax

	BASE	PREMIER
Employee Only	☐ $1.91	☐ $4.59
Employee & One Dependent*	☐ $3.83	☐ $9.87
Employee & Family*	☐ $7.03	☐ $19.06

SECTION 3: EMPLOYEE & DEPENDENT INFORMATION

(YOU MUST LIST A PRIMARY CARE PHYSICIAN (PCP #) BELOW, IF SELECTING MEDICAL COVERAGE FOR YOU AND YOUR DEPENDENTS)

Relationship	M/F	Last Name/First Name	Social Security Number	✓**	Coverage Desired: MEDICAL	DENTAL	VISION	HOSPITAL INDEMNITY	ACCIDENT INSURANCE	CONSTANT CREDIT	DOB MM/DD/YY	PCP #	Check One*: DP	CDP	AC
				☐											
				☐											
				☐											
				☐											

* IF ENROLLING A DOMESTIC PARTNER, CHILD OF A DOMESTIC PARTNER OR ADULT CHILD(REN) PLEASE SELECT THE APPROPRIATE BOX. ** PLEASE CHECK MARK (✓) ANY DEPENDENT WHO RESIDES OUTSIDE MIAMI-DADE, BROWARD, OR PALM BEACH AREA.

SECTION 4: FLEXIBLE SPENDING ACCOUNTS* YOU MUST COMPLETE THIS SECTION IF YOU WISH TO PARTICIPATE IN EITHER OR BOTH SPENDING ACCOUNTS FOR 2020.

☐ I elect to contribute this amount each pay period to my Healthcare Spending Account. ☐ Cancel Coverage	$
☐ I elect to contribute this amount each pay period to my Dependent Care Spending Account. ☐ Cancel Coverage * PLEASE REFER TO PAGES INSIDE YOUR BENEFITS REFERENCE GUIDE FOR FEE INFORMATION.	$

SECTION 5: POST-TAX PRODUCTS

ARAG Legal - Ultimate Advisor	☐ Employee Only $6.15	☐ EE + Family $8.12	☐ Cancel	$
ARAG Legal - Ultimate Advisor Plus	☐ Employee Only $7.98	☐ EE + Family $10.53	☐ Cancel	$

AHL Hospital Indemnity Coverage* ☐ Low ☐ Medium ☐ High ☐ Cancel Coverage $
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family * PLEASE PROVIDE DEPENDENT INFORMATION IN SECTION TWO IF ELECTING DEPENDENT COVERAGE.

AHL Accident Insurance ☐ Low Plan ☐ High Plan ☐ Cancel Coverage *PLEASE PROVIDE DEPENDENT INFORMATION IN SECTION TWO IF ELECTING DEPENDENT COVERAGE. $
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family

Ocenture ID Commander ☐ Employee Only $4.85 ☐ EE + Family $10.38 ☐ Cancel Coverage $

Ocenture ConstantCredit ☐ Employee Only $5.31 ☐ EE + Spouse* $10.62 *PLEASE PROVIDE DEPENDENT INFORMATION IN SECTION TWO IF ELECTING DEPENDENT COVERAGE. ☐ Cancel Coverage $

Pet Assure ☐ $3.69 **PETplus** ☐ Single Pet $2.08 ☐ Multiple Pet $3.92 **Pet Assure/PETplus** ☐ Single Pet $5.77 ☐ Multiple Pet $7.61 ☐ Cancel Coverage $

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

A. I elect the following coverage for 2020 (If you are currently enrolled in this benefit, do not answer the questions in B.)

Short-Term Disability	☐ Option I ☐ Option II	☐ Buy-Up Plan (For Companies 200 & 300)	☐ Add	☐ Cancel Coverage	$
Long-Term Disability	☐ Option I ☐ Option II		☐ Add	☐ Cancel Coverage	$

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
*Please refer to pages inside your Benefits Reference Guide for fee information.

☐ 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 ☐ NO If yes, please explain. _____

Is your Spouse/Domestic Partner and or child(ren) employed by JHS and eligible for benefits? ☐ YES ☐ NO

IMPORTANT
- I certify that the information supplied in this application is true to the best of my knowledge.
- I hereby authorize my employer to reduce my gross salary before Federal income and Social Security taxes are calculated by the total amount of salary reduction indicated above in the selections made in Section 1, 3 & 5.
- I understand the contribution to my Social Security account may be reduced since contributions will be based on my income after reduction.
- I understand that the funds in one Flexible Spending Account cannot be used to reimburse expenses covered by another account.
- I understand that expenses for which I am reimbursed cannot be claimed on my income tax returns, nor are they eligible 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 throughout 2020, unless I terminate employment or file an approved Change In Status, through the FBMC Office, before the end of the plan year.
- I understand and agree that my employer and FBMC Benefits Management, Inc. will not incur any liability resulting from my failure to sign or accurately complete this Selection Form.
- I understand that all dependent children may be covered until the end of the calender year in which the child reaches the age of 26.
- I understand that if a dependent has a different last name than mine, legal documents evidencing dependent status must be submitted to the group plans within 30 days of the coverage effective date. Failure to supply documentation may make the dependent ineligible for coverage and premiums are not refundable.
- I agree for myself and covered members of my family to be bound by the benefits, deductibles, copayments, exclusions, limitations, and other items of the Contracts, Agreements, and Plan 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 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).
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents; 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plans before seeking reimbursement from my FSA; 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	DATE