

**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	
BIRTH DATE		LAWSON EMPLOYEE #	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	DATE HIRED
				ENROLLMENT STATUS (CHECK ONE)	
				<input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> APPEAL <input type="checkbox"/> SUPERSEDE <input type="checkbox"/> CHANGE IN STATUS DATE OF QUALIFYING EVENT   -- / -- / --	

**FOR OFFICE USE ONLY**  
**EFFECTIVE DATE:**  
**PAYROLL EFFECTIVE DATE:**

**SECTION 2:**

Waive Medical    Waive Dental    Waive Vision

(Please mark one box only.) Bi-weekly rates for:	<b>MEDICAL</b> <input type="checkbox"/> Pretax <input type="checkbox"/> Post-Tax <input type="checkbox"/> \$50 Non-Wellness Surcharge			<b>DENTAL</b> <input type="checkbox"/> Pretax <input type="checkbox"/> Post-Tax			
	JACKSON FIRST HMO	JACKSON SELECT HMO PLAN*	JACKSON POS PLAN*	- Standard -		- Enriched -	
Employee Only	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$16.54	<input type="checkbox"/> \$110.25	DHMO	PPO	DHMO	PPO
Employee & Child(ren)†	<input type="checkbox"/> \$105.00	<input type="checkbox"/> \$155.38	<input type="checkbox"/> \$346.68	Employee Only	<input type="checkbox"/> \$0.00 <input type="checkbox"/> \$0.00	<input type="checkbox"/> \$2.10	<input type="checkbox"/> \$4.45
Employee & Spouse / Domestic Partner	<input type="checkbox"/> \$120.00	<input type="checkbox"/> \$183.00	<input type="checkbox"/> \$417.84	Employee & One Dependent	<input type="checkbox"/> \$2.42 <input type="checkbox"/> \$14.09	<input type="checkbox"/> \$6.52	<input type="checkbox"/> \$22.89
Employee & Family	<input type="checkbox"/> \$160.00	<input type="checkbox"/> \$260.31	<input type="checkbox"/> \$722.30	Employee & Family	<input type="checkbox"/> \$5.64 <input type="checkbox"/> \$31.53	<input type="checkbox"/> \$13.10	<input type="checkbox"/> \$45.72
				<b>VISION</b> <input type="checkbox"/> Pretax <input type="checkbox"/> Post-Tax		<b>BASE</b>	
				Employee Only		<input type="checkbox"/> \$1.91	<input type="checkbox"/> \$4.59
				Employee & One Dependent*		<input type="checkbox"/> \$3.83	<input type="checkbox"/> \$9.87
				Employee & Family*		<input type="checkbox"/> \$7.03	<input type="checkbox"/> \$19.06

† 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.

**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						DOB	PCP #	Check One*				
				MEDICAL	DENTAL	VISION	HOSPITAL INDEMNITY	ACCIDENT INSURANCE	CONSTANT CREDIT			MM/DD/YY	DP	CDP	AC	
				<input type="checkbox"/>												
				<input type="checkbox"/>												
				<input type="checkbox"/>												
				<input type="checkbox"/>												

\* 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**

<b>ARAG Legal - Ultimate Advisor</b>	<input type="checkbox"/> Employee Only \$6.15	<input type="checkbox"/> EE + Family \$8.12	<input type="checkbox"/> Cancel	\$
<b>ARAG Legal - Ultimate Advisor Plus</b>	<input type="checkbox"/> Employee Only \$7.98	<input type="checkbox"/> EE + Family \$10.53	<input type="checkbox"/> 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   \$

**Ocature ID Commander**    Employee Only \$4.85    EE + Family \$10.38    Cancel Coverage   \$

**Ocature 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	<input type="checkbox"/> Option I <input type="checkbox"/> Option II	<input type="checkbox"/> Buy-Up Plan (For Companies 200 & 300)	<input type="checkbox"/> Add <input type="checkbox"/> Cancel Coverage	\$
Long-Term Disability	<input type="checkbox"/> Option I <input type="checkbox"/> Option II		<input type="checkbox"/> Add <input type="checkbox"/> 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 calendar 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
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