RESET FORM

Jackson HEALTH SYSTEM

2024 JACKSON HEALTH SYSTEM
ACA Part-Time Medical Benefit Selection Form

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

January 1, 2024- December 31, 2024

PLEASE WRITE IN ALL CAPITAL LETTERS

SECTION 1: IMPORTANT NOTICE FOR NEW EMPLOYEES -

This must be completed during the Open Enrollment period, 11/06/2023 - 11/22/2023. This form can be submitted via fax

LAST NAME	FIRST NAME	MI	SS#

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

EMAIL ADDRESS	WORK PHONE	ANNUAL SALARY	WORK LOCATION/COMPANY CODE

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

FOR OFFICE USE ONLY:
EFFECTIVE DATE:

PAYROLL EFFECTIVE DATE:

SECTION 2: MEDICAL

☐ Waive Medical ☐ $45 Jackson First Rider (for dependents)

(Please mark one box only)

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

Bi-weekly rates for:	JACKSON FIRST HMO	JACKSON SELECT HMO PLAN*	JACKSON POS PLAN*
Employee Only	☐ $0.00	☐ $57.75	☐ $173.25
Employee & Child(ren)†	☐ $105.00	☐ $197.41	☐ $440.46
Employee & Spouse/ Domestic Partner	☐ $120.00	☐ $232.50	☐ $530.87
Employee & Family	☐ $160.00	☐ $330.72	☐ $917.68

† 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	Date of Birth	PCP #	Check One*		
					MEDICAL	MM/DD/YY		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.

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.
- 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 the amount of salary reduction will include the items specified above and will continue in effect throughout 2024, 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).

EMPLOYEE SIGNATURE	DATE