JBI, Ltd. Health Open Enrollment Form Effective 9/1/2023

☐ New Employee ☐ Address Change ☐ Beneficiary Change ☐ Open Enrollment ☐ Change in Family Status (please specify)
☐ Marriage ☐ Divorce ☐ Birth or Adoption of Child ☐ Death/Termination of Dependent Relationship ☐ Change of Job or Job Status ☐ Other

Employee Information

Name **(First, MI, Last):**			Social Security Number - -
Street Address:		Apt.	Hire Date (mm/dd/yyyy): / /
City	State	Zip	Birth Date (mm/dd/yyyy): / /
Home Phone: Cell Phone:	Personal email:	Marital Status:	Annual Salary

1. Health Plan Coverage (Medical, Dental and Vision Insurance) -

☐ **Gold Option**	☐ **Silver Option**	☐ **Waive Health Plan Coverage –** Reason: _____	
Coverage Tiers: ☐ **Employee Only**	☐ **Employee + Spouse**	☐ **Employee + Child(ren)**	☐ **Employee + Family**

2. Dependent Information (to be enrolled for Health Plan Coverage)

☐ No Changes to Dependents Enrolled (leave blank)
☐ I want to make changes made to my Dependents enrolled for the Health Plan as shown below

Dependent's Name (First, MI, Last)	**Sex (M/F)**	**Relationship to You (Spouse/Child)**	**Social Security Number**	**Birth Date (mm/dd/yyyy)**
			- -	/ /
			- -	/ /
			- -	/ /
			- -	/ /

3. Group Basic Life/AD&D & Voluntary Life/AD&D Insurance

☐ No changes to current Voluntary coverages ☐ I want to make a change to my current coverages (additional forms required through RSL)
☐ No changes to current beneficiaries ☐ I wish to make a change to my beneficiaries

BENEFICIARY NAME (complete only if updating) **(First, MI, Last)**	**Gender** (M/F)	**Relationship**	**Social Security Number**	**Date of Birth**

4. Colonial Life Supplemental Insurance

☐ No Changes to my Current Supplemental elections with Colonial Life

I understand that I ***must*** also complete an online enrollment/change application to update my existing supplemental elections with Colonial Life subject to approval. I understand that if I do not complete the required Colonial Life documentation, my existing supplemental insurance elections will not be changed and will remain the same.

☐ I want to make changes to my Current Supplemental elections ☐ Accident ☐ Medical Bridge ☐ Cancer ☐ Critical Illness ☐ Other
☐ Attached is a copy of my Colonial Life electronic enrollment and/or request for change form requesting changes to my current supplemental elections

5. Your Authorization

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for my benefit plan elections as part of flexible benefits plan under Section 125 of the Internal Revenue Code. I further understand that I may not revoke or change my participation in this plan until the next plan anniversary unless I experience a qualified change in family status. I understand that the choices I make will stay in effect through **August 31, 2024**, unless I have a qualifying change in family status. I understand that my previous selections for Voluntary Term Life/AD&D through Reliance Standard Life and Supplemental Insurance through Colonial Life will be automatically rolled over unless I also completed the appropriate change / enrollment requirements for Reliance Standard Life and Colonial Life and my request was approved by the appropriate carrier. I understand that each year ALL of my elections will automatically roll over from year to year unless I make a request for change my elections during the open enrollment period.

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make necessary pre-tax deductions for the contributions, if any, required for the Medical, Dental, Vision, Cancer, Accident, & Medical Bridge insurance; (3) authorize my employer to make after tax deductions for my Voluntary Term Life, Voluntary AD&D, & Critical Illness; (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I have reviewed the statements on this application and they are true and complete.

SIGNATURE:

_____

DATE:

_____

Printed Name

_____