



Salary Reduction Authorization/Waiver Form

INSTRUCTIONS: Please fill out the "Employee Information" section, check the appropriate box, print your name on the line, sign and date the form and return to Human Resources.

EMPLOYEE INFORMATION			PLEASE PRINT!
Name:		SSN: _____ - _____ - _____	
Address:	City:	State:	ZIP:
Birth Date: ___/___/_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

PLAN ENROLLMENT

I elect to participate in one of the High Deductible Health Plans with Health Savings Account and I agree that my annual cash compensation will be reduced by the weekly contribution amounts (on a pre-tax basis) for the health benefit plan.

Please check the line that applies to your coverage.

SPOUSE ELIGIBILITY

In order for an employee to cover their spouse under medical benefits, they must attest that their spouse does not have any other available group coverage. By signing below, I certify that my spouse does not have access to other group medical coverage through their own employer. I understand that if my spouse becomes eligible for other group medical coverage in the future, I am required to notify Human Resources within 30 days of the change. **INITIAL:** _____

COVERAGE LEVEL	OPTION 1	OPTION 2
Employee Only	<input type="checkbox"/> \$15.00	<input type="checkbox"/> \$50.00
Employee/Child(ren)	<input type="checkbox"/> \$35.00	<input type="checkbox"/> \$90.00
Employee/Spouse	<input type="checkbox"/> \$85.00	<input type="checkbox"/> \$160.00
Family	<input type="checkbox"/> \$95.00	<input type="checkbox"/> \$170.00
WAIVE	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00

DEPENDENT ENROLLMENT INFORMATION

Dependent First & Last Name	Gender (M / F)	Relationship (Spouse, Child)	Date of Birth (MM/ DD/YYYY)	SSN #	Add Cancel Coverage	Select Plans to Add/ Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

HEALTH SAVINGS ACCOUNT (HSA)

I would like to contribute \$ _____ per weekly pay period (\$ _____ annually) to my HSA for the upcoming calendar or the remainder of the current year.

DENTAL PLAN ENROLLMENT

I elect to participate in the Principal Dental PPO Plan.*

COVERAGE LEVEL	
Employee Only	<input type="checkbox"/> \$0.00
Employee/Child(ren)	<input type="checkbox"/> \$0.00
Employee/Spouse	<input type="checkbox"/> \$0.00
Family	<input type="checkbox"/> \$0.00
WAIVE	<input type="checkbox"/> \$0.00

*This plan is 100% covered by the employer. There will be NO cost to the employee.

VISION PLAN ENROLLMENT

I elect to participate in the VBA Vision Plan Coverage Level.

COVERAGE LEVEL	
Employee Only	<input type="checkbox"/> \$1.05
Employee/Child(ren)	<input type="checkbox"/> \$ 2.55
Employee/Spouse	<input type="checkbox"/> \$ 2.55
Family	<input type="checkbox"/> \$ 2.55
WAIVE	<input type="checkbox"/> \$0.00

BENEFICIARY INFORMATION

JCC offers our employees Basic Life and AD&D Insurance and Long-Term Disability Insurance. JCC pays 100% of the premium for both of these benefits and enrollment is automatic.

Please indicate your beneficiary designation for your Life Insurance benefits in the event of your death. You may indicate a Primary and Contingent Beneficiary. You may also name more than one Primary and/or Contingent Beneficiary. Unless designated otherwise, payment will made in equal shares or all to the survivor. You have the right to change this beneficiary designation at any time.

Beneficiary Type	Beneficiary Name	Beneficiary Address	Date of Birth (MM/ DD/YYYY)	SSN #	Relationship	% of Benefits
<input type="checkbox"/> P <input type="checkbox"/> C						
<input type="checkbox"/> P <input type="checkbox"/> C						
<input type="checkbox"/> P <input type="checkbox"/> C						
<input type="checkbox"/> P <input type="checkbox"/> C						

I understand that if I am enrolling in or waiving medical and/or prescription drug benefits, vision, and dental benefits, I cannot change this election until the next Open Enrollment period, unless I experience a qualified change in status (e.g., termination of employment, divorce, marriage, etc.). Also, the election change must be on account of and consistent with the change in election event, as described in the Plan. Additionally, I agree that I was given the opportunity to enroll in the group health benefits plan offered by my employer and I understand that, if waiving coverage, I will have no health benefits coverage available to me (and my children and/or spouse, if any) through my employer health plan. If I do not complete and return a new benefit election form, I will be treated as having elected to continue all before tax benefits under the plan for the following plan year, with the exception of Health Savings Account. For the Health Savings Account, I understand that if I do not submit a new election form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. Furthermore, I understand that it is my responsibility to notify and submit the required supporting documentation to Human Resources within 31 days of experiencing a qualified change in status.

I have read and agree to the terms of my enrollment or waiver set forth in this agreement. Any previous election and agreement under the Plan relating to the same benefits, including any prior election form/salary reduction agreement, is hereby revoked.

PRINT NAME

SIGNATURE

DATE