SECTION 125 POP
FLEX PLAN ENROLLMENT FORM

JACOBSON COMPANIES, INC
and affiliated entities

This form submitted for:

☐ Enrollment ☐ Re-Enrollment ☐ Name Change ☐ Address Change ☐ Termination
☐ Birth/Adoption ☐ Marriage ☐ Divorce ☐ Termination of Spouse's employment ☒ Other open enrollment

Employee Name: _____

Mailing Address: _____

Date of Birth: _____ Hire Date: _____ Date Eligible: _____

Employment Status: ☒ FT ☐ PT ☐ Other

Employee SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ E-mail Address: _____

PLEASE ENTER YOUR PLAN YEAR ANNUAL ELECTION IN THE APPROPRIATE BOX.

ELECTION DESCRIPTION	ANNUAL ELECTION	AMOUNT PER PAY PERIOD (weekly)	MAXIMUM ANNUAL ELECTION
Individual Insurance Contributions (POP)			
Medical Group Plan:			
Dental Group Plan:			
Vision Group Plan:			
HSA Employee Contribution:			
AFLAC Plan (pretax portion only)			
TOTAL ELECTION AMOUNT PER PAY PERIOD:		$	
PAY PERIOD SCHEDULE: Weekly			

I acknowledge that I have received a copy of the Summary Plan Description (SPD) and agree to abide by the rules and requirements under the Plan. I understand that amounts shown will be withheld from my paycheck each processing period to provide benefits under the Plan for "qualifying expenses" as described in the SPD. In order to receive reimbursement from my account, I understand that I must submit documentation to support my requests for reimbursement for any "qualifying expenses" which are incurred during the Plan Year by either myself of any of my family members who qualify as my dependent(s) as defined by the SPD and any applicable state and federal laws. I have been advised that any account balances, which have not been used to pay for eligible benefits incurred during the Plan Year, will be forfeited in accordance with the current provisions of this Plan and the Internal Revenue Code. I understand that the above shown deferral(s) will remain in effect for this Plan Year and cannot be changed except upon the event of a "change of status" as defined by the Internal Revenue Service (IRS) and only if such a change is provided for under the provisions of the Plan. I also understand that my election for insured benefits or group health benefits will NOT automatically renew with each subsequent Plan Year and **I must re-elect these deferrals each Plan Year**. Finally, I understand that by reducing my taxable wage base, my future Social Security benefits could be reduced, and I do hereby indemnify my Employer, Plan Administrator and Claims Administrator from any claims I may have as a result of my decision.

_____ _____

PARTICIPANT (Employee) SIGNATURE - - **(REQUIRED)** DATE SIGNED - - **(REQUIRED)**

WAIVER OF PARTICIPATION I acknowledge that I have been given the opportunity to participate in the Plan. The benefits have been explained to me, but I hereby waive my rights to participate in the Plan at this time. I understand that by waiving my right to participate, I will not be eligible to participate in the Plan until the next anniversary date except upon the event of a "change of status" as defined by the IRS and only if such a change is provided for under the Plan and I notify my Employer within 30 days of the event.

Signature: _____ Date: _____

Required – please name your beneficiary for your company provided life insurance through Standard Insurance.

LIFE INSURANCE BENEFICIARY _____ Percent _____
LIFE INSURANCE BENEFICIARY _____ Percent _____
LIFE INSURANCE BENEFICIARY _____ Percent _____

Sum of % of all Beneficiaries must Equal 100%