Health, Dental, Vision and Life Benefits Election Form

J Solutions, Inc. is offering three health plans, one dental plan, one vision plan, one mandatory life plan, and one voluntary life plan this election period. Please make your selections below, sign, and return this form to J Solutions, Inc. Remember to refer to the payroll deduction schedules and Summary of Benefits and Coverage to help you select the plan that is right for you.

If you do not wish to participate in a plan, please check the box(es) marked "waive", and sign and return the form.

Employee Name_____

UnitedHealthcare Medical Insurance - Employer/Employee Paid

I choose the following health insurance coverage:

☐ **Option 1:** $3,000 Deductible PPO Plan
☐ **Option 2:** $6,000 Deductible HMO Plan – Non-Gated
☐ **Option 3:** $4,000 Deductible HSA Plan
☐ **Waive:** I choose not to participate in either health plan.

If you have elected coverage, please choose one of the following coverage categories:

_____ **Employee Only**
_____ **Employee + Spouse**
_____ **Employee + Child(ren)**
_____ **Employee + Family**

Humana Voluntary Dental Insurance - 100% Employee paid

I choose the following dental insurance coverage:

☐ **Employee Only**
☐ **Employee + Spouse**
☐ **Employee + Child(ren)**
☐ **Employee + Family**
☐ **Waive:** I choose not to participate in the dental plan.

Humana Voluntary Vision – 100% Employee Paid

I choose the following vision insurance coverage:

☐ **Employee Only**
☐ **Employee + Spouse**
☐ **Employee + Child(ren)**
☐ **Employee + Family**

Humana Life Insurance Beneficiary – 100% Employer Paid

☐ **Waive:** I choose not to participate in the vision plan.

_____**Name & Relationship (Primary)**

_____**Name & Relationship (Contingent)**

Guardian Voluntary Life – 100% Employee Paid

I choose the following life insurance coverage:

☐ **Employee Only**
☐ **Employee + Spouse**
☐ **Employee + Child(ren)**
☐ **Waive:** I choose not to participate in the voluntary life insurance plan.

If enrolling in Guardian for the first time, additional enrollment documents will be sent.

Dependent Information:

Type of Dependent	Dependent's Full Legal Name	Dependent Gender M/F	Dependent Date of Birth	Dependent Social Security Number
Spouse				
Child				
Child				
Child				
Child				

I understand the coverage I have elected is effective _____.
If I waive coverage, I cannot enroll until the December 2021 open enrollment, unless I have a qualifying event.

_____ _____
Employee Signature Date