J Solutions, Inc

LifeHealth, Dental, Vision and Life Benefits Election Form

J Solutions, Inc. is offering three BCBS of Texas health plans, Humana dental, vision & an employer paid life plan, and a Guardian voluntary life plan for the upcoming plan year. Please make your selections below, sign, and return this form to J Solutions, Inc. Remember to refer to the payroll deduction schedule and Summary of Benefits and Coverages 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_____

BLUE CROSS BLUE SHIELD HEALTH INSURANCE- EMPLOYER/EMPLOYEE PAID

BCBS Application Required

I choose the following health insurance coverage:

- ☐ **Option 1:** $3,000 Deductible PPO MTBCP026 Plan
- ☐ **Option 2:** $5,000 Deductible HMO MTBAB039 Plan (Texas Residents Only)
- ☐ **Option 3:** $4,000 Deductible HSA MTBCP006H 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**
- ☐ **Waive:** I choose not to participate in the vision plan.

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Humana Life Insurance Beneficiary – 100% EMPLOYER PAID

_____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				

***If you are adding or removing dependents or enrolling in the coverage for the first time a BCBS and Guardian application are required. ***

I understand the coverage I have elected is effective _____.
If I waive coverage, I am not eligible to enroll until the 2024 open enrollment, unless I have qualifying event.

_____ _____

Signature Date