2025-26 Enrollment Application

(Email Completed Forms to wortiz@jfcglobal.com)

ASSOCIATE INFORMATION

Name________________________________ Social Security Number____________________

Employer______________________________ Hire Date______________________________

Birth Date_____________________________ Sex ☐ Male ☐ Female

Address_______________________________ Phone Number__________________________

City/State/Zip__________________________ Email__________________________________

DEPENDENT INFORMATION

Name________________________________ Name________________________________

Social Security Number__________________ Social Security Number__________________

Birth Date_____________________________ Birth Date_____________________________

☐ Male ☐ Female ☐ Spouse ☐ Child ☐ Male ☐ Female ☐ Spouse ☐ Child

Name________________________________ Name________________________________

Social Security Number__________________ Social Security Number__________________

Birth Date_____________________________ Birth Date_____________________________

☐ Male ☐ Female ☐ Spouse Child ☐ Male ☐ Female Spouse ☐ Child

COVERAGE ELECTIONS

Medical Election (choose only 1)				
Weekly Rates	Associate Only	Associate /Spouse	Associate /Child(ren)	Family
EnhancedCare	❑ $22.38	❑ $43.83	❑ $45.04	❑ $65.57
EliteCare	❑ $45.37	❑ $98.06	❑ $100.12	❑ $147.63
Advantage MV*	❑ $92.08	❑ $181.15	❑ $170.54	❑ $229.62
*Rates for the MV plan are subject to change based on affordability. Please contact your employer for specific rates.				

Hospital Indemnity & Dental Election				
Weekly Rates	Associate Only	Associate /Spouse	Associate /Child(ren)	Family
ExtraCare (Hospital)	❑ $11.30	❑ $22.61	❑ $22.61	❑ $33.92
Dental	❑ $7.56	❑ $15.08	❑ $16.39	❑ $25.65

Vision Election			
Weekly Rates	Associate Only	Associate + 1	Family
Vision	❑ $1.68	❑ $3.20	❑ $4.21

☐ waive coverage

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ASSOCIATE ACKNOWLEDGMENT

I hereby acknowledge the offer of health insurance coverage, providing Minimum Essential Coverage (MEC) and Minimum Value (MV), for myself, and my eligible dependents. If electing coverage, I authorize my employer to make salary reductions for my portion of the insurance premiums. I understand that I may not make changes to my coverage elections until my employer's next open enrollment period or due to a qualifying event.

*Signature____ Date ______________________

*My typed name is my signature and constitutes acceptance/agreement as if signed in writing.