JL PROPERTIES, INC.

2020-2021 EMPLOYEE BENEFITS GUIDE

Effective May 1, 2020 to April 30, 2021

Please watch each of these videos for the overview of your insurance benefits, effective 05/01/2020.

Part 1:
Instructions for Open Enrollment

Part 2

Part 3

Inside This Guide

This guide is not intended to be a complete description of the insurance coverage offered, nor is it a binding contract. Controlling provisions are provided in each benefit plan policy. Should there be a difference between this guide and the office plan documents, the official plan documents will govern.

More information about specific terms and conditions of each plan is included in the Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC).

Welcome to your JL Properties, Inc. 2020-2021 Benefits!

Your needs, and those of your family, are unique to you. That's why we provide a comprehensive and flexible benefits program that you can customize to fit your personal situation. Our program offers you and your family important healthcare coverage and financial security.

Some of the benefits we offer are paid for in full by the company. For others, it is a shared contribution between you and the company. Other benefits are also available to you at reasonable group rates.

Your benefits are an important part of your total compensation. Please take the time to review and evaluate all the options available to you and your family.

Benefits Overview

EMPLOYER PAID BENEFITS	
Benefits	**Carrier**
Basic Term Life	Principal Financial
Cafeteria Plan	Professional Benefit Services (PBS)

BENEFIT OPTIONS REQUIRING EMPLOYEE CONTRIBUTIONS	
Benefits	**Carrier**
Medical	Aetna
Voluntary Dental	Principal Financial
Voluntary Vision	Principal Financial
Voluntary Life/AD&D	Principal Financial
Voluntary Short-Term Disability (STD)	Principal Financial
Voluntary Long-Term Disability (LTD)	Principal Financial

Open Enrollment

Open Enrollment is your once a year opportunity to review your benefit plan elections and make adjustments that meet the needs of you and your family.

Changes to medical, cafeteria, dental and vision benefits made during Open Enrollment will go into effect **May 1, 2020**.

Flexible Spending Accounts run on a plan year. Open Enrollment for these plans is typically held in April with changes effective May 1.

What's New or Changing?

What's New or Changing?

1. **Medical, Rx**:
   Changes in formulary prescription drugs.

2. **Voluntary Dental & Vision**:
   No changes to current benefits.

3. **Basic Life/AD&D**:
   No changes to current benefits.

4. **Voluntary Life/AD&D, STD & LTD:**
   No changes to current benefits.

5. **Cafeteria Plan:**
   No changes to current benefits.

Action Items

- **All Benefits**: It is not necessary to complete new enrollment forms during open enrollment unless you are making changes to your benefits, and/or adding or dropping dependents.

- **FSA**: Designate an annual 2020-2021 contribution amount. If you don't make an election, you will not be enrolled for the new plan year.

Making Benefit Changes During the Year

The benefit elections you make during your initial enrollment period will be in effect through April 30, 2021.

If you have a "qualified life event," you may make changes to certain benefits if you apply for the change and provide supporting documentation to Human Resources. Proof of life events is subject to approval by your company. Changes are effective retroactive to the date of the event. You have 30 days after a qualifying event to make enrollment changes.

Qualifying life events include:

- Your marriage
- Your divorce or legal separation
- Birth, adoption or placement for adoption of an eligible child
- Death of your spouse, domestic partner or covered child
- Change in you or your spouse/domestic partner's work status that affects benefits eligibility (for example, starting a new job, leaving a job, changing from part-time to full-time, starting or returning from an unpaid leave of absence, etc.)
- Your spouse's Open Enrollment
- A change in your child's eligibility for benefits
- Gain or loss of Medicare or Medicaid during the year
- Relocation

Other qualifying events may also apply.
Please contact Human Resources.

Eligibility and Enrollment

Who is Eligible?

You are eligible for benefits if you are:

- An active full-time employee working **30** or more hours per week

Your dependents are eligible if they are:

- Your legal spouse or domestic partner
- Your and/or your domestic partner's child(ren)* up to age 26
- Your disabled child(ren)* up to any age (if disabled prior to age 19)

** Includes natural, step, legally adopted/or a child placed for adoption, or a child under your legal guardianship.*

When Can You Enroll in Benefits?

You can enroll for benefits:

- When you are initially eligible for coverage; you have a certain number of days from the date you are eligible for coverage to submit your enrollment.
- During the annual Open Enrollment period.
- During the plan year, if you experience a Qualifying Life Event.

Please Note:

Federal regulations require your company to obtain the following information during enrollment:

- Social Security numbers for your dependents covered by the medical plan
- Dates of birth and your relationship to your dependents

When Does Coverage Begin?

Benefits for new hires, unless explained otherwise, will become effective on the **first of the month following 60 days**.

Termination of Coverage

If you or a covered dependent no longer meet the eligibility requirements or if your employment ceases, your medical, dental, vision, and Health Care FSA coverage will end on the last day of the month in which you become ineligible. You may be eligible to elect COBRA for yourself and your eligible dependents for medical, dental, and vision coverage. Life/AD&D and Disability coverages will end on the day you become ineligible. Your life coverages are convertible.

You are responsible for informing Human Resources if any of your dependents become ineligible for benefits.

About Domestic Partner Coverage

To enroll your same-sex or opposite-sex domestic partner and his or her dependents for coverage, you will be required to submit appropriate declaration forms, and proof of domestic partnership may be necessary.

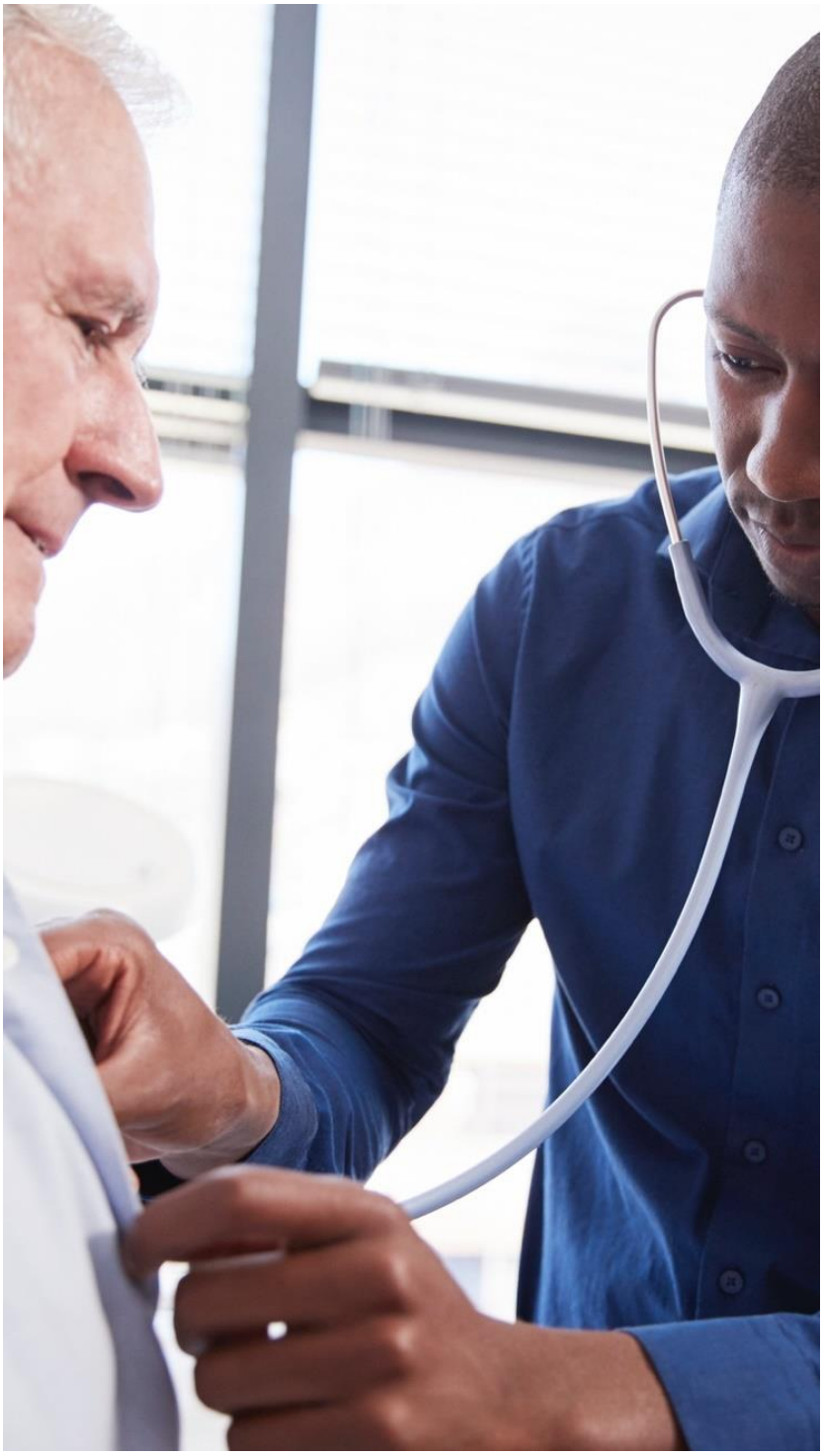
Under federal law, your company contribution toward the cost of healthcare coverage for your domestic partner and his or her dependents is considered taxable income to you.

Domestic partner premiums will be deducted on a post-tax basis. You may wish to consult with a tax adviser for more information.

Medical Plan

JL Properties, Inc. offers one medical plan through **Aetna** with the following features:

- Option to receive care from in-network or out-of-network providers; higher benefits are paid when using in-network providers.
- Preventive care is covered at 100% when using an in-network provider.
- Includes prescription drug coverage.
- Deductibles and out-of-pocket maximums accumulate on a calendar year.
- Always refer to your plan booklet for specific benefit levels and limitations.



How to Find a Doctor

Start your search at **www.aetna.com** (or, if you are already a member, log in to Aetna Navigator). Click on Find a Doctor. Use the simple online instructions to perform a general search. You also may search for a particular physician by name, specialty or other options.

Medical Plan

Aetna	Open Choice PPO Plus 2500	
Medical	**You Pay**	
	Maximum Savings	**Standard Savings**
Plan Year Deductible *(Individual / Family)*	$2,500 / $7,500	$2,500 / $7,500
Coinsurance	20%	40%
Plan Year Out-of-Pocket Max[1] *(Individual / Family)*	$5,500 / $11,000	$5,500 / $11,000
Preventive Services[2]	Covered in full	Covered in full
Primary Care Office Visit	$25 Copay Deductible waived	$45 Copay Deductible waived
Specialty Care Office Visit	$25 Copay Deductible waived	$45 Copay Deductible waived
Urgent Care Facility	$50 Copay Deductible waived	$50 Copay Deductible waived
Emergency Room Care	20% after $100 Copay Deductible waived	20% after $100 Copay Deductible waived
Inpatient Hospital/Surgery	20% after deductible	40% after deductible
Outpatient Diagnostic Laboratory **Outpatient Diagnostic X-ray** (except for Complex Imaging Services) **Outpatient Diagnostic X-ray for Complex Imaging Services** (Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required)	20% after deductible	40% after deductible

Limitations and maximums may apply. Please refer to the plan summaries and Summary of Benefits and Coverage for more information.

[1] Plan Year Out-of-Pocket Maximum includes deductibles, copays and coinsurance

[2] Preventive care services are covered in accordance with Health Care Reform.

Medical Plan – Additional Benefits

Aetna	Open Choice PPO Plus 2500
	You Pay
	Maximum Savings / Standard Savings
Routine Eye Exams 1 every 12 months	Covered in Full Deductible waived
Vision Hardware 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months	Covered in Full up to $200 Deductible waived
Routine Hearing Screening	Covered in Full Deductible waived

Prescription Drugs

When you enroll in a medical plan, you receive comprehensive prescription drug coverage through **Aetna**.

Some medications may be subject to prior authorization, quantity limits or step therapy requirements to be approved for coverage.

Aetna	Open Choice PPO Plus 2500
Retail	**You Pay**
Tier 1: Preferred Generic	$15 Copay
Tier 2: Preferred Brand Name	$30 Copay
Tier 3: Non-Preferred Generic and Brand Name	$50 Copay
Mail Order	**You Pay**
Tier 1 / Tier 2 / Tier 3	$30 / $60 / $100
Drug List	Advanced Control Formulary
Supply Limit Per Fill	Retail: Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay Mail Order: Applicable for 31-90 day supply Advanced Control Fomulary: Applicable for a 30 day supply of Specialty Care Medication

Retail Pharmacy	Mail Order	Specialty Pharmacy
✓Locate a participating retail pharmacy ✓View a list of approved drugs	✓ Use for maintenance drugs such as medication for high blood pressure, arthritis or diabetes ✓No additional cost for delivery	✓Medication used to treat complex conditions like multiple sclerosis, hepatitis C and rheumatoid arthritis ✓Prescription can only be filled once every 30 days

Where to Seek Care

Teladoc – Virtual Care

Teladoc allows you to resolve your routine medical issues anytime you need care from wherever you happen to be. Teladoc is a national network of board-certified physicians who provide quality health care through the convenience of phone or online video consultations for members of any age. Teladoc physicians can diagnose, treat, and write prescriptions, when necessary, for routine medical conditions, including:

- Sore throat and stuffy nose
- Sinus infection
- Bronchitis
- Allergies
- Pink eye

For more information, visit the Teladoc website at www.teladoc.com/aetna or call 1-855-835-2362.

Aetna's Informed Health Line

As a member of an Aetna health insurance plan, you have instant access to information that can help you make informed choices about health care. You can quickly search these credible resources:

- Call toll free anytime, day or night – Available 24 hours a day, 7 days a week
- Talk to a registered nurse who can provide information on more than 5,000 health and wellness topics
- Listen to the Audio Health Library, a recorded collection of more than 2,000 health topics. Transfer easily to a registered nurse at any time during the call
- Using your secure Aetna Navigator member website, www.aetna.com, browse one of the most advanced online health databases available today.
- Language translation services available.

Visit online at www.aetna.com or call 1-800-556-1555.

Where to Seek Care (Continued)

Emergency Care vs. Urgent Care

When you need help in a hurry, you have choices. Of course, when it's a **life-threatening problem, you should call 911 or go straight to the nearest hospital emergency room (ER).**

In the ER, true emergencies are treated first, so unless your life is in danger, you'll wait – sometimes for hours. The ER is also the most expensive option for care.

For non-life-threatening problems, call your doctor, call your nurse line or go to an urgent care center.

GO TO URGENT CARE

- Moderate fever
- Colds, cough or flu
- Bruises and abrasions
- Cuts and minor lacerations
- Minor burns and skin irritations
- Eye, ear, or skin infections
- Sprains or strains
- Possible fractures
- Urinary tract infections
- Respiratory infections

OR

GO TO EMERGENCY ROOM

- **Heart attack or stroke**
- **Chest pain or intense pain**
- **Shortness of breath**
- **Severe abdominal pain**
- **Head injury or other major trauma**
- **Loss of consciousness**
- **Major burns or severe bleeding**
- **One-sided weakness or numbness**
- **Open fractures**
- **Poisoning or suspected overdose**

Cafeteria Plan

Healthcare FSA

Not available to HSA plan participants

This FSA allows you to submit eligible medical, dental and vision expenses for reimbursement. You can deposit up to $2,750 to the Healthcare FSA for the 2020 calendar year.

Enrolled in Group Medical Plan
$200 per month / $2,400 per year ($100 semi-monthly)

Dependent Care FSA

Available to all benefit eligible employees

Dependent Care FSAs are used to pay for the costs of dependent care that enable you to work. This care may be for a child under age 13 and for older dependents, including children, spouses and parents who are physically or mentally unable to care for themselves and who live with you for more than half the year. Eligible **expenses include daycare, before-school and after-school care, babysitters and elder daycare**. For the 2020 calendar year, you can deposit up to $5,000 to a Dependent Care FSA ($2,500 if you are married and filing separately).

Not Enrolled on the Group Medical Plan*
$310 per month / $3,720 per year ($155 semi-monthly)

** Must show proof of other coverage*

You Cafeteria plan will be administered by **Professional Benefits Services**.

How the Cafeteria Plan Works

You may use your cafeteria plan funds towards the following:

- Offset the cost of your Medical Premiums (only if covered under JL Properties Health Plan)
- Voluntary Dental
- Voluntary Vision
- Voluntary Term Life/AD&D
- Voluntary Short Term Disability
- Voluntary Long Term

The remaining balance may be used toward the following:

- Medical FSA (Maximum annual Employer contribution towards Medical FSA is $500)
- Dependent Daycare FSA
- Employee Funds / Balance - 25% is added to gross wages (taxable) Example: $100 monthly leftover = $25 added to your monthly wages

How To Save

When Using Your Medical And Prescription Plans:

Use In-Network Doctors

By using in-network doctors, clinics, hospitals and pharmacies, you pay the lowest cost for care. When you visit out-of-network doctors, our health plan covers less of the cost.

Choose the Right Type of Care

When you need care, know your options. Urgent care centers, online doctor visits or a call to the medical plan nurse line can help save time and money.

Use freestanding imaging centers for MRIs, CT Scans and other imaging can help save money. Just be sure they are in-network.

Use Your Preventive Care Benefits

Most preventive care services are covered at 100% when you use in-network providers. Getting regular exams, screenings and immunizations can save you a lot of money in the long run by catching problems early or preventing them altogether.

Ask Your Doctor for Generic Drugs

The next time you need a prescription, ask your doctor if it is appropriate to use a generic drug rather than a brand name drug. Generic drugs contain the same active ingredients, are identical in dose, form and administrative method AND are less expensive than their brand name counterparts.

If you must take a brand name drug, ask your doctor for samples or coupons. Also check the drug manufacturer's website for available rebates and discounts.

Search Good Rx for Cheaper Rx Prices

Drug prices sometimes vary significantly between pharmacies. GoodRx collects and compares prices for every FDA approved prescription drug at more than 70,000 pharmacies.

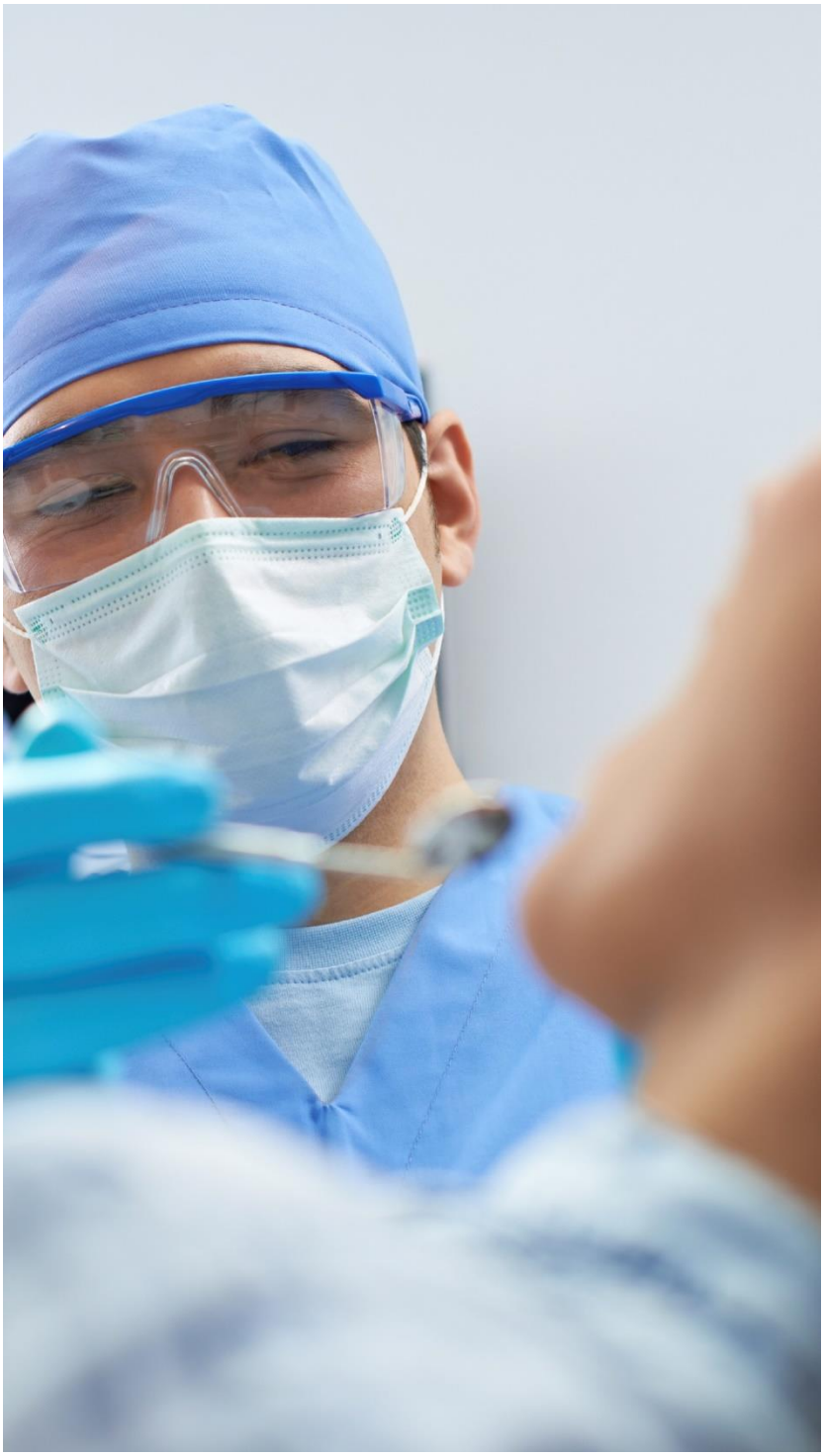
Access GoodRx at www.goodrx.com to find the lowest price pharmacy near you and/or print FREE coupons. You can also get coupons on-the-go through Good Rx's mobile app – just show your phone to the pharmacist.

Voluntary Dental Plans

JL Properties, Inc. offers two dental plans through **Principal**. Your choice of dentists can determine the cost savings you receive. In-Network providers are paid directly by **Principal** and agree to accept negotiated fees as "payment in full" for services rendered.

When you use out-of-network providers, **Principal** will apply the applicable percentage of the allowed amount and you are responsible for paying the balance of the bill.

In-network coverage is provided when you use **Principal network** providers.



Important Information!

If you do not enroll in dental benefits when you are first eligible, you will become a late entrant. Late entrants will only be eligible for exams, cleanings and fluoride applications for the first 12 months they are covered.

How to Find a Dentist

1. Visit www.principal.com/dentist.
2. Begin your search by picking the state where you would like to find a provider. Next, specify a network. Depending on the network chosen, you may be transferred to a partner site.
3. Enter the name of the provider you are looking for (if known). If you are looking for a nearby dentist, enter the city and state and/or zip code. Be sure to indicate how far you are willing to travel.

Voluntary Dental Plans

Principal	Plan 1 PPO 1000	Plan 2 PPO 3000
Dental	**You Pay**	**You Pay**
	In-Network	**In-Network**
Calendar Year Plan Deductible	$50 Per Individual / $150 Per Family	$50 Per Individual / $150 Per Family
Calendar Year Maximum	Up to $1,000 per person each calendar year	Up to $3,000 per person each calendar year
Preventive Services (no deductible)	0%	0%
Basic Services (after deductible)	20%	20%
Endodontics **Periodontics** (after deductible)	20%	20%
Major Services (after deductible)	50%	50%
Notes	Preventive Passport included (exempts Preventive services from applying to Calendar Year Maximum)	

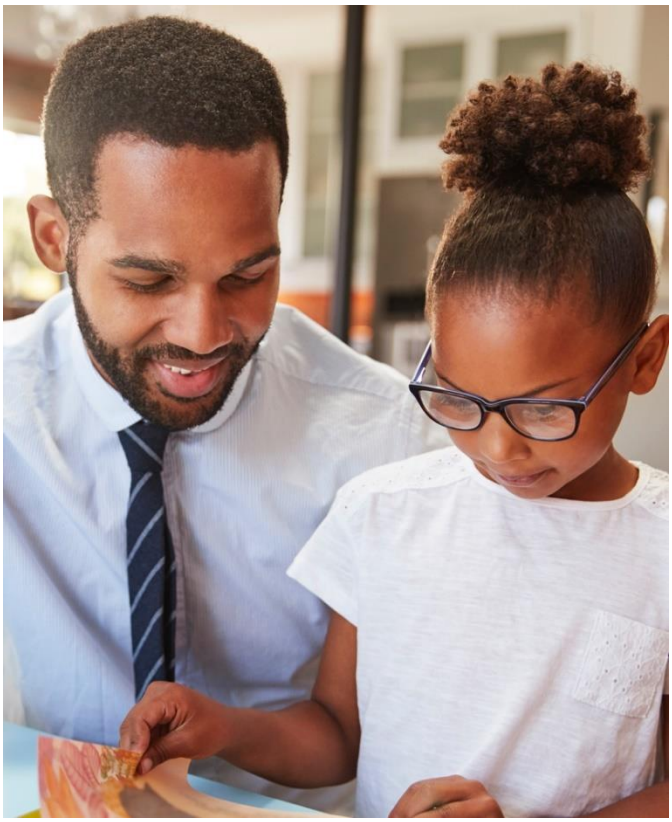
Voluntary Vision Plan

Routine eye exams are important for maintaining good vision and can also provide early warning of other health conditions. The **Principal** vision plan provides coverage for exams, glasses and contact lenses, as shown below.

In-network coverage is provided when you use **VSP Choice network** providers.

Find a VSP Doctor at www.vsp.com. Log in to gain instant access to tools to help manage your vision benefits or to find an eye doctor near you who participates in your plan. If you choose not to log in, you may search as a guest; however, VSP can't guarantee the doctors on the list will participate in your plan.

No ID card will be provided; give your SSN to your vision provider when obtaining services.



Principal	Frequency	In-Network
Vision		**You Pay**
	In-Network	In-Network
Eye Exam	Once every 12 months	$10 Copay
Prescription Glasses	Once every 12 months	$25 Copay
Frame	Once every 24 months	Amount over $150 allowance
Lenses (Single vision, lined bifocal, lined trifocal)	Once every 12 months	Included in Prescription Glasses
Contacts – instead of glasses	Once every 12 months	Amount over $150 allowance

Benefit allowances for services from non-VSP providers will be lower.

Basic Life/AD&D & Voluntary Life/AD&D Insurance

Basic Life/AD&D

JL Properties, Inc. provides Basic Life insurance coverage of **$10,000**. This coverage includes an Accidental Death and Dismemberment (AD&D) provision that also pays **$10,000** in the event of accidental death and certain other conditions. Basic Life and AD&D insurance is administered by **Principal** and is paid for by your company. You are automatically enrolled in this benefit.

Voluntary Life/AD&D

As a new hire, you can purchase Voluntary Life insurance for you, your legal spouse and dependent children without providing medical information up to certain guarantee issue (GI) amounts (see chart). If you leave **JL Properties, Inc.**, this coverage can be taken with you.

Employee and spouse amounts applied for over the GI as a new hire will require you to provide Evidence of Insurability (EOI) for review and approval by **Principal**.

Benefit amounts reduce at age 65. Please refer to the benefit summary for details.

If you elect not to enroll within **30** days of your date of hire, you will still be able to purchase coverage in the future, however, ALL amounts elected will be subject to the EOI requirements provision. At that time, if your evidence of insurability is not satisfactory to **Principal** you will not have Voluntary Life coverage.

Employees can also elect to purchase Employee, Spouse and Dependent Child Voluntary AD&D coverage in increments and maximums equal to the Voluntary Life benefits.

Employees pay the full cost of Voluntary Life and Voluntary AD&D insurance on an after-tax basis.

Voluntary Life/AD&D			
	Employee Life Benefits	**Spouse Life Benefits**	**Child Life Benefits**
Benefit Amount	You may choose to purchase benefits in increments of$10,000	You may choose to purchase benefits in $5,000 increments	For eligible children 14 days or older, you may choose to purchase benefits of: $2,500 or $5,000 or $10,000 Eligible children under 14 days of age receive $1,000.
Minimum	$10,000	$5,000	Not Applicable
Maximum	$500,000	$100,000	Not Applicable
		Cannot exceed 100% of employee life amount	
Proof of Good Health Form*	If you are under age 70: $130,000 If you are age 70 and over:$10,000	If your spouse is under age 70: $30,000 If your spouse is age 70 and over:$10,000	Not Applicable

To enroll in Voluntary Spouse and/or Child Life, you must be enrolled in Voluntary Employee Life.

** Required if adding voluntary life amounts greater than listed to the right*

Voluntary Disability Insurance

Principal administers our Disability insurance benefit plans. **You** pay the cost of Short-Term and Long-Term Disability insurance.

Voluntary Short-Term Disability

Short-Term Disability (STD) benefits become payable when you are unable to work due to an injury or illness unrelated to work. If you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until the benefit duration has ended.

- **Benefit Begins**:
  1st day of accident or 8th day for illness
- **Benefit Amount**:
  60% of your weekly salary to $1,800 per week
- **Benefit Duration**:
  Up to 13 weeks

STD benefits integrate with state mandated disability plans.

Voluntary Long-Term Disability

Long-Term Disability (LTD) benefits are provided as income protection in the event you become disabled for an extended period. Proof of disability is required.

- **Benefit Begins**:
  After 90 days of qualified disability
- **Benefit Amount**:
  60% of basic monthly earnings to $8,000 per month
- **Benefit Duration**:
  To age 65

Claims for newly covered employees will be denied if you received medical treatment, medical advice, care or services or took prescribed drugs or medicines in the last 6 months prior to the effective date of this coverage and the disability began in the first 12 months after your effective date of coverage.

Employee Assistance Program (EAP)

We understand how challenging it can be to balance your work and personal life, and we are committed to helping you do just that.

Offered through **Principal / Magellan Ascend**, the EAP plan can provide you and your family and household members with information and assistance on a wide range of topics and issues including work stress, debt problems, family issues, relationship worries, parenting challenges, anxiety, grief and much more.

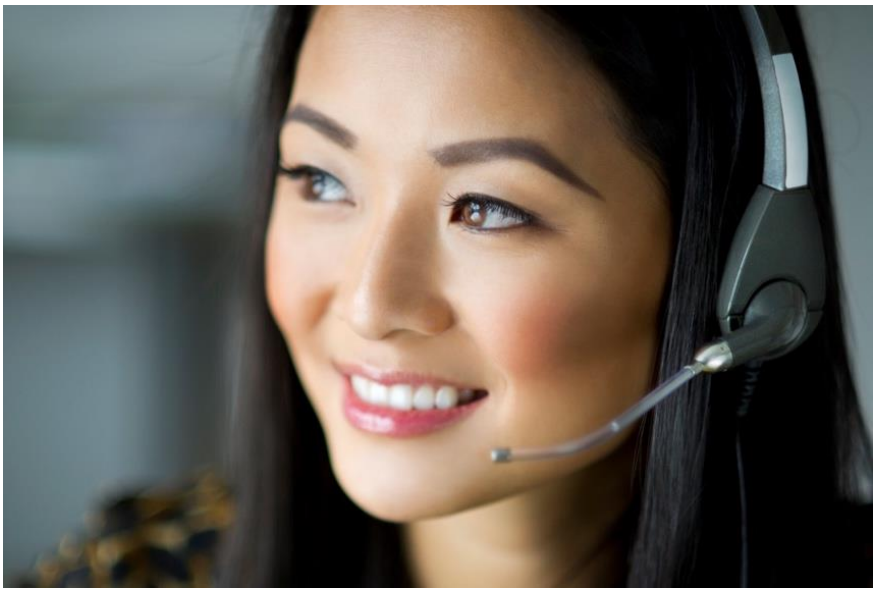
- LifeMart Discount Center, with savings on a variety of products and services
- Self-care mobile apps to help with insomnia, anxiety, depression, substance use, obsessive compulsive disorder and chronic pain
- Health and wellness articles, guides, webinars and podcasts
- Online assistance with elder care, child care and other family life resources
- Help with teen and adolescent issues, including eating disorders and relationships
- Tips on parenting and grandparenting
- 24/7 phone consultation with licensed mental health professionals and referrals to supportive resources
- Ongoing personal coaching sessions with scheduled telephone appointments

This EAP service is available at no cost to you and your family.

Help is just a click or call away — 24/7

Online: MagellanAscend.com
Enter **Principal Core** for the company name

Call: 800-450-1327
International: 800-662-4504
TTY: 800-456-4006



Cost of Coverage – Effective 5/1/2020

Voluntary Life/AD&D costs are taken from your paycheck after taxes, and the benefits paid are not taxable. The tax-free exemption is not available for domestic partners unless they are an eligible tax dependent as defined in IRS code §152 and that premiums for those dependents must be paid with post tax dollars.

Voluntary Dental Rates		
Per Pay (24 pays)	**PLAN 1 (PPO 1000)**	**PLAN 2 (PPO 3000)**
	EE pays	**EE pays**
Employee Only	$20.17	$29.63
Employee + 1 Dependent	$39.94	$58.68
Employee + 2 Dependents	$68.31	$100.36

Voluntary Vision Rates	
Per Pay (24 pays)	**VOLUNTARY VISION**
	EE pays
Employee Only	$5.50
Employee + Spouse	$8.63
Employee + Child(ren)	$9.13
Employee + Family	$14.00

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Voluntary-term life/AD&D - employee

Estimated employee semi-monthly premium amounts
End of the rate guarantee period: 04/30/2021

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$10,000	$0.49	$0.53	$0.73	$1.09	$1.61	$2.54	$3.92	$5.39
$20,000	$0.98	$1.05	$1.45	$2.18	$3.22	$5.08	$7.83	$10.77
$30,000	$1.47	$1.58	$2.18	$3.27	$4.83	$7.62	$11.75	$16.16
$40,000	$1.96	$2.10	$2.90	$4.36	$6.44	$10.16	$15.66	$21.54
$50,000	$2.45	$2.63	$3.63	$5.45	$8.05	$12.70	$19.58	$26.93
$60,000	$2.94	$3.15	$4.35	$6.54	$9.66	$15.24	$23.49	$32.31
$70,000	$3.43	$3.68	$5.08	$7.63	$11.27	$17.78	$27.41	$37.70
$80,000	$3.92	$4.20	$5.80	$8.72	$12.88	$20.32	$31.32	$43.08
$90,000	$4.41	$4.73	$6.53	$9.81	$14.49	$22.86	$35.24	$48.47
$100,000	$4.90	$5.25	$7.25	$10.90	$16.10	$25.40	$39.15	$53.85
$110,000	$5.39	$5.78	$7.98	$11.99	$17.71	$27.94	$43.07	$59.24
$120,000	$5.88	$6.30	$8.70	$13.08	$19.32	$30.48	$46.98	$64.62
$130,000	$6.37	$6.83	$9.43	$14.17	$20.93	$33.02	$50.90	$70.01
$140,000	$6.86	$7.35	$10.15	$15.26	$22.54	$35.56	$54.81	$75.39
$150,000	$7.35	$7.88	$10.88	$16.35	$24.15	$38.10	$58.73	$80.78
$160,000	$7.84	$8.40	$11.60	$17.44	$25.76	$40.64	$62.64	$86.16
$170,000	$8.33	$8.93	$12.33	$18.53	$27.37	$43.18	$66.56	$91.55
$180,000	$8.82	$9.45	$13.05	$19.62	$28.98	$45.72	$70.47	$96.93
$190,000	$9.31	$9.98	$13.78	$20.71	$30.59	$48.26	$74.39	$102.32
$200,000	$9.80	$10.50	$14.50	$21.80	$32.20	$50.80	$78.30	$107.70
$210,000	$10.29	$11.03	$15.23	$22.89	$33.81	$53.34	$82.22	$113.09
$220,000	$10.78	$11.55	$15.95	$23.98	$35.42	$55.88	$86.13	$118.47
$230,000	$11.27	$12.08	$16.68	$25.07	$37.03	$58.42	$90.05	$123.86
$240,000	$11.76	$12.60	$17.40	$26.16	$38.64	$60.96	$93.96	$129.24
$250,000	$12.25	$13.13	$18.13	$27.25	$40.25	$63.50	$97.88	$134.63
$260,000	$12.74	$13.65	$18.85	$28.34	$41.86	$66.04	$101.79	$140.01
$270,000	$13.23	$14.18	$19.58	$29.43	$43.47	$68.58	$105.71	$145.40
$280,000	$13.72	$14.70	$20.30	$30.52	$45.08	$71.12	$109.62	$150.78
$290,000	$14.21	$15.23	$21.03	$31.61	$46.69	$73.66	$113.54	$156.17
$300,000	$14.70	$15.75	$21.75	$32.70	$48.30	$76.20	$117.45	$161.55
$310,000	$15.19	$16.28	$22.48	$33.79	$49.91	$78.74	$121.37	$166.94
$320,000	$15.68	$16.80	$23.20	$34.88	$51.52	$81.28	$125.28	$172.32
$330,000	$16.17	$17.33	$23.93	$35.97	$53.13	$83.82	$129.20	$177.71
$340,000	$16.66	$17.85	$24.65	$37.06	$54.74	$86.36	$133.11	$183.09
$350,000	$17.15	$18.38	$25.38	$38.15	$56.35	$88.90	$137.03	$188.48
$360,000	$17.64	$18.90	$26.10	$39.24	$57.96	$91.44	$140.94	$193.86
$370,000	$18.13	$19.43	$26.83	$40.33	$59.57	$93.98	$144.86	$199.25

Reduced benefit	65-69
$6,500	$6.38
$13,000	$12.77
$19,500	$19.16
$26,000	$25.55
$32,500	$31.93
$39,000	$38.32
$45,500	$44.70
$52,000	$51.09
$58,500	$57.48
$65,000	$63.87
$71,500	$70.25
$78,000	$76.63
$84,500	$83.02
$91,000	$89.40
$97,500	$95.80
$104,000	$102.18
$110,500	$108.57
$117,000	$114.95
$123,500	$121.34
$130,000	$127.73
$136,500	$134.11
$143,000	$140.50
$149,500	$146.88
$156,000	$153.27
$162,500	$159.65
$169,000	$166.05
$175,500	$172.43
$182,000	$178.82
$188,500	$185.20
$195,000	$191.59
$201,500	$197.97
$208,000	$204.36
$214,500	$210.75
$221,000	$217.13
$227,500	$223.52
$234,000	$229.90
$240,500	$236.29

Reduced benefit	70 & over
$5,000	$8.05
$10,000	$16.09
$15,000	$24.14
$20,000	$32.18
$25,000	$40.23
$30,000	$48.27
$35,000	$56.32
$40,000	$64.36
$45,000	$72.41
$50,000	$80.45
$55,000	$88.50
$60,000	$96.54
$65,000	$104.59
$70,000	$112.63
$75,000	$120.68
$80,000	$128.72
$85,000	$136.77
$90,000	$144.81
$95,000	$152.86
$100,000	$160.90
$105,000	$168.95
$110,000	$176.99
$115,000	$185.04
$120,000	$193.08
$125,000	$201.13
$130,000	$209.17
$135,000	$217.22
$140,000	$225.26
$145,000	$233.31
$150,000	$241.35
$155,000	$249.40
$160,000	$257.44
$165,000	$265.49
$170,000	$273.53
$175,000	$281.58
$180,000	$289.62
$185,000	$297.67

Voluntary Term Life insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.
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JL PROPERTIES

Voluntary-term life/AD&D - employee

Estimated employee semi-monthly premium amounts
End of the rate guarantee period: 04/30/2021

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$380,000	$18.62	$19.95	$27.55	$41.42	$61.18	$96.52	$148.77	$204.63
$390,000	$19.11	$20.48	$28.28	$42.51	$62.79	$99.06	$152.69	$210.02
$400,000	$19.60	$21.00	$29.00	$43.60	$64.40	$101.60	$156.60	$215.40
$410,000	$20.09	$21.53	$29.73	$44.69	$66.01	$104.14	$160.52	$220.79
$420,000	$20.58	$22.05	$30.45	$45.78	$67.62	$106.68	$164.43	$226.17
$430,000	$21.07	$22.58	$31.18	$46.87	$69.23	$109.22	$168.35	$231.56
$440,000	$21.56	$23.10	$31.90	$47.96	$70.84	$111.76	$172.26	$236.94
$450,000	$22.05	$23.63	$32.63	$49.05	$72.45	$114.30	$176.18	$242.33
$460,000	$22.54	$24.15	$33.35	$50.14	$74.06	$116.84	$180.09	$247.71
$470,000	$23.03	$24.68	$34.08	$51.23	$75.67	$119.38	$184.01	$253.10
$480,000	$23.52	$25.20	$34.80	$52.32	$77.28	$121.92	$187.92	$258.48
$490,000	$24.01	$25.73	$35.53	$53.41	$78.89	$124.46	$191.84	$263.87
$500,000	$24.50	$26.25	$36.25	$54.50	$80.50	$127.00	$195.75	$269.25

Reduced benefit	65-69
$247,000	$242.68
$253,500	$249.07
$260,000	$255.45
$266,500	$261.83
$273,000	$268.22
$279,500	$274.61
$286,000	$281.00
$292,500	$287.38
$299,000	$293.77
$305,500	$300.15
$312,000	$306.54
$318,500	$312.93
$325,000	$319.32

Reduced benefit	70 & over
$190,000	$305.71
$195,000	$313.76
$200,000	$321.80
$205,000	$329.85
$210,000	$337.89
$215,000	$345.94
$220,000	$353.98
$225,000	$362.03
$230,000	$370.07
$235,000	$378.12
$240,000	$386.16
$245,000	$394.21
$250,000	$402.25

If your age changes to a different rate band during the guarantee period, your premium will change to reflect the new rate band effective on the next policy anniversary date.

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JL PROPERTIES

Voluntary-term life/AD&D - spouse

Estimated spouse semi-monthly premium amounts
End of the rate guarantee period: 04/30/2021

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$5,000	$0.25	$0.27	$0.37	$0.55	$0.81	$1.28	$1.96	$2.70
$10,000	$0.49	$0.53	$0.73	$1.09	$1.61	$2.54	$3.92	$5.39
$15,000	$0.74	$0.79	$1.09	$1.64	$2.42	$3.82	$5.88	$8.08
$20,000	$0.98	$1.05	$1.45	$2.18	$3.22	$5.08	$7.83	$10.77
$25,000	$1.23	$1.32	$1.82	$2.73	$4.03	$6.36	$9.79	$13.47
$30,000	$1.47	$1.58	$2.18	$3.27	$4.83	$7.62	$11.75	$16.16
$35,000	$1.72	$1.84	$2.54	$3.82	$5.64	$8.90	$13.71	$18.85
$40,000	$1.96	$2.10	$2.90	$4.36	$6.44	$10.16	$15.66	$21.54
$45,000	$2.21	$2.37	$3.27	$4.91	$7.25	$11.44	$17.62	$24.24
$50,000	$2.45	$2.63	$3.63	$5.45	$8.05	$12.70	$19.58	$26.93
$55,000	$2.70	$2.89	$3.99	$6.00	$8.86	$13.98	$21.54	$29.62
$60,000	$2.94	$3.15	$4.35	$6.54	$9.66	$15.24	$23.49	$32.31
$65,000	$3.19	$3.42	$4.72	$7.09	$10.47	$16.52	$25.45	$35.01
$70,000	$3.43	$3.68	$5.08	$7.63	$11.27	$17.78	$27.41	$37.70
$75,000	$3.68	$3.94	$5.44	$8.18	$12.08	$19.06	$29.37	$40.39
$80,000	$3.92	$4.20	$5.80	$8.72	$12.88	$20.32	$31.32	$43.08
$85,000	$4.17	$4.47	$6.17	$9.27	$13.69	$21.60	$33.28	$45.78
$90,000	$4.41	$4.73	$6.53	$9.81	$14.49	$22.86	$35.24	$48.47
$95,000	$4.66	$4.99	$6.89	$10.36	$15.30	$24.14	$37.20	$51.16
$100,000	$4.90	$5.25	$7.25	$10.90	$16.10	$25.40	$39.15	$53.85

Reduced benefit	65-69
$3,250	$3.19
$6,500	$6.38
$9,750	$9.58
$13,000	$12.77
$16,250	$15.96
$19,500	$19.16
$22,750	$22.36
$26,000	$25.55
$29,250	$28.74
$32,500	$31.93
$35,750	$35.12
$39,000	$38.32
$42,250	$41.51
$45,500	$44.70
$48,750	$47.89
$52,000	$51.09
$55,250	$54.28
$58,500	$57.48
$61,750	$60.67
$65,000	$63.87

Reduced benefit	70 & over
$2,500	$4.02
$5,000	$8.05
$7,500	$12.07
$10,000	$16.09
$12,500	$20.11
$15,000	$24.14
$17,500	$28.16
$20,000	$32.18
$22,500	$36.20
$25,000	$40.23
$27,500	$44.25
$30,000	$48.27
$32,500	$52.29
$35,000	$56.32
$37,500	$60.34
$40,000	$64.36
$42,500	$68.38
$45,000	$72.41
$47,500	$76.43
$50,000	$80.45

Child(ren) premium amounts (per family) --*Child(ren) are covered until age 26*

$2,500	$0.25
$5,000	$0.50
$10,000	$1.00

If your age changes to a different rate band during the guarantee period, your premium will change to reflect the new rate band effective on the next policy anniversary date.

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Costs|
Voluntary Short Term Disability

JL PROPERTIES

Short term disability

Estimated weekly benefit & semi-monthly deduction amount

End of rate guarantee period: 04/30/2021

To determine your estimated weekly benefit amount, multiply your weekly earnings by your benefit percentage. See your benefit summary for the definition of earnings.

Weekly earnings: $_____

If your weekly earnings are greater than $3,000 then use $3,000 as your earnings.

X Benefit percentage: 0.60

= Estimated weekly benefit amount: $_____

Age	Semi-Monthly rate
Age 24 & Under	0.0275
25-29	0.0380
30-34	0.0380
35-39	0.0280
40-44	0.0190
45-49	0.0180
50-54	0.0225
55-59	0.0275
60-64	0.0350
65-69	0.0375
70+	0.0395

To determine your estimated semi-monthly deduction, multiply your estimated weekly benefit amount by your age rate in the box at the right.

Estimated weekly benefit amount: $_____

X Age rate: $_____

X Employee Contribution Percent: 100%

= Employee's estimated semi-monthly deduction: $_____

Example

Age 30; weekly earnings: $2,900; age rate is 0.038; Employee Contribution: 100%

Estimated weekly benefit amount : $2,900.00 X 0.60 = $1,740.00
Employee's estimated semi-monthly deduction : $1,740.00 X 0.038 X 1.00 = $66.12

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If your age changes to a different rate band during the guarantee period, your deduction amount will change to reflect the new rate band effective on the next policy anniversary date.

This is a general statement of Short Term Disability insurance underwritten by Principal Life Insurance Company. It is not an insurance contract and does not contain all of the qualifications and restrictions of the coverage being offered to you. If any provision presented here is found to be in conflict with federal or state law, that provision will be applied to comply with federal or state law. The group policy determines all rights, benefits, exclusions and limitations of the insurance described here. For more details about the coverage, refer to the policy that will be issued to each member.

Costs|
Voluntary Long Term Disability

JL PROPERTIES -FEMALE

Long term disability

Estimated monthly benefit amount & semi-monthly deduction amount

End of rate guarantee period: 04/30/2021

To determine your estimated semi-monthly deduction, multiply your covered monthly earnings by your age rate in the box at the right. See your benefit summary for the definition of earnings.

Covered monthly earnings: $_____

If your monthly earnings are greater than $13,333.33 then use $13,333.33 as your earnings.

X Age rate: _____

X Employee Contribution Percent: 100%

= Employee's estimated semi-monthly deduction : $_____

Age	Semi-monthly rate
Under age 24	0.00145
25-29	0.00205
30-34	0.00270
35-39	0.00285
40-44	0.00440
45-49	0.00820
50-54	0.00855
55-59	0.00855
60-64	0.00665
65-69	0.00470
70+	0.00225

To determine your estimated monthly benefit amount, multiply your covered monthly earnings by your benefit percentage.

Covered monthly earnings: $_____

If your monthly earnings are greater than $13,333.33 then use $13,333.33 as your earnings.

X Benefit percentage: 0.60

= Estimated monthly benefit amount: $_____

Example

Age 30; covered monthly earnings: $13,000; age rate is 0.0027; Employee Contribution: 100%

Employee's estimated semi-monthly deduction : $13,000.00 X 0.0027 X 1.00 = $35.10
Estimated monthly benefit amount : $13,000.00 X 0.60 = $7,800.00

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If your age changes to a different rate band during the guarantee period, your monthly deduction will change to reflect the new rate band effective on the next policy anniversary date.

This is a general statement of Long Term Disability insurance underwritten by Principal Life Insurance Company. It is not an insurance contract and does not contain all of the qualifications and restrictions of the coverage being offered to you. If any provision presented here is found to be in conflict with federal or state law, that provision will be applied to comply with federal or state law. The group policy determines all rights, benefits, exclusions and limitations of the insurance described here. For more details about the coverage, refer to the policy that will be issued to each member.

Costs|
Voluntary Long Term Disability

JL PROPERTIES -MALE

Long term disability

Estimated monthly benefit amount & semi-monthly deduction amount

End of rate guarantee period: 04/30/2021

To determine your estimated semi-monthly deduction, multiply your covered monthly earnings by your age rate in the box at the right. See your benefit summary for the definition of earnings.

Covered monthly earnings: $_____

If your monthly earnings are greater than $13,333.33 then use $13,333.33 as your earnings.

X Age rate: _____

X Employee Contribution Percent: 100%

= Employee's estimated semi-monthly deduction : $_____

Age	Semi-monthly rate
Under age 24	0.00120
25-29	0.00115
30-34	0.00170
35-39	0.00215
40-44	0.00360
45-49	0.00420
50-54	0.00595
55-59	0.00760
60-64	0.00760
65-69	0.00505
70+	0.00240

To determine your estimated monthly benefit amount, multiply your covered monthly earnings by your benefit percentage.

Covered monthly earnings: $_____

If your monthly earnings are greater than $13,333.33 then use $13,333.33 as your earnings.

X Benefit percentage: 0.60

= Estimated monthly benefit amount: $_____

Example

Age 30; covered monthly earnings: $13,000; age rate is 0.0017; Employee Contribution: 100%

Employee's estimated semi-monthly deduction : $13,000.00 X 0.0017 X 1.00 = $22.10
Estimated monthly benefit amount : $13,000.00 X 0.60 = $7,800.00

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If your age changes to a different rate band during the guarantee period, your monthly deduction will change to reflect the new rate band effective on the next policy anniversary date.

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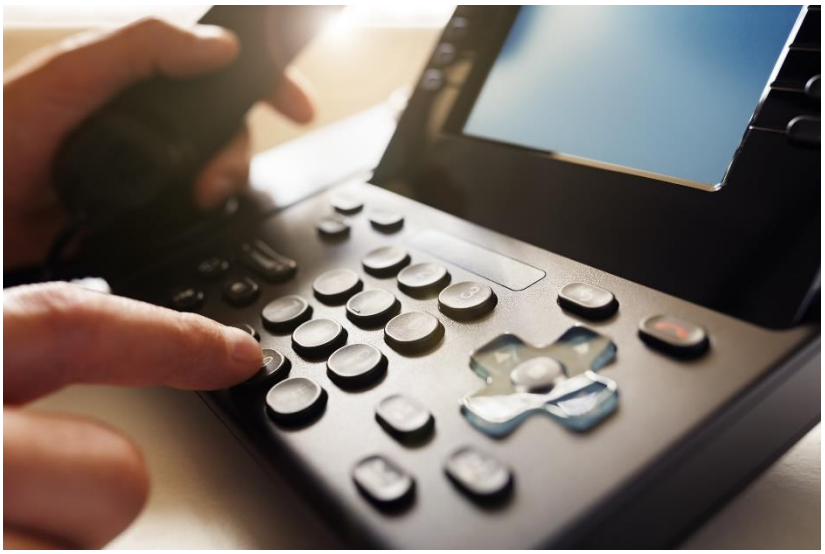
Resources/Contact Information



Benefit	Provider	Phone	Website / Email
Medical, Rx	Aetna	1-800-872-3862	www.aetna.com
Voluntary Dental **Voluntary Vision** **Group Life/AD&D** **Voluntary Life/AD&D** **Voluntary STD** **Voluntary LTD**	Principal Financial Group	1-800-986-3343	www.principal.com
Cafeteria Plan	Professional Benefits Services, Inc.	1-800-982-2012	www.profben.com cafeteria@profben.com

Wilson Albers, our employee benefits consultant, is available to assist you should you have claims or service issues you are unable to resolve by contacting the insurance carrier directly. If you have questions or problems that you feel are not being addressed properly by our insurance carriers' customer service departments, please give Wilson Albers a call at 907-277-1616.

Benefit Definitions

What is a premium?

A premium (sometimes called a contribution) is the semi-monthly cost you pay for health insurance, whether you use medical services or not. Premiums are deducted directly from your paycheck.

What is a deductible?

A deductible is the amount you pay out of your pocket before your insurance pays.

The deductible runs from January – December each year. Once you have met that dollar amount, you have met the requirements for the plan year.

What does a copay pay for?

Copayments or copays, are pre-set dollar amount you are expected to pay for office visits, procedures or prescription drugs under your insurance plan.

Once the copay has been met, the insurance company pays all remaining costs.

What counts towards my out-of-pocket maximum?

An out-of-pocket maximum is an annual cap on the dollar amount you are expected to pay out of your own pocket for services (including deductibles, copays, and coinsurance) throughout the plan year.

Once you meet the out-of-pocket amount, your insurance provider will cover 100% of remaining medical expenses for the year.

What does coinsurance mean?

Coinsurance is a set percentage of service costs that you will be expected to pay once you have met your annual deductible.

When your annual deductible is met, your insurance provider pays for their portion of the full cost of the service and you pay the coinsurance, or remaining percentage.

Enrollment Checklist

Remember that the choices you make during open enrollment will take effect on **May 1, 2020** and remain in effect until **April 30, 2021**. Only qualifying events will allow you to make a change before that date.

- ❑ Review enrollment materials
- ❑ Review all available plans and options to see which is best for you
- ❑ Consider the coverage you may be eligible for
- ❑ Review contributions
- ❑ Make sure you have all required information available
- ❑ Review accuracy of enrollment information
- ❑ Updated your beneficiary information
- ❑ Submit information before deadline

Notes

Brought to you by:

WILSON ALBERS
AN ALERA GROUP COMPANY

2020-2021

Enrollment | Change Forms

aetna®

Enrollment/Change Request
Aetna Life Insurance Company

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	Group Number (IMO Only)		Customer Code (Optional)	

A. Type of Activity - Employee Completes Sections A - E. ***Please Print Clearly.***

Instructions: *Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.*

Enrollment - *Check one.*
☐ New Enrollee/Subscriber ☐ Rehire/Reinstatement
Effective Date / / Date of Rehire/Reinstatement / /
Date of Hire / /

Change - *Check all that apply.*
☐ Add Spouse ☐ Add Dependent Child ☐ Name Change ☐ Other ☐ Control/Suffix/Acct/Plan
Date of Event / / Reason

Remove or Terminate - *Check all that apply.*
☐ Remove Spouse ☐ Remove Dependent Child ☐ Employee Withdrawal/ Termination ☐ Cancel Coverage
Effective Date / / Reason

Continuation of Coverage, i.e., COBRA, State - ***Not all options are available. Contact Employer for available options.***
Coverage For: ☐ Employee ☐ Dependents
Length of Continuation (months): ☐ 18 ☐ 36 ☐ Other ____
☐ 29 - Attach disability determination from the Social Security Admin.
Date of Loss of Coverage / /
Date of Qualifying Event / /
Continuation of Coverage Expiration Date / /

B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Home Telephone ( )	Work Telephone ( )

Employee Status ☐ Active ☐ Retired	Home Address	Apt. No.	City, State	ZIP Code

Beneficiary Designation - **Full Beneficiary Name** (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D).	Social Security Number of Beneficiary	Relationship to Employee	Earnings ☐ Annually $ ☐ Weekly $	☐ Insurance Amount $ ☐ Supplemental Life $ ☐ AD&D Amount $

C. Plan Options - **Your selection must be offered by your employer.**

Check One:
☐ Aetna Choice® POS II
☐ Aetna HealthFund®
☐ Aetna Open Access® Elect Choice
☐ Aetna Open Access® Managed Choice
☐ Elect Choice® EPO
☐ Managed Choice® POS
☐ Open Choice® PPO
☐ Traditional Choice®
☐ Aexcel®
☐ Aexcel® Plus
☐ Other ____

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

D. Individuals Covered - **List individuals for whom you are adding/changing/removing coverage.** ☐ **Check this box if you are refusing coverage for your dependents.** **Provide details for "Yes" responses below.*

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation. Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None".)	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Primary Medical Office ID Number	Current Patient	Race/Ethnicity - *Optional* (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.) Code	Other
		Self	☐ ☐	/ /		Yes * ☐	Yes * ☐	Yes * ☐	Yes N/A ☐		Yes ☐		
			☐ ☐	/ /		☐	☐	☐	☐		☐		
			☐ ☐	/ /		☐	☐	☐	☐		☐		
			☐ ☐	/ /		☐	☐	☐	☐		☐		
			☐ ☐	/ /		☐	☐	☐	☐		☐		

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
01 - White
02 - African American or Black
03 - Hispanic or Latino
04 - Asian
05 - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to **Prior Insurance Plan** and/or **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your **Member Identification Number**.

2. If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your **Member Identification Number**.

3. Does any dependent listed above live at a different address than the employee? If "Yes," who and what address? ☐ Yes ☐ No

Special Remarks

E. Employee Signature ☐ *By checking this box you agree to use Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future. To view this material please visit Aetna Navigator®.*

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.	**Employee Signature** - *Required* X	E-Mail Address	Date / /	**Primary Language Spoken**

Instructions

Employer - Complete the **Employer Group Information** at the top of the form.

Employee - Complete Sections A - E.

Section A - Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) and Date of Event(s) where requested.

Section B - Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.
- Beneficiary Designation - Complete only if your employer is offering Aetna Life Insurance coverage.

Section C - Plan Options: Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
  - Relationship Code - Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- If you or your dependent(s) were covered under your employer's or other **Prior Insurance Plan** or currently have **Other Medical Coverage**, check the "Yes" box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** in the space provided in Number 1.
- If you or your dependent(s) have **Other Rx Drug Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** in the space provided in Number 2.
  - **NOTE**: In some instances your medical carrier will differ from your Rx Drug carrier.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- Primary Medical Office ID Number - Locate the office ID number for the primary care physician from the appropriate provider directory or from "DocFind®", Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Section E - Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.
- By checking the box on the reverse side you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Principal®

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - AK

Company name	Division level	Account number/unit number
JL PROPERTIES	ALL MEMBERS	1053525

Employee Information

Name			Social security number	
Mailing address (street)			Birth date	☐ male ☐ female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? ☐ Yes ☐ No	
Date employed full-time	Hours worked per week		Job occupation/class	Location
Salary amount	Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly			
What is your payroll mode? ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly			Employer ZIP 99501	Employer county ANCHORAGE MUNICIPALITY

Dental

☐ Elect ☐ Decline Choose from one of the following options.

Option #1

Design description: MEMBERS ELECT HIGH PLAN

	Employee:	Spouse:	Child:
	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

Option #2

Design description: MEMBERS ELECT LOW PLAN

	Employee:	Spouse:	Child:
	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ Yes ☐ No

Vision

Employee:	Spouse:	Children:
☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

Short Term Disability

Employee: ☐ Elect ☐ Decline

Long Term Disability

Employee: ☐ Elect ☐ Decline

Group Term Life

Employee:

☒ Elect

Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Voluntary Term Life

Employee: ☐ Elect ☐ Decline	$_____	
Spouse: ☐ Elect ☐ Decline	$_____	Birth date
Children: ☐ Elect ☐ Decline	$ _____	

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write “same as above” in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Name	Percentage	Relationship

Address	Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship

Address	Social security number

Name	Percentage	Relationship

Address	Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: You are covered by both group term life and voluntary term life coverage and if you only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

☐ spouse's group coverage ☐ individual insurance

☐ other _____ ☐ other coverage offered by my employer

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	☐ male ☐ female	Social security number	
Name(s) of child(ren)	Birth date	☐ male ☐ female	Social security number	☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **

* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? ☐ Yes ☐ No

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified

when a claim is filed.

- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- Explanation of Benefits reflecting claims payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and/or my dependents will be used by Principal Life only as allowed by law.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X_____ **Date Signed** _____

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

Principal®

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Change Form - AK

PLEASE USE BLACK INK
PLEASE ENTER DATES AS MM/DD/YYYY

Company name	Account/unit number
JL PROPERTIES	1053525

Employee Information (Change of name and address)

Your name (last, first, middle initial)	Date of Birth	Social security number

New name (last, first, middle initial)

Your new address (street)	(city)	(state)	(ZIP code)

Home phone number	Email address

Complete for Adding, Canceling or Changing a Coverage. If this is initial enrollment, please complete an Enrollment Form. NOTE: Employee coverage must be elected to elect any dependent coverage.

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
Dental	☐ Add ☐ Cancel ☐ Change to: Change to date:	☐ Add ☐ Cancel ☐ Change to: Change to date:	☐ Add ☐ Cancel ☐ Change to: Change to date:
	In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself or your dependents) with a prior carrier? ☐ yes ☐ no		
Vision	☐ Add ☐ Cancel ☐ Change to: Change to date:	☐ Add ☐ Cancel ☐ Change to: Change to date:	☐ Add ☐ Cancel ☐ Change to: Change to date:
Group Term Life	☐ Add ☐ Cancel ☐ Change to: Change to date:	☐ Add ☐ Cancel ☐ Change to: Change to date:	☐ Add ☐ Cancel ☐ Change to: Change to date:
Supplemental Term Life	☐ Add ☐ Cancel ☐ Change to: Change to date:		

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
Voluntary Term Life (VTL)	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____ or _____ X salary	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____
Short Term Disability	☐ Add ☐ Cancel Occupation: _____ Change to: _____ Change to date: _____ $ _____		
Long Term Disability	☐ Add ☐ Cancel Occupation: _____ Change to: _____ Change to date: _____ $ _____		
Critical Illness	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____
Accident	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____

Complete if the coverage you are adding or changing is based on your salary.

Salary $ _____ ☐ yearly ☐ bi-weekly ☐ monthly ☐ weekly ☐ hourly

* Domestic Partners can only be added if your employer allows this coverage. If adding a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60439).

Nicotine Products

Has any person used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months?

Employee: ☐ yes ☐ no Spouse or Domestic Partner: ☐ yes ☐ no

Reason for Adding a Coverage or Dependent

Date of event

☐ marriage ☐ loss of other group coverage* ☐ open enrollment*
☐ birth/adoption ☐ court order (attach a copy) ☐ change in job status
☐ annual enrollment (if available) ☐ other _____

*For loss of other group coverage and open enrollment, you must complete the following:

Name of prior dental carrier	Date coverage ended
Name of prior life carrier	Date coverage ended
Name of prior vision carrier	Date coverage ended

Reason for Canceling a Coverage or Dependent

Date of request/ineligibility

☐ divorce ☐ age limit ☐ individual insurance
☐ spouse's or domestic partner's group coverage
☐ other _____

Beneficiary Designation

Complete Beneficiary Designation/Change (GP34795) if adding life coverage, accident coverage with AD&D, or changing beneficiary.

Complete for Adding or Canceling a Dependent (Include last name if different from the employee)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ spouse ☐ domestic partner
		☐ male ☐ female		☐ child ☐ foster child*
		☐ male ☐ female		☐ child ☐ foster child*
		☐ male ☐ female		☐ child ☐ foster child*

* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court? ☐ yes ☐ no

To determine eligibility for disabled child(ren) (over the maximum age); see your employer for the required forms.

Employee Signature (Read and sign below)

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including stepchild(ren), foster child(ren) and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age will be verified when claims are submitted.
- If I cancel dental or vision coverage, I or my dependents may enroll at a later date; however, enrolling late will affect the level of benefits.
- If I cancel any type of life, disability, or critical illness coverage, I may apply at a later date; however, I must provide proof of good health at my own expense and coverage will only become effective subject to approval from Principal Life Insurance Company.
- If I cancel coverage, I cannot under any circumstance enroll in the policy once I have retired.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.

Employee Signature (Read and sign below) - continued

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

I declare that the information I have completed on this change form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Principal Life.

Your signature X _____ **Date signed** _____

Note – Make two copies: one for employer and one for employee

You must complete all pages of this form.

Statement of Health - AK

Principal Life Insurance Company
P.O. Box 4934
Grand Island, NE 68802

Principal®

PLEASE USE BLACK INK

PLEASE ENTER DATES AS MM/DD/YYYY

Account number 1053525

Instructions

1. The Employee Information section should always be completed with the information about the employee.
2. The employee must ALWAYS sign the last page.
3. When coverage is being requested for an eligible dependent(s), this form applies to all persons requesting coverage.
   a. Complete the Eligible Dependent Information section, if applicable.
   b. Complete the Health Information section for you and your eligible dependents, if applicable.
   c. The spouse or domestic partner must sign the last page if spouse or domestic partner coverage is being requested.
4. After completing and signing this form, make a copy for your records.

Employee Information

Your name (last, first, middle initial)	Gender	Social security number	Date of birth
JL PROPERTIES	☐ male ☐ female		

Mailing address (street)

City	State	ZIP code

Email address

Home phone number	Employer name

Eligible Dependent Information – Please provide the requested information for the eligible dependents electing coverage.

Name (last, first, middle initial) Spouse or domestic partner	Gender	Social security number	Date of birth
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		

If additional dependents, list on separate page. Please sign and date the separate page.

Health Information **120**

To prevent delays give full details to "yes" answers for everyone requesting coverage. If more space is needed, attach a separate page giving full details. Sign and date all those pages.

1. **Employee's height** ___ ft. _____ in. **weight** _____ lbs.

   Spouse's or domestic partner's height ___ ft. _____ in. **weight** _____ lbs.

2. ☐ yes ☐ no — Is any person receiving medical treatment or taking prescription medication?

3. ☐ yes ☐ no — Is any person currently pregnant?

4. ☐ yes ☐ no — **In the past 5 years,** has any person had surgery, been hospitalized or consulted with a doctor/physician or medical practitioner, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment? Provide results of all tests.

5. ☐ yes ☐ no — **In the past 5 years,** has any person been diagnosed with or received treatment for any of the following (check all that apply)?

   ☐ cancer/tumor(s) ☐ liver disorder/hepatitis ☐ bone/joint disorder ☐ infertility

   ☐ back/spine disorder ☐ kidney/urinary disorder ☐ digestive disorder ☐ blood disorder

   ☐ stroke ☐ migraines/headaches ☐ alcohol/drug abuse ☐ gland/thyroid disorder

   ☐ skin/eyes/ears/nose/throat disorder ☐ multiple sclerosis/neurological disorder ☐ organ or other transplants

   ☐ asthma/respiratory disorder ☐ heart or circulatory disorder ☐ psychological/mental disorder

   ☐ Other conditions – including prescription medicine _____

   _____

   ☐ High blood pressure – last reading and date _____/_____

   ☐ Diabetes – last HbA1c reading and date _____/_____

6. ☐ yes ☐ no — **In the last 5 years,** has any person had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV test or AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex)?

Provide details for all "yes" answers on Page 3.

Name of person diagnosed	Date diagnosed	Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment
☐ weekly ☐ monthly ☐ yearly ☐ other

Names and addresses of doctors/physicians, medical practitioners, hospitals or other health care providers

Name of person diagnosed	Date diagnosed	Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment
☐ weekly ☐ monthly ☐ yearly ☐ other

Names and addresses of doctors/physicians, medical practitioners, hospitals or other health care providers

Name of person diagnosed	Date diagnosed	Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment
☐ weekly ☐ monthly ☐ yearly ☐ other

Names and addresses of doctors/physicians, medical practitioners, hospitals or other health care providers

Name of person diagnosed	Date diagnosed	Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment
☐ weekly ☐ monthly ☐ yearly ☐ other

Names and addresses of doctors/physicians, medical practitioners, hospitals or other health care providers

If more space is needed, attach a separate page giving full details. Sign and date all those pages.

Notice of Information Practices 120

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life Insurance Company. We will do this by having you complete this Statement of Health. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse or domestic partner, (b) employer, (c) medical professionals or institutions, (d) pharmacy benefit managers, and (e) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, (d) the employer, and (e) our reinsurer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531.

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life is not liable for anyone's claim which happens or begins before the effective date and approval of coverage. No information will be considered to have been given to Principal Life unless it is stated on this form.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause coverage, if issued, to be cancelled as never effective.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- If approved for coverage, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- I authorize any physician, medical practitioner, health care provider, hospital, clinic or medically related facility, pharmacy benefit manager, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents, employees or reinsurers performing business transactions, any such data.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date signed. I understand I may revoke this authorization at any time. The request for revocation must be in writing and sent to: Group Operations, Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531. I understand that a revocation is not effective if Principal Life has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest coverage under the policy itself. A photocopy of this form shall be as valid as the original. I understand additional medical records may be requested at the time a claim is filed.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for coverage. This information will not be used for any purposes prohibited by law.
- Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

Employee's signature **X**	**Date signed**
Spouse's or domestic partner's signature* **X**	**Date signed**

*Spouse's or domestic partner's signature only required if Voluntary Term Life or Critical Illness coverage is elected.

Principal®

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

UTMA Beneficiary Designation

Company Name	**Account/Unit Number**
JL PROPERTIES	1053525

Employee Information

Your name (last, first, middle initial)	Social security number

NOTE: This form is a supplement to Employee Enrollment and Waiver.

Minor Beneficiary – UTMA: ONLY COMPLETE IF THE BENEFICIARY LISTED IS A MINOR.

If any proceeds become payable to a beneficiary who is then a "minor" as defined in the applicable Uniform Transfers to Minors Act, as specified herein, such proceeds shall be paid to _____
(Name)

_____
(Address)

as custodian for such beneficiary:

(Check One Only) See instructions on Page 2.

☐ under the Iowa Uniform Transfers to Minor Act.

☐ under the Uniform Transfers to Minor Act of the state where the beneficiary shall reside at the time of payment. In the event the beneficiary resides in California or Ohio at the time of payment, the custodianship is to continue until the beneficiary reaches the age of ___ for California (insert 18, 19, 20, 21, 22, 23, 24 or 25) or ___ for Ohio (insert 18, 19, 20 or 21).

In the event a substitute custodian is needed, the following is/are nominated, in the order named:

Name	Address
Name	Address

If no state is specified (by name or description) above, or if the state so specified has not enacted the Uniform Transfers to Minors Act, or if the law of the state so specified does not provide for such payment to a custodian, the custodianship shall be established under the Iowa Uniform Transfers to Minors Act. If the specified Uniform Transfers to Minors Act would require the beneficiary's custodianship to terminate at or before the time of payment, the proceeds payable to that beneficiary shall be paid to the beneficiary rather than to a custodian.

Signature

Read important instructions on Page 2 before signing.

_____ _____
Signature of employee Date signed

Note: make a copy of Page 1 for your records and distribute copy to employee.

Minor Beneficiary – UTMA Instructions – Please Note the Following:

1. You may wish to consult with your attorney about the completion of this beneficiary designation. The following comments are of a general nature and are not intended to be legal advice, or to substitute for legal advice.
2. **Naming a custodian and substitutes.** A custodian must be named in the blank following the words "paid to" in the designation. It is strongly recommended that you also name at least one (and preferably two or more) substitute custodians on the lines provided for that purpose. A substitute custodian would serve if, at the time of payment, the first-named custodian is deceased or otherwise unable or unwilling to serve. The custodian (and each substitute) listed on the beneficiary designation should be either: (1) an individual who is now an adult; or (2) a trust company, such as a financial institution with a trust department.
3. **Specifying the state law.** You may specify that the custodianship be established under the Iowa Uniform Transfers to Minors Act, regardless of where the minor lives. Principal Life Insurance Company is based in Iowa and therefore may transfer funds to a custodian in any state for the benefit of a minor in any state if the beneficiary designation specifies that the transfer shall be made under the Iowa Uniform Transfers to Minors Act. The Iowa Uniform Transfers to Minors Act defines a "minor" as an individual who has not reached age 21.

   Alternatively, you may specify that the custodianship be established under the law of whatever state the beneficiary may live in at the time of payment. If this happens to be a state that has not enacted the Uniform Transfers to Minors Act, the designation specifies that the custodianship will be established under the Iowa Uniform Transfers to Minors Act. If there is a possibility that the minor beneficiary will live in California or Ohio at the time of payment, you may wish to fill in one or both of the blanks specifying the age at which the custodianship is to terminate (see below). The ability to specify such an age in the beneficiary designation is a unique feature of the Ohio and California Uniform Transfers to Minors Acts.

   The state specified in the designation may affect the age at which the beneficiary will have control of the money. Under the Uniform Transfers to Minors Act as enacted in many states, a custodianship created pursuant to a beneficiary designation terminates when the beneficiary reaches the legal age of majority (usually 18), even though custodianships created pursuant to a lifetime gift may terminate at a later age. However, under the Iowa Uniform Transfers to Minors Act, and in a few states, a custodianship created pursuant to a beneficiary designation continues until the beneficiary reaches age 21. As noted above, custodian nominations under the California Uniform Transfers to Minors Act may specify an age (up to the age of 25) for the custodianship to terminate. If no age is specified, the California custodianship will terminate at age 18. Custodianships under the Ohio Transfers to Minors Act terminate at age 21 unless the beneficiary designation specifies that it will terminate at age 18, 19 or 20.

Beneficiary Designation/Change

Principal Life Insurance Company
Des Moines, Iowa 50392-0002

Principal®

Company Name	Account/Unit Number
JL PROPERTIES	1053525

Employee Information

Your name (last, first, middle initial)	Social security number

Section I Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. If designating a minor, please check the applicable box and complete the Minor Beneficiary – UTMA section on Page 4.

Primary Beneficiaries:

Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number

Contingent Beneficiaries:

Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number

Section II **Voluntary Term Life Beneficiary Designation** (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage on Page 1, write "same as Section I" in the beneficiary section below.)

NOTE: If you are covered by both group term life and voluntary term life coverage and only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. If designating a minor, please check the applicable box and complete the Minor Beneficiary – UTMA section on Page 4.

Primary Beneficiaries:

Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number

Contingent Beneficiaries:

Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number

Section III Accident Beneficiary Designation (Complete if Accident Insurance includes Accidental Death and Dismemberment (AD&D). If you want to use the same beneficiary designation as indicated for group term life coverage on Page 1, write "same as Section I" in the beneficiary section below)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. If designating a minor, please check the applicable box and complete the Minor Beneficiary – UTMA section on Page 4.

Primary Beneficiaries:

Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number

Contingent Beneficiaries:

Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number
Name	Check here if a minor ☐	Percentage	Relationship
Address			Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to said company.

Minor Beneficiary – UTMA: ONLY COMPLETE IF THE BENEFICIARY LISTED ABOVE IS A MINOR.

If any proceeds become payable to a beneficiary who is then a "minor" as defined in the applicable Uniform Transfers to Minors Act, as specified herein, such proceeds shall be paid to _____
(Name)

_____
(Address)

as custodian for such beneficiary:

(Check One Only) See instructions on Page 5.

☐ under the Iowa Uniform Transfers to Minor Act.

☐ under the Uniform Transfers to Minor Act of the state where the beneficiary shall reside at the time of payment. In the event the beneficiary resides in California or Ohio at the time of payment, the custodianship is to continue until the beneficiary reaches the age of ___ for California (insert 18, 19, 20, 21, 22, 23, 24 or 25) or ___ for Ohio (insert 18, 19, 20 or 21).

In the event a substitute custodian is needed, the following is/are nominated, in the order named:

Name	Address
Name	Address

If no state is specified (by name or description) above, or if the state so specified has not enacted the Uniform Transfers to Minors Act, or if the law of the state so specified does not provide for such payment to a custodian, the custodianship shall be established under the Iowa Uniform Transfers to Minors Act. If the specified Uniform Transfers to Minors Act would require the beneficiary's custodianship to terminate at or before the time of payment, the proceeds payable to that beneficiary shall be paid to the beneficiary rather than to a custodian.

Section III Signature

Read important instructions on Page 5 before signing.

_____ _____
Signature of employee Date signed

Note: make a copy of Page 1, 2, 3, and 4 for your records and distribute copy to employee.

Minor Beneficiary – UTMA Instructions – Please Note the Following:

1. You may wish to consult with your attorney about the completion of this beneficiary designation. The following comments are of a general nature and are not intended to be legal advice, or to substitute for legal advice.
2. **Naming a custodian and substitutes.** A custodian must be named in the blank following the words "paid to" in the designation. It is strongly recommended that you also name at least one (and preferably two or more) substitute custodians on the lines provided for that purpose. A substitute custodian would serve if, at the time of payment, the first-named custodian is deceased or otherwise unable or unwilling to serve. The custodian (and each substitute) listed on the beneficiary designation should be either: (1) an individual who is now an adult; or (2) a trust company, such as a financial institution with a trust department.
3. **Specifying the state law.** You may specify that the custodianship be established under the Iowa Uniform Transfers to Minors Act, regardless of where the minor lives. Principal Life Insurance Company is based in Iowa and therefore may transfer funds to a custodian in any state for the benefit of a minor in any state if the beneficiary designation specifies that the transfer shall be made under the Iowa Uniform Transfers to Minors Act. The Iowa Uniform Transfers to Minors Act defines a "minor" as an individual who has not reached age 21.

   Alternatively, you may specify that the custodianship be established under the law of whatever state the beneficiary may live in at the time of payment. If this happens to be a state that has not enacted the Uniform Transfers to Minors Act, the designation specifies that the custodianship will be established under the Iowa Uniform Transfers to Minors Act. If there is a possibility that the minor beneficiary will live in California or Ohio at the time of payment, you may wish to fill in one or both of the blanks specifying the age at which the custodianship is to terminate (see below). The ability to specify such an age in the beneficiary designation is a unique feature of the Ohio and California Uniform Transfers to Minors Acts.

   The state specified in the designation may affect the age at which the beneficiary will have control of the money. Under the Uniform Transfers to Minors Act as enacted in many states, a custodianship created pursuant to a beneficiary designation terminates when the beneficiary reaches the legal age of majority (usually 18), even though custodianships created pursuant to a lifetime gift may terminate at a later age. However, under the Iowa Uniform Transfers to Minors Act, and in a few states, a custodianship created pursuant to a beneficiary designation continues until the beneficiary reaches age 21. As noted above, custodian nominations under the California Uniform Transfers to Minors Act may specify an age (up to the age of 25) for the custodianship to terminate. If no age is specified, the California custodianship will terminate at age 18. Custodianships under the Ohio Transfers to Minors Act terminate at age 21 unless the beneficiary designation specifies that it will terminate at age 18, 19 or 20.

Sample Beneficiary Designations

Be sure to use given names such as “Mary M. Doe,” not “Mrs. John Doe” and include address and relationship of the beneficiary or beneficiaries to you.

Proposed Beneficiary	**Suggested Wording for Beneficiary “name”**
Insured’s Estate	My Estate
Trust with Individual Trustees	Richard Doe and John Smith, Trustees, or a Successor in Trust under (Trust Name) established XX/XX/XXXX
Present or Living Trust	ABC Bank & Trust Company, Des Moines, Iowa. Trustee under (Trust Name) established XX/XX/XXXX
Testamentary Trust	Trustee of Mary I Doe Trust or Successor in Trust established by the Last Will & Testament of the Insured Dated XX/XX/XXXX

Professional Benefit Services, Inc.
Affordable administration of employee benefit plans

Enrolling in a Cafeteria Plan

It is time to enroll in your company's cafeteria plan. Please fill out the enclosed enrollment form and return it to your employer.

What is a cafeteria Plan?

Authorized through Section 125 of the IRS code, pretax dollars are used to pay for eligible health premiums, certain medical/health care expenses and dependent day care costs. The plan allows you to avoid taxation on a portion of your income. You save taxes on every dollar you deposit.

How does it work?

You elect to deposit a portion of your salary pretax into a cafeteria account. This account is used to reimburse you for eligible expenses. You determine how much money you will spend on an annual basis for eligible expenses and elect to take a monthly salary reduction for those expenses. The funds are placed into a special account that you may withdraw when eligible claims are submitted and processed. The reimbursement is completely tax free for the covered expenses.

What can I enroll for?

Employer Sponsored Insurance Premiums

- You are automatically enrolled for your portion of health, dental and vision premiums (Sponsored by your employer).

Flexible Spending Account Expenses (FSA)

- Most out-of-pocket medical, dental and vision expenses

Expenses include amounts paid for the diagnosis, treatment or prevention of disease, and for treatments affecting any part or function of the body for you and your eligible dependents. The expenses must be to alleviate or prevent a physical defect or illness. Expenses solely for cosmetic reasons generally are not reimbursable expenses under the Cafeteria Plan. (IRS Code 105 & 213 Medical Expenses) If you have a question on a specific expense, please call PBS.

You will elect an amount for the entire year. This amount will be equally divided by your number of payrolls per year.

Dependent Day Care Account

- Day care expenses for your tax dependent under the age of 13.
- Adult, elder or child day care expenses for your tax dependent who is mentally or physically handicapped.

Dependent day care expenses include expenses incurred for the care of a dependent so that you and your spouse can work, look for work or be a full-time student. School tuition may not be reimbursed.

You will elect an annual amount which will be equally divided by your number of payrolls per year. The dependent care account does not pay out more than has been withheld YTD, therefore you can only be reimbursed the amount you have paid in. Submit claims for daycare expenses after the dates of service have been incurred.

How much should I enroll for?

Every household is unique. You don't want to put away too much or too little. Fill out the worksheet to determine what to enroll for annually. You will need to claim all your funds by the end of the plan year's run out period.

If you have any questions please call Professional Benefit Services, Inc.

FSA Expense Worksheet

Medical	$ _____
Insurance Deductibles	$ _____
Co-Pays	$ _____
Routine Exams	$ _____
Prescriptions	$ _____
Medical Equipment	$ _____
Chiropractor Visits	$ _____
Physical Therapy	$ _____
Other	$ _____
Total Annual Medical Expenses	$ _____
Vision	$ _____
Insurance Deductibles/ Co-Pays	$ _____
Eye Exams	$ _____
Glasses	$ _____
Prescription Sun Glasses	$ _____
Contacts	$ _____
Contact Lens solutions	$ _____
Total Annual Vision Expenses	$ _____
Dental	$ _____
Insurance Deductibles/Co-pays	$ _____
Cleanings	$ _____
X-Rays	$ _____
Fillings	$ _____
Crowns	$ _____
Other	$ _____
Total Annual Dental Expenses	$ _____
Orthodontics	$ _____
Orthodontia	$ _____
Retainers	$ _____
Total Annual Orthodontia Expenses	$ _____
Total of all FSA Expenses	$ _____

Professional Benefit Services, Inc.
1193 Royvonne S.E., Suite 22, Salem, Oregon 97302
(503) 371-7622 or 1-800-982-2012 Fax: (503) 364-6901 or 1-866-248-9742
cafeteria@profben.com

Professional Benefit Services, Inc
Affordable administration of employee benefit plans

Frequently Asked Questions

What types of services/products are eligible?

Eligible expenses include amounts paid for the diagnosis, treatment or prevention of disease, and for treatments affecting any part or function of the body for you and your eligible dependents. The expenses must be to alleviate or prevent a physical defect or illness. Expenses solely for cosmetic reasons generally are not reimbursable expenses under the Cafeteria Plan. (IRS Code 105 & 213 Medical Expenses) If you have a question on a specific expense, please call PBS.

What services/products require a letter of necessity?

- All over the counter (OTC) items such as cough medicines, pain relievers, acid controllers and diaper rash ointment will not be reimbursed under a health FSA, HRA or HSA unless accompanied by a doctor's prescription. The prescription needs to state the duration of the treatment and will be required every plan year. Insulin and some other OTC items, such as band-aids, will continue to be eligible for reimbursement without a prescription. Personal use, cosmetic and general care items are not eligible.
- Dietary supplements, nutritional supplements, vitamins and herbal supplements will not be eligible for reimbursement if taken for general health. If recommended by a medical practitioner to treat a specific medical condition, they may be eligible for reimbursement. Contact your plan administrator for further information.
- Services for massage therapy, weight loss programs and gym memberships will not be reimbursed under a health FSA, HRA or HSA unless accompanied by a letter of medical necessity written by a physician that includes the medical diagnosis and the duration of the prescribed treatment. A new letter of necessity will be required at the beginning of every plan year.

Professional Benefit Services will maintain a copy of the prescription or letter of necessity on file, however, with each new plan year a new prescription will be required. If you have any questions as to what kinds of expenses are eligible, please call our office.

How much money may I deposit each year?

You may deduct a total of $5,000 in the Dependent Day Care Account ($2,500, if married filing taxes separately). Health care reimbursement expenses (FSA) will be limited to an annual maximum chosen by your employer. *The IRS sets the maximum FSA contribution. For 2020 the maximum is $2750. Your plan may still have a lower maximum.* Any funds left in your accounts at the end of the year that you are unable to use, will revert to the company and you will lose them. **Only deduct what you know you can use.**

Can I participate in the pretax Dependent Day Care Account and still receive a tax credit for my dependent care?

You cannot participate in the plan and receive a tax credit for the same dependent care expenses. Also, the maximum amount of expenses that may be taken into account to determine your available federal tax credit will be reduced, dollar for dollar, by the amount of your reimbursement under the plan. (For example: You shelter $1,800 under the Cafeteria Plan. At the end of the year, your dependent day care expenses are $2,000. You may claim the additional $200 on your federal tax form.)

How are taxes handled?

Again, there are no taxes payable for the amounts deducted pretax. The reimbursement is handled as a fringe benefit provided by your employer. Dollars designated to a pretax account are deducted from your paycheck prior to the computation of taxes. Please be aware that the lower income figure is reported to Social Security and could result in a slightly lower retirement benefit for you.

How do I get my reimbursement?

Send a completed claim form along with documentation to Professional Benefit Services and they will prepare a distribution for you. If you have a benefits card, use it at the point of sale to pay for your health care expenses, eliminating the need for a claim form. Card transactions or claims submitted for reimbursement must be for services incurred in the plan year. The IRS requires the date of service, not the date of your payment to the provider, to be in the plan year. Claims submitted representing expenses from the prior plan year will be denied.

When you use your benefits card or submit a claim for reimbursement, keep all original receipts or invoices in your files for income tax purposes or in the case that your transaction is audited and you need to send us a copy. The copies should be clean and clear so they can be read in this office. Please make sure the receipts show date(s) of service, type of service, and the amount charged for the service. We are unable to accept credit card charge slips as proof of service. We cannot reimburse finance fees or late charges.

What happens if I don't spend all the money in my account?

You must incur expenses for all the money in your pretax accounts for services received (incurred) during the plan year or forfeit your money remaining in the account to your employer. This is the IRS "Use or Lose Rule." You will have a set number of days after the end of your plan year to submit claims for your funds. You can only claim expenses incurred during your plan year. If your employment terminates before the end of the plan year, your plan year will also terminate unless you are eligible for, and elect, COBRA coverage. Your plan may have optional plan features that can extend the plan year, or roll money ($500 cap) over into the next plan year. These plan features will be located in your summary plan description.

Can I switch dollars between accounts?

No. The dollars must be used in each account as you specified on your enrollment form.

Can I change the amount I deposit?

You may change the amount you deposit once a year during the annual open enrollment period. You may only change your amounts during the plan year if you experience an IRS-defined Qualified Family Status Change. IRS Qualified Family Status Changes include: marriage, divorce, death of a spouse or child, birth or adoption of a child, change in job status from full-time to part-time or part-time to full-time by the employee or the employee's spouse, termination or commencement of employment of a spouse, the taking of an unpaid leave of absence by the employee or the employee's spouse, a significant change in hours of work of the employee or the employee's spouse, a return from FMLA leave, and the issuance of a Qualified Medical Child Support Order. Any changes to your pretax account must be consistent with the family status change event. (For example, if you go from full-time to part-time or part-time to full-time employment, you may reduce or increase your dependent day care deduction.)

Professional Benefit Services, Inc.
Phone: (800)982-2012, (503)371-7622 Fax: (503)364-6901, (866)248-9742
Email: cafeteria@profben.com Website: www.profben.com

Professional Benefit Services, Inc.
Affordable administration of employee benefit plans

CLAIM FORM
CAFETERIA PLAN

Employer:		
Participant Name:		***Employee ID: (SSN)*** XXX-XX_____
Mailing Address:		***Phone Number:***
City:	***State:*** ***Zip:***	***Email Address:***

SECTION 125 REIMBURSEMENT EXPENSES

Flexible Spending Expense (FSA)	$
Dependent Daycare Expense (DCA)	$

This is to certify that I have incurred expenses in the amounts shown above that qualify for reimbursement under the provisions of my employer's Section 125 Cafeteria Plan.

I am attaching copies of documentation from my service provider that shows date(s) and type(s) of service (i.e., a bill or receipt from the Doctor, hospital, lab, pharmacy, day care provider, etc.). I certify that these expenses have been incurred by myself or my tax dependent and have not been reimbursed, or are not reimbursable, under any other health plan coverage. Since these expenses are being reimbursed by my employer, they may not be claimed on my income tax filings at year end. I understand that it is my responsibility to inform PBS of any address change.

To view your balance and transaction history, please visit http://profben.wealthcareportal.com/Page/Home

Participant Signature: _____Date submitted: _____

New claim submission app is available for android and iphone users. Scan the QR code or search "PBS Wealthcare" in your App Store/Play Store and install. Registration can be found at https://profben.wealthcareportal.com/Page/Home

Google Apple

Send claims to: Professional Benefit Services, Inc.
1193 Royvonne S.E., Suite 22 Salem, Oregon 97302
Phone: (800)982-2012, (503)371-7622 Fax: (503)364-6901, (866)248-9742
Email: cafeteria@profben.com Website: www.profben.com

2020 Daycare Information Form

****You may only claim reimbursement through the Dependent Care Account until the end of the month of the child's 13th birthday****

Employee Name: _____

Name of Provider (or Business): _____

Provider's Address: _____

Type of Care Provided:
Must be Custodial in nature so that the parent/guardian can work*

- ☐ Daycare/Preschool
- ☐ Before School/After School
- ☐ Babysitting
- ☐ Day Camp
- ☐ Other (please specify):_____

Child(ren) Name(s):	**Date of Birth:**
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

Employee Signature: _____ **Date:** _____