great place to work

Universal Enrollment/Change Form
Publix Super Markets, Inc.
Enrollment Form and Payroll Reduction Agreement For Publix Super Markets, Inc. Elective Compensation Plan

Check One Below:

- ☐ *New Enrollment*
- ☐ *Open Enrollment*
- ☐ *Coverage Change - IRS Permitted Election Change*
- ☐ *COBRA Enrollment*

FAX: 863-413-5771

If making a change, complete the following:

☐ ***Effective Immediately***

Select one and provide reason: ______________________

- ☐ *Add Dependent(s)*
- ☐ *Remove Dependent(s)*
- ☐ *Medicare/Medicaid/CHIP Entitlement*
- ☐ *Cancel Coverage*
- ☐ *Other*

Health Plan

☐ *BCBS* ☐ *Kaiser*

Check One Health Plan Coverage Option:

- ☐ *Associate Only*
- ☐ *Associate + Spouse*
- ☐ *Associate + Child(ren)*
- ☐ *Associate + Spouse +Child(ren)*

Dental Plan

☐ *HMO* ☐ *PPO*

Check One Dental Plan Coverage Option:

- ☐ *Associate Only*
- ☐ *Associate + 1 Dependent*
- ☐ *Associate + 2 or More Dependents*

Vision Plan

☐

Check One Vision Plan Coverage Option:

- ☐ *Associate Only*
- ☐ *Associate + 1 Dependent*
- ☐ *Associate + 2 or More Dependents*

Associate Personnel Number	*Associate Last Name*	*MI*	*Associate First Name*	*Phone Number*

Mailing Address	*City*	*State*	*Zip Code*

Select Plan: *Please select the plan in which you wish to enroll. See your enrollment materials for plan information and availability in your area. You must provide supporting legal documentation for dependent(s) being enrolled.*

Relation to You	Last Name	First Name	MI	Gender	Social Security Number *REQUIRED* for enrolling	Birth Date MM DD YY	Health Plan Action	Dental Plan Action	Vision Plan Action
Self						/ /	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel
						/ /	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel
						/ /	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel
						/ /	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel
						/ /	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel
						/ /	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel
						/ /	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel	☐ Enroll ☐ Cancel

Tobacco Usage Affidavit: **You must complete and submit** *a Tobacco Usage Affidavit, which is available on PASSport, every time you enroll in or request a change to the BCBS PPO plan. Failure to submit a properly completed Tobacco Usage Affidavit with this form will result in paying the higher tobacco user payroll deduction, even if you previously submitted one.*

Newborn Dependents: *Social Security Number required within 60 days of enrollment.*

Disabled Dependents: *Please refer to your Associate Benefits Book or call 1-800-741-4332.*

When you select coverage in the Group Health Benefit Plan, Group Dental Plan and/or Group Vision Plan, you must enroll in the Publix Super Markets, Inc. Elective Compensation Plan. As a participant, you are entitled to purchase benefits on a pretax basis through pay period deductions. The payroll reduction and coverage period is January 1 through December 31.

Any previous election with respect to coverage elected on this form and any corresponding payroll reduction agreement under the Publix Super Markets, Inc. Elective Compensation Plan is hereby revoked. Any previous election with respect to other benefit plans covered by the Publix Super Markets, Inc. Elective Compensation Plan shall remain in effect. By signing below, I acknowledge and affirm that I have READ AND UNDERSTAND THE INFORMATION BELOW:

I UNDERSTAND that coverage will not be effective until this enrollment election is accepted and processed by the Publix group benefits department. I CERTIFY that all statements made on this enrollment election are complete and true. I UNDERSTAND that material misrepresentations, omissions, concealment of facts or incorrect statements may prevent recovery under any contracts issued and may also void any contracts. While I am enrolled in coverage and/or while I and/or any of my covered dependents, including adult children are receiving benefits, I DO HEREBY AUTHORIZE any doctor, hospital or other provider to furnish the insurance company or any other contracted plan claims administrator with any and all records in connection with a claim for benefits pertaining to me and any of my covered dependents and adult children that are reasonably required to process such claim. This release specifically includes, but is not limited to, authorization to release any and all medical records and information associated with (or with reference to) the following conditions: exposure to HIV infections, ARC, AIDS, alcohol or drug dependency and mental and nervous disorders. All dependents and adult children enrolled under my coverage have authorized me to voluntarily allow the release of the above information. I ACKNOWLEDGE and UNDERSTAND that this consent must be in effect in order for claims to be processed and paid on my behalf or on behalf of my covered dependents and adult children, but that I or any covered dependent, upon assuming the age of majority, or adult child nevertheless may revoke this consent at any time by notifying Publix and the insurance company in writing of such revocation. I UNDERSTAND that Publix will not disclose my health information to anyone else without my consent except as permitted or required by law, including disclosure to investigate, and if necessary, take appropriate disciplinary action against me in connection with any misleading statements or omissions of information in the enrollment process. **Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an enrollment election containing any false, incomplete or misleading information is guilty of a felony in the third degree.**

DATE: ______________________ ASSOCIATE SIGNATURE ____

Retain a copy for your records

IMPORTANT INFORMATION ABOUT THE ELECTIVE COMPENSATION PLAN

By signing the front of this form, I acknowledge and affirm that I have READ AND UNDERSTAND THE INFORMATION BELOW:

- My pay will be reduced by the amount of my required pay period deduction if I have elected coverage on this enrollment election and the reduction will continue for each succeeding pay period until this agreement is amended or terminated, as permitted under the respective plan(s).
- I CANNOT CHANGE OR REVOKE THIS GROUP BENEFITS ELECTION AND PAYROLL REDUCTION AGREEMENT BEFORE THE NEXT OPEN ENROLLMENT PERIOD UNLESS I EXPERIENCE A QUALIFIED "PERMITTED ELECTION CHANGE," as defined by the Internal Revenue Code and recognized by Publix, and provide supporting legal documentation and/or notarized evidence of such permitted election change within 30 days of such event to the Publix group benefits department. The payroll reduction and coverage period is January 1 through December 31.
- Prior to January 1 of each year, I will be offered the opportunity to change my election for the following payroll reduction and coverage period. IF I DO NOT PROVIDE A NEW ENROLLMENT ELECTION AT THAT TIME, I will be treated as continuing my most recent election for the next payroll reduction and coverage period UNLESS NOTIFIED OTHERWISE.
- The cost of coverage under the plans may be increased or decreased during the payroll reduction period as a result of a change in the associate share cost of coverage and my payroll reduction may be adjusted upward or downward without my further consent.
- The reduction in my cash compensation by the pay period deduction with pretax dollars under this agreement shall be in addition to any reduction under other payroll reduction agreements for other benefits covered by the Elective Compensation Plan.
- The Plan Administrator may reduce or cancel my payroll reduction election or otherwise modify this agreement in the event it believes it advisable in order to satisfy certain provisions of the Internal Revenue Code or in the administration of the respective plan(s).
- This agreement will automatically terminate if the respective Plan is terminated or discontinued or if I cease to meet the eligibility requirements for participation in the respective plan(s).

IMPORTANT INFORMATION ABOUT IRS PERMITTED ELECTION CHANGES

Generally, coverage elections (plan and tier selected) are irrevocable for the payroll reduction and coverage period, and changes cannot be made until the next open enrollment period. The IRS only permits changes to coverage if certain events occur. Additionally, the changes to coverage must be consistent with the change event. The Elective Compensation Plan only allows changes to be made within 30 days of the IRS permitted election change event. The IRS permitted election changes recognized by Publix, along with brief descriptions of each, are as follows:

Legal Marital Status	Events that change an associate's legal marital status and coverage availability, including marriage, divorce, legal separation, annulment or death of a spouse. *Example: If you get married, the IRS permits you to add your spouse to your coverage.*
Number of Dependents	Events that change an associate's number of dependents, including birth, adoption or death of a dependent. *Example: If you adopt a child, the IRS permits you to add the child to your coverage.*
Employment Status	A termination or commencement of employment by an associate or his/her spouse or dependent. *Example: If your spouse is hired at a new place of employment and obtains health coverage when initially eligible as offered by that employer, the IRS permits you to remove your spouse from your coverage*.
Unpaid Leave	Events such as an unpaid FMLA or disability leave. *Example: If you begin an unpaid leave and can't afford your coverage, the IRS permits you to cancel it.*
Ineligible Dependent	Events that cause an associate's dependent to satisfy or cease to satisfy requirements for coverage or eligibility under the plan. *Example: If your dependent reaches the limiting age under the plan, you can (and must) cancel his/her coverage.*
Residence or Worksite	A change in the place of residence or work of the associate, spouse or dependent. *Example: If you transfer to another state where your health plan does not offer coverage, the IRS permits you to change to another health plan offered in that state.*
Judgment/Court Order	Events such as when a court order or judgment is issued, including a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), requiring coverage for a dependent. *Example: If a court order is issued requiring you to provide health coverage for your eligible dependent child(ren), the IRS permits you to add the child(ren) named in the court order to your coverage.*
Medicare/Medicaid/CHIP Entitlement	Events in which an associate, spouse or dependent becomes entitled to Medicare, Medicaid or Children's Health Insurance Program (CHIP). *Example: If you become entitled to Medicare and enroll in it, the IRS permits you to cancel your coverage.*
Significant Coverage Change	A significant change in cost or coverage for a plan in which an associate, spouse or dependent is enrolled. *Example: If you are covered by your spouse's employer, and your spouse's employer will no longer cover spouses of employees, the IRS permits you to elect coverage through Publix (provided you meet eligibility requirements).*
Loss of Other Coverage	Events in which "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA) is available. *Example: If you declined coverage through Publix due to enrollment in a plan offered by your spouse's employer, and you and/or your family lose that coverage, the IRS permits you to elect coverage through Publix (provided you meet eligibility requirements).*

PLEASE NOTE: This list is intended only to provide a brief summary of the IRS regulations and Elective Compensation Plan provisions. It is not intended as a substitute for the actual laws, regulations and/or Plan provisions. Any changes to the laws, regulations and/or Plan provisions may materially alter the information above. In the event of any discrepancy between this summary and the laws, regulations and/or Plan provisions, then the applicable laws, regulations and/or Plan provisions control.

REQUIRED DOCUMENTATION FOR IRS PERMITTED ELECTION CHANGES

In addition to this completed enrollment form, additional documentation is required for changes to current coverage. Legal documentation of marriages, divorces, adoptions, births, deaths, judgments, court orders, etc., should be attached to the completed enrollment form when being submitted to the Publix group benefits department.