



Group Benefits

Long-Term Disability/Short-Term Disability

DISABILITY ENROLLMENT/CHANGE FORM

Enrollment Form and Payroll Reduction Agreement for Publix Super Markets, Inc. Elective Compensation Plan

EMPLOYER INFORMATION	Publix Super Markets, Inc.			
ENROLLMENT INFORMATION	Please check one: <input type="checkbox"/> Permitted Election Change (PEC) Reason: _____ <input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment			
ASSOCIATE INFORMATION	ASSOCIATE NAME	PRNR	DOB	
	ADDRESS	CITY	ST	ZIP
BENEFIT ELECTION	SHORT-TERM DISABILITY (Policy # GRH-205208)		<input type="checkbox"/> YES	<input type="checkbox"/> NO
	LONG-TERM DISABILITY (Policy # GLT-205208)		<input type="checkbox"/> YES	<input type="checkbox"/> NO

For enrollments that require proof of good health, you must complete a Personal Health Application (PHA). The Hartford will send you a letter with instructions on how to access the PHA and your completion deadline. You can monitor your enrollment status on PASSport.

For coverage to begin, The Hartford must approve your PHA. If you aren't actively at work on the day your coverage becomes effective, you'll be enrolled when you're actively at work again.

When you select coverage in the Group Long-Term Disability and/or Short-Term Disability Plans, 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. I UNDERSTAND that enrollment in the Long-Term and Short-Term Disability Plans will require that I while applying for or receiving benefit furnish the insurance company or any other contracted plan claims administrator with any and all records, including but not limited to any doctor, hospital and other provider records or 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, in connection with a claim for benefits pertaining to me are reasonably required to process such claim and/or to continue coverage under the Long-Term or Short-Term Disability Plans. I ACKNOWLEDGE and UNDERSTAND that this information must be provided in order for claims to be processed and paid on my behalf. 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.**

ASSOCIATE SIGNATURE: _____ DATE: _____

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. For questions regarding what events allow for a permitted election change, and the documentation you need to support any election change contact the Publix group benefits department.
- 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 for the disability plans, 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.*

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.