Crosby's HENRY'S

SECTION 125 ELECTION FORM

REASON FOR ENROLLMENT

☐ OPEN ENROLLMENT ☐ NEW HIRE

☐ QUALIFYING EVENT: _____

{ Describe Qualifying Event }

MEDICAL

ADVANTAGE PLAN		ECONOMY PLAN	
☐ $45.00 per week	SINGLE	$28.50 per week	☐
☐ $90.00 per week	COUPLE	$73.50 per week	☐
☐ $90.00 per week	SINGLE PARENT	$73.50 per week	☐
☐ $122.50 per week	FAMILY	$106.00 per week	☐

☐ I am waiving healthcare coverage. I have other coverage with: _____

DENTAL { Full Timer's Only }

☐ $7.50 per week	SINGLE	SINGLE PARENT	$15.00 per week	☐
☐ $15.00 per week	COUPLE	FAMILY	$20.00 per week	☐

☐ I am waiving dental coverage. I have other coverage with: _____

GROUP LIFE INSURANCE { Full Timer's Only }

☐ No Cost SINGLE

ASSOCIATE INFORMATION

☐ Full Time STATUS Part Time ☐

NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

EMPLOYEE # _____ STORE # _____ STORE: _____

EFFECTIVE DATE OF COVERAGE: _____

AUTHORIZATION

I accept the benefits provided by these group plans and authorize the processing of my enrollment. I also authorize payroll deductions from my earnings for the required contributions toward the cost of coverage.

_____ _____

Associate Signature Date

(JBR 11/23)

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to 1-617-246-7531

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transfering To:

Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group #, Transferring To

Type of Transaction
☐ ADD ☐ CANCEL
☐ CHANGE Three digit termination code ☐☐☐
☐ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)
☐ Open Enrollment ☐ New Hire ☐ COBRA
Change to Family ☐ Add Spouse ☐ Add Dependent
☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
☐ Other: _____

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice ☐ Blue Choice New England ☐ Blue Medicare Rx (Part D) ☐ Dental Blue ☐ HMO Blue ☐ HMO Blue New England ☐ Managed Blue for Seniors ☐ Medex (Group) ☐ Network Blue ☐ PPO ☐ Saver Blue

Membership Type (Medical) ☐ Individual ☐ Family

Membership Type (Dental) ☐ Individual ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Home Phone ( )	Cell Phone ( )	Email
Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ☐ / N ☐	Other Insurance Company Name / City / State
PCP ID # (see instructions)	Name of PCP / City / State	Is this your current PCP? Y ☐ / N ☐

Are you covered by Medicare?[2] Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ☐ / N ☐	☐ 65+ ☐ Disabled ☐ ESRD / If Retired, Date

3. Member 2

Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered)

Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ☐ / N ☐	Other Insurance Company Name / City / State	
PCP ID # (see instructions)	Name of PCP / City / State		Is this your current PCP? Y ☐ / N ☐	

Are you covered by Medicare?[2] Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ☐ / N ☐	☐ 65+ ☐ Disabled ☐ ESRD / If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ☐ / N ☐	Full-time student and aged 19 or older ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental	

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ☐ / N ☐	Full-time student and aged 19 or older ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental	

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ☐ / N ☐	Full-time student and aged 19 or older ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental	

Please check if you are using separate forms for additional dependent children ☐ Total # of dependents: _____

5. Personal Savings Account

☐ **HSA: Health Savings Account**	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

BENEMAX

BENEDENT® ENROLLMENT FORM

GROUP NAME:

SECTION 1 – ENROLLEE (Complete this section for new enrollment or change of status) **PLEASE PRINT**

EMPLOYEE NAME
(Last, First, Middle Initial)_____,_____,_____

SOCIAL SECURITY NUMBER _____-_____-_____ **EMPLOYMENT DATE** ___/___/_____ **EFFECTIVE DATE OF COVERAGE** ___/___/_____

MAILING ADDRESS_____ **TELEPHONE #** _____

CITY _____ **STATE**_____ **ZIP CODE**_____

E-MAIL ADDRESS _____

BIRTHDATE
MONTH DAY YEAR
___/___/_____

SEX
Male ☐
Female ☐

Are you or any of your covered dependents covered under another dental plan?
Yes ☐ If yes, please list carrier & plan name: _____
No ☐

SECTION 2 – CHANGES TO EXISTING ENROLLMENT (Complete for all changes)

☐ Name Change ☐ Add new dependent ☐ Delete dependent ☐ Address change listed above

Effective date of change ___/___/_____

Reason for change _____

SECTION 3 – DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Birthdate
(Last, First, Middle Initial)_____,_____,_____ ___/___/_____
Social Security Number _____-_____-_____ Sex Male ☐ Female ☐ Coverage change Add ☐ Delete ☐

Child Name Birthdate
(Last, First, Middle Initial)_____,_____,_____ ___/___/_____
Social Security Number _____-_____-_____ Sex Male ☐ Female ☐ Coverage change Add ☐ Delete ☐

Child Name Birthdate
(Last, First, Middle Initial)_____,_____,_____ ___/___/_____
Social Security Number _____-_____-_____ Sex Male ☐ Female ☐ Coverage change Add ☐ Delete ☐

Child Name Birthdate
(Last, First, Middle Initial)_____,_____,_____ ___/___/_____
Social Security Number _____-_____-_____ Sex Male ☐ Female ☐ Coverage change Add ☐ Delete ☐

SECTION 4 – WAIVER (only required if waiving coverage)

I am waiving coverage in the Group Dental Plan for this plan year. I understand that I will not be able to join the plan until the next open enrollment date unless I experience a qualifying change in family status.

Employee Signature _____ Date_____

SECTION 5 - SIGNATURE

I am enrolling in the Group Dental Plan for the coming plan year and I authorize appropriate payroll deductions.

Employee Signature _____ Date_____

unum[sm]

GROUP INSURANCE ENROLLMENT FORM
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Policyholder Name CROSBYS MARKETS INC | **Policy No.** 97838 | **Division No.**

Employee Social Security Number ___ - ___ - ____ | **Gender** M ☐ F ☐ | **Date of Birth (mm/dd/yyyy)** __/__/____ | **Hours Worked Per Week** ____

Employee First Name | **M.I.** | **Last Name**

Employee Street Address | **City** | **State** | **Zip Code**

Original Date of Hire __/__/____ | **Annual Salary** $ ___,___,___ | **Occupation**

☐ **Exempt** ☐ **Non-Exempt**

☐ **Date entered into an eligible class** ***(ex: part time to full time)*** **or**
☐ **Rehire Date or**
☐ **Date of promotion to an eligible class** __/__/____

Spouse First Name (if coverage is selected) | **Spouse Date of Birth (mm/dd/yyyy)** __/__/____

COVERAGE ELECTIONS: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life/AD&D ☑ Yes ☐ No **Dependent Life** ☐ Yes ☑ No **LTD** ☐ Yes ☑ No **STD** ☐ Yes ☑ No

AMOUNT OF COVERAGE SELECTED FOR:

LIFE/AD&D You: $ ___,___,___ Spouse: $ ___,___,___ Child: $ ___,___

Note: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting and will become effective upon approval either on the first of the month coincident with or next following the date Unum approves your Evidence of Insurability form. If you **DO NOT APPLY FOR** coverage for you or your dependent (s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. You may complete and electronically submit an Evidence of Insurability form—please see your Plan Administrator.

Beneficiary Information:

Name (last name, first, middle initial):	**Relation to You:**	**Benefit %:**
If the beneficiary(ies) named above are not living, then pay:		

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ *Date* _____ *Work Phone* _____ *Home Phone* _____

BENEFICIARY DESIGNATION FORM
GROUP LIFE AND GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
Unum Life Insurance Company of America
Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)	Social Security Number

Employer Name	Check the coverages listed below to which this beneficiary designation applies:
CROSBY'S MARKETS, INC.	☑ Basic Life ☐ Supplemental Life ☑ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 4: Signature

X _____ _____

Employee Signature **Date**

BENEMAX PO Box 950,Medfield, MA 02052 Phone: 800-528-1530

FLEXIBLE SPENDING PLAN ELECTION FORM
CROSBY'S MARKETS, INC.
PLAN YEAR: 1/01/2025 - 12/31/2025

Employee Information			
Employee Name		*Social Security Number*	
Home Address *Street*	*City*	*State*	*Zip*
Date of Birth	*E-mail address or Phone number*	*Eff. Date of Enrollment*	*First Payroll Date*

Dependents			
Name	*Date of Birth*	*Name*	*Date of Birth*
Name	*Date of Birth*	*Name*	*Date of Birth*

Benefit election / Authorization

I authorize **Crosby's Markets** to reduce my gross paycheck each pay period by the following pre-tax amounts to fund flexible spending account(s):

_____Healthcare Flexible Spending Account (HFSA) Total for plan year $_____
For reimbursement of health related expenses for myself and my eligible dependents **(Maximum election $3,300)**

_____Dependent Daycare Assistance Account (DCAP) Total for plan year $_____
For reimbursement of employment related dependent daycare expenses
(Maximum election $5,000 per plan year if filing jointly; $2,500 if married and filing separately)

By signing below, I understand that:

- These contributions to my flexible spending account(s) will be deducted from my paycheck on a per pay period basis.
- I understand that this authorization cannot be changed during the plan year unless I experience a change in family status as established by IRS regulations.
- I understand that any money in excess of $660.00 remaining in the healthcare flexible spending account at the end of the plan year will be forfeited.
- I understand that any unused money remaining in the dependent daycare assistance account at the end of the plan year and grace period will be forfeited in accordance with the rules and regulations established by the IRS.
- I understand that if I leave the company before the end of the plan year, I have 90 days from the date of termination in which to submit claims that were incurred before my termination date.

Employee Signature	*Date*
X	

MASSACHUSETTS

FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

$150

Qualified for Reimbursement:

- A full service health club with cardiovascular and strength-training equipment like treadmills, bikes, weight machines, and free weights
- A fitness studio with instructor-led group classes such as yoga, Pilates, Zumba®, kickboxing, indoor cycling/ spinning, and other exercise programs
- Online fitness memberships, subscriptions, programs, or classes
- Cardiovascular and strength-training equipment for fitness that is purchased for use in the home, such as stationary bikes, weights, exercise bands, treadmills, fitness machines

Not Qualified for Reimbursement:

- One-time initiation or termination fees
- Fees paid for gymnastics, tennis, pool-only facilities, martial arts schools, instructional dance studios, country clubs or social clubs, sports teams or leagues
- Personal trainer sessions
- Fitness clothing

Get Started

To submit your reimbursement, sign in to MyBlue at **bluecrossma.org**.

Your reimbursement is waiting!

MASSACHUSETTS

FITNESS REIMBURSEMENT REQUEST

Please print all information clearly. To verify that this reimbursement is offered within your plan, or for more information, you can sign in to MyBlue at **bluecrossma.org** or call the Member Service number on your ID card.
All fitness reimbursement requests must be submitted by March 31 of the following year.

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	**Subscriber's Last Name**	**First Name**	**Middle Initial**
Address – Number and Street	**City**	**State**	**ZIP Code**
Employer's Name			

Claim Information

Member's Last Name	**First Name**	**Middle Initial**	**Date of Birth** ___/___/___

Claim is for (choose one and color in the entire box):

- ☐ Subscriber (policyholder)
- ☐ Spouse (of policyholder)
- ☐ Ex-Spouse
- ☐ Dependent (up to age 26)
- ☐ Other (specify): _____

Name, Address, and Phone Number of Qualified Fitness Expense

Total Dollars requested for Qualified Fitness Expense: $ _____

Calendar year that fees were paid: _____

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)
I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these services. I enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/___

Complete this form and mail it to:
Blue Cross Blue Shield of Massachusetts,
Local Claims Department,
PO Box 986030, Boston, MA 02298

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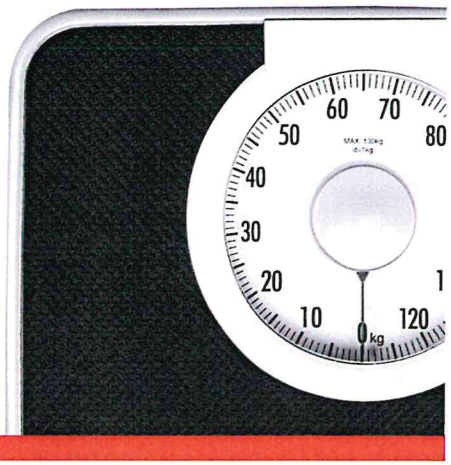
MASSACHUSETTS

WEIGHT-LOSS REIMBURSEMENT



Your reward for healthy behavior:
Receive up to $150 annually when you participate in a qualified weight-loss program.[1]

Qualified for Weight-Loss Reimbursement

Participation fees for:

- Hospital-based programs and Weight Watchers® in-person
- Weight Watchers online and other non-hospital programs (in-person or online) that combine healthy eating, exercise, and coaching sessions with certified health professionals such as nutritionists, registered dietitians, or exercise physiologists.

Not Qualified for Weight-Loss Reimbursement

- One-time initiation or termination fees
- Food, supplements, books, scales, or exercise equipment
- Individual nutrition counseling sessions, doctor/nurse visits, lab tests, or other services that are covered benefits under your medical plan

GET REIMBURSED IN THREE EASY STEPS

1

Choose
Start by picking a qualified weight-loss program.

2

Complete
Once you pay for the program, fill out the attached form, or sign in to MyBlue to submit online at **member.bluecrossma.com/login**.

3

Mail
Send the completed form to the address listed.

Be sure to check with your doctor before starting any weight-loss program.

1. To verify this reimbursement is offered for your plan, or for more information, sign in to MyBlue at **bluecrossma.com/myblue** or call the Member Service number on your ID card. Most plans offer the reimbursement shown, but refer to your plan information for specific details.

Questions?

Contact Member Service by calling the phone number on your member ID card.

WEIGHT-LOSS REIMBURSEMENT REQUEST

Please Print All Information Clearly: To verify this reimbursement is offered within your plan, or for more information, please sign in to MyBlue at **bluecrossma.com/myblue** or call the Member Service number on your ID card. All weight-loss reimbursement requests must be submitted by March 31 of the following year.

Complete this form and mail it to: Blue Cross Blue Shield of Massachusetts, Local Claims Department , PO Box 986030, Boston, MA 02298

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters) | **Subscriber's Last Name** | **First Name** | **Middle Initial**

Address – Number and Street | **City** | **State** | **Zip Code**

Employer's Name

Claim Information

Member Last Name | **First Name** | **Middle Initial** | **Gender** (color in the entire box) ❑ Male ❑ Female | **Date of Birth** ___/___/____

Claim is for (choose one and color in the entire box):

❑ Subscriber (policyholder)
❑ Spouse (of policyholder)
❑ Ex-Spouse
❑ Dependent (up to age 26)
❑ Other (specify):

Name, Address, and Phone Number of Qualified Weight-Loss Program

Total dollars requested: $ _____

Monthly program participation fee: $ _____

Calendar Year: ___/___/____

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)
I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified weight-loss program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/____

Important Information:

- Weight-loss reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a completed request.
- Reimbursement requests must be submitted by March 31 of the following year.
- Keep copies of proof of payment in case we request it from you. Proof of payment includes:
  - Receipts (cash/check/credit/electronic) for participation fees clearly documenting your name, the weight-loss program name, and individual amounts charged with date paid.
  - Your weight-loss program membership or participation agreement clearly documenting your name and date of enrollment/participation.
- Your reimbursement may be considered taxable income, so consult a tax advisor.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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