ShopRite Supermarkets, Inc.
2027 Plan Enrollment Form

☐ Changes to Plan ☐ Changes to Address **No Changes. No FSA. No Form Needed** Effective Date: _____

A. Associate Information

Last Name _____ First Name _____ Middle Initial _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Personal Email: _____

Social Security Number: _____ Date of Birth: _____ Date of Hire: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

Coverage: All Weekly Contributions are on a Pre-Tax Basis

	Aetna Choice POS II Plan (with Dental/Vision Coverage)	**Aetna Choice POS II Basic Plan** (with Dental/Vision Coverage)	**(No Medical)** Dental/Vision Only
Associate	[ ] $48.50/Week	[ ] $8.32/Week	[ ] $5.67/Week
Associate Plus 1	[ ] $85.86/Week	[ ] $16.01/Week	[ ] $13.88/Week
Associate - Family	[ ] $136.91/Week	[ ] $23.45/Week	[ ] $13.88/Week
	[ ] **Waived**	[ ] **Waived**	[ ] **Waived**

B. Spouse or Same Sex Spouse Information: Employed spouses MUST be covered by their own employer. Affordable Care Act requires large employers to provide affordable coverage. Your spouse's plan would pay the claim first and the ShopRite "AETNA" Plan would follow the Coordination of Benefit Rules.

Question?	YES	NO	Insurance Company Information	Effective Date	Who is Covered?
Is your Spouse eligible for employee Health Benefits through their employer?					
Are they eligible for Prescription?					
Are they eligible for Dental Coverage?					
Are they eligible for Vision Coverage?					

Spouse's Name _____ Male ☐ Female ☐ Date of Birth: _____

Spouse's Social Security Number: _____ Date of Marriage: _____

Spouse's Employer: _____

Address of Employer: _____ State: _____ Zip: _____

ShopRite Supermarkets, Inc.
2027 Plan Enrollment Form

C. Dependent Information: Please list all eligible dependent children.

Name	Son	Daughter	Social Security Number	Date of Birth (Must be under age 26)
	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		

D. Flexible Spending Account 2027: You must sign up each plan year.

[ ] I do not want to participate in either Flexible Spending Account for 2027.

Please note: You are reimbursed for eligible expenses incurred during 2027 and the accompanying grace period only. If you do not incur enough eligible expenses during that time period to use the full amount in your account, the remaining balance will be forfeited in accordance with federal law.

[ ] I elect to participate on a pre-tax basis in the **Health Care Spending Account for 2027**. My total amount is $_____PER YEAR. The amount will be deducted by weekly payroll deduction. Annual Limits: **$250.00 up to $3,500.00.** I understand in order to be reimbursed for over-the counter medicines and drugs they must be prescribed by my physician.

[ ] Yes, I elect to participant in the **Aetna Streamline Option** for **2027**. I hereby request reimbursement for all eligible medical expenses (as defined by IRS guidelines), from my Health Care Spending Account for the entire plan year. I understand that any/all amounts not reimbursed under my benefits plans will automatically be paid from by Health Care Spending Account up to my annual election, an Explanation of Payment will not be produced for any further claims for the plan year. I certify that neither I nor any of my dependents have any other health coverage (except as provided by ShopRite Supermarkets, Inc.) and that the expenses automatically reimbursed will not be submitted for payment under any other plan. I further declare that I will not deduct these expenses on my federal income tax return.

[ ] I elect to participate on a pre-tax basis in the **Dependent Care Spending Account for 2027**. My total amount is $_____PER YEAR (cannot be less than **$260.00** or exceed **$7,500** per family or **$3,750.00** if you are married and you file separate tax returns). This amount will be deducted weekly payroll deduction.

Signature Required: Please note that your enrollment election is binding for the plan year unless you have a Qualifying Life Event and the Plan Administrator receives a completed enrollment form within 31 days from the date of the event. Please contact the Plan Administrator if you believe that you may be affected by this rule.

By signing below, you acknowledge that, to the best of your knowledge, the above information is complete and true. You understand that falsification by you will allow ShopRite Supermarkets, Inc. to recover payments made, cancel your coverage and/or refuse to pay claims.

By signing below, you are hereby applying for enrollment of yourself and your eligible dependents for coverage under the health and welfare plan provided by ShopRite Supermarkets, Inc. and agree to abide by the terms and conditions of the plan document and the certificate of insurance.

Signature of Associate: _____ Date: _____

Send completed forms to **srsbenefits@wakefern.com**.
For questions, contact: **Veena Sai**, veena.sai@wakefern.com, 908-527-7389 (phone), 723-491-4982 (fax)