Qualifying Life Events (QLE)

Any benefits eligible associates who wish to enroll in the J.Crew Health Plan or make changes to their current elections outside of their initial eligibility or the annual Open Enrollment periods may do so if they are able to provide any of the QLE documents listed below, within 31 days of their qualifying life event. Otherwise, changes or cancellation of coverage can only be made during the annual Open Enrollment period for an effective date of January 1st.

The tables below are some examples of Qualifying Life Events:

Qualifying Life Event	Required Documentation
Marriage	Copy of official Marriage Certificate
Divorce/Legal Separation	Copy of official court order specifying effective date of divorce/legal separation
Birth/Adoption of Child	Copy of newborn's birth certificate/Adoption paperwork
Death of Spouse and/or child	Copy of death certificate
Recent Loss of Coverage (within 31 days only)	Copy of an official letter from insurance provider or employer providing the insurance, stating when the coverage terminated
Recent Gain of Coverage under another plan(within 31 days only)	Copy of an official letter from insurance provider or employer providing the insurance, stating when the coverage became effective
Dependent reaches age 26	Coverage ends on the last day of the month

Return a completed Full-Time Benefit Enrollment/Change Form and required dependent documents (if applicable) to the appropriate HR/Benefits Dept. listed below:

DC/CC Associates – dcbenefits@jcrew.com, your local HR Drop Box or fax

- Asheville: 828-687-6498
- Lynchburg: 434-385-5795
- San Antonio: 210-730-9152

Field & 770 / 30-30 Associates – benefits@jcrew.com or 212.209.6600

Please note that when changing your elections during a QLE, the effective date is the event date (e.g. If you wish to cancel your benefits because you had a recent gain of coverage under another plan effective April 15, your J.Crew Health Plan will terminate on April 15.)

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Tobacco Premium Policy
January 1 - December 31, 2018

The Quit For Life Program is available at no cost to Associates and their eligible dependents *(e.g. spouse and children ages 18–26)* enrolled in the J.Crew Group, Inc. Health Plan through Aetna or Anthem. J.Crew will also cover the prescription medications, Chantix® and Bupropion, at a zero co-pay for 180 days when you enroll in the Quit For Life Program.

Tobacco Premium Policy:

- Associate and their eligible covered dependents must be tobacco free and all must pledge to remain tobacco free through December 31, 2018 to be considered a Non-Tobacco User.

- If either the Associate or any of his or her eligible covered dependents that is covered under the J.Crew Group, Inc. Health Plan uses tobacco, the Associate will pay $40 more per month in premiums under the Health Plan unless all such users have a Medical Condition and produces proof to J.Crew that indicates that for medical reasons, he or she cannot cease the use of tobacco products. If this is the case, the Associate will be able to avoid the surcharge if the Associate and/or his or her dependents enrolls in and remains in the Quit For Life Program through December 31, 2018.

- Associate who intentionally falsifies his/her non-tobacco use or that of an eligible covered dependent will be immediately subject to the tobacco premium and may be subjected to termination of the health plan coverage with responsibility for all claims incurred, as well as discipline up to and including termination of employment.

- The tobacco premium will remain in effect and will not be removed until the first day of each calendar year in which the associate and/or his or her dependent is able to sign the affidavit stating that they no longer use tobacco products.

Tobacco-Use Affidavit:

- Associates must verify for themselves and on behalf of their eligible covered dependent their tobacco status by acknowledging a Tobacco-Use Affidavit during their initial benefits eligibility period and every year during the annual open enrollment period.

- Associates who fail to acknowledge the Tobacco-Use Affidavit will be considered a tobacco user and will be subjected to the tobacco premium.

Tobacco-Use Affidavit

I attest to J.Crew Group, Inc. that I have carefully read and understand the Tobacco Premium Policy. Based on the policy, I and/or my eligible covered dependents under the J.Crew Health Plan certify that we are:

_____**Tobacco Users** *(currently use tobacco products such as cigarettes, cigars, chewing tobacco, snuff).*

_____**Non-Tobacco Users** *(do not use tobacco products such as cigarettes, cigars, chewing tobacco, snuff) and commit not to utilize tobacco products through December 31, 2018.*

_____**Medical Condition** *(currently use tobacco products but will produce proof acceptable to J.Crew, that indicates that for medical reasons, I and/or my eligible dependents cannot cease the use of tobacco products)*

To be considered a Non-Tobacco User, I understand that I and/or my eligible dependents may not use tobacco through December 31, 2018. I understand that if I and/or my eligible covered dependents are or become tobacco users, the tobacco premium will be applied as set forth in the tobacco premium policy and information will be provided to Quit for Life Program so they can help with tobacco cessation. No Personal Health Information will be disclosed. I further understand and agree to notify J.Crew within thirty (30) days of my and/or any of my eligible dependents becoming users of tobacco products. I understand that from the time I and/or any of my eligible dependents become Tobacco Users, the benefits of being considered Non-Tobacco Users will cease.

I understand that if do not answer this Tobacco-Use Affidavit, I and/or my eligible covered dependents will be automatically considered tobacco users, regardless of our tobacco use.

AGREED & ACCEPTED:

By: _____ _____

Associate's Signature Associate's Name *(Print Name)*

Dated: _____ SAP #: _____

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J.CREW | *Benefits*

Full -Time Benefit Enrollment / Change Form (2018)

Shaded items to be completed by Human Resources

Action Date:	Effective Date:	☐ Weekly	☐ Bi-Weekly

SECTION 1: Information About You *Please clearly print the following information.*

Name _____ Associate # _____

First Last

Address _____ Date of Birth _____

Street Apt # City State Zip

Check your work location: ☐ Asheville ☐ Lynchburg ☐ San Antonio ☐ 770 ☐ Madewell Corp. ☐ Factory Store #_____ ☐ Madewell Store #_____ ☐ Retail Store #_____

Action: (Check One) ☐ New Hire Enrollment ☐ Re-Hire Enrollment ☐ Employment Status Change ☐ Family Status Change ☐ Open Enrollment

SECTION 2: Coverage Type and Level *Please check one of the options below.*

☐ Medical - Preferred Provider Organization (PPO) ☐ Medical - Consumer Choice Plan (CCP)
☐ Associate Only ☐ Associate + Child(ren) * ☐ Associate + Spouse * ☐ Associate + Family * ☐ Waive Coverage –Reason _____

If your spouse is eligible for medical coverage through his/her employer and you elect to cover him/her under J.Crew medical plan, you will incur a $100.00 monthly spousal surcharge. An associate who intentionally falsifies his/her spouse as not having access to coverage through an employer will be immediately subject to the spousal surcharge and may be subjected to termination of the health plan with responsibility for all claims incurred, as well as discipline up to and including termination of employment.
**If you are electing coverage for your spouse, you must provide a marriage certificate. If you are electing coverage for your child(ren), you must provide a birth certificate/adoption paperwork.*

☐ Dental
☐ Associate Only ☐ Associate + Child(ren) * ☐ Associate + Spouse * ☐ Associate + Family * ☐ Waive Coverage
**If you are electing coverage for your spouse, you must provide a marriage certificate. If you are electing coverage for your child(ren), you must provide a birth certificate/adoption paperwork.*

☐ Vision
☐ Associate Only ☐ Associate + Child(ren) * ☐ Associate + Spouse * ☐ Associate + Family * ☐ Waive Coverage
**If you are electing coverage for your spouse, you must provide a marriage certificate. If you are electing coverage for your child(ren), you must provide a birth certificate/adoption paperwork.*

SECTION 3: Personal Information *Please provide the information requested for you and each dependent for which you are electing coverage.*

First Name	Last Name	Social Security #	Gender (M or F)	Birth Date	Relationship
					Self
					Spouse
					Child
					Child
					Child

SECTION 4: Flexible Spending Account (FSA) Elections
Please indicate whether you want to participate in a Health Care and/or Dependent Care Account(s) and provide the annual amount you want to contribute.
(Note: The IRS may limit the amount you can contribute.)

For the Health Care FSA, I elect:
☐ Full Scope FSA: $ _____ *(PPO plan, $2,650 annual maximum)*
☐ Limited Purpose FSA: $ _____ *(CCP plan only, $2,650 annual maximum)*
☐ Waive

For the Dependent Care FSA, I elect:
☐ To contribute this amount from my pay: $ _____ *($5,000 annual maximum)*
☐ Waive

SECTION 5: H.S.A. Contribution (If Electing CCP medical Only)
☐ To contribute this amount from my pre-tax pay: $ _____
(combined annual associate & J.Crew's contribution: $3,450 single / $6,900 family.)
☐ Waive

SECTION 6: Supplemental Long-Term Disability Insurance Coverage
☐ 60% of base monthly pay; $15,000 maximum monthly benefit
☐ Waive

SECTION 7: Supplemental Life Insurance Coverage
If electing for the first time after initial enrollment; you will undergo medical underwriting- coverage amount cannot exceed $500,000.00
☐ One (1) times annual base pay ☐ Two (2) times annual base pay ☐ Three (3) times annual base pay ☐ Waive
☐ Four (4) times annual base pay ☐ Five (5) times annual base pay

Spouse/Partner Life
☐ $20,000 ☐ $10,000
☐ $5,000 ☐ $2,500 ☐ Waive

Child Life
☐ $2,000 ☐ $4,000 ☐ Waive

SECTION 8: MetLaw (administered by Hyatt Legal)
☐ Enroll *(also complete the MetLaw Enrollment Form)*
☐ Waive

SECTION 9: Beneficiary Information please designate your primary and contingent beneficiaries for your automatic basic and/or supplemental life insurance. If you elect more than one Primary and/or Contingent Beneficiaries, the total percent of benefit must equal 100%.

Primary Beneficiaries –Name	Relationship	Date of Birth	Social Security #	Percent of Benefit
1.				
2.				
Contingent Beneficiaries –Name	**Relationship**	**Date of Birth**	**Social Security #**	**Percent of Benefit**
1.				
2.				

SECTION 10: Authorization *Please read the following information carefully and then sign and date this form. Your completed form should be returned to Human Resources.*
I acknowledge that I have reviewed all the benefit materials made available to me on the benefits portal (www.myjcrewbenefits.com) and/or through HR. I elect the options indicated on this form. I authorize J.Crew to reduce my base pay by the amount needed to maintain the benefit elections on this form. I understand that if I submit my enrollment form after the first of the month, but still within the 31-day eligibility period, any missed premiums will be retroactively deducted in lump sum from my paycheck. I understand that I cannot cancel or change my coverage elections at anytime, and that coverage can only be canceled or changed during the company designated Open Enrollment Period or within 31-days of a Qualifying Life Event.

Your Signature _____ Date _____

Before submitting your form, please check over the following items to make sure you:
☐ Read through the entire Benefits Guide
☐ Sign and date this Full Time Benefit Enrollment / Change Form
☐ Select a primary and contingent beneficiary
☐ Attach a copy of your marriage certificate, civil union certificate or birth certificate/adoption paperwork (if applicable)
☐ Attach a copy of the Tobacco-Use Affidavit

Submit your completed enrollment/change form, along with applicable dependent certificates to your local HR/Benefits Department, listed below. Be sure to retain your email/fax confirmation for your record.

DC/CC Associates: dcbenefits@jcrew.com, your local HR Drop Box or fax
Asheville: 828-687-6498
Lynchburg: 434-385-5795
San Antonio: 210-730-9152

Field / 770 & 30-30: benefits@jcrew.com or 212-209-6600

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