Qualifying Life Events (QLEs)

Any benefits eligible associates who wish to enroll in the J.Crew Health Plan or make other changes to their current benefit elections outside of their initial eligibility period or an annual Open Enrollment period on account of a qualifying life event ("QLE") may do so only if the election change is consistent with the QLE and they are able to provide documentation as required by HR within 31 days of the QLE. Otherwise, changes or cancellation of coverage can only be made during the annual Open Enrollment period for an effective date of January 1st.

The table below lists the most common QLEs and the documentation that is required to make an election change on account of each event:

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 a Dependent *(spouse, domestic partner, child)*	Copy of death certificate
Loss of Coverage under another plan	Copy of an official letter from insurance provider or employer providing the insurance, stating when the coverage terminated
Gain of Coverage under another plan	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 automatically on the last day of the month; no documentation required

In order to make an election change on account of a QLE, return a completed Full-Time Benefit Enrollment/Change Form and required documentation (if applicable) to the appropriate HR/Benefits Dept.
via email / fax listed below:

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

Asheville: 828-687-6498 **Lynchburg**: 434-385-5795

Home Offices & Field Associates – benefits@jcrew.com or 212.209.6600

For more information about mid-year election changes, please email the appropriate HR/Benefits Dept. listed above.

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Full -Time Benefit Enrollment / Change Form (2019)

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 ☐ TX CC ☐ Home Offices ☐ 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.*

☐ Enroll in Medical - Preferred Provider Organization (PPO) ☐ Enroll Medical - Consumer Choice Plan (CCP)
☐ Associate Only ☐ Associate + Child(ren) * ☐ Associate + Spouse/Domestic Partner * ☐ Associate + Family *
☐ Waive Medical 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. If you electing coverage for Domestic Partner; a Declaration of Domestic Partnership form with three proofs must be provided Due to I.R.S regulations, you must pay taxes on any amount J.Crew contributes towards the portion of the medical, dental, and vision benefits you receive for your domestic partner and any children of your domestic partner that you cover. (See the Benefits Guide for additional information)

☐ Enroll in Dental
☐ Associate Only ☐ Associate + Child(ren) * ☐ Associate + Spouse/Domestic Partner * ☐ Associate + Family *
*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.
☐ Waive Dental Coverage – Reason _____

☐ Enroll in Vision
☐ Associate Only ☐ Associate + Child(ren) * ☐ Associate + Spouse/Domestic Partner * ☐ Associate + Family *
*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.
☐ Waive Vision Coverage – Reason _____

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 or Domestic Partner
					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, $2,700 annual maximum*)
☐ Limited Purpose FSA: $ _____(*CCP plan only, $2,700 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: $3,500 single / $7,000 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 & TX: 434-385-5795
Home Offices / Field benefits@jcrew.com or 212-209-6600

J.Crew GROUP | Benefits

Tobacco Premium Policy

January 1 - December 31, 2019

The Quit For Life Program is available at no cost to Associates and their eligible dependent(s) *(e.g. spouse, domestic partner 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 dependent(s) must be tobacco free and all must pledge to remain tobacco free through December 31, 2019 to be considered a Non-Tobacco User.

- If either the Associate or any of his or her eligible covered dependent(s) 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 under which he or she cannot cease the use of tobacco products. Proof of this Medical Condition must be provided to J.Crew.

- An 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 tobacco use or non-use on a Tobacco-Use Affidavit during their initial benefits eligibility period and every year during the annual open enrollment period.

- Associates who fail to acknowledge their use or non-use of tobacco on a Tobacco-Use Affidavit will be considered tobacco users and will be subjected to the tobacco premium.

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Tobacco-Use Affidavit

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

_____**Tobacco Users** *(this means that I and/or one or more of my covered dependents currently use tobacco products such as cigarettes, cigars, chewing tobacco, snuff).*

_____**Non-Tobacco Users** *(this means that I and all of my covered dependents do not use tobacco products such as cigarettes, cigars, chewing tobacco, snuff) and commit not to utilize tobacco products through December 31, 2019.*

_____**Medical Condition** *(this means that all of those who are covered under J. Crew Health Plan through me who currently use tobacco products will produce proof acceptable to J.Crew, that indicates that for medical reasons, I and/or my eligible dependent(s) cannot cease the use of tobacco products)*

To be considered a Non-Tobacco User, I understand that I and/or my eligible dependent(s) may not use tobacco through December 31, 2019 or have produced medical proof of me/us not being able to cease tobacco usage. I understand that if I have not produced this medical proof, if I or my eligible covered dependent(s) are or become tobacco users, the tobacco premium will be assessed from the beginning of the calendar year. I understand that from the time I and/or any of my eligible dependent(s) 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 dependent(s) will be automatically considered tobacco users, regardless of our tobacco use.

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 #: _____