

## DROP

### Enter DROP

Dear Employee,

Congratulations! I understand that you are interested in applying for DROP. Please call the Florida Retirement System at 1-844-377-1888 to confirm that you qualify for DROP and to obtain an estimate of your pension benefit which will assist you in making your option selection. Through the secure web environment of Online Services, you may calculate your own informal benefit estimate. The web address is <http://frs.myflorida.com>. Please make sure to print the estimate(s). Please review your DROP estimate information and be prepared to make your option election.

The DROP application will be provided, completed and notarized on the day of your appointment. It will be necessary for you to provide identification (such as your FL Driver License or FL ID) for the notary public. You will need to provide the name, date of birth and social security number of your beneficiary (beneficiaries) regardless of option selection.

When completing a retirement application, an option selection is required. Please review the information on the retirement option election. If you are married and select Option 1 or 2, your spouse's notarized signature is required on the Spousal Acknowledgment (SA-1) form which will be provided on the day of your appointment.

Option 1 is the basic monthly benefit and will provide you, the retiree, with the maximum monthly benefit you will be eligible to receive. The benefit will stop at your death.

Options 2, 3, and 4 are less than the Option 1 amount and are designed to provide a continuing benefit to a beneficiary or joint annuitant.

Option 2 is a reduced monthly benefit payable for your lifetime. If you die within a period of ten years from your retirement date or DROP begin date, your designated beneficiary will receive the same monthly benefit you were receiving until the monthly benefits payable to both you and the beneficiary equal the balance of the ten year period. You will need to provide the date of birth and social security number of your beneficiary (beneficiaries). If you die after that ten year period, there is no continuing benefit to the beneficiary. The amount of reduction of Option 2 depends on your age only. Option 2 would be particularly appropriate if you are in ill health and your beneficiary does not qualify as a joint annuitant. Anyone can be named as a beneficiary under Option 2, as well as charities, organizations, or your estate or trust.

If you choose either option 3 or 4, your beneficiary must qualify as your joint annuitant. Your spouse, your natural and legally adopted child who is either under 25 or your natural and legally adopted child who is physically or mentally disabled and incapable of self-support (regardless of age) may qualify as your joint annuitant. **Please note that if you are electing Option 3 or**

**Option 4 and elect your legal spouse as your joint annuitant, a copy of your marriage license must be provided.**

Option 3 is a reduced monthly benefit payable for your lifetime. Upon your death, your joint annuitant, if living, will receive the same monthly benefit you were receiving. No further benefits are payable after both you and your joint annuitant are deceased.

Option 4 is an adjusted monthly benefit payable to you while both you and your joint annuitant are living. Upon the death of either you or your joint annuitant, the monthly benefit payable to the survivor is reduced to two-thirds of the monthly benefit received when both were living. No further benefits are payable after both you and your joint annuitant are deceased.

Additionally, proof of your birth date must be submitted at the time of your application. If you select Option 3 or 4, you must also submit birth date verification for your joint annuitant. We will accept legible photocopies of one of the following (except for g.):

- a. Birth Certificate
- b. Delayed birth certificate
- c. Census report more than 30 years old
- d. Life Insurance policy more than 30 years
- e. Letter from the Social Security Administration stating the date of birth it has established for the payment of benefits
- f. Certificate of Naturalization
- g. In the absence of one of the above, a document from two of the following
  - (1) Birth certificate of child, showing age of parent (limit one)
  - (2) Baptismal certificate more than 30 years old
  - (3) Hospital record of birth
  - (4) School record at time of entering grammar school

You will have the opportunity to cash out hours from your **Personal Leave/Vacation** bank at the time of your DROP enrollment (Extended Illness/Sick Time cash out is **not** an option). The cash out request will not be process for 100% of your Personal Leave. You must maintain at least 12 hours in your Personal Leave bank. Please contact an authorized 403b/457 representative from the attached contact list in the event that you would like to shelter your Personal Leave cash out from taxes. You will need to provide the tax shelter representative with your latest check stub. The completed payroll authorization form/ salary reduction agreement form must be turned in on the day of your appointment to accompany the cash out request.

If you wish to make an appointment, please fax a copy of your DROP estimate to 305-355-5011 and include your telephone number or e-mail address on the cover sheet so that I may be contact you with an appointment. Please be advised that after the first month of participation, a DROP participant can not add additional service, change benefit payment options, change DROP begin date or change type of retirement (e.g. from service retirement to disability retirement).

Regards,

Nicole Taylor  
Benefits  
Human Resources Capital Management



Benefits Department  
Human Resources Capital Management  
1801 NW 9 Avenue, Suite 712  
Miami, Florida 33136  
Telephone: 786-466-8355

## DROP Termination

Dear Employee,

This is in response to your inquiry concerning retirement. If you are interested in the DROP Termination process, please be advised that you will need to contact the Florida Retirement System (FRS) at 1-844-377-1888. Inform FRS of the date that you are terminating employment and terminating DROP at least 1 month in advance. You will need to bring the original DP-Term form (that you should receive from FRS upon your notification to them of your termination date) on the day of your appointment. **The “Employer Certification of Employment Termination” section of the DP-Term form will be signed by me at the time of your appointment as I am the authorized signer for FRS.**

In order for me to provide you with an appointment to process your retirement application, you must terminate your employment. Please present your manager written notification of your intentions to retire and include the effective date at least one month in advance. JHS managers are now required to use Lawson Manager Self Service (MSS) to enter these types of actions. Upon HR-Benefits receiving confirmation that the electronic PAM has been approved, you will be contacted with an appointment. Please be advised that you will need to provide identification (such as your FL Driver License or FL ID) for the notary public on the day of your appointment to process your retirement.

Employee group coverage is cancelled the last day of the pay period in which the separation of employment date falls and for which you experience a regular insurance deduction or made direct payment to Jackson Health System. At the time of retirement, you will have the opportunity to change your insurance election and enroll in any of the available JHS Retiree Insurance plans if you are currently insured. Any dependent that is currently insured under your plan may also be maintained on your coverage.

The Jackson Health System- Selection Form for New Retirees has been included in your packet to allow you time to review the rates and prepare to make your insurance selection at the time of your appointment. If you are electing life insurance, you will need to provide the date of birth and social security number of your beneficiary (beneficiaries). **In order to be eligible to enroll in the Retiree Group insurance upon retirement from Jackson Health System/Public Health Trust, you must transition into retirement within 30 days of your termination date. You will have 30 days from your termination date to enroll or change your Retiree insurance election.**

If you need information on Social Security and Medicare, please call them at 1-800-772-1213 (or website [www.ssa.gov](http://www.ssa.gov)). Please contact an authorized 403b/457 representative from the attached contact list in the event that you would like to shelter your Personal Leave/Extended Illness payout from taxes. You will need to meet with the tax shelter representative to obtain the appropriate form(s). We recommend that you print a copy of your latest check stub to assist you in determining your payout. The completed and signed payroll authorization form must be turned in on the day of your appointment.

Please have your manager email me upon receipt from Process Flow that the electronic PAM has been approved. If you wish to make an appointment, please fax (or e-mail) me your DP-Term form to 305-355-5011. Include your telephone number and e-mail address on the cover sheet so that I may contact you with an appointment.

Regards,

Benefits  
Human Resources Capital Management

**2017 NEW RETIREE JACKSON HEALTH SYSTEM ENROLLMENT FORM UNDER 65 AND NOT MEDICARE ELIGIBLE**

LAST NAME		FIRST NAME		MI	SSN		
ADDRESS			CITY		STATE	ZIP	
HOME PHONE NUMBER	CELL PHONE NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	BIRTH DATE (MM/DD/YYYY) / /		EFFECTIVE DATE (MM/DD/YYYY) / /	
E-MAIL ADDRESS							

**SECTION 1: INSTRUCTIONS** Retirees: Please note that all cancellations are IRREVOCABLE. Please remember to complete the Dependent Information section if you have coverage that includes dependents. If you cancel a benefit, you cannot elect it at a later date.

**SECTION 2: RETIREE MEDICAL**  
 (Please mark one box only)  CANCEL MEDICAL

Monthly rates for:

	MEDICAL			
	JACKSON FIRST HMO	SELECT HMO PLAN	STANDARD HMO PLAN	POS PLAN
Retiree Only	<input type="checkbox"/> \$387.42	<input type="checkbox"/> \$419.23	<input type="checkbox"/> \$519.80	<input type="checkbox"/> \$1,222.29
Retiree & Spouse/DP Under 65	<input type="checkbox"/> \$881.73	<input type="checkbox"/> \$948.46	<input type="checkbox"/> \$1,159.57	<input type="checkbox"/> \$2,362.72
Retiree & Child(ren) <sup>†</sup>	<input type="checkbox"/> \$811.01	<input type="checkbox"/> \$872.85	<input type="checkbox"/> \$1,068.40	<input type="checkbox"/> \$2,267.66
Retiree & Spouse/DP Under 65, plus Child(ren) <sup>†</sup>	<input type="checkbox"/> \$1,096.37	<input type="checkbox"/> \$1,177.78	<input type="checkbox"/> \$1,435.23	<input type="checkbox"/> \$2,906.67
Retiree Under 65 & Spouse/DP Over 65 on Medicare - High HMO No Rx	N/A	N/A	<input type="checkbox"/> \$763.84	<input type="checkbox"/> \$1,466.33
Retiree Under 65 & Spouse/DP Over 65 on Medicare - High HMO	N/A	N/A	<input type="checkbox"/> \$1,081.26	<input type="checkbox"/> \$1,783.75

<sup>†</sup> Option also applies to Adult Children (AC) between 26 through 30 years of age, children of a Domestic Partner and/or eligible dependents.

**SECTION 3: RETIREE DENTAL**  
 (Please mark one box only)  CANCEL DENTAL

\*Guardian DHMO Plans are not available outside Florida  
**NOTE:** Dental coverage is not provided to Adult Children (AC).

Monthly rates for:	- Standard -		- Enriched -	
	GUARDIAN DHMO*	GUARDIAN PPO	GUARDIAN DHMO*	GUARDIAN PPO
Retiree Only	<input type="checkbox"/> \$8.00	<input type="checkbox"/> \$31.22	<input type="checkbox"/> \$14.57	<input type="checkbox"/> \$40.87
Retiree & One Dependent	<input type="checkbox"/> \$13.24	<input type="checkbox"/> \$61.76	<input type="checkbox"/> \$24.15	<input type="checkbox"/> \$80.81
Retiree & Family	<input type="checkbox"/> \$20.22	<input type="checkbox"/> \$99.55	<input type="checkbox"/> \$38.39	<input type="checkbox"/> \$130.30

**SECTION 4: RETIREE VISION**  
 (Please mark one box only)  CANCEL VISION

**NOTE:** Vision coverage is not provided to Adult Children (AC).

Monthly rates for:	Retiree Only	Retiree & One	Retiree & Family
GUARDIAN/DAVIS	<input type="checkbox"/> \$4.14	<input type="checkbox"/> \$8.30	<input type="checkbox"/> \$15.23

**SECTION 5: RETIREE & DEPENDENT INFORMATION**

Please list below a Preferred Dental Provider (PDP) if enrolling in a DHMO Dental Plan.

Relationship	M/F	Last Name/First Name	SSN	Coverage Desired				Date of Birth MM/DD/YY	Check One*			List the PDP # of your: Dental Provider
				Medical	Dental	Vision	Constant Credit		DP/CDP	AC		
Self												

\* If enrolling a Domestic Partner, Child of a Domestic Partner or Adult Child(ren), please select the appropriate box. **NOTE:** You may only continue or cancel dependent coverage. You may not add new dependents.

**SECTION 6: LIFE INSURANCE & VOLUNTARY BENEFITS (Monthly Rates)**

**Life Insurance**  Elect Life Insurance  Decline Life Insurance **NOTE:** Life Insurance coverage is reduced when you reach age 65. The coverage options are \$15,000 or \$20,000.  
 \$ \_\_\_\_\_ x .00017 = \_\_\_\_\_ Base Annual Salary Monthly Premium Life insurance.

<b>ARAG Legal - UltimateAdvisor</b>	<input type="checkbox"/> Retiree Only \$13.33	<input type="checkbox"/> Retiree + Family \$17.60
<b>ARAG Legal - UltimateAdvisor Plus</b>	<input type="checkbox"/> Retiree Only \$17.30	<input type="checkbox"/> Retiree + Family \$22.82
<b>Ocenture ConstantCredit</b> <small>*Please provide dependent information in Section two if electing dependent coverage.</small>	<input type="checkbox"/> Retiree Only \$11.50	<input type="checkbox"/> Retiree + Spouse* \$23.00
<b>Ocenture ID Commander Plan</b>	<input type="checkbox"/> Retiree Only \$10.50	<input type="checkbox"/> Retiree + Family \$22.50
<b>Pet Assure</b> <input type="checkbox"/> \$7.00	<b>PETPlus</b> <input type="checkbox"/> Single Pet \$4.50 <input type="checkbox"/> Multiple Pets \$8.50	<b>Pet Assure/PETPlus</b> <input type="checkbox"/> Single Pet \$11.50 <input type="checkbox"/> Multiple Pets \$15.50

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. Section 817.234 (1) (b)

RETIREE SIGNATURE	DATE
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# 2017 NEW RETIREE BENEFIT ENROLLMENT FORM FOR 65 AND OVER AND/OR MEDICARE ELIGIBLE

LAST NAME		FIRST NAME		MI	SSN			
ADDRESS			CITY		STATE	ZIP		
HOME PHONE NUMBER		CELL PHONE NUMBER		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	BIRTH DATE (MM/DD/YY) / /		
E-MAIL ADDRESS					EFFECTIVE DATE (MM/DD/YYYY) / /			

## SECTION 1: INSTRUCTIONS

**RETIREES:** Please note that all cancellations are IRREVOCABLE. Please remember to complete the Dependent Information section if you have coverage that includes dependents. If you cancel a benefit, you cannot elect it at a later date.

SECTION 2: RETIREE MEDICAL (Please mark one box only) <input type="checkbox"/> CANCEL MEDICAL	M E D I C A L	
NOTE: In electing the supplemental plan for myself and eligible dependent, I understand that enrollment in Part B is required. <b>Monthly rates for:</b>	HIGH PLAN	HIGH with No RX Plan
Retiree 65 and Over Only	<input type="checkbox"/> \$561.46	<input type="checkbox"/> \$244.04
Retiree 65 and Over & Spouse/DP 65 and Over†	<input type="checkbox"/> \$1,101.90	<input type="checkbox"/> \$478.97
Retiree 65 and Over & Spouse/DP Over 65† plus Child(ren)† on AvMed POS Plan	<input type="checkbox"/> \$2,147.27	N/A
Retiree 65 and Over & Spouse/DP Over 65† plus Child(ren)† on AvMed Standard HMO	<input type="checkbox"/> \$1,650.50	N/A
Retiree 65 and Over & Child(ren)† on AvMed POS Plan	<input type="checkbox"/> \$1,606.83	<input type="checkbox"/> \$1,289.41
Retiree 65 and Over & Child(ren)† on AvMed Standard HMO	<input type="checkbox"/> \$1,110.06	<input type="checkbox"/> \$792.64
Retiree 65 and Over & Spouse/DP Under 65†, Child(ren)† on AvMed POS Plan	<input type="checkbox"/> \$2,245.84	N/A
Retiree 65 and Over & Spouse/DP Under 65†, Child(ren)† on AvMed Standard HMO	<input type="checkbox"/> \$1,476.89	<input type="checkbox"/> \$1,159.47
Retiree 65 and Over & Spouse/DP Under 65 on AvMed POS Plan	<input type="checkbox"/> \$1,783.75	<input type="checkbox"/> \$1,466.33
Retiree 65 and Over & Spouse/DP Under 65 on AvMed Standard HMO	<input type="checkbox"/> \$1,080.26	<input type="checkbox"/> \$763.84

† Option also applies to Adult Children (AC) between 26 through 30 years of age, children of a Domestic Partner and/or eligible dependents.

DEPENDENT COVERAGE ONLY	(Please mark one box only) M E D I C A L			
NOTE: Monthly rates for Retiree 65 & Over with Non-JHS Medical Plan:	Jackson First HMO Plan	Select HMO Plan	Standard HMO Plan	POS Plan
Spouse/DP Under 65†	<input type="checkbox"/> \$387.42	<input type="checkbox"/> \$419.23	<input type="checkbox"/> \$519.80	<input type="checkbox"/> \$1,222.29
Child(ren)†	<input type="checkbox"/> \$423.59	<input type="checkbox"/> \$453.62	<input type="checkbox"/> \$548.60	<input type="checkbox"/> \$1,045.37
Spouse/DP Under 65† and Child(ren)†	<input type="checkbox"/> \$811.01	<input type="checkbox"/> \$872.85	<input type="checkbox"/> \$1,068.40	<input type="checkbox"/> \$2,267.66

## SECTION 3: RETIREE DENTAL (Please mark one box only) CANCEL DENTAL \* Guardian DHMO plans are not available outside of Florida.

Monthly rates for:	- Standard -		- Enriched -	
	GUARDIAN DHMO*	GUARDIAN PPO	GUARDIAN DHMO*	GUARDIAN PPO
Retiree Only	<input type="checkbox"/> \$8.00	<input type="checkbox"/> \$31.22	<input type="checkbox"/> \$14.57	<input type="checkbox"/> \$40.87
Retiree & One Dependent	<input type="checkbox"/> \$13.24	<input type="checkbox"/> \$61.76	<input type="checkbox"/> \$24.15	<input type="checkbox"/> \$80.81
Retiree & Family	<input type="checkbox"/> \$20.22	<input type="checkbox"/> \$99.55	<input type="checkbox"/> \$38.39	<input type="checkbox"/> \$130.30

SECTION 4: RETIREE VISION (Please mark one box only) <input type="checkbox"/> CANCEL VISION	Monthly rates for:	Retiree Only	Retiree & One	Retiree & Family
NOTE: Vision coverage is not provided to Adult Children (AC).	GUARDIAN/DAVIS	<input type="checkbox"/> \$4.14	<input type="checkbox"/> \$8.30	<input type="checkbox"/> \$15.23

## SECTION 5: RETIREE & DEPENDENT INFORMATION Please list below a Preferred Dental Provider (PDP) if enrolling in a DHMO Dental Plan.

Relationship	M/F	Last Name/First Name	SSN	Coverage Desired				Date of Birth MM/DD/YY	Check One*			List the PDP # of your: Dental Provider
				Medical	Dental	Vision	Constant Credit		DP/CDP	AC		
Self												

\* If enrolling a Domestic Partner, Child of a Domestic Partner or Adult Child(ren), please select the appropriate box. NOTE: You may only continue or cancel dependent coverage. You may not add new dependents.

## SECTION 6: LIFE INSURANCE AND VOLUNTARY BENEFITS (Monthly Rates)

<b>ARAG Legal - UltimateAdvisor</b>	<input type="checkbox"/> Retiree Only \$13.33	<input type="checkbox"/> Retiree + Family \$17.60
<b>ARAG Legal - UltimateAdvisor Plus</b>	<input type="checkbox"/> Retiree Only \$17.30	<input type="checkbox"/> Retiree + Family \$22.82
<b>Ocature ID Commander</b>	<input type="checkbox"/> Retiree Only \$10.50	<input type="checkbox"/> Retiree + Family \$22.50
<b>Ocature ConstantCredit</b>	<input type="checkbox"/> Retiree Only \$11.50	<input type="checkbox"/> Retiree + Spouse* \$23.00
<b>Pet Assure</b> <input type="checkbox"/> \$7.00	<b>PETplus</b> <input type="checkbox"/> Single Pet \$4.50 <input type="checkbox"/> Multiple Pet \$8.50	<b>Pet Assure/PETplus</b> <input type="checkbox"/> Single Pet \$11.50 <input type="checkbox"/> Multiple Pet \$15.50
<b>Life Insurance</b>	<input type="checkbox"/> Elect LIFE INSURANCE	<input type="checkbox"/> Decline LIFE INSURANCE
	<b>Life Insurance Benefit/Rates:</b>	
		<b>AGE 65-69</b>
		<b>AGE 70-74</b>
		<b>AGE 75+</b>
	\$15,000.00	\$8.55
	\$20,000.00	\$11.40
		\$14.10
		\$18.80
		\$19.50
		\$26.00

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. Section 817.234 (1) (b)

RETIREE SIGNATURE	DATE
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**Jackson Health System Employer HMO Plan benefits overview**  
**\$0 plan premium**

	<b>Benefits</b>	<b>HMO</b>
<b>Physician Services</b>	Primary Care Physician	\$0 copayment
	Specialist	\$20 copayment
	Allergy Injections and Serum	\$0 copayment
	Diagnostic Tests and X-rays	\$0-\$20 copayment
<b>Preventive Care</b>	Routine Immunizations	\$0 copayment
	Routine Physical Exams	\$0 copayment (one per year)
	Routine Colonoscopy	\$0 copayment (one per year)
	Routine Mammogram	\$0 copayment (one per year)
<b>Hospital Services</b>	Inpatient care	\$75 copayment per day (days 1-5) per admission; 100% after day 5
	Outpatient Surgical Services	\$100 copayment
	Emergency Room	\$65 copayment
<b>Additional Medical Services</b>	Skilled Nursing Facility	100% for days 1-7, 100% after \$50 copayment per day (days 8-100) per benefit period
	Home Health Services	\$0 copayment
	Durable Medical Equipment	\$0 copayment
	Immediate Care Facility	\$20 copayment
<b>Extra Benefits</b>	SilverSneakers®	Available
	Smoking Cessation Program	Available
	Dental (Routine)	\$0 copayment per visit for the following every 12 months: 1 Amalgam or Composite filling, 1 oral evaluation, 1 cleaning, 2 series of bitewing x-ray films
	Vision (Routine)	\$0 copayment per visit for 1 routine eye exam with a maximum allowance of \$150 each plan year for contact lenses, eyeglasses-lenses and frames or one free pair of select eye-wear

If you have any questions or need help, please call us at 1-800-824-8242 (TTY: 711) and select option 2. You can call Monday – from Friday, 8 a.m. – 8 p.m. Eastern time.

Humana is a Medicare Advantage organization with a Medicare contract. The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. Limitations, copayments and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on of each year.



## Personal Leave

Payout of 100% of accrued bank up to 500 hours at current base hourly rate of pay. The 500-hour accrual maximum includes converted sick leave.

## Extended Illness

For employees covered under the AFSCME Bargaining Unit, please refer to your Union contract or contact your local representative.

Payout after a minimum of ten years of full-time continuous employment in accordance with the following schedule:

Less than 10 years	No payment
10 years but less than 11 years	25% payment
11 years but less than 12 years	30% payment
12 years but less than 13 years	35% payment
13 years but less than 14 years	40% payment
14 years but less than 15 years	45% payment
15 years but less than 16 years	50% payment
16 years but less than 17 years	55% payment
17 years but less than 18 years	60% payment
18 years but less than 19 years	65% payment
19 years but less than 20 years	70% payment
20 years but less than 21 years	75% payment
21 years but less than 22 years	77.5% payment
22 years but less than 23 years	80% payment
23 years but less than 24 years	82.5% payment
24 years but less than 25 years	85% payment
25 years but less than 26 years	87.5% payment
26 years but less than 27 years	90% payment
27 years but less than 28 years	92.5% payment
28 years but less than 29 years	95% payment
29 years but less than 30 years	97.5% payment
30 years or more	100% payment

Employees with less than thirty (30) years full-time continuous Trust/County employment who retire or resign from the Trust will be eligible to receive payment for up to a maximum of 1,000 hours of accrued extended illness leave.

**Tax Sheltered Annuity(TSA) Contact List**  
**403(b) Retirement Plans & 457 Deferred Compensation Plans**

Please contact the following providers for information and/or assistance with the Tax Sheltered Annuity 403(b) Retirement Plans and Deferred Compensation 457 Plans.

**FIDELITY Investments:**  
**403(b)**

**1-800-343-0860**  
#51502 (Employer Plan Number)  
**Julie Cornell-Armengol**  
800-603-4015  
[Julie.Cornell@FMR.com](mailto:Julie.Cornell@FMR.com)

**LINCOLN Financial Group:**  
**403(b) & 457**

**Doris Obregon**  
786-720-9728  
[Doris.Obregon@LFG.com](mailto:Doris.Obregon@LFG.com)

**Nationwide Retirement Solutions:**  
**457**

**Aaron R. Schwartz**  
305-439-9550  
[schwara5@nationwide.com](mailto:schwara5@nationwide.com)  
#609177 (Employer Plan Number)

**VALIC:**  
**403(b) & 457**

**Denise Abi-Fadel**  
305-505-8290  
[denise.abi-fadel@valic.com](mailto:denise.abi-fadel@valic.com)  
**Dida Langsdale**  
305-984-2236  
[candida.langsdale@valic.com](mailto:candida.langsdale@valic.com)  
**Molly Shrauner**  
786-877-1891  
[molly.shrauner@valic.com](mailto:molly.shrauner@valic.com)  
**Armando Vazquez**  
305-409-3156  
[armando.vazquez@valic.com](mailto:armando.vazquez@valic.com)  
**Al Wishneff**  
954-224-7018  
[albert.wishneff@valic.com](mailto:albert.wishneff@valic.com)

**VOYA Financial**  
**403(b) & 457**

**Pam Boatman**  
305-234-3246  
[pam.boatman@voyafa.com](mailto:pam.boatman@voyafa.com)  
  
**Gwenn Wayne**  
954-486-2236  
[gwenn.wayne@voyafa.com](mailto:gwenn.wayne@voyafa.com)  
Group#09058