TeamStaffingServices

JOIN THE WINNING TEAM

LAST NAME: FIRST NAME:

ADDRESS: CITY: STATE:

ZIP: PHONE #: ALTERNATE #:

SOCIAL SECURITY #: DRIVERS LICENSE #:

STATE: EXPIRATION: EMAIL ADDRESS:

HOURLY RATE EXPECTED: TEMP: PERM: HOURS AVAIL: TO:

DAYS AVAILABLE TO WORK: **S M T W T F S** SHIFT: 1ST 2ND 3RD LAST MINUTE: YES NO

EMPLOYMENT HISTORY:

COMPANY NAME: POSITION HELD:

FROM: TO: COMPANY ADDRESS:

SUPERVISOR AND PHONE #:

COMPANY NAME: POSITION HELD:

FROM: TO: COMPANY ADDRESS:

SUPERVISOR AND PHONE #:

COMPANY NAME: POSITION HELD:

FROM: TO: COMPANY ADDRESS:

SUPERVISOR AND PHONE #:

PLEASE CIRCLE SKILLS:

ASSEMBLERS MACHINIST WAREHOUSE FOOD/CHEF UPHOLSTERY DRAFTING CDL

HOSPITALITY HOUSEKEEPING DRIVER FORK LIFT PRINTING SECRETERIAL GENERAL LABORER

OTHER:

PLEASE CIRCLE:

TRANSPORTATION: OWN CAR BUS OTHER:

DRIVER LICENSE: YES NO CLASS: A B E DRIVERS LICENSE VALID: YES NO

STEEL TOE SHOES: YES NO CAPABLE OF LIFTING: 30LBS. 50LBS. 80LBS.

FORKLIFT CERTIFIED: YES NO ARE YOU ELIGIBLE FOR EMPLOYMENT IN THIS COUNTRY? YES NO

IS THERE ANY REASON YOU MIGHT BE UNABLE TO PERFORM DUTIES? YES NO

HAVE YOU BEEN CONVITED OF A FELONY IN THE LAST (7) YEARS? YES NO

APPLICANT'S SIGNATURE: **DATE:**

I HEREBY CERTIFY THAT THE INFORMATION ON THIS APPLICATION FORM AND ANY ATTACHMENTS LISTED BELOW (HEREAFTER MADE A PART OF THIS APPLICATION) IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND AGREE TO HAVE ANY STATEMENTS CHECKED BY **TEAM STAFFING SERVICES** UNLESS I HAVE INDICATED TO THE CONTRARY. I AUTHORIZE THE REFERENCES LISTED ABOVE TO PROVIDE **TSS** ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION THAT THEY MY HAVE FURTHER, I RELEASE ALL PARTIES AND PERSONS FROM ANY AND ALL LIABILITY FOR ANY CHANGES THAT MAY RESULT FROM FURNISHING SUCH INFORMATION TO **TSS** AS WELL AS FROM USE OR DISCLOSESURE OF SUCH INFORMATION BY **TSS** OR ANY OF ITS AGENTS, EMPLOYEES AND REPRESENTATIVES. I UNDERSTAND ANY MISREPRESENTATION, FALSIFICATION OR MATERIAL OMMISSION OF INFORMATION MAY RESULT IN MY FAILURE TO RECEIVE A JOB OR IF I AM HIRED IN MY DISMISSAL FROM EMPLOYMENT.

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Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.) ▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

TEAM STAFFING SERVICES

Join the Winning Team
Medical Questionnaire

Name: _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip: _____

Please answer each question by checking YES or NO. ****ALL questions must be answered.**

HAVE YOU EVER?	Y	N
Received worker's compensation (in any state)		
Receive or have received a pension or disability for injury		
Had any prolonged hospitalization		
Had any serious medical illness		
Been advised to have an operation		
Been rejected for the military service		
Been in an automobile accident		
Been given a prescription for back support or brace		
Been refused life insurance		
Had a hernia or rupture		
Worn a truss		
Sprained or injured your back		
Had surgery to your back		
Had to wear a back support or brace		
Do you or have you ever received physical therapy		
Do you use medication regularly, prescription or OTC		
Had surgery or injury to your neck		
Had an injury to your knee		
Worn a knee brace		
Had surgery on your knee		
Had an injury to your ankle		
Had surgery on your ankle		
Had an injury to your feet or heels		
Had surgery to your feet or heels		
Had a fracture of any bones		
Had an injury to your wrist or hand		
Do you use a hearing aid		
Do you have hearing loss		
Had an injury to your head		
Had an injury to your shoulder or elbow		

HAVE YOU EVER HAD?	Y	N
Tuberculosis		
Hay Fever		
Paralysis		
Polio		
Allergic Reaction to drugs		
Swelling of legs/ankle/feet		
Nerve trouble		
Foot/Leg/Arm/Hand amputation		
Partial/total loss of one or both eyes		
Uncontrolled bleeding (hemophilia)		
Muscular dystrophy		
Nervous breakdown		
Frequent headaches		
Diabetes		
High Blood pressure		
Back pain while lifting		
Fainting and/or dizzy spells		
Epilepsy		
Seizures or Convulsions		
Heart trouble		
Dislocations		
Arthritis or Rheumatism		
Skin rashes or eczema		
Stomach ulcer		
Cerebral palsy		
Multiple Sclerosis		
Parkinson's Disease		
Bone Inflammation (osteomyelitis)		
Blood Clots (thrombophlebitis)		
Asthma		

The information on this form will not be used to discriminate against a qualified individual with a disability, due to the existence of the disability regarding the following: job application procedures, hiring, advancement or discharge of the employee, employee compensation, job training and other terms, conditions or privileges of employment.

Under penalty of perjury, I declare that the foregoing and that all facts alleged are true to the best of my knowledge and belief.

Employee Signature _____ **Date** _____

Employer Signature _____ **Position** _____ **Date** _____

TeamStaffingServices

JOIN THE WINNING TEAM

Team Staffing Services Employees,

Please be advised that it is your responsibility to contact our office for work. When you are on an assignment that is ending it is your responsibility to contact our office for a new assignment. Failure to do so may result in denial of unemployment benefits.

Print Name: _____

Signature: _____

Date: _____

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TeamStaffingServices

JOIN THE WINNING TEAM

COURTESY POLICY

We depend on everyone to show up for work on time as scheduled. On your first day or on any day after, in the event you cannot report to work we ask for the courtesy of a phone call letting us know you will not be able to report to work. The statements below explain our policy in place to prevent "NO CALL & NO SHOWS" from happening. We are available 24 hours a day by calling (407) 888-4746. If there is no answer, please leave a message and a representative will call you back.

Upon accepting a short-term position with Team Staffing Services, we ask if for any reason you will not be able to complete your position to notify a Team Staffing Services representative within 4 hours of your start time. If you do not notify a Team Staffing Services representative within the 4-hour time frame your pay rate for that day or week will revert back from what it was originally quoted to minimum wage ($10.00 per hour), which is required by law.

_____
Applicant Initials

Upon accepting a long-term and/or temp-to-hire position with Team Staffing Services, we ask if for any reason you will not be able to complete your position to notify a Team Staffing Services representative giving 24 hours advance notice to cancel your position. If you do not notify a Team Staffing Services representative within the 24-hour notice, your pay rate for that week will revert back from what it was originally quoted to minimum wage ($10.00 per hour), which is required by law.

_____
Applicant Initials

I _____ understand the above policy and courtesy statement.

_____ _____
Applicant Signature Date

_____ _____
Team Staffing Representative Date

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TeamStaffingServices

JOIN THE WINNING TEAM

AUTHORIZATION TO RELEASE CRIMINAL BACKGROUND AND PERSONAL INFORMATION

I, _____ give TEAM STAFFING SERVICES my permission to run my driving record and conduct a criminal background check using my name and personal information.

I also give permission to check employment and personal references.

I understand that this information will be given to 3rd party potential employers.

I understand that the information given and received will be kept confidential.

Signature of Applicant: _____

Date Signed: _____

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TeamStaffingServices

JOIN THE WINNING TEAM

Team Staffing Services Employees,

We are proud to announce that we are a Drug-Free Workplace. Because we wish to provide you with a safe working environment we will adhere to all guidelines established for a Drug-Free Workplace.

In signing this letter, you are stating that, if we choose, you will submit to random drug testing at our expense. If you test positive you will be immediately terminated. Also, if you are injured on the job we will automatically require an immediate drug test. If your results are positive your injury will not be covered under our insurance and you will be held liable for all expenses.

In partnership with you, we can help keep your work environment a safe environment. Thank you for your cooperation.

Print Name: _____

Signature: _____

Date: _____

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TeamStaffingServices

JOIN THE WINNING TEAM

TEAM STAFFING SERVICES DRUG SCREEN RESULTS

COMPANY INFORMATION

COMPANY NAME: TEAM STAFFING SERVICES

ADDRESS: 6220 SOUTH ORANGE BLOSSOM TRAIL, SUITE 511, ORLANDO, FL 32809

NAME OF COLLECTOR: _____

PHONE: 407-888-4746 FAX: 407-888-3441

DONOR INFORMATION

LAST NAME: _____ FIRST NAME: _____

DRIVERS LICENSE #: _____ GOVERNMENT ISSUED I.D.: _____

SCREEN RESULTS

TIME COLLECTED: _____ TIME INTERPRETED: _____

TEMPERATURE: _____ NORMAL (90-100) _____ OTHER _____

DRUG NAME	SYMBOL	NEGATIVE	CONFIRM
COCAINE	(COC)		
MARIJUANA	(THT)		
OPIATES	(OPI)		
AMPHETAMINES	(AMP)		
PHENCYCLIDINE	(PCP)		
BENZODIAZEPINE	(BZD)		
BARBITURATE	(BAR)		
METHODONE	(MTD)		
METHAMPHETAMINE	(MET)		
ECSTASY	(MDMA)		

CERTIFICATION

I HEREBY AGREE TO SUBMIT TO A URINALYSIS FOR THE PURPOSE OF TESTING FOR DRUG METABOLITES. THIS SPECIMEN IS MY OWN AND HAS NOT BEEN SUBSTITUTED OR ADULTERED.

DONOR SIGNATURE _____ DATE _____

I HEREBY CERTIFY THE SPECIMEN HAS BEEN PROVIDED BY THE DONORIDENTIFIED ABOVE.

COLLECTOR SIGNATURE _____ DATE _____

I HEREBY CERTIFY THAT A SECURE SAMPLE WAS RECEIVED FOR CONFIRMATION

Employee Direct Deposit

No More Extra Trips To The Bank!

To request Direct Deposit of your paycheck, read and complete the following authorization agreement and give it to your payroll department. If you are eligible to participate, they'll set you up on Direct Deposit.

Please deposit my entire net pay into the account specified below.

Cirlcle One: Checking Savings

Bank Name: _____

Account #: _____

Routing / Transit #: _____

Attach a voided check, bank letter or specification sheet. Deposit tickets are NOT accepted.

If you are splitting your deposit, please select the second account and mark the percentage or the correct dollar amount to be deposited.

Cirlcle One: Checking Savings

Bank Name: _____

Account #: _____

Routing / Transit #: _____

Split amount Percentage to this account % or flat dollar amount $

Attach a voided check, bank letter or specification sheet. Deposit tickets are NOT accepted.

EMPLOYEE INFORMATION

Name: _____

Social Security #: _____

Home Address: _____

City: _____

State: _____ Zip: _____

Responsibility of Employee

Upon enrolling in the direct deposit program, the Employee will affirm whether the entire payment amount, is or is not, subject to being forwarded to a bank in another country. Should the employee's IAT status change at any time in the future, the employee should notify the state or the inquiring agency. Should the employee receive payroll via direct deposit at a U.S. financial institution and then have the entire payroll amount forwarded to a bank in another country, the employee should advise Team Staffing Services (hereinafter client name), client name may provide a general notice regarding the IAT rules, or it may make a specific inquiry of you. If the employee does not advise client name that the employee meets the definition of an IAT payee, the employee will be presumed to be a non-IAT payee. Should the Employee's IAT status change at any time in the future, the Employee should notify client name.

Please indicate if the Employee is an IAT payee by placing a check here: [ ]

Authorization

I authorize my employer, Team Staffing Services (hereinafter client name) to deposit my net pay each payday directly into my account. In the event that client name deposits funds erroneously into my account, I hereby authorize client name to debit my account for an amount not to exceed the original amount of erroneous credit. Any dispute arising out of or in correction with this agreement, if not otherwise resolved, shall be determined by arbitration in Cleveland, Ohio, in accordance with the rules of the American Arbitration Association, and it's the expressed desire of both parties that the prevailing party be awarded the costs and attorney's fees and that the award be entered as a judgment in any jurisdiction in which the non-prevailing party does business. This authorization will remain in full force and effect until client name and the bank have received written notice from me of its termination in such time and in such manner as to afford client name and Bank a reasonable opportunity to act on it.

Employee Signature: _____ Date: _____

TEAM STAFFING SERVICES

JOIN THE WINNING TEAM

Limited Benefit & Self-Funded Minimum Essential Coverage (MEC) Enrollment Guide

Complete the Enrollment Form to Elect or Decline Coverage

IMPORTANT PLAN INFORMATION: You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

1. You **MUST** complete the Enrollment Form as part of your New Hire Process.
2. Elect or decline all benefits on the Enrollment Form.
3. You **MUST** Sign and Date the bottom of the form, even if you decline coverage.
4. Return the Enrollment Form to your Branch Manager.
5. Keep the Benefits at a Glance page for your records.

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Enrollees of California: In order to enroll in the Fixed Indemnity Medical Benefit, you and any dependent must have minimum essential coverage and be enrolled in major medical coverage.

THE FIXED INDEMNITY MEDICAL PLAN IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS COVERAGE AS DEFINED IN FEDERAL HEALTH LAW.

The Essential StaffCARE Fixed Indemnity Medical, Prescription Drug, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1214, 26.212, and 26.213. The Term Life/Accidental Death and Dismemberment and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

The MEC Wellness/Preventive Plan is an employer-sponsored, self-funded plan that has been deemed to be in compliance with ACA rules and regulations. More information about Preventive Services may be found on the government website at: https://www.healthcare.gov/coverage/preventive-care-benefits. For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

Voluntary Electronic Availability of Summary Health Information for MEC/Wellness Preventive Plan

A sample copy of the Summary of Benefits and Coverage ("SBC") from Essential StaffCARE ("ESC") is available at the following link: www.enrollment.care/info/sbcmec.

While you may have other health plans, this is the link for your MEC plan with ESC. This important document explains the terms and conditions of your Health Plan, including eligibility, coverage amounts and exclusions along with your rights and responsibilities. At any time, you may request paper copies or revoke your consent to electronic delivery, free of charge, by calling 1-866-798-0803.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

ESC Essential StaffCARE

VSI **251600-TST** | OFFICE USE ONLY LOCATION _____ Rehire Date __/__/____

ENROLLMENT FORM

ESC/MEC NA P1M v23.

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name	Phone	
Social Security #	Date of Birth / /	Gender M F
Address		Apt. #
City	Zip	State

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare benefits?
☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rate:

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only	☐ **$19.98**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + 1	☐ **$40.54**	**$10.80**	**$4.92**	**$0.90**	
Employee + Family	☐ **$54.14**	**$17.82**	**$6.56**	**$1.80**	
	☐ **NO** to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] STD is not available to persons who work in **CA, HI, NJ, NY,** or **RI**

For Term Life / Accidental Death & Dismemberment please write in your beneficiary information. Accidental Death & Dismemberment is part of the Group Term Life Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Gender M F	Relationship
				☐ Spouse ☐ Child ☐ Domestic Partner
				☐ Spouse ☐ Child ☐ Domestic Partner
				☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82516000-M-TST **Direct Payment Monthly Rate**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the healt insurance exchange. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offere and provided by your employer. Note: The Patient Protection and Affordable Care Act (PPACA) individual mandate no longe imposes a penalty at the federal level, however, please check with your state for any state specific individual mandate requirement or penalties. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ **$58.19** Employee Only ☐ **$69.53** Employee + 1 ☐ **$80.87** Employee + Family ☐ **NO** to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benef plans; I've been offered self-funded ACA compliant coverage (MEC Wellness/Preventive) and open enrollment is only available fc a limited time. I also understand that making no benefit selection is a declination of benefit coverage and benefit coverage is onl available to employees who are over the age of 18.

DATE __/__/____ ▶ **SIGNATURE**

Policy Number **251600-TST**

LIMITED BENEFITS SUMMARY

FIXED INDEMNITY MEDICAL BENEFIT

For more details, please see your Summary Plan Description.

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by an accident or illness. If the covered event cost more, you pay the difference. But if the covered event costs less, you keep the difference.

Outpatient Benefits[1]		**Inpatient Benefits**	
Physician Office Visit (Virtual or In-Person)	$105 per day	Standard Care	$300 per day
Diagnostic (Lab)	$75 per day	Intensive Care Unit Maximum[3]	$400 per day
Diagnostic (X-Ray)	$200 per day	Inpatient Surgery	$2,000 per day
Ambulance Services	$300 per day	Anesthesia	$400 per day
Physical, Speech, or Occupational Therapy	$50 per day	Skilled Nursing[4]	$100 per day
Emergency Room Benefit—Sickness	$200 per day	First Hospital Admission (1 per year)	$250
Emergency Room Benefit—Accident[2]	$500 per day	Annual Inpatient Maximum[5]	No Limit
Outpatient Surgery	$500 per day	**Prescription Drugs (via reimbursement)**[6,7]	
Anesthesia	$200 per day	Annual Maximum	$600
Annual Outpatient Maximum	$2,000	Generic Coinsurance / Brand Coinsurance	70% / 50%
Wellness Care			
Wellness Care (one per year)	$100		

[1]all outpatient benefits are subject to the outpatient maximum [2]covers treatment for off the job accidents only [3]pays in addition to standard care benefit [4]for stays in a skilled nursing facility after a hospital stay [5]subject to internal limits of plan [6]not subject to outpatient maximum [7]To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc.

DENTAL BENEFIT

Waiting Period/Coinsurance **Annual Maximum Benefit** $750 **Deductible** $50

Coverage A	None / 80%	Exams, Cleanings, Intraoral Films, and Bitewings
Coverage B	3 Months / 60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures
Coverage C	12 Months / 50%	Periodontics, Crowns, Endodontics, Bridges and Dentures

VISION BENEFIT

	In-Network		**Out-of-Network**	
	You Pay	Plan Pays	You Pay[3]	Plan Pays
Eye Exam[1] (including dilation)	$10 Copay	100%	100%	$35
Standard Contact Lens Fit Exam (includes follow up)	Up to $55	$0	100%	$0
Premium Contact Lens Fit Exam (includes follow up)	100%, after 10% discount	$0	100%	$0
Frames (once every 24 months)	80%, after $110 allowance	20% plus $110 allowance	100%	$55
Standard Plastic Lenses (single, bifocal, trifocal)[1,2]	$25 Copay	100%	100%	$25-$55
Contact Lenses (Conventional) (materials only)[1]	85%, after $110 allowance	15% plus $110 allowance	100%	$88
Contact Lenses (Disposable) (materials only)[1]	100%, after $110 allowance	$110 allowance	100%	$88
Contact Lenses (Medically Necessary) (materials only)[1]	$0 Copay	100%	100%	$200

[1]Once every 12 months [2]$15 higher in AK, CA, HI, OR, WA [3]After plan payment

GROUP TERM LIFE BENEFIT

Employee Amount	$10,000 (reduces to $7,500 at 65; $5,000 at 70)	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$5,000 (terminates at age 70)	**Infant Amount (15 days to 6 mos)**	$1,000

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D is part of the Group Term Life Benefit.)

Employee Amount	$20,000	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$20,000	**Infant Amount (15 days to 6 mos)**	$2,500

SHORT-TERM DISABILITY BENEFIT

Benefit Amount	60% of base pay up to $150 per week
Waiting Period/Maximum Benefit Period	7 days for injury or sickness / up to 26 weeks

OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT [1]

Policy Number **82516000-M-TST**

The optional MEC Wellness/Preventive Benefit **DOES NOT** cover medical services. This plan provides coverage for preventive services such as immunization and routine health screening. It does not cover conditions caused by accident or illness.

Benefit	**In-Network**	**Non-Network**	**MONTHLY MEC PREMIUM**	**MEC**
Preventive Services for Adults	100%	40%	**Employee Only**	$58.19
Preventive Services for Women	100%	40%	**Employee + 1**	$69.53
Covered Preventive Services for Children	100%	40%	**Employee + Family**	$80.87

For more information about preventive services, please visit www.healthcare.gov

WEEKLY LIMITED BENEFITS PREMIUM

	Medical	**Dental**	**Vision**	**Term Life**	**STD**
Employee Only	$19.98	$5.40	$2.42	$0.60	$4.20
Employee + 1	$40.54	$10.80	$4.92	$0.90	-
Employee + Family	$54.14	$17.82	$6.56	$1.80	-

LIMITED BENEFIT EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

FIXED INDEMNITY MEDICAL

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
- Declared or undeclared war
- Serving on full-time active duty in the armed forces
- The covered person's commission of a felony
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions
- Hearing examinations or hearing aids
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force
- Services provided by a member of the covered person's immediate family.

The fixed indemnity medical plan is not available to residents of Hawaii, New Hampshire or Puerto Rico.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

VISION

No benefits will be paid for any materials, procedures or services provided under worker's compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent, or a person who resides in your home
- Declared or undeclared war or act of war
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony
- Your participation in a riot
- If you engage in an illegal occupation
- Release of nuclear energy
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

Short-Term Disability benefits are not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

For Accidental Death and Dismemberment benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

Attempted suicide or intentionally self inflicted injury; bodily or mental infirmity; disease of any kind; or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound or accidental ingestion of poisonous food substance; voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you, your spouse or domestic partner; you, your spouse's or domestic partner's child; sibling or parent; or a person who resides in your home; declared or undeclared war or act of war; your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony; your participation in a riot; if you engage in an illegal occupation; release of nuclear energy; operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; work-related injury or sickness.

Member Services:

For frequently asked questions and network information for the Fixed Indemnity Medical Plan, visit *https://enrollmen care/info/bcs/ind.* For questions and a full list of preventive services covered by the MEC Wellness/Preventive Plan, as we as the MEC SBC, please visit *https://enrollment.care/info/bcs/mmdp.* A paper copy is also available, free of charge, b calling Essential StaffCARE Customer Service 1-866-798-0803.

PLEASE NOTE: To make changes or cancel coverage by telephone call (800) 269-7783. Your pin code for enrolling/making change is **142** + _ _ _ _ (last four digits of your SSN). Your Company has chosen to take your payroll deductions on a **Post-Tax** basis.

Essential StaffCARE Customer Service: 1-866-798-0803

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets an to add, change, or cancel coverage.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit www.paisc.com and click on "Members."