New Employee Packet

- ☐ Employee Information form
- ☐ Authorization for Direct Deposit
- ☐ Fed W-4
- ☐ OK W-4
- ☐ Form I-9

  Must include copy of Driver's License and copy of either Social Security Card or Passport
- ☐ Health Insurance Application (even if denying)
- ☐ Dental Insurance Application (only if applicable)

Manager's Responsibility

- ☐ Request email to be set-up
- ☐ Request Mylee sales number
- ☐ Rate of Pay: _____
- ☐ Start Date: _____
- ☐ Position: _____
- ☐ Reviewed with employee location of personnel manual on forms page
- ☐ Review pay periods, pay dates and pay stub password protection information
- ☐ Paperwork completed and turned into corporate

Signed: _____

Summary of LifeStyles Benefits

(Refer to Personnel Manual for Details)

For Full-time employees working an average of 35 hours or more, per week:

- Health insurance (employee only) paid by LifeStyles after 90 days of employment
- PTO after 1 year of employment
- SIMPLE IRA after 1 year of employment
- Dental insurance (employee paid)
- Employee Purchase discounts
- Holidays (store closed):
  - New Year's Day
  - July 4th
  - Thanksgiving
  - Christmas

LifeStyles Stores, Inc.
CORPORATE OFFICES
1801 West 33rd Street • Edmond, OK 73013
tel:(405)348-7422 x 107 fax(405)216-8976

Employee Information

Name: _____

Address: _____

City, Zip: _____

Phone: _____

Cell: _____

SS# : _____

DOB: _____

Emergency Contact Information

Name: _____

Relationship to employee: _____

Phone: _____

Cell: _____

LifeStyles
1801 W. 33rd Street • Edmond, OK 73013
www.LifeStylesStores.com

Authorization for Direct Deposit

This form authorizes LifeStyles Stores, Inc. to send credit entries (and any appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my account indicated below. This authorizes the financial institution holding the Account to post all such entries.

Bank Account Information:

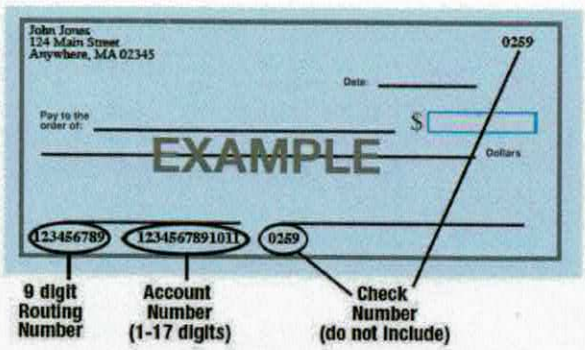
Account Type: Checking _____ Savings _____

Bank Name: _____

City, State: _____

Routing No.: _____

Account No.: _____



This authorization will be in effect until LifeStyles Stores, Inc. receives a written termination notice from me and has a reasonable opportunity to act on it.

Please e-mail my payroll stubs to:

E-mail: _____

Signature: _____

Name: _____

Date: _____

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	**7**	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

Form OK-W-4
March 2018

OKLAHOMA TAX COMMISSION

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

This certificate is for income tax withholding purposes only. Type or print.

NOTE: Do NOT mail to the Oklahoma Tax Commission.

Your First Name and Middle Initial	**Last Name**	**Your Social Security Number**

Home Address (Number and Street or Rural Route)	**Filing Status** ☐ **Single** ☐ **Married** ☐ **Married, but withhold at higher Single rate**

City or Town	**State**	**ZIP Code**

1. Allowance For Yourself: Enter 1 for yourself	1	
2. Allowance For Your Spouse: Does your spouse work? ☐ Yes ☐ No If Yes, enter 0. If no, enter 1 for your spouse...	2	
3. Allowance For Dependents: Enter the number of dependents you will claim on your tax return. Do not claim yourself or your spouse or dependents that your spouse has already claimed on his or her Form OK-W-4	3	
4. Additional Allowances: You may claim additional allowances if you itemize your deductions or have other state tax deductions or credits that lower your tax. Enter the number of additional allowances you would like to claim	4	
5. Total Number of Allowances You Are Claiming: Add Lines 1 through 4 and enter total here	5	
6. Additional Withholding: If you expect to have a balance due (as a result of interest income, dividends, income from a part-time job, etc.) on your tax return, you may request your employer to withhold an additional amount of tax from each pay period. To calculate the amount needed, divide the amount of the expected balance due by the number of pay periods in a year. Enter the additional amount to be withheld each pay period here	6	$
7. Exempt Status: If you had a right to a refund of all of your Oklahoma income tax withheld last year because you had no tax liability and this year you expect a refund of all Oklahoma income tax withheld because you expect to have no tax liability, write "Exempt" on Line 7. See information below	7	
8. If you meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Oklahoma tax liability, write "Exempt" on line 8 and complete Form OW-9-MSE. See information below	8	
9. If income earned as a member of any active duty component of the Armed Forces of the United State is eligible for the military income deduction write "exempt" on Line 9	9	

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's Signature (Form is not valid unless you sign it)	**Date** (MM/DD/YYYY)

Form OK-W-4 is completed so you can have as much "take-home pay" as possible without an income tax liability due to the state of Oklahoma when you file your return. Deductions and exemptions reduce the amount of your taxable income. If your income is less than the total of your personal exemption plus your standard deduction, you should mark "Exempt" on Line 7 above. The following amounts of your annual Oklahoma adjusted gross income will not be taxed by the state of Oklahoma when you file your individual income tax return.

Single	**Married Filing Joint**
$1,000 - personal exemption	$ 2,000 - personal exemption
$6,350 - standard deduction	$12,700 - standard deduction
$7,350 - Total	$14,700 - Total
+$1,000 for each dependent	+$1,000 for each dependent

ITEMS TO REMEMBER:

- If your filing status is married filing joint and your spouse works, do not claim an exemption on Form OK-W-4 for your spouse.
- If you and your spouse have dependents, please be sure only one of you claim the dependents on your Form OK-W-4. If both spouses claim the dependents as an allowance on Form OK-W-4, it may cause you to owe additional Oklahoma income tax when you file your return.
- If you have more than one employer, you should claim a smaller number or no allowances on each Form OK-W-4 filed with employers other than your principal employer so the amount withheld will be closer to your amount of total tax.
- If you itemize your deductions, instead of using the standard deduction, the amount not taxed by Oklahoma may be a greater or lesser amount.
- If you are claiming an "Exempt" status due to the Military Spouses Residency Relief Act you must provide Form OW-9-MSE "Annual Withholding Tax Exemption Certification for Military Spouses".

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last | First | Middle Initial | Maiden Name

Address *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

City | State | Zip Code | Social Security #

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):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*) _____

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title:				
Issuing authority:				
Document #:				
Expiration Date *(if any)*:				
Document #:				
Expiration Date *(if any)*:				

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)* | B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)				2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		3. School ID card with a photograph		
		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		5. U.S. Military card or draft record		
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		5. Native American tribal document
		8. Native American tribal document		6. U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**For persons under age 18 who are unable to present a document listed above:**		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		10. School record or report card		8. Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Application for Health Insurance

Employee Information:

Name: _____

Address: _____

City: _____

State: _____

Zip code: _____

SS #: _____

DOB: _____

Phone: _____

Date of Hire: _____

Dependent Information:

Only complete this portion if you are adding your spouse at your own expense.

Spouce's Name: _____

Address: _____

City: _____

State: _____

Zip code: _____

SS #: _____

DOB: _____

Dependent Information:

Only complete this portion if you are adding dependents at your own expense.

Child's Name: _____

Address: _____

City: _____

State: _____

Zip code: _____

SS #: _____

DOB: _____

Dependent Information:

Child's Name: _____

Address: _____

City: _____

State: _____

Zip code: _____

SS #: _____

DOB: _____

☐ By checking the box to the left, I only want health insurance for myself.

☐ By checking the box to the left, I am requesting health insurance for any dependents listed above.

☐ By checking the box to the left, I am **declining** health insurance for myself (and/or my dependents).

Signed: _____ Date: _____

Memo:

To: All employees
From: Tracy Reppert
Date: November 28, 2018
Re: Optional Dental Insurance

Attached you will find the Fusion High Plan dental insurance that is now available to all employees and their dependents. Please let me know if you have any questions.

ALL COSTS ASSOCIATED WITH THIS DENTAL INSURANCE IS AT EMPLOYEE EXPENSE!

Please review the attached and if you are interested, complete the enrollment form and return it to me *no later than December 20th* for a 1/1/19 effective date. Your premiums will be deducted directly from your pay check and the calculation will be based as follows:

Employee only:
$33.41 per month x 12 months, divided by 26 pay periods
$33.41 x 12 = $400.92 per year divided by 26 = $15.42 deduction per pay check.

Employee + Spouse:
$68.42 per month x 12 months, divided by 26 pay periods
$68.42 x 12 = $821.04 per year divided by 26 = $31.58 deduction per pay check.

Employee + Children: (no additional premium for more than one child)
$88.09 per month x 12 months, divided by 26 pay periods
$88.09 x 12 = $821.04 per year divided by 26 = $40.68 deduction per pay check.

Employee + Family: (no additional premium for more than one child)
$123.10 per month x 12 months, divided by 26 pay periods
$123.10 x 12 = $1,477.20 per year divided by 26 = $56.82 deduction per pay check.

Fusion High Plan

We combine two benefits — dental and vision — into one plan that lets you and your family receive the care you need most.

Dental and Vision Benefits You Expect

- Your annual maximum has been combined into one amount. This plan's annual maximum benefit is $1,500 for each person covered on your plan, and you get to choose how to spend it. You can use it all toward dental expenses, or you can use up to $150 for vision expenses.
- We process both dental and vision claims for Fusion, so you can enjoy the same quick turnaround.
- Visit the providers of your choice — no network restrictions — although for dental, you can make your benefit dollars go further by visiting one of our Ameritas Dental Network providers. If interested, visit ameritas.com, Find a Provider.

Deductible	$50/Calendar Year Waived on Type 1 No Family Maximum
Annual Maximum (Calendar Year)	$1,500
Flat Max Vision Benefit	$150

Type 1 Procedures	Plan Pays
Exams (2 per benefit period) Bitewing x-rays (1 per benefit period) Full Mouth/Panoramic x-rays (1 in 5 years) Periapical x-rays Cleaning (2 per benefit period) Fluoride for Children 18 and under (1 per benefit period) Sealants (age 15 and under) Space Maintainers	Covered at 100%
Type 2 Procedures	
Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Endodontics (surgical) Periodontics (nonsurgical) Periodontics (surgical) Simple Extractions Complex Extractions	Covered at 80% (after deductible)
Type 3 Procedures	
Inlays/Onlays Crowns (1 in 5 years per tooth) Crown Repair Denture Repair Implants Prosthodontics, i.e. fixed bridge, removable complete/partial dentures (1 in 8 years)	Covered at 50% (after deductible)

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Orthodontia

Perceptions and attitudes surrounding braces may have changed over the years, but the goal of orthodontic treatment remains the same: to help each patient achieve a beautiful smile. **Your plan provides child orthodontia coverage, and will pay 50% of the cost, to $1,500 per child.**

Secure Member Account

We'll provide an ID card for each person covered under your plan. You also can get instant access to your ID cards, certificate of coverage, claims information and check your remaining benefits by creating a secure member account.

Added Value for Ameritas Members

Ameritas' added extras make your benefits even more valuable.

Rx Savings: Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CV, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance. To receive the discount, visit Ameritas.com and sign into (or create) a secure member account where you can access and print an Rx savings ID card.

How to Submit a Vision Claim

Pay the provider for services. Ask the provider to complete Ameritas Vision/LASIK Claim Form GC 325, so you can send it in for reimbursement, along with your receipts (remember to keep a copy of your receipts for your records). **Claim must be filed within 90 days after completion of the service. The claims filing address is:**

Ameritas Life Insurance Corp.
Claims Office
P.O. Box 82520
Lincoln, NE 68501-2520
Fax 402-467-7336

Access the Ameritas Claim Form:

Visit ameritas.com, Account Access, Dental/Vision/Hearing drop down, and under Resources click on Forms. On the Forms page, select Claim Forms drop down and download Ameritas Vision/LASIK Claim Form GC 325.

We're Here to Help

At Ameritas, we do more than provide coverage – we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to Midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. Just call toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritas.com. Once you're enrolled, you can select Account Access to sign in to (or create) a secure member account.

This brohcure highlights the dental and vision coverage available through Ameritas Life Insurance Corp. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

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Dental and Vision Benefits Employees Use, and Expect

Offering employee benefits can help you find and retain the talent you rely on to keep your small business running smoothly. And it's more affordable for you and your employees than you might think.

We Make Your Job Easier

- **Ameritas employee benefits are hands-off and hassle-free for you**

42% of employees say improving their benefits package is one thing their employer could do to keep them in their jobs.[1]

- **Toll-free claims call center for member questions**
- **Customized, easy-to-use plans that fit your specific needs**

Example of Annual Dental Costs			
Service	Estimated Cost Without Insurance	Dental Plan Pays In-Network	Member Pays
Exam (Type 1)	$54	100% = $54	$0
Bitewing x-rays (Type 1)	$48	100% = $48	$0
Composite Filling (Type 2)	$176	80% = $141	$35 + $50 deductible
Crown (Type 3)	$1,182	50% = $591	$591 + $50 deductible
Total	$1,460	$834	$726

To see how many network providers are in your area, visit ameritas.com, Find a Provider.

[1] 2016 Aflac WorkForces Report employee benefits study

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Fusion

Fusion

combine two benefits — dental and vision — into one plan that lets your employees and their dependent family members receive the care they need most.

Employees use all of their annual maximum benefit for dental, or use $100 or $150 (depending on plan selected) toward vision expenses.

Flexibility for You

- Available to groups of 3+ enrolled employees
- Two benefits share one policy, one enrollment form, one payroll entry and one bill
- Employees and their families can choose how to spend benefit dollars
- Employees can visit the vision provider of their choice

Options listed are available in most states. Check with your Ameritas representative for product approval and availability.

Plan Comparison	Fusion Base Plan	Fusion High Plan	Traditional High Plan
Benefit Maximums (per person)			
Dental	$1,000/calendar year	$1,500/calendar year	$2,000/calendar year
Vision (plus EyeMed discounts)	$100/calendar year (leaves $900 for dental)	$150/calendar year (leaves $1,350 for dental)	no vision benefit
Orthodontia	no benefit	child only $1,500 lifetime benefit	child only $2,000 lifetime benefit
Deductibles			
Dental Type 1 Preventive Procedures	$0	$0	$0
Dental Type 2 Basic & Type 3 Major Procedures	$50/calendar year	$50/calendar year	$50/calendar year
What the plan pays after deductibles			
Type 1 Preventive Procedures	100%	100%	100%
Type 2 Basic Procedures	80%	80%	80%
Type 3 Major Procedures	50%	50%	50%*
Orthodontia	N/A	50%	50%
Out-of-Network Allowance	U&C**	U&C**	U&C**
Waiting Period	None	None	None
Annual Open Enrollment	Yes	Yes	Yes

* includes teeth whitening benefit

Monthly Rates*			
Employee Only	$27.28	$33.41	$33.77
Employee & Spouse	$56.09	$68.42	$69.35
Employee & Children	$63.22	$88.09	$94.85
Employee, Spouse & Children	$92.02	$123.10	$130.44

Dental Procedure Summary			
Routine Exam	Type 1	Type 1	Type 1
Bitewing X-rays	Type 1	Type 1	Type 1
Full Mouth/Panoramic X-rays	Type 1	Type 1	Type 1
Periapical X-rays	Type 1	Type 1	Type 1
Cleaning	Type 1	Type 1	Type 1
Fluoride for Children 13 & under	Type 1	Type 1	Type 1

*Monthly rates are valid for groups with effective dates of 8/1/2017 through 9/30/2018, and are guaranteed for 12 months.

**90th U&C means 9 out of 10 dentists in a specific ZIP Code area charge at or below the plan allowance for a procedure. We determine the Usual and Customary (U&C) allowance listed on the plan summary page using information including data from a nationally recognized independent data source. Plan members are reimbursed based on the appropriate charges in the dentist's ZIP Code area. We review our U&C allowances annually.

Plan Comparison	Fusion Base Plan	Fusion High Plan	Traditional High Plan
Dental Procedure Summary cont'd			
Sealants for Children	Type 1	Type 1	Type 1
Space Maintainers	Type 1	Type 1	Type 1
Restorative Amalgams (silver colored filling) & Restorative Composites (tooth colored filling)	Type 2	Type 2	Type 2
Endodontics (nonsurgical)	Type 2	Type 2	Type 2
Endodontics (surgical)	Type 2	Type 2	Type 2
Simple Extractions	Type 2	Type 2	Type 2
Periodontics (nonsurgical)	Type 3	Type 2	Type 2
Periodontics (surgical)	Type 3	Type 2	Type 2
Complex Extractions	Type 3	Type 2	Type 2
Anesthesia	Type 3	Type 2	Type 2
Inlays/Onlays	Type 3	Type 3	Type 3
Crowns	Type 3	Type 3	Type 3
Crown Repair	Type 3	Type 3	Type 3
Denture Repair	Type 3	Type 3	Type 3
Implants	Type 3	Type 3	Type 3
Prosthodontics (fixed bridge, removable complete/ partial dentures)	Type 3	Type 3	Type 3

Vision Network Discounts

Network discounts available through EyeMed make it even easier for covered employees to save on exams, eye wear and laser vision correction. The EyeMed provider will need to see your Eye Care ID Card.

EyeMed Network Discounts		
Vision Services	Service Detail	Member Cost
Exam	With dilation as necessary	$5 off routine exam $10 off contact lens exam
The following lenses, frame and lens options discounts and fees apply only if a complete pair of glasses is purchased		
Standard Plastics Lenses	Single Vision Bifocal Trifocal	$50 $70 $105
Frame	Available at provider location	35% off retail price
Lens Options	Standard Progressive Premium Progressive Standard Polycarbonate Tint (solid or gradient) Scratch-Resistant coating Anti-Reflective Coating Ultraviolet Coating Other Add-ons	$65 plus standard lens cost 20% discount $40 $15 $15 $45 $15 20% discount
Items purchased separately will be discounted 20% off the retail price		
Contact Lenses	Conventional	15% off retail price
	Does not include disposables. Discount applies to materials only (it does not apply to fitting). After initial purchase, replacement contacts by mail are offered at substantial savings online through eyemedvisioncare.com.	
Laser Vision Correction	LASIK or PRK For a nearby location and discount authorization, call 1-877-5LASER6.	15% off retail price or 5% off promotional price
Frequency	All services listed	Unlimited

Note: Based on applicable laws, reduced costs may vary by doctor location.

Support for Members

It's very simple – we do whatever it takes to help our customers get the care they need. Our customer connections call center is certified as a Center of Excellence by BenchmarkPortal, the largest call center benchmarking program of its kind in the world.

87% of phone calls answered within 30 seconds

99% claims processing accuracy exceeds 99%

English and Spanish, multilingual interpretation

claims processed in an average of 9 business days

secure member account

We'll provide an ID card for each covered member. Plus, members get instant access to ID cards, certificate of coverage, claims information and remaining benefits by creating a secure member account.

dental limitations and exclusions

Covered expenses will not include and no benefits will be payable for expenses incurred:

All Plans

- for any procedure except exams, cleaning and fluoride applications for the first 12 months when an employee or dependent becomes classified as a late entrant. An employee or dependent who does not enroll within 31 days from the date the person qualifies for the insurance, or who elects to become covered again after canceling a premium contribution agreement, will be classified as a late entrant.
- for any treatment which is for cosmetic purposes, except as specifically listed in the Table of Dental Procedures.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the plan member is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
- for any procedure begun before the plan member was covered under the dental expense benefit.
- for any procedure begun after the member's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the member's insurance under the dental expense benefit terminates.

(continued)

- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to:
  - alter vertical dimension;
  - restore or maintain occlusion;
  - splint or replace tooth structure lost because of abrasion or attrition
- for any procedure which is not shown on the Table of Dental Procedures.
- for orthodontic treatment (unless otherwise specified in this contract.)
- for which the plan member is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
- for charges for which the plan member is not liable or which would not have been made had no insurance been in force.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.

Limitations for Fusion Base Plan

- to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within eight years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the plan member is covered under the dental expense benefit, it will be a covered expense.
- to replace any prefabricated stainless steel and resin crowns within five years of the date of the last placement of these items. But if a replacement is required because of accidental bodily injury sustained while the plan member is covered under the dental expense benefits.

Limitations for High Plans

- to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the plan member is covered under the dental expense benefit, it will be a Covered Expense.
- or an ortho program which was begun on or after the member's 19th birthday.
- in any quarter of an ortho program if the member was not covered under the orthodontic expense benefits for the entire quarter.
- after the member's insurance under the orthodontic expense benefits terminates.

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| 800-776-9446 | ameritas.com

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas.

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental benefits only. Review your certificate carefully.**
As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Employee Acknowledgment

LifeStyles

I became an employee at Lifestyles voluntarily. I understand and acknowledge that there is no specified length to my employment at Lifestyles and that my employment is at will. I understand and acknowledge that "at will" means that I may terminate my employment at any time, with or without cause or advance notice. I also understand and acknowledge that "at will" means that Lifestyles may terminate my employment at any time, with or without cause or advance notice, as long as they do not violate federal or state laws. I understand and acknowledge that there may be changes to the information, policies, and benefits in the handbook. The only exception is that Lifestyles will not change or cancel its employment-at-will policy. I understand that Lifestyles may add new policies to the handbook as well as replace, change, or cancel existing policies. I understand that I will be told about any handbook changes and I understand that handbook changes can only be authorized by the chief executive officer of Lifestyles Stores, Inc.

I understand and acknowledge that this handbook is not a contract of employment or a legal document. I have received the handbook and I understand that it is my responsibility to read and follow the policies contained in this handbook and any changes that may be made to it.

By initialing each item below, I have read and understand the expectations of my employment with LifeStyles and the magnitude of which breaking one of these policies may lead to termination of my employment.

☐ I understand my wages and payroll information is confidential and should not be shared with anyone. In the event I share, or in any way make known, payroll information about myself or others, I may be subject to immediate termination.

☐ I understand that the following examples of infractions of rules of conduct may result in disciplinary action, up to and including termination of employment.

- Dishonesty
- Theft or inappropriate removal or possession of company property
- Delivering store merchandise to individuals without proper sales documentation or payment
- Falsification of timekeeping records
- Working under the influence of alcohol or drugs
- Fighting or threatening violence in the workplace
- Negligence or improper conduct leading to damage of company or customer owned property
- Insubordination or other disrespectful conduct
- Excessive absenteeism or any absence without notice
- Sexual Harassment
- Unauthorized use of phones, email, mail, computer or other company owned equipment
- Unauthorized disclosure of business "secrets" or confidential information
- Violation of personnel policies
- Unsatisfactory performance or conduct

☐ I understand that I MAY NOT download programs, play games on my computer, upload music, photos, etc. on to any company owned computer without the express permission of upper management. I understand doing so may result in disciplinary action, up to and including termination of employment.

Employee Name: _____

Employee Signature: _____ Date: _____