

Personnel Record & Application - <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time / Check if Temporary <input type="checkbox"/>				
Last Name		First Name	Middle Name	Social Security Number:
Street Address		City	State	Zip Code
Home Phone: () -		Are you a United States Citizen or legally eligible to work in the U. S.? <input type="checkbox"/> Yes <input type="checkbox"/> No (if hired, you will be required to provide documentation that you are eligible to work in the U.S.)		
Cell Phone: () -		Are you 18 or over? _____		
Emergency Contact: _____		Date of Birth- _____		
Emergency Contact # : () -		Driver's License #- _____ State: _____		
Title of Position Applying For			Date Available to Work	
Have you ever pleaded guilty, no contest or been convicted of a felony? [] Yes [] No If yes, give dates and details:				
Answering yes to these questions does not constitute an automatic rejection for employment. Date of the offense, seriousness and nature of the violation, rehabilitation and position applied for will be considered.				

Technical or Certificate Programs				
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Employment History Please provide the following information for your previous three employers, beginning with the most recent: (Please attach an additional page if necessary, do not use "see attached resume".)		
Employer:	Dates Employed: From _____ To _____	Job Title:
Address:		
Telephone:	Job Duties:	
Weekly Pay Start: _____ Finish: _____		
Reason for Leaving:		

I certify that my answers are true and complete to the best of my knowledge. I authorize you to make such investigations and inquiries of my personal, employment, educational, financial and other related matters as may be necessary for an employment decision. I hereby release employers, schools or individuals from all liability when responding to inquiries in connection with my application. In the event I am employed, I understand that false or misleading information given in my application or interview(s) may result in discharge.

Signature _____ Date _____

OFFICE USE ONLY	
Company Name: _____	Job Title: _____
Job Description: _____	W/C Code: _____
Date of Hire: _____	Hours Per Week: _____
Rate of Pay: _____	Full Time: _____ Part Time: _____
Frequency of Pay: Weekly _____ Bi-Weekly _____	SemiMonthly _____ Monthly _____

Employee's Withholding Certificate

OMB No. 1545-0074

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.

2023

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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, other details, and privacy.

Step 2: 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.

Multiple Jobs or Spouse Works

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits	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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

Step 4(b)—Deductions Worksheet (Keep for your records.)

- 1** Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$25,900 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$19,400 \text{ if you're head of household} \\ \bullet \$12,950 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$110	\$850	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,770	\$1,870
\$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
\$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
\$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
\$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
\$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
\$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
\$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
\$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
\$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
\$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
\$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
\$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
\$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
\$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
\$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
\$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
\$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$400	\$930	\$1,020	\$1,020	\$1,250	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970	\$2,040	\$2,040
\$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
\$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
\$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
\$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
\$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
\$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
\$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
\$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
\$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
\$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
\$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
\$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
\$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
\$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$760	\$910	\$1,020	\$1,020	\$1,020	\$1,190	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040
\$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
\$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
\$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
\$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
\$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
\$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
\$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
\$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
\$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
\$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
\$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
\$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number <div></div>		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)				
		If you check Item Number 4. , enter one of these:				
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee					Today's Date (mm/dd/yyyy)	

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority		Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

Examples of many of these documents appear in the Handbook for Employers (M-274).

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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 		<ol style="list-style-type: none"> 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 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. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-top: 10px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p>The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>
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*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code



Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)		Check here if you used an alternative procedure authorized by DHS to examine documents.	

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)		Check here if you used an alternative procedure authorized by DHS to examine documents.	

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)		Check here if you used an alternative procedure authorized by DHS to examine documents.	

DIRECT DEPOSIT INSTRUCTIONS

Any employees that would like to enroll in the payroll direct deposit option would need to submit the direct deposit form and one of the following items:

- 1) Letter from their financial institution on their letterhead with the employee's name, account number and routing number.
- 2) Copy of a voided check.
- 3) An employee currently using a debit card for their direct deposit will need to submit a form from the issuing institution with the employee's name, account number and routing number. These forms normally come with the debit card that the employee would like their payroll checks loaded to.

Our direct deposit process for the employee's first check is one penny is deposited into the employee's account and the remainder of their wages is paid via a live paper check. Once the employee's penny is credited to their account, they will need to notify J Solutions and their next check will go 100% direct deposit.

Employee Information for Direct Deposit

Please print legibly

Employee Name: _____ Social Security No.: _____

What Portion of Net Pay Would You Like Deposited?

You may have all or part of your paycheck deposited directly to your bank account(s).

Select one of the following options to indicate the portion of your total paycheck you want deposited.

☐ 100% of Net Pay ☐ Indicated Percent _____% ☐ Indicated Dollar Amount \$_____

How Do You Want The Direct Deposit Made?

Please identify up to four bank accounts where you want your check deposited, and indicate the amount or percentage of your paycheck you want deposited in each account.

Account for the Balance of the Direct Deposit Amount:	Account for the Balance of the Direct Deposit Amount:
Bank Name:	Bank Name:
Bank Routing Number:	Bank Routing Number:
Bank Account Number:	Bank Account Number:
Type of Account: Checking <input type="radio"/> Savings <input type="radio"/>	Type of Account: Checking <input type="radio"/> Savings <input type="radio"/>
<input type="radio"/> The remainder of the check will be automatically deposited in this account	Indicate Deposit Amount for this Account: (select one)
	<input type="radio"/> Percent of Direct Deposit Amount _____%
	<input type="radio"/> Selected Dollar Amount \$_____
Account for the Balance of the Direct Deposit Amount:	Account for the Balance of the Direct Deposit Amount:
Bank Name:	Bank Name:
Bank Routing Number:	Bank Routing Number:
Bank Account Number:	Bank Account Number:
Type of Account: Checking <input type="radio"/> Savings <input type="radio"/>	Type of Account: Checking <input type="radio"/> Savings <input type="radio"/>
Indicate Deposit Amount for this Account: (select one)	Indicate Deposit Amount for this Account: (select one)
<input type="radio"/> Percent of Direct Deposit Amount _____%	<input type="radio"/> Percent of Direct Deposit Amount _____%
<input type="radio"/> Selected Dollar Amount \$_____	<input type="radio"/> Selected Dollar Amount \$_____

Signature _____ Date _____

J SOLUTIONS

WORKFORCE CONFIDENTIALITY AGREEMENT

I understand that J Solutions has a legal and ethical responsibility to maintain privacy, including obligations to protect the confidentiality of clients' information and to safeguard the privacy of client information.

In addition, I understand that during the course of my employment/assignment/affiliation at J Solutions, I may see or hear other Confidential Information such as financial data and operational information pertaining to the business that J Solutions is obligated to maintain as confidential.

As a condition of my employment/assignment/affiliation with J Solutions I understand that I must sign and comply with this agreement. By signing this document I understand and agree that:

I will disclose Information and/or Confidential Information only if such disclosure complies with J Solutions policies, and is required for the performance of my job.

My personal access code(s), user ID(s), access key(s) and Password(s) used to access computer systems or other equipment are to be kept confidential at all times.

I will not access or view any information other than what is required to do my job. If I have any question about whether access to certain information is required for me to do my job, I will immediately ask my supervisor for clarification.

I will not discuss any information pertaining to the practice in an area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events).

I understand that it is not acceptable to discuss any business information in public areas.

I will not make inquiries about any business information for any individual or party who does not have proper authorization to access such information.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purging of Business Information or

Confidential Information. Such unauthorized transmissions include, but are not limited to, removing and/or transferring Business Information or Confidential Information from J Solutions' computer system to unauthorized locations (for instance, home).

Upon termination of my employment/assignment/affiliation with J Solutions, I will immediately return all property (e.g. Keys, documents, ID badges, etc.) to J Solutions.

I agree that my obligations under this agreement regarding Business Information will continue after the termination of my employment/assignment/affiliation with J Solutions.

I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my employment/assignment/affiliation with J Solutions and/or suspension, restriction or loss of privileges, in accordance with J Solutions' policies, as well as potential personal civil and criminal legal penalties.

I understand that any Confidential Information or Business Information that I access or view at J Solutions does not belong to me.

I have read the above agreement and agree to comply with all its terms as a condition of continuing employment.

Signature of employee/physician/
Student/volunteer

Date

Print Your Name

PAYROLL DEDUCTION AUTHORIZATION

I authorize PEO Company, to deduct from my wages the following: local, state, and federal taxes; any court ordered payments; any deductions required by state or federal law; deductions for loss or damage to any uniforms, machinery, merchandise, equipment, tools, vehicles, or other property provided by PEO Company which I do not return or which are not returned in good condition; any unpaid loans or advances which I owe to PEO Company and, any personal expenses or charges owed by me to PEO Company.

In addition, I authorize the full unpaid amount of any such charges or expenses to be deducted from my final paycheck on the termination of my employment with PEO Company.

I acknowledge that I have received, read, and understand the contents of this PEO Company policies and safety program. If unable to read, the contents of the safety program have been read and explained to me by my supervisor. I understand that my compliance with all stated PEO Company policies, including safety, is a condition of continued employment with this PEO Company.

Employee Signature

Date

48- HOUR RULE

Any occupational injury not reported within 48 hours will be considered non-occupational injury and therefore may result in loss of occupational injury benefits.

Employee Signature

Date

DRUG TESTING POLICY AND CONSENT TO DRUG TESTING

It is the policy of the Client Company that the use of alcohol, illegal drugs or inhalants will not be tolerated. Although the Client Company recognizes that many such products have legitimate uses, it is the policy of the Client Company not to tolerate misuse or abuse of industrial solvents, aerosol propellants, paint thinners, lacquer thinners, paints, lacquers, dopes, or any other similar product which could be used to produce an intoxicated state by inhalation of its vapors or gases (which will be called "inhalants" in this document). The Client Company maintains a list of all such substances which may be used, or with which its workers or contractors may come in contact in the course of their work. The presence of detectable residues to off other industrial solvents, aerosol propellants, paint thinners, lacquer thinners, paints, lacquers, dopes (this list is by way of example only, and does not constitute a complete statement of all products or substances which may be abused by inhalation) is cause for immediate dismissal without notice. Consumption of alcohol or use of illegal drugs during working hours or in such a way as to leave a detectable trace of alcohol or illegal drugs in the body is cause for immediate dismissal without notice.

I understand that the Client Company policy prohibits any Employee from engaging in work or being on Client Company premises or the premises of any Client with a detectable level of alcohol, any illegal or controlled drug, drug by-product or drug metabolite or inhalant or by-product of metabolite of an inhalant in the body, including in the breath, blood, urine or hair. This policy does not apply to the proper use of medication prescribed for me by a physician.

I understand that it is a condition of, but not a guarantee or promise of, employment, continued employment, advancement or promotion that I follow the Client Company's policies on drugs, alcohol and inhalants, and the policies of any Client Client Company where I may be assigned. I understand that I may be asked to participate in drug, alcohol and inhalant testing ("Testing") to determine whether I comply with such policies.

I understand that I may refuse to participate in any Testing required by the Client Company or the Client Client Company, but I understand and agree that my failure to participate in testing will be cause of immediate termination, and that I will not be eligible to be re-hired. If I participate in Testing, my signature or mark below indicates my consent to the taking of samples of my breath, hair, blood, urine or other bodily fluids and the analysis of such samples by a laboratory selected by the Client Company, without charge to me. I consent to the disclosure of all negative and confirmed positive test results to the Client Company and any Client Client Company where I may be assigned.

I agree that I will disclose the names of any prescription or over-the-counter medications which I may be taking at the time of testing or may have taken within the thirty (30) days immediately prior to Testing. If my failure to disclose such medications causes positive results which must be confirmed and if the Client Company elects to have the results confirmed by further and more specific laboratory tests, I agree that I will furnish any further samples which may be required in order to perform the confirmatory test and reimburse the Client Company for the actual costs of such screening test and confirmation. I understand that I may refuse to participate in further Testing and/or refuse to reimburse the Client Company for expenses

incurred in confirmatory analysis, but I understand and agree that my failure to participate in Testing or to agree to reimburse the Client Company will be cause for immediate termination, and that I will not be eligible to be re-hired.

I understand that I may be required to participate in Testing, after the occurrence of any on-the-job event that did or could have resulted in personal injury or property damage, or for any other reasonable cause. I understand that a confirmed positive test for the presence of drugs or alcohol is grounds for the immediate termination of my employment for cause.

As a consideration of my employment, continued employment, advancement or promotion with the Client Company, I waive, and agree to release and hold harmless both the Client Company and any Client Client Company, and any testing laboratory along with their agents and employees from any claim or cause of action arising out of the taking of a sample of my breath, blood, urine, hair or other bodily fluids, arising out of the test, or arising out of the disclosure of negative and confirmed positive test results.

DEFINITION: **The following definition applies to this and all other Client Company policies unless another definition is expressly indicated in the policy.**

Premises means, except as otherwise limited in this definition or applicable law, ALL PLACES AND VEHICLES owned, leased, used, controlled by, or otherwise under the dominion of the Client Company, or where Employees are engaged in work on behalf of, or service to, the Client Company. Premises specifically include parking lots and sidewalks and other surrounding areas in the vicinity of any Client Company Premises. A personal vehicle used on Client Company Business is subject to this policy and to inspection, search or testing for the enforcement of this policy while the vehicle is in use on Client Company Business. Where a person to be searched is not an employee of the Client Company, this definition shall be limited to the real estate, improvements, vehicles and trailers actually owned, possessed, or otherwise under the dominion of the Client Company, not including any public roads, parking areas, sidewalks or other such areas surrounding such real estate and improvements.

Employee Signature

Date

EMPLOYMENT SEPARATION ACKNOWLEDGEMENT

Regardless of the type of separation, it is the employee's responsibility to report to the PEO Company in order to conduct a complete exit interview. This interview must take place within three (3) calendar days from the last paid day of employment. During this interview the employee will return all files, documents, equipment, keys, or other property belonging to the client company. The employee will be interviewed and a complete review of the departing assignment will be conducted by the PEO Company for any possible reassignment of employment. All final paychecks for hours worked will be paid on the pay day following the separation date. Accrued unused paid leave will be included in the final paycheck.

Any employee who separates in good standing may re-employ provided they are qualified for the position they are applying for. Any person re-employed with at least one-year time & service and who is re-employed within three months of separation will keep all accumulated time & service.

Employee Signature

Date

ACKNOWLEDGEMENT:

I acknowledge that I have read and understand the contents of this policy. If I am unable to read, I acknowledge that the contents have been read and explained to me. I understand there is a copy of the Employee Manual available for further review located at the Client Company office and the PEO Company office. The Client Company may change or withdraw any of the policies at its sole discretion, at any time and without advance notice. I understand that compliance with all Client Company policies is a condition of, but not a guarantee or promise of my employment and continued employment with the Client Company. I further understand that my failure to comply immediately and fully with Client Company policies will result in disciplinary action, which may include immediate termination for cause.

Employee Name (printed)

Employee Signature

Date

J SOLUTIONS, INC.

	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual \$50	Family \$150	Individual \$50	Family \$150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	Unlimited			
Preventive services <ul style="list-style-type: none"> • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 14) • Sealants (permanent molars, through age 14) • Space maintainers (primary teeth, through age 14) • Oral Cancer Screening (1 per year, ages 40 and older) 	100% no deductible		100% no deductible	
Basic services <ul style="list-style-type: none"> • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Composite fillings (1 per tooth every 2 years, molar teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14) • Periodontics (periodontal cleanings 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment) 	80% after deductible		80% after deductible	
Major services <ul style="list-style-type: none"> • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth every 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use) • Implants (1 every 5 years for implant placement, crowns, bridges, and dentures) 	50% after deductible		50% after deductible	

Humana Dental Traditional Plus 14

Orthodontia services

Adult/child orthodontia - Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: \$2,000 lifetime orthodontia maximum.

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Waiting periods

Enrollment type	Group size	Preventive	Basic	Major ¹	Orthodontia ¹
Initial enrollment, open enrollment, and timely add-on	2-9 enrolled employees	No	No	12 months ²	24 months ²
Initial enrollment, open enrollment, and timely add-on	10 or more enrolled employees	No	No	No	12 months ² (No waiting period for employer-sponsored)
Late applicant ^{3,4}	2+ enrolled employees	No	12 months	12 months	12 months (24 months for 2-9 enrolled employees)

¹ Preventive Plus does not cover major and orthodontia services.

² Waiting periods may be decreased or waived based on the number of months the member had dental insurance immediately before their effective date. Members must have prior orthodontic insurance to reduce or waive the orthodontic waiting period.

³ Late applicants not allowed with open enrollment option.

⁴ Waiting periods do not apply to endodontic or periodontic services unless a late applicant.

Humana Dental Traditional Plus 14

Feel good about choosing a HumanaDental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your HumanaDental Traditional Preferred plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.

* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* HumanaDental helps you feel good about your dental health so you can smile confidently.

* American Academy of Cosmetic Dentistry

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit Humana.com.

Use your HumanaDental benefits

Find a dentist

With HumanaDental's Traditional Preferred plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in the HumanaDental Traditional Preferred Network. To find a dentist in HumanaDental's Traditional Preferred Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

The other side of this page gives you a summary of HumanaDental benefits. Your plan certificate describes your HumanaDental benefits, including limitations and exclusions. You can find it on MyHumana, your personal page at **HumanaDental.com** or call 1-800-233-4013.

See your dentist

Your HumanaDental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at **Humana.com**.

Learn what your plan paid

After HumanaDental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

Humana group dental plans are offered by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc., Humana Medical Plan of Utah, CompBenefits Company, CompBenefits Dental, Inc., Humana Employers Health Plan of Georgia, Inc. or DentiCare, Inc. (d/b/a CompBenefits)

This is not a complete disclosure of plan qualifications and limitations. Your agents will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.



Humana.com



Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235 or if you use a TTY, call 711.

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J SOLUTIONS, INC.

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary • Retinal imaging ¹	\$10 Up to \$39	Up to \$30 Not covered
Contact lens exam options ² • Standard contact lens fit and follow-up • Premium contact lens fit and follow-up	Up to \$55 10% off retail	Not covered Not covered
Frames ³	\$130 allowance 20% off balance over \$130	\$65 allowance
Standard plastic lenses ⁴ • Single vision • Bifocal • Trifocal • Lenticular	\$15 \$15 \$15 \$15	Up to \$25 Up to \$40 Up to \$60 Up to \$100
Covered lens options ⁴ • UV coating • Tint (solid and gradient) • Standard scratch-resistance • Standard polycarbonate - adults • Standard polycarbonate - children <19 • Standard anti-reflective coating • Premium anti-reflective coating - Tier 1 - Tier 2 - Tier 3 • Standard progressive (add-on to bifocal) • Premium progressive - Tier 1 - Tier 2 - Tier 3 - Tier 4 • Photochromatic / plastic transitions • Polarized	\$15 \$15 \$15 \$40 \$40 \$45 Premium anti-reflective coatings as follows: \$57 \$68 80% of charge \$15 Premium progressives as follows: \$110 \$120 \$135 \$90 copay, 80% of charge less \$120 allowance \$75 20% off retail	Not covered Not covered Not covered Not covered Not covered Not covered Premium anti-reflective coatings as follows: Not covered Not covered Not covered Up to \$40 Premium progressives as follows: Not covered Not covered Not covered Not covered Not covered Not covered
Contact lenses ⁵ (applies to materials only) • Conventional • Disposable • Medically necessary	\$130 allowance, 15% off balance over \$130 \$130 allowance \$0	\$104 allowance \$104 allowance \$200 allowance

Humana Vision 130

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency <ul style="list-style-type: none"> • Examination • Lenses or contact lenses • Frame 	Once every 12 months Once every 12 months Once every 24 months	Once every 12 months Once every 12 months Once every 24 months
Diabetic Eye Care: care and testing for diabetic members <ul style="list-style-type: none"> • Examination <ul style="list-style-type: none"> - Up to (2) services per year • Retinal Imaging <ul style="list-style-type: none"> - Up to (2) services per year • Extended Ophthalmoscopy <ul style="list-style-type: none"> - Up to (2) services per year • Gonioscopy <ul style="list-style-type: none"> - Up to (2) services per year • Scanning Laser <ul style="list-style-type: none"> - Up to (2) services per year 	\$0 \$0 \$0 \$0 \$0	Up to \$77 Up to \$50 Up to \$15 Up to \$15 Up to \$33

Optional benefits

- ¹ Member costs may exceed \$39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
- ² Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
- ³ Discounts may be available on all frames except when prohibited by the manufacturer.
- ⁴ Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
- ⁵ Plan covers contact lenses or frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - War or any act of war, whether declared or not;
 - Any act of international armed conflict; or
 - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
 - Is not a visual necessity;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional endorsement; or
 - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis ¹.



¹ Thompson Media Inc.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.



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Coverage	Loss	Benefit
Life insurance	Death	Your beneficiary will receive \$15,000.
Accelerated death benefit ¹	Terminal illness with a life-expectancy of 24 months or less. You must have continuous coverage a minimum of six months in order to qualify.	50 percent of the life benefit amount to a maximum benefit of \$250,000. The final life benefit amount will be reduced by the amount of the accelerated death benefit paid (may vary by state).
Accidental death or bodily injury (AD&D)	Death as the result of an accident.	Your beneficiary will receive \$15,000.
	As the result of an accident, loss of: both hands or feet; sight of both eyes; one hand and one foot; one hand or one foot and sight of one eye; complete paralysis (quadriplegia)	You will receive \$15,000.
	As the result of an accident, loss of: one hand; one foot; sight of one eye; loss of thumb and index finger of same hand; partial paralysis (paraplegia and hemiplegia)	50 percent of the life benefit amount.
AD&D includes the following benefits:		
Common carrier benefit	Death or dismemberment as a fare paying passenger	200 percent of life benefit amount
Seat belt-airbag-helmet benefit	Death as the result of an auto accident while properly using a seat belt, or wearing a properly fitted and fastened motorcycle helmet in a motorcycle accident.	Amount of your accidental death benefit increases by 10 percent, but not less than \$1,000 or more than \$10,000. In addition, we will increase your accidental death benefit by 5 percent, to a maximum of \$5,000 but no less than \$500, for a properly functioning airbag.
Education benefit	Death as the result of an accident.	Actual expense to a maximum of \$5,000 or 5 percent of death benefit. Payable up to four years for employee's dependent children or until age 25. Dependent must be a full-time student beyond 12th grade at a college, university or vocational school on the date of the employee's death or within 365 days after the death.
Childcare benefit	Death as the result of an accident.	Actual expense to a maximum of \$5,000 or 5 percent of death benefit. For a dependent in a licensed childcare center up to four consecutive years after the employee's death, or until the child's 13th birthday.
Coma benefit	Employee is in a coma caused by a body injury, the coma begins within 365 days after the accident; and the person remains in a coma for more than 31 consecutive days	One time payment of 5 percent of the employee's benefit, subject to a maximum of \$5,000.

Humana Basic Life

AD&D includes the following benefits:

Repatriation benefit	Death as the result of an accident.	Actual expenses to a maximum of \$5,000 if employee dies as a result of an accidental death at least 150 miles from his/her principal place of resident, and there are expenses for preparing and transporting the employee's body to a mortuary.
Spouse training benefit	Death as the result of an accident.	Actual expense to a maximum of \$5,000 or 5 percent of death benefit for one year after the employee's death. Survivor must be enrolled as a student in an accredited school on the date of the employee's death or within 365 days after the death.
Coverage	Loss	Benefit
Dependent insurance	Death of spouse Death of dependent child*	No dependent coverage selected. No dependent coverage selected.

¹ Residents of Alabama, Illinois, Indiana, Massachusetts, Michigan, Ohio, Oklahoma, Virginia and Washington must have continuous coverage a minimum of 30 days to qualify for illness coverage. Residents of Texas must have continuous coverage a minimum of six months to qualify for illness coverage. For accidents, coverage begins on the effective date of the policy.

*Some limitations apply.

Age reduction schedule

Beginning at age 65 (or age 70 in schedule three), employee life coverage will reduce based on the benefit amount in force on the employee's 64th birthday (or age 69 in schedule three). Basic Dependent Spouse Life terminates at age 65.

Age	Schedule two
65	35 percent
70	50 percent

Rate guarantee

Rate is guaranteed not to change for one year from the effective date of the policy.

Eligibility to participate

Active, full-time employees are eligible for coverage.

Waiver of premium

If you are totally disabled for at least six consecutive months prior to age 60, you can continue life insurance coverage and waive the premium. Waiver ends at age 65.

Conversion privilege

If your employment ends, you may be eligible to convert your coverage to an individual whole life insurance policy.

How much life insurance do you need?

The real question is:

How much will your loved ones need for short and long-term expenses?

According to the American Council of Life Insurers (ACLI), a guideline is a life insurance amount equal to 10 times your annual income. No rule applies to everyone, however, because financial situations and goals vary from person to person and family to family. Use our simple online life insurance calculator at **HumanaLife.com** to help determine your life insurance needs.



Questions

Check out **HumanaLife.com**.

Call 1-800-233-4013 anytime for automated information line or 8 a.m. to 6 p.m. for a customer service representative.

Insured by Humana Insurance Company or Humana Insurance Company of Kentucky.

This is not a complete disclosure of plan qualifications and limitations. Please review your Certificate of insurance for a complete list of benefits. The Certificate of Insurance is the document upon which eligibility and benefit payment will be determined. Your agent/broker will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage.

Humana®

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Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-320-1235 (TTY: 711) まで、お電話にてご連絡ください。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłt'ígo Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kóji' hódíłniih 1-877-320-1235 (TTY: 711).



Life insurance

If something happens to you, life insurance can help your family reduce financial stress.

Life insurance helps protect your family's finances by providing a cash benefit if you pass away. This ensures that they'll be financially supported, and can cover important things from bills to funeral costs. With life policies, you can get affordable life insurance protection for a set period of time.

Who is it for?

Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through an employer is an easier and more affordable option than individual life insurance.

What does it cover?

Life insurance protects your loved ones by providing a benefit (which is usually tax-exempt) if you pass away.

Why should I consider it?

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income.

With a life insurance benefit, your family will have extra money to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts.

Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation.

You will receive these benefits if you meet the conditions listed in the policy.



Preparing and planning

Jorge's never considered purchasing life insurance, but after being offered it through work, he decides it's a smart way to protect his family.

Jorge has a mortgage, and because his wife is helping to take care of her mother, she only works part-time. In addition, his daughter is about to start college.

Jorge looks at how his family would be affected by losing him.

Average funeral cost: **\$9,000**

Average mortgage debt: **\$202,000**

Average cost of college: **\$17,000 - \$44,000**

Average household credit card debt: **\$8,500**

With life insurance, Jorge can make sure that part of these costs are covered if something happens to him.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.



Your life coverage

VOLUNTARY TERM LIFE

Employee Benefit	\$25,000 increments to a maximum of \$100,000. See Cost Illustration page for details.
Spouse/Domestic Partner Benefit	\$5,000 increments to a maximum of \$25,000. See Cost Illustration page for details.†
Child Benefit	Your dependent children age 14 days to 26 years. \$1,000 increments to a maximum of \$10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue coverage up to: Employee \$10,000, 65-69 \$10,000, \$0. Spouse \$5,000, 65-69 \$5,000, \$0. Dependent children \$10,000.
Premiums	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes



Your life coverage

VOLUNTARY TERM LIFE

Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

‡ **Spouse/DP coverage terminates at age 70.**

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Policy Election Amount	Monthly premiums displayed. Policy Election Cost Per Age Bracket								
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
Employee									
\$25,000	\$1.25	\$1.50	\$2.50	\$4.75	\$7.00	\$11.00	\$17.00	\$26.75	\$43.25
\$50,000	\$2.50	\$3.00	\$5.00	\$9.50	\$14.00	\$22.00	\$34.00	\$53.50	\$86.50
\$75,000	\$3.75	\$4.50	\$7.50	\$14.25	\$21.00	\$33.00	\$51.00	\$80.25	\$129.75
\$100,000	\$5.00	\$6.00	\$10.00	\$19.00	\$28.00	\$44.00	\$68.00	\$107.00	\$173.00
Policy Election Amount									
Spouse/DP									
\$5,000	\$0.25	\$0.30	\$0.50	\$0.95	\$1.40	\$2.20	\$3.40	\$5.35	\$8.65
\$10,000	\$0.50	\$0.60	\$1.00	\$1.90	\$2.80	\$4.40	\$6.80	\$10.70	\$17.30
\$15,000	\$0.75	\$0.90	\$1.50	\$2.85	\$4.20	\$6.60	\$10.20	\$16.05	\$25.95
\$20,000	\$1.00	\$1.20	\$2.00	\$3.80	\$5.60	\$8.80	\$13.60	\$21.40	\$34.60
\$25,000	\$1.25	\$1.50	\$2.50	\$4.75	\$7.00	\$11.00	\$17.00	\$26.75	\$43.25
Policy Election Amount									
Child(ren)									
\$1,000	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17
\$2,000	\$0.34	\$0.34	\$0.34	\$0.34	\$0.34	\$0.34	\$0.34	\$0.34	\$0.34
\$3,000	\$0.51	\$0.51	\$0.51	\$0.51	\$0.51	\$0.51	\$0.51	\$0.51	\$0.51
\$4,000	\$0.68	\$0.68	\$0.68	\$0.68	\$0.68	\$0.68	\$0.68	\$0.68	\$0.68
\$5,000	\$0.85	\$0.85	\$0.85	\$0.85	\$0.85	\$0.85	\$0.85	\$0.85	\$0.85
\$6,000	\$1.02	\$1.02	\$1.02	\$1.02	\$1.02	\$1.02	\$1.02	\$1.02	\$1.02
\$7,000	\$1.19	\$1.19	\$1.19	\$1.19	\$1.19	\$1.19	\$1.19	\$1.19	\$1.19
\$8,000	\$1.36	\$1.36	\$1.36	\$1.36	\$1.36	\$1.36	\$1.36	\$1.36	\$1.36
\$9,000	\$1.53	\$1.53	\$1.53	\$1.53	\$1.53	\$1.53	\$1.53	\$1.53	\$1.53
\$10,000	\$1.70	\$1.70	\$1.70	\$1.70	\$1.70	\$1.70	\$1.70	\$1.70	\$1.70

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.

Premiums for Voluntary Life Increase in five-year increments

Spouse/DP coverage premium is based on Employee age.

†Benefit reductions apply.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-I-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

Guardian Group Life Insurance underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.
Policy Form # GP-1-LIFE-15

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Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information



Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.

Visit <https://www.guardiananytime.com/notice48> to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.

Visit <https://www.guardiananytime.com/notice46> to read more.

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**The Guardian Life Insurance Company of America**

The Guardian Life Insurance company of America underwrites group term life, accidental death and dismemberment, Short term disability, Long term disability, critical illness, dental, vision, and accident coverages.

Enrollment/Change Form**Page 1 of 6**

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: J SOLUTIONS, INC.		Group Plan Number: 00476055	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX	Initial Enrollment	Add Employee/Dependents	Drop/Refuse Coverage
Information Change			

Class: _____	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer)
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About You: First, MI, Last Name: _____		Employer Provided Identification: _____		Social Security Number ____ - ____ - ____ <small>Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.</small>	
Address _____		City _____		State _____	Zip _____
Gender: M F		Date of Birth (mm-dd-yy): ____ - ____ - ____			
Phone (indicate primary): Home (____) ____ - ____ Work (____) ____ - ____ Mobile (____) ____ - ____					
Email Address (indicate primary) Home _____ Work _____					
Are you married or do you have a partner? Yes No Date of marriage/union: ____ - ____ - ____ Do you have children or other dependents? Yes No Placement date of adopted child: ____ - ____ - ____					

About Your Job:		
Job Title: _____		
Work Status: Active Retired Cobra/State Continuation	Date of full time hire: ____ - ____ - ____	Annual Salary: \$ _____
Hours worked per week: _____		

About Your Family: Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Your dependent's Social Security Number must be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.					
Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner").		Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____		
Child/Dependent 1:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent	
Child/Dependent 2:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent	
Child/Dependent 3:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent	
Child/Dependent 4:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent	

CEF2021-TX

www.guardianlife.com

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DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER**DATE FORM PUBLISHED: Oct 14, 2022**

<p>Drop Coverage:</p> <p>Drop Employee Drop Dependents</p> <p>The date of withdrawal cannot be prior to the date this form is completed and signed.</p> <p>Last Day of Coverage: ____ - ____ - ____</p> <p>Termination of Employment Retirement</p> <p>Last Day Worked: ____ - ____ - ____</p> <p>Other Event: _____</p> <p>Date of Event: ____ - ____ - ____</p>	<p>Coverage Being Dropped:</p> <p>Voluntary Life Employee Spouse Child(ren)</p>
<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:</p> <p>Covered under another insurance plan</p> <p>Other _____</p> <p>(additional information may be required)</p>	

<p>Voluntary Term Life Coverage: You must be enrolled to cover your dependents. <i>Benefit reductions apply. Please see plan administrator.</i></p>					
<p>The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.</p>					
<p>Employee</p>					
Policy Amount	<i>Check one box only</i>				
\$10,000*	\$25,000	\$50,000	\$75,000	\$100,000	
<p>Guarantee Issue up to: Employee \$10,000*, 65-69 \$10,000, \$0. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.</p>					
<p><input type="checkbox"/> I do not want this coverage</p>					

<p>Add Voluntary Life for Spouse</p>					
Policy Amount					
\$5,000*	\$10,000	\$15,000	\$20,000	\$25,000	
<p>Guarantee Issue up to: Spouse \$5,000*, 65-69 \$5,000, \$0.</p>					
<p><i>*The amount may not be more than 50% of the employee amount for Voluntary Life.</i></p>					
<p><input type="checkbox"/> I do not want this coverage</p>					

<p>Add Voluntary Life for Dependent/Child(ren)</p>					
Policy Amount					
\$1,000	\$2,000	\$3,000	\$4,000	\$5,000	\$6,000
\$7,000	\$8,000	\$9,000	\$10,000*		
<p><i>*Guarantee Issue Amount</i></p>					
<p><i>*The amount may not be more than 10% of the employee amount for Voluntary Life.</i></p>					
<p><input type="checkbox"/> I do not want this coverage</p>					

<p>Important Notes:</p> <ul style="list-style-type: none"> Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

LIFE INSURANCE *continued***Name your beneficiaries:** (Primary beneficiary percentages must total 100%)

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. **Employer** maintains beneficiary information.)**Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.**

Please contact your employer for any record of or changes to your beneficiary information.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.**Are any of the beneficiaries identified above considered a minor in the state in which they reside?** Check one box only. Yes No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Signature

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

LIFE ONLY: I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.

I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.

I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.

I hereby apply for the group benefit(s) that I have chosen above.

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

SIGNATURE OF EMPLOYEE X _____

DATE _____

Enrollment Kit 00476055, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: 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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person 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 confinements in state prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

Oregon: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material thereto, may be committing a fraudulent act, and may be subject to civil penalties or denial of insurance benefits.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the 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.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

