Lawrence Transportation Services
2016 Benefits Enrollment Form

Coverage to Begin: _____

THIS FORM MUST BE SIGNED & RETURNED

A) Employment Information

❑ New Hire: Date _____ /_____ / _____
❑ Change in Employment Status: Date _____ / _____ / _____
❑ Loss of other Coverage ❑ Change in Marital Status ❑ Birth / Adoption ❑ Medical Support Order

❑ Lawrence Transportation Company ❑ Lawrence NationaLease ❑ Freight Plus ❑ LTX, Inc.

B) Employee Information

Last, First MI	☐ Male ☐ Female	Social Security Number
Street Address	☐ Single ☐ Married	Date of Birth MM/DD/YYY
City / State / Zip	Phone number	email Address

C) Medical Insurance

I elect MEDICAL coverage for:
- ❑ Employee only
- ❑ Employee + _____ dependents
- ❑ Employee + *Spouse
- ❑ Employee + *Spouse + _____ dependents

*Spouses must complete *Spousal Coverage* form

I waive MEDICAL coverage for:
- ❑ Employee and ALL dependents
- ❑ Spouse
- ❑ Dependents

Is anyone covered by Medicare? **No** ☐ **If Yes:** Part A ☐ Part B ☐

D) Dental Insurance

I elect DENTAL coverage for:
- ❑ Employee only
- ❑ Employee + _____ dependents
- ❑ Employee + Spouse
- ❑ Employee + Spouse + _____ dependents

I waive DENTAL coverage for:
- ❑ Employee, spouse and ALL dependents
- ❑ Spouse
- ❑ Dependents

E) Medical and/or Dental Dependent Information

(Must be completed for **ALL** dependents)

1)Last, First MI	❑ Male ❑ Female	❑ Married spouse ❑ Child by birth ❑ Child by adoption ❑ Step-child	Date of Birth	Social Security Number
If over age 19, full-time student? ❑ No ❑ Yes				
2)Last, First MI	❑ Male ❑ Female	❑ Married spouse ❑ Child by birth ❑ Child by adoption ❑ Step-child	Date of Birth	Social Security Number
If over age 19, full-time student? ❑ No ❑ Yes				
3)Last, First MI	❑ Male ❑ Female	❑ Married spouse ❑ Child by birth ❑ Child by adoption ❑ Step-child	Date of Birth	Social Security Number
If over age 19, full-time student? ❑ No ❑ Yes				

D.) Additional Medical Insurance

Complete if anyone has had medical coverage within the past 63 days
A Certificate of Creditable Coverage (COCC) may be requested from Meritain.

Name of Insurance Company Address & Phone No.	Name of Insured	Policy #	Date Policy began	Date Policy ended	Reason policy Terminated

E.) Flexible Spending Accounts — Plan year: 2016

Medical Reimbursement Account (MRA) — $2,550 maximum / calendar year

❑ **YES** I elect $ _____ to be divided by _____ pay periods. SIGN below. — GetMOR card

*election amount is divided by number of pay periods remaining in calendar year.

❑ **NO**, I do **NOT** choose to participate. SIGN below.

Dependent Care Account (DCA) — $5,000 maximum / calendar year

❑ **YES** I elect $_____ to be divided by _____ pay periods. SIGN below. — GetMOR card

*election amount is divided by number of pay periods remaining in calendar year.

❑ **NO**, I do **NOT** choose to participate. SIGN below.

EMPLOYEE AUTHORIZATION FOR PRE-TAX REIMBURSEMENT: I hereby authorize my employer to deduct election amounts pre-tax by payroll deduction. I understand that 1) my Social Security benefits may be reduced as a result of my election, 2) the amount elected for the Plan year may be used for reimbursement of eligible medical and/or dependent care expenses incurred during the Plan year, 3) a maximum of $500.00 may be rolled over at the end of each Plan year. Any amount over $500.00 will be forfeited and may not be paid to me in cash, 4) the MRA and DCA are separate accounts and amounts may NOT be combined or converted, 5) elections are allowed through payroll deduction ONLY and cease upon termination of employment, 6) MRA reimbursement claims may continue to the date employment terminates, 7) DCA reimbursement claims may continue until the end of the Plan year or until account balance is exhausted, whichever occurs first.

F.) Group Term Life Insurance Beneficiary Information

$25,000 employer paid term life insurance. Beneficiaries must be at least 18 years of age. Indicate % of benefit for each.

1) Beneficiary Last Name, First, MI	Relationship	Social Security Number	% of Benefit
Address	City	State Zip	
2) Beneficiary Last Name, First, MI	Relationship	Social Security Number	% of Benefit
Address	City	State Zip	
3) Beneficiary Last Name, First, MI	Relationship	Social Security Number	% of Benefit
Address	City	State Zip	

I understand that by signing this form I am making an election concerning my benefits for the Plan year subject to changes amended by the Plan Sponsor and/or insurance company. I revoke any previous election and authorize my employer to reduce my regular compensation to provide premium contributions for the remainder of the Plan year in equal amounts per pay period. I understand benefit elections can be changed only under "Qualifying Events" as defined by the Plan. This election is binding subject to my right to make changes according to the provisions of the benefit program and subject to any changes required to comply with federal tax laws. I have received, read and understand the materials and disclaimers explaining the benefits program. This enrollment form is not an employment agreement.

Employee Signature: _____ **Date:** _____