

COPY

DRIVERS LICENSE

AND

SOCIAL SECURITY CARD

OR

BIRTH CERTIFICATE

COPY

OF

LONG FORM PHYSICAL

WITH CARD.

**IF ONLY HAVE CARD THAT WILL
GET APPROVAL. WILL HAVE TO
GO IN FOR A PHYSICAL.**

DRIVER PRE-QUALIFICATION FORM

Thank you for applying for a driving position with our company. We are committed to providing the highest quality of service to our customers. In order to do this we are seeking the most qualified individuals. The following is a list of minimum qualifications required by our company. **Please read carefully and sign in the space provided if you meet these qualifications.** If you do not meet these qualifications, return this to the person you received it from and explain the reason. If you meet these qualifications, an in-depth background investigation will be conducted and a hiring decision will be made.

1. **Must be at least twenty-three (23) years of age.**
2. **Must have at least one (1) year of recent verifiable all weather tractor-trailer experience in the past three (3) years if applying for a tractor-trailer position. Must have at least one (1) year of verifiable all weather straight-truck experience in the past three (3) years if applying for a straight truck position.**
3. **Must not have had a D.W.I or D.U.I. conviction in the past (5) years. There can be no current pending D.W.I. or D.U.I. charges.**
4. **No major chargeable accidents in the past three (3) years while driving a commercial motor vehicle.**
5. **No more than three (3) moving violations in the last three (3) years of which only one (1) can be a major moving violation.**
6. **No more than three (3) minor accidents in the last five (5) years.**
7. **Possess only one (1) driver's license and it must be from the state of residence.**
8. **Fill out the application completely to include ten (10) years of employment history. If you do not have the information at this time, return the application and come back when you have the information. We do not allow applications to be removed from the office area.**
9. **You will be required to pass a D.O.T. physical. We will only accept an applicant's existing physical if there is at least 12 months remaining before expiration. We will not accept any physical issued for less than a one (1) year period.**
10. **You will be required to provide a urine sample to be used for our Federally Mandated Drug Screening program. All new and re-hire applicants must pass this drug screen before being employed.**

I, _____ the undersigned, meet the above qualifications and further agree to abide by all company polices. Misrepresentation on the application will result in immediate termination.

DATE _____

SIGNATURE _____

Job Description

Job Title: Driver of Semi Tractor / Trailer

Department / Terminal _____

Report To: Terminal Manager/Dispatcher/Operations Supervisor

General Purpose: Pick up and deliver to assigned locations in compliance with applicable rules and regulations.

This job description may be revised at any time as dictated by customer needs and management decision.

Essential Functions

1. Receive and follow dispatch orders. Call in daily if on the Casual Board and not working.
2. Pre-trip vehicle inspection.
3. Hook up to correct trailer as directed by dispatcher.
4. Drive vehicle on specified route observing DOT and our safe driving rules and regulations.
5. Communicate with dispatch as directed.
6. Sleep in sleeper bunk when team driver is driving or during overnight stops.
7. Deliver product and assist in loading and unloading as assigned.
8. Backhaul product or return to domicile location as directed.
9. Communicate with client for direction on breakdowns, accidents, product spills, emergencies, and other problems.
10. Fuel vehicle as needed at approved locations.
11. Prepare trip record and DOT logs daily.
12. Be responsible for advance from company by obtaining receipts for expenses.
13. Participate in safety programs.
14. Comply with all DOT and FMCSR regulations.

Physical and mental requirements:

1. Demonstrate sound judgment in operation of vehicle.
2. Work 60 -70 hours per week, within federal guidelines, including nights and weekends.
3. Pull, twist, bend, and lift 75 pounds to shoulder height as required to perform essential functions.
4. Climb in and out of tractor and to top of trailer for inspection.
5. Sit for up to 11 hours per day.
6. Drive vehicle and load/unload in extreme winter and summer temperatures and conditions.
7. Communicate, read, understand, and write as required to perform essential functions.

Date: _____

Signature: _____

DATE OF APPLICATION: ___/___/___

APPLICATION

COMPANY Market Express

ADDRESS _____

CITY _____ STATE _____ ZIP _____

In compliance with Federal and State equal opportunity laws, qualified applicants are considered for all positions without regard to race, religion, sex, national origin, age, marital status, or non-job related disability.

TO BE READ AND SIGNED BY APPLICANT

I understand that information I provide regarding current and/or previous employers may be used, and those employer(s) will be contacted, for the purpose of investigating my safety performance history as required by 49 CFR 391.23(d) and (e).

I also understand that I have the right under 49 CFR 391.23(i)(1) to:

- Review information provided by previous employers
- Have errors in the information corrected by previous employers and for those previous employers to re-send the corrected information to the prospective employer, and
- Have a rebuttal statement attached to the alleged erroneous information, if the previous employer(s) and I cannot agree on the accuracy of the information

Applicant Signature: X _____ **Date** ___/___/___

DRIVER NAME _____

(LAST) (FIRST) (MIDDLE)

ADDRESS _____

CITY _____, STATE _____, ZIP _____

TELEPHONE NUMBER (____) _____ - _____ CELL PHONE NUMBER (____) _____ - _____

DATE OF BIRTH ___/___/___ SOCIAL SECURITY NUMBER ____ - ____ - ____

EMAIL ADDRESS _____

PREVIOUS ADDRESSES FOR THE PAST THREE (3) YEARS

1) ADDRESS _____

CITY _____, STATE _____, ZIP _____ FROM _____ TO _____

2) ADDRESS _____

CITY _____, STATE _____, ZIP _____ FROM _____ TO _____

3) ADDRESS _____

CITY _____, STATE _____, ZIP _____ FROM _____ TO _____

NOTE: COMPANY POLICY STATES THAT THE APPLICANT MUST PROVIDE A COMPLETE 10 YEAR WORK HISTORY AND ACCOUNT FOR ALL GAPS BETWEEN JOBS PRIOR TO BEING CONSIDERED FOR EMPLOYMENT.

EMPLOYMENT HISTORY

PLEASE LIST STARTING WITH MOST RECENT EMPLOYER, USE ADDITIONAL SHEET IF NEEDED.

CURRENT OR LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

SECOND LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

THIRD LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

* The Federal Motor Carrier Safety Regulations apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle: 1) weighs or has a GVWR of 10,001 pounds or more, 2) is designed or used to transport 9 or more passengers, or 3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

**Any gaps in employment and/or unemployment must be explained.

NOTE: COMPANY POLICY STATES THAT THE APPLICANT MUST PROVIDE A COMPLETE 10 YEAR WORK HISTORY AND ACCOUNT FOR ALL GAPS BETWEEN JOBS PRIOR TO BEING CONSIDERED FOR EMPLOYMENT.

EMPLOYMENT HISTORY

PLEASE LIST STARTING WITH MOST RECENT EMPLOYER, USE ADDITIONAL SHEET IF NEEDED.

FOURTH LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

FIFTH LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

SIXTH LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

* The Federal Motor Carrier Safety Regulations apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle: 1) weighs or has a GVWR of 10,001 pounds or more, 2) is designed or used to transport 9 or more passengers, or 3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

**Any gaps in employment and/or unemployment must be explained.

NOTE: COMPANY POLICY STATES THAT THE APPLICANT MUST PROVIDE A COMPLETE 10 YEAR WORK HISTORY AND ACCOUNT FOR ALL GAPS BETWEEN JOBS PRIOR TO BEING CONSIDERED FOR EMPLOYMENT.

EMPLOYMENT HISTORY

PLEASE LIST STARTING WITH MOST RECENT EMPLOYER, USE ADDITIONAL SHEET IF NEEDED.

SEVENTH LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

EIGHTH LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

NINTH LAST EMPLOYER COMPANY NAME: _____

ADDRESS: _____, CITY _____ STATE _____

PHONE: _____ FAX: _____ E-MAIL: _____

SUPERVISOR NAME: _____ REASON FOR LEAVING? _____

JOB DESCRIPTION: _____ FROM: ____/____/____ TO: ____/____/____

Was this job designated as a safety sensitive function in any DOT regulated mode subject to controlled substances and alcohol testing specified by 49 CFR Part 40? YES NO *Was this job subject to FMCSA Regulations? YES NO

**ACCOUNT FOR PERIOD BETWEEN JOBS – Include dates (month/year) and reason _____

* The Federal Motor Carrier Safety Regulations apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle: 1) weighs or has a GVWR of 10,001 pounds or more, 2) is designed or used to transport 9 or more passengers, or 3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

**Any gaps in employment and/or unemployment must be explained.

COMMERCIAL DRIVER'S LICENSE INFORMATION

LICENSE # _____ TYPE _____ STATE _____ EXP. DATE ____/____/____
(A,B, OR C)

ENDORSEMENTS (check all that apply): DOUBLE/TRIPLE TRAILERS TANK VEHICLES
 PASSENGER VEHICLES HAZARDOUS MATERIALS

LIST ANY ADDITIONAL LICENSE(S) HELD IN THE PAST 3 YEARS:

STATE ____ TYPE ____ LICENSE # _____ EXP. DATE: ____/____/____
STATE ____ TYPE ____ LICENSE # _____ EXP. DATE: ____/____/____

HAS YOUR PERMIT, CDL, OR PRIVILEGE TO OPERATE A MOTOR VEHICLE EVER BEEN DENIED, SUSPENDED, OR REVOKED? NO YES IF YES, EXPLAIN _____

COLLISIONS

PLEASE LIST ALL MOTOR VEHICLE COLLISIONS IN WHICH YOU WERE INVOLVED (BOTH COMMERCIAL AND PRIVATE VEHICLE) DURING THE PAST THREE YEARS PRIOR TO THE APPLICATION DATE. **IF NONE, WRITE "NONE"**

<u>DATE</u>	<u>DESCRIPTION</u>	<u>STATE</u>	<u># OF INJURIES</u>	<u># OF FATALITIES</u>	<u>HAZ. MAT. SPILL</u>
____/____/____	_____	_____	_____	_____	<input type="checkbox"/> NO <input type="checkbox"/> YES
____/____/____	_____	_____	_____	_____	<input type="checkbox"/> NO <input type="checkbox"/> YES
____/____/____	_____	_____	_____	_____	<input type="checkbox"/> NO <input type="checkbox"/> YES

TRAFFIC CONVICTIONS AND FORFEITURES

PLEASE LIST ALL TRAFFIC CONVICTIONS AND/OR FORFEITURES (BOTH COMMERCIAL AND PRIVATE VEHICLE) FOR THE PAST THREE YEARS (OTHER THAN PARKING). **IF NONE, WRITE "NONE"**

<u>DATE</u>	<u>LOCATION</u>	<u>CHARGE</u>	<u>PENALTY</u>
____/____/____	_____	_____	_____
____/____/____	_____	_____	_____
____/____/____	_____	_____	_____
____/____/____	_____	_____	_____

DRIVING EXPERIENCE

<u>EQUIPMENT CLASS</u>	<u>TYPE OF EQUIPMENT</u> (VAN, TANK, FLAT, ETC.)	<u>DATES</u> FROM TO or	<u>APPROX. MILES</u> <u>DRIVEN</u>
STRAIGHT TRUCK	_____	_____	_____
TRACTOR & SEMI TRAILER	_____	_____	_____
OTHER	_____	_____	_____
LIST COMMODITIES HAULED: _____			

EDUCATION

PLEASE CIRCLE THE HIGHEST GRADE COMPLETED: 1 2 3 4 5 6 7 8 9 10 11 12 COLLEGE: 1 2 3 4

OTHER TRAINING : _____

HAVE YOU RECEIVED ANY SAFETY AWARDS OR SPECIAL TRAINING? _____

DO YOU HAVE FULL KNOWLEDGE OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS? YES NO

GENERAL

HAVE YOU BEEN A DRIVER FOR THIS COMPANY BEFORE? YES NO

IF SO, WHEN? ____ / ____ WHERE? _____

IS THERE ANY REASON YOU MIGHT BE UNABLE TO PERFORM THE FUNCTIONS OF THE JOB FOR WHICH YOU HAVE APPLIED? YES NO

ARE YOU PREVENTED FROM LAWFULLY BECOMING EMPLOYED IN THIS COUNTRY BECAUSE OF VISA OR IMMIGRATION STATUS? YES NO

Proof of citizenship or immigration status will be required upon employment.

HAVE YOU EVER BEEN CONVICTED FOR DUI, DWI OR OUI? YES NO

HAVE YOU EVER TESTED POSITIVE OR REFUSED A DOT DRUG OR ALCOHOL TEST? YES NO

IN CASE OF EMERGENCY, CONTACT: _____ () _____
Name Telephone number Relationship

MUST BE READ AND SIGNED BY THE APPLICANT

- It is agreed and understood that the employer or its agents may investigate the applicant's background to ascertain any and all information of concern to applicant's record whether same is of record or not, and applicant releases employers and persons named herein from all liability for any damages on account of furnishing such information.
- In accordance with the provision so Section 604(b)(2)(a) of the Fair Credit Reporting Act Public Law 9f-508, as amended by the Consumer Credit Reporting Act of 1996 (Title II, Subtitle D, Chapter 1, of Public Law 104-208), you are being informed that reports verifying your previous employment, previous drug and alcohol test results, and your driving record may be obtained on you for employment purposes. These reports are required by Sections 382.413, and 391.25 of the Federal Motor Carrier Safety Regulations.
- The applicant agrees to furnish such additional information and complete such examinations as necessary to complete applicant's employment file.
- It is agreed and understood that this application for employment in no way obligates the employer to employ the applicant.
- It is agreed and understood that if hired, the applicant may be on a probationary period during which time applicant may be discharged without recourse. Further, any false statement herein submitted will be deemed sufficient reason for rejection or termination of the applicant's employment, irrespective of time lapsed before discovery.
- In connection with my application for employment with you, I understand that an investigative consumer report is being requested from Hire Right Services and/or Asurint that will include information as to my character, work habits, performance, and experience, along with reasons for termination of past employment obtained from previous employers. Further, I understand that you will be requesting information concerning my driving record and/or information from various state agencies which maintain records concerning traffic offenses, accidents, etc., as well as information from Hire Right Services and/or Asurint concerning (1) previous driving record requests made by others from such stage agencies and (2) claims involving me in the files of insurance companies. I have a right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. I hereby consent to your obtaining the above-described information from Hire Right Services and/or Asurint, and agree that such information which Hire Right Services and/or Asurint has or obtains, and my employment history with you, if I am hired, will be supplied by Hire Right Services and/or Asurint to other companies which subscribe to Hire Right Services and/or Asurint.
- IF HIRED BY YOU, I FURTHER CONSENT TO YOUR FURNISHING TO HIRE RIGHT SERVICES AND/OR ASURINT INFORMATION CONCERNING MY CHARACTER, WORK HABITS, PERFORMANCE DRIVING RECORD AND EXPERIENCE, AS WELL AS ANY REASONS FOR TERMINATION OF MY EMPLOYMENT, AND FURTHER CONSENT TO HIRE RIGHT SERVICES AND/OR ASURINT FURNISHING SUCH INFORMATION IN THE FUTURE TO OTHER COMPANIES WHICH SUBSCRIBE TO HIRE RIGHT SERVICES AND/OR ASURINT FROM WHICH I MAY BE SEEKING EMPLOYMENT, AND TO INSURANCE COMPANIES OR THEIR AGENTS IN CONNECTION WITH ISSUANCE OR MAINTENANCE OF INSURANCE COVERAGE.
- The applicant agrees to conform to the rules and regulations of the Company, and understands that employment and compensation can be terminated with or without cause, at any time, at the option of either the Company or the individual.
- The applicant further understands that no personnel recruiter or interviewer or other representative of the Company other than the President, has any authority to enter into any agreement for employment for any specified period of time.
- If requested to do so, I agree to submit to physical and psychological testing prior to employment, or at any time during my employment, including but not limited to a polygraph and/or urine analysis to test for drugs or alcohol. It is agreed and understood that the answers to the foregoing questions are true and correct, and that any misrepresentations of information given above shall be considered an act of dishonesty. Further, this certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

X _____
Applicant Signature

____ / ____ / ____
Date

Company Name: _____

Richmond Office

Ph 800.367.2875 Fax 765.966.6279

Date _____	Reply to <u>Hunter</u>
Company _____	Email <u>hunterh@premiumdrivers.com</u>
City, State _____	Phone <u>800-367-2875</u>
Phone _____	Fax <u>866-539-5641</u>
Fax _____	
Email _____	
Applicant: _____ SS#: _____	
Dates per applicant: _____ to _____	
Are the dates above correct? Yes No Full Time Part Time	
If no, what are the correct dates? _____ to _____	
Position with your company: _____	
Type of Cargo Hauled: _____	
Type of Vehicle Operated: Tractor Trailer Straight Truck Other _____	
Type of Trailer: Dry Van Flatbed Reefer Tanker Dump Other _____	
Type of Driving: Local Regional OTR HazMat? Yes No	
Reason for Leaving: Quit Discharged Layoff Please explain: _____	
Eligible for rehire? Yes No Upon Review _____	

ACCIDENTS:
Pursuant to §391.23, please complete the following for any accidents the applicant was involved in the last 3 years.
If none, please check this box.

Date	Location	Description	# Injuries	# Fatalities	Hazmat Spill?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Completed by:

Signature: _____	Title: _____	Date: _____
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AUTHORIZATION /LIABILITY RELEASE

I hereby authorize the company stated below to release all record of employment, including assessments of my job performance, ability and fitness to include drug and alcohol test results and accidents to Premium Transportation Group, Inc. (or their authorized agents) which may request such information in connection with my application for employment with them. I hereby release this company from any and all liability of any type as a result of providing this information to Premium Transportation Group, Inc. This information is being requested in compliance with §40.25 and §391.23. Information about HireRight's privacy practices is available at www.hireright.com/Privacy-Policy.aspx.

Signature of Applicant: _____	Company: _____	Date: _____
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Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street NW, Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street NW, Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identity theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer

reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-567-8688.
- The following FCRA right applies with respect to nationwide consumer reporting agencies:

CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

You have a right to place a “security freeze” on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is

placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
<p>1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates</p> <p>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:</p>	<p>a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552</p> <p>b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue NW Washington, DC 20580 (877) 382-4357</p>
<p>2. To the extent not included in item 1 above:</p> <p>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks</p> <p>b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act.</p> <p>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations</p> <p>d. Federal Credit Unions</p>	<p>a. Office of the Comptroller of the Currency Customer Assistance Group P.O. Box 53570 Houston, TX 77052</p> <p>b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480</p> <p>c. Division of Depositor and Consumer Protection National Center for Consumer and Depositor Assistance Federal Deposit Insurance Corporation 1100 Walnut Street, Box #11 Kansas City, MO 64106</p> <p>d. National Credit Union Administration Office of Consumer Financial Protection 1775 Duke Street Alexandria, VA 22314</p>
<p>3. Air carriers</p>	<p>Assistant General Counsel for Office of Aviation Protection Department of Transportation 1200 New Jersey Avenue SE Washington, DC 20590</p>
<p>4. Creditors Subject to the Surface Transportation Board</p>	<p>Office of Public Assistance, Governmental Affairs, and Compliance Surface Transportation Board 395 E Street SW Washington, DC 20423</p>
<p>5. Creditors Subject to the Packers and Stockyards Act, 1921</p>	<p>Nearest Packers and Stockyards Division Regional Office</p>
<p>6. Small Business Investment Companies</p>	<p>Associate Administrator, Office of Capital Access United States Small Business Administration 409 Third Street SW, Suite 8200 Washington, DC 20416</p>
<p>7. Brokers and Dealers</p>	<p>Securities and Exchange Commission 100 F Street NE Washington, DC 20549</p>
<p>8. Institutions that are members of the Farm Credit System</p>	<p>Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090</p>
<p>9. Retailers, Finance Companies, and All Other Creditors Not Listed Above</p>	<p>Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue NW Washington, DC 20580 (877) 382-4357</p>

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND INVESTIGATION

I acknowledge receipt of the separate document entitled A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand the document. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by Premium Transportation Group, Inc. or any of its subsidiaries at any time after receipt of this authorization and throughout my employment, as allowable by applicable law. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, ~~current or former~~ employer, or insurance company to furnish any and all background information requested by **Asurint, P.O. Box 14730, Cleveland, OH 44114, 800-906-2034, <https://www.asurint.com/privacy-policy>** and/or **HireRight, LLC 3349 Michelson Drive, Suite 150, Irvine, CA 92612 800-400-2761, www.hireright.com/Privacy-Policy.aspx** and/or Premium Transportation Group, Inc or any of its subsidiaries. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original and I agree to receive any notices, relating to my background check, electronically.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law

New York City applicants only: By signing this form, you further authorize the Company to provide you with a copy of your consumer report, the New York City Fair Chance Act Notice form, and any other documents, to the extent required by law, at the mailing address and/or email address you provide to the Company.

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you like to receive a copy of a consumer report if one is obtained by the Company.

Print Name: _____

Signature: _____

Date: _____

Statement of Employment Status/Verification

() Statement of Self-Employment

() Statement of Unemployment

I _____, was () self-employed () unemployed from _____
to _____.

My self-employment / unemployment consisted of: _____

The following references can verify my self-employment:

Name: _____

Address: _____

Telephone: _____

I did business with the following bank(s): Please write on back if you need more space

Name of Bank: _____

Address: _____

Telephone: _____

If Owner/Operator, please list all companies and address leased or trip leased with, for the ten year history prior to this application date. (Please write on the back if you need more space)

1. Name: _____ Phone: _____

Address: _____

2. Name: _____ Phone: _____

Address: _____

3. Name: _____ Phone: _____

Address: _____

ADDITIONAL EMPLOYMENT VERIFICATION

Regulations require all employment be verified for the last 10 years. Other forms of employment verification required (choose one or more) **Please attach.**

() Self-Employment 1099 copies enclosed

() Yearly Profit & Loss Statements

() IRS Tax Filing Form 1040

() Copies of Checks (1st & Last)

() Copies of Unemployment Reg. Card

() Copies of Unemployment Check

I certify that all entries are true and complete. I am submitting this form as an addendum to my application for verification purposes.

Signature

Date



**Please do not fill out any
paperwork past this point
until we have approved the
applicant.**



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

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

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

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

Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

STOP **Employer Completes Next Page** STOP




Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Section 2 Do Not Write In This Space 
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name PEI Ohio, Inc.		
Employer's Business or Organization Address (Street Number and Name) 615 Commerce Road 190 Highland Drive		City or Town Richmond Medina	State IN OH	ZIP Code 47374 44256

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Hire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

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

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
--	---------------------------	---

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

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 a nonimmigrant alien authorized to work for a specific employer because of his or her status: <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 alien's nonimmigrant status 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 	OR	<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 <li style="text-align: center;">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 	AND	<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

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

Refer to the instructions for more information about acceptable receipts.

7 DAY PRIOR HOURS STATEMENT

Instructions: Motor carriers when using a driver for the first time shall obtain from the driver a signed statement giving the total time on-duty during the immediately preceding 7 days and time at which such driver was last relieved from duty prior to beginning work for such motor carrier. Rule 395.8(j) (2) Federal Motor Carrier Safety Regulations. NOTE: Hours for any compensated work during the preceding 7 days, including work for a non-motor carrier entity, must be recorded on this form.

DRIVER NAME (print): _____
 SOCIAL SECURITY #: _____
 DRIVER'S LICENSE: STATE: _____ NUMBER: _____ CLASS: _____
 ENDORSEMENTS: _____ RESTRICTIONS: _____

DAY	1	2	3	4	5	6	7		
DATE									
HOURS WORKED								TOTAL HOURS	

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT I WAS RELIEVED FROM WORK ON:

DATE: ____/____/____ AT _____ A.M. P.M.
Time

X _____ /____/____
Driver's Signature Date

DRIVER CERTIFICATION FOR OTHER COMPENSATED WORK

INSTRUCTIONS: When employed by a motor carrier, a driver must report to the motor carrier all on-duty time working for other employers. The definition of on-duty time found in Section 395.2 paragraphs 8 and 9 of the Federal Motor Carrier Safety Regulations includes time performing any other work in the capacity of, or in the employ or service of a common, contract or private motor carrier, also performing any compensated work for any non-motor carrier entity.

Are you currently working for another employer? YES NO

At this time do you intend to work for another employer while still employed by this company? YES NO

I hereby certify that the information given above is true and I understand that once I begin driving for this company, if I begin working for any additional employer(s) for compensation that I must inform this company immediately of such employment activity.

X _____ /____/____
Driver's Signature Date

X _____ /____/____
Company Representative Date

**RELEASE & DOCUMENTATION OF PRE-EMPLOYMENT
TESTING INFORMATION BY APPLICANT/DRIVER REQUIRED
BY PART 40.25(j).**

PART 40.25(j) requires Employers to ask Applicant/Driver whether he/she has tested positive or refused to test on any Pre-employment alcohol or drug test administered by an Employer to which the Applicant/Driver applied but did not obtain safety sensitive transportation work covered by DOT agency alcohol and drug testing rules during the past three (3) years.

NAME _____ DATE _____

SOCIAL SECURITY # _____

Applicant/Driver Please answer items listed below.

- A. During the past three (3) years have you tested positive on a Pre-employment alcohol or drug test administered by Employer to which you applied for but did not obtain a safety sensitive transportation work covered by Department of Transportation (DOT) drug and alcohol testing rules?

YES _____ NO _____

- B. During the past three (3) years have you **refused** to test on a Pre-employment alcohol or drug test administered by an Employer to which you applied for but did not obtain a safety sensitive transportation work covered by the Department of Transportation (DOT) drug and alcohol testing rules?

YES _____ NO _____

If you answered **YES** to either of the questions above, please provide documentation of your successful completion of the return – to – duty process required by Part 40 Subpart O.

Date: _____ Name (Print) _____

Signature of Applicant/Driver _____

Witness _____

**Record keeping requirements: If “yes” to either question – 5 year retention.
If “no” to both questions – discard after employment terminates.**

Driver Acknowledgement Statement

- I acknowledge receipt of, and certify that I have fully read and understand the drug & alcohol policy and educational materials implemented by my employer and that it is to be used along with sections 40, 382, and 392 of the Federal Motor Carriers Safety Regulations.

_____ **Drug & Alcohol Policy and Education/Training Booklet**
(Initial)

- I hereby attest, as a commercial driver license holder, I understand the Federal Motor Carrier Safety Regulations as prescribed by the U.S. Department of Transportation. I further understand that obeying these regulations are a condition of my initial and continued employment.

_____ **Federal Motor Carrier Safety Regulations**
(Initial)

Driver's Name: _____

Driver's Signature: _____

Date: _____

Company Representative: _____

Date: _____

Employee's Withholding Certificate

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

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: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) 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)
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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 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2023 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, 2024.

Your privacy. 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).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

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.

If you (and your spouse) have a total of only two jobs, you may 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 2023 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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.

- 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 2023 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: { \$27,700 if you're married filing jointly or a qualifying surviving spouse; \$20,800 if you're head of household; \$13,850 if you're single or married filing separately } 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 territories 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 Surviving Spouse

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	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600



Note: These instructions are written for employees to address withholding from wages. However, this form can also be completed and submitted to a payor if an agreement was made to voluntarily withhold Illinois Income tax from other (non-wage) Illinois income.

Who must complete Form IL-W-4?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay (see Publication 130, Who is Required to Withhold Illinois Income Tax). If you are claiming exempt status from Illinois withholding, you must check the exempt status box on Form IL-W-4 and sign and date the certificate. Do not complete Lines 1 through 3.

If you are a resident of a Iowa, Kentucky, Michigan, or Wisconsin, or a military spouse, see Form W-5-NR, Employee's Statement of Nonresidence in Illinois, to determine if you are exempt.

If you are an Illinois resident who works for an employer in a non-reciprocal state but you work from home or in locations in Illinois for more than 30 working days, you may need to adjust your withholding or begin making estimated payments. For additional information, go to tax.illinois.gov.

Note If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

When must I submit this form?

You should complete this form and give it to your employer on or before the date you start work. You must submit Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

Example: If you have a baby and file a new Form IL-W-4 with your employer to claim an additional allowance for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have submitted takes effect or until your employer is required by the Department to disregard it. Your employer is required to disregard your Form IL-W-4 if

- you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption, or
- the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4.

What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax that you may claim on your Illinois Income tax return.

What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (e.g., your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will

receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

Note: For tax years beginning on or after January 1, 2017, the personal exemption allowance, and additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind, may **not** be claimed on your Form IL-1040 if your adjusted gross income for the taxable year exceeds \$500,000 for returns with a federal filing status of married filing jointly, or \$250,000 for all other returns. You may complete a new Form IL-W-4 to update your exemption amounts and increase your Illinois withholding.

How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

Note If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

How do I avoid underpaying my tax and owing a penalty?

You can avoid underpayment by reducing the number of allowances or requesting that your employer withhold an additional amount from your pay. Even if your withholding covers the tax you owe on your wages, if you have non-wage income that is taxable, such as interest on a bank account or dividends on an investment, you may have additional tax liability. If you owe more than \$500 tax at the end of the year, you may owe a late-payment penalty or will be required to make estimated tax payments. For additional information on penalties see Publication 103, Uniform Penalties and Interest. Visit our website at tax.illinois.gov to obtain a copy.

Where do I get help?

- Visit our website at tax.illinois.gov
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to
**ILLINOIS DEPARTMENT OF REVENUE
PO BOX 19044
SPRINGFIELD IL 62794-9044**

Illinois Withholding Allowance Worksheet

General Information

Use this worksheet as a guide to figure your total withholding allowances you may enter on your Form IL-W-4.

Complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions Worksheet for federal Form W-4.

If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

- No one else can claim me as a dependent.
- I can claim my spouse as a dependent.

- 1 Enter the total number of boxes you checked. 1 _____
- 2 Enter the number of dependents (other than you or your spouse) you will claim on your tax return. 2 _____
- 3 Add Lines 1 and 2. Enter the result. This is the total number of basic personal allowances to which you are **entitled**. You are not required to claim these allowances. The number of basic personal allowances that you choose to claim will determine how much money is withheld from your pay. See Line 4 for more information. 3 _____
- 4 Enter the total number of basic personal allowances you choose to claim on this line and Line 1 of Form IL-W-4 below. This number may not exceed the amount on Line 3 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 4 _____

Step 2: Figure your additional allowances

Check all that apply:

- I am 65 or older.
- I am legally blind.
- My spouse is 65 or older.
- My spouse is legally blind.

- 5 Enter the total number of boxes you checked. 5 _____
- 6 Enter any amount that you reported on Line 4 of the Deductions Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. 6 _____
- 7 Divide Line 6 by 1,000. Round to the nearest whole number. Enter the result on Line 7. 7 _____
- 8 Add Lines 5 and 7. Enter the result. This is the total number of additional allowances to which you are **entitled**. You are not required to claim these allowances. The number of additional allowances that you choose to claim will determine how much money is withheld from your pay. 8 _____
- 9 Enter the total number of additional allowances you elect to claim on Line 2 of Form IL-W-4, below. This number may not exceed the amount on Line 8 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 9 _____

IMPORTANT: If you want to have additional amounts withheld from your pay, you may enter a dollar amount on Line 3 of Form IL-W-4 below. This amount will be deducted from your pay in addition to the amounts that are withheld as a result of the allowances you have claimed.

----- Cut here and give the certificate to your employer. Keep the top portion for your records. -----

Illinois Department of Revenue IL-W-4 Employee's Illinois Withholding Allowance Certificate

Social Security number _____

Name _____

Street address _____

City _____ State _____ ZIP _____

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate.

- 1 Enter the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 _____
- 2 Enter the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 _____
- 3 Enter the additional amount you want withheld (deducted) from each pay. 3 _____

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature _____

Date _____

PRINT NAME _____

CLIENT NAME/LOCATION _____

PEI OHIO, Inc

190 Highland Dr., Medina, OH 44256

Phone: 800-633-4785 Payroll Fax: 330-725-1998

DIRECT DEPOSIT AUTHORIZATION

I hereby authorize PEI OHIO, Inc. (hereinafter called "Company"), to initiate credit entries and to initiate, if necessary, debit entry adjustments for any credit entry done in error to my account(s) shown below.

Once the authorization is received by the Company, the information may be verified (pre-noted) before the direct deposit is initiated. For accuracy, the Company may run a trial transaction with the designated financial institution. I understand that my next pay may be in the form of a check.

This authorization will remain in full force until the Company has received written notification from me of its termination, in such time and in such manner as to afford the Company and Depository a reasonable opportunity to act on it.

Signature _____

Date _____

SSN _ _ _ - _ _ - XXXX

BANK NAME _____	CITY, STATE _____
CHECKING _____ or SAVINGS _____	AMOUNT \$ _____ or ENTIRE CHECK _____
TRANSIT/ROUTING # (9 DIGITS) _ _ _ _ _	ACCOUNT # _____
<small>.....Note: Cannot begin with a 5</small>	

BANK NAME _____	CITY, STATE _____
CHECKING _____ or SAVINGS _____	AMOUNT \$ _____ or ENTIRE CHECK _____
TRANSIT/ROUTING # (9 DIGITS) _ _ _ _ _	ACCOUNT # _____
<small>..... Note: Cannot begin with a 5</small>	

For accuracy, attach copy of void check below

www.premiumdrivers.com

Welcome to Premium Drivers Online, your solution for secure, online, employee data. Just a simple mouse click and you can have your personnel and financial data available to you within seconds in a secure, password-protected system.

[Please review this Quick Start to help you get started!](#)

LOGGING IN

FIRST TIME LOGIN

The first time login process is quick and easy. Login to your personalized login portal

www.premiumdrivers.com

Once on the Premium website click on the EZ WEB LOGIN icon in the upper right hand corner of the website

Follow the “create a new login” prompts. You **will receive an email to finalize the process**. If you do not see the email in your inbox, check your junk or quarantine folders. Due to the confidential nature of the information available in the system, leading industry security standards are used to keep your data secure; therefore, in order to complete the first time login process you will also need to enter a set of validation credentials.

Your validation key is comprised of the first four letters of your last name (or your full last name if it is shorter than 4 letters – ALL CAPS) and the last four digits of your social security number. (ABCD1234). Your validation password is your eight digit birth date (mm/dd/yyyy).

The first time login process also includes creating your own password, choosing a personalized picture and label to identify your login, and answering a security question. These items are necessary each time you login from a new or different computer.

FORGOT YOUR PASSWORD?

Premium Drivers Online provides a safe and secure way to retrieve your account in the event you have forgotten your password. Log in using your email address as usual and click on the “I forgot my password!” link on the following page.



CLICK THE FOLLOWING LINK TO RECREATE YOUR PASSWORD

Is the Picture and Label Correct?

Welcome,

Before you enter your password, please verify that the picture and label shown to the left match those you chose when you created your login.

[I forgot my password!](#)

Questions? Email us at ezweb@premiumdrivers.com



401 (k) RETIREMENT SAVINGS PLAN

Dear Valued Employee:

Premium Transportation Group offers all employees 21 years of age and older the opportunity to participate in our 401(k) Retirement Savings Plan. Our plan is administered by Lincoln Financial Group.

We offer several different investment options. You may enroll the first day of each month during the year. You may change your deferral percentages or amounts at any time. If you have rollover funds from previous employment, you may roll them into our plan immediately upon commencement of employment.

Please choose one of the options below, sign and date the form.

_____ **I am interested in the Premium Transportation Group 401 (k) Plan. Visit our website at www.premiumdrivers.com to fill out the 401 (k) contact form located in the employee section and a packet will be emailed to you. If you need assistance, please contact our office at: 330-722-7974.**

_____ I am not interested in the Premium Transportation Group 401 (k) Plan.

Employee Signature Date

Social Security Number

enrollment/change/waiver Group Insurance Form

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



Policy and Div. # 010- _____ Cert. # _____	COBRA: If individual is a continuee: _____	Qualifying Event: _____	Date of Event: _____
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Name and Address of Employer (Policyholder) _____

to enroll Dental Eye Care To terminate all coverages

Employee Information

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

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth _____ Male Female Full time date of hire _____ Rehire: Rehire date _____

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

Street address _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

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

Are you covered under another eye care insurance plan? Employee: Yes No Dependents: Yes No

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

Print full legal name (last, first, MI)	Dental		Eye Care		Relationship	Sex	Date of birth	Social Security no.	College student?
	add	drop	add	drop					
1 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
2 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
3 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
4 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
5 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>

Please Sign (employee/policyholder) The certificate provides dental and eye care benefits only. Review your certificate carefully.

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

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

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

Employee late entrant date _____	Effective Date	Class	Dep. Code
Dependent late entrant date _____			

2 to change

Name Change New Name _____ Old Name _____

Add Dependent Coverage
 If due to marriage, what is the date of marriage? _____ If due to birth/adoption, what is the date of event? _____
 If due to loss of coverage, date and reason: _____
 If other, the date of event and please explain: _____

Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop: _____
 Due to divorce Due to death Due to annual election period Exceeds maximum age to qualify as dependent
 Other (please explain) _____

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

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

because _____

Name of insurance company and employer of dependent _____

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

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-3797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

Note for Florida Residents: 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.

Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Note for Louisiana Residents: 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 fines and confinement in prison.

Note for Maryland Insureds: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico and Rhode Island Residents: 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.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: 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.

Note for Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Note for Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Note for Washington, D.C. Residents: 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 fines and confinement in prison.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number** – to make sure plan members are added to the correct group.
- **Department/Division Numbers** – so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers** – the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date** – needed so the correct effective date is calculated for new members.
- **Class Number** – needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

- 1) submit clear, legible enrollment forms.
- 2) underline or circle important information.
- 3) use blue or black ink.

Don't:

- 1) submit dark copies as they appear black on imaging.
- 2) highlight, which blackens the area so it cannot be read.
- 3) write on the top or bottom margins. This information is not always captured on the image system.



Please see prices below for the optional Dental and Vision benefits. The monthly premium will be divided into your pay cycle (weekly, bi-weekly, etc) and deducted through your payroll.

You are eligible to choose the Dental and Vision benefits on the Ameritas form.

If you choose to waive dental and Vision benefits, please mark to waive the coverage on the Ameritas form in section 3.

	monthly
EE	21.74
EE/SP	46.75
EE/CHILDREN	39.14
FAMILY	65.22
VISION	monthly
EE	4.29
EE/SP	8.14
EE/CHILDREN	9.55
FAMILY	13.43

Sun Life

One Sun Life Executive Park, Wellesley Hills, MA 02481



Group Enrollment Form

Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

Employer use (check one): New employee Change COBRA

1. General Information

Employer Name Premium Transportation Group, Inc.	Account / Policy Number 956091	Location
--	--	-----------------

2. Employee Information

Employee's Full Legal Name (First, M.I., Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Street Address		City	State	Zip Code
Occupation	Eligibility Class (if applicable)	Social Security Number	Phone Number	
Date employed: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Date:	<input type="checkbox"/> Return from layoff <input type="checkbox"/> Rehire	Date:	
Current Active Employment Type # of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Earnings \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other: _____			

3. Dependent Information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

Relationship	Full legal name (First, M.I., Last)	Gender	Social Security number	Date of birth	Student Y/N
Spouse					
Children					

4. Benefit Elections

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is.

***to ensure your choice of coverage please enter the amount, if left blank default amount will be minimum coverage**

<input type="checkbox"/>	<input type="checkbox"/>	Employee Voluntary Life and Accidental Death & Dismemberment (AD&D)	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Spouse Voluntary Life and Accidental Death & Dismemberment (AD&D)	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Child(ren) Voluntary Life and Accidental Death & Dismemberment (AD&D)	\$ _____

4. Benefit Elections (continued)

Elect	Refuse	Coverage
<input type="checkbox"/>	<input type="checkbox"/>	Short-Term Disability (STD) \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Long-Term Disability (LTD) \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Accident: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family
<input type="checkbox"/>	<input type="checkbox"/>	Critical Illness: Employee amount \$ _____ Spouse amount \$ _____ Child(ren) amount \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital Indemnity: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

Employer provided benefits--Your employer pays the premiums for the following benefits if you are eligible for them. Enrollment is automatic; no election is required.

- Employee Basic Life and Accidental Death & Dismemberment (AD&D)

5. Beneficiary Designation Information

Primary Beneficiary Designation

On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy. Designation applies to all coverages for which a beneficiary designation is required.

Primary Beneficiary(ies)	Percent share of proceeds*		
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

*Must equal 100%

Secondary Beneficiary Designation

On the lines below, list the individual(s) who should receive the proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if a primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

*Must equal 100%

6. Signature and authorization information

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If applying for coverage more than 31 days past my eligibility date, Evidence of Insurability may be required.
- For Life, Short-Term Disability, Long-Term Disability, and Critical Illness insurance, Evidence of Insurability may be required for amounts over my Guarantee Issue for this enrollment.
- Increases to current Life, Short-Term Disability, Long-Term Disability, and Critical Illness benefits may require Evidence of Insurability.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application, if required for the elected coverage(s), to be approved by Sun Life Assurance Company of Canada (Wellesley, MA).
- Coverages may include benefit waiting periods, limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined and are able to perform their normal activities.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

X

Employee Signature

Today's Date

To the Employee: Make a copy of this form for your records before submitting it to your employer.

To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment Form.

Sun Life Assurance Company of Canada

Group Statement of Health Application



1 General information

Employer name	Account/policy number	Location	Date effective
Street address	City	State	Zip code
Type of activity: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Reason:	Occupation		

2 Employee information

Employee's Full Legal Name (First, MI, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Street Address	City	State	Zip Code
Marital Status	Social Security Number	Phone number	
Date employed: <input type="checkbox"/> Full-Time Date: <input type="checkbox"/> Part-Time Date: <input type="checkbox"/> Rehire <input type="checkbox"/> Return from layoff Date:			
Current Active Employment Type # of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Employee Status: <input type="checkbox"/> Management <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired	Salary	

You need to complete all sections of this form including electing or refusing insurance coverage below and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Your employer will tell you your Maximum Guaranteed Issue amount. See the Statement of health section for details.

3 Benefit elections

Critical Illness coverage*:

Do all persons to be insured currently have a major medical or basic hospital and basic medical plan in force that will not be replaced?..... Yes No

If "No," such persons are not eligible for this insurance.

Do all persons to be insured currently have existing specified disease coverage in force or pending with the same or different insurer?..... Yes No

If "Yes," such persons are not eligible for this insurance.

Coverage Amount Elected

Employee coverage: \$ _____

Spouse coverage **: \$ _____

* Critical Illness is a limited policy. The certificate has exclusions and limitations including benefit waiting period for certain conditions which may affect any benefits payable.

** A Spouse may only be covered if you are.

HSA compatible:

Based on the limited available regulatory guidance, Sun Life Assurance Company of Canada ("the Company") believes its "Critical Illness Insurance" is appropriate for use with an HSA and may be purchased when employees and/or their family members are covered under an HDHP. However, the Company cannot provide legal or tax advice. If there are legal or tax questions, we suggest that the employee consult their own legal or tax advisor before purchasing this insurance.



4 Dependent information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

Relationship	Full legal name (First, MI, Last)	Gender	Social Security number	Date of birth
Spouse / Partner				

5 Health and personal history (complete the following for all those applying for coverage requiring underwriting)

Failure to provide complete responses will result in underwriting delays or non-payment of claims. This request for coverage is not effective until approved in writing by Sun Life Assurance Company of Canada ("The Company"). No information provided by you or your agent shall bind The Company unless you provide such information in writing on this form. No agent or broker has authority to alter the contents of this form.

Employee:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: _____ Ft. _____ In.	Weight: _____ lbs.
Spouse:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: _____ Ft. _____ In.	Weight: _____ lbs.

	Employee		Spouse/ partner	
	Yes	No	Yes	No
1. Have any of the proposed Insureds ever been diagnosed by a licensed medical professional with, received medical advice for, or sought treatment for any of these ailments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Cirrhosis of the liver or chronic hepatitis, kidney disease or abnormal kidney function, diabetes, chronic disease of the pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Stroke, transient ischemic attack (TIA), aneurysm, paralysis, optic neuritis, disorder of the brain or spinal cord, circulatory disease or disorder, heart attack, angina?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Chronic Obstructive Pulmonary Disease (COPD), emphysema, cystic fibrosis, status asthmaticus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Transplant of an organ, stem cells, or bone marrow or advised of the need of transplant of an organ, stem cells, or bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Cancer or malignancy, leukemia, melanoma, cancer of the bone marrow, benign brain tumor, Hodgkin's disease or non-Hodgkin's lymphoma (not including basal cell carcinoma of the skin that has been removed)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the last 3 years, have any of the proposed Insureds had an in-situ tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the last 6 months, have any of the proposed Insureds had high blood pressure requiring a change in medication or increase in dosage OR at any last follow up, were any pressure readings 150/95 or greater?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any of the proposed Insureds ever been diagnosed by a licensed medical professional of: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6 Acknowledgement, authorization for release and disclosure of health related information, and signature

Acknowledgement

I acknowledge, to the best of my knowledge and belief, that:

- The information I have provided in the Application is true, accurate and complete.
- I have read, or had read to me, this completed Application, and understand that any false statements or misrepresentations made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me, the fraud warning for my state.

I also confirm my understanding that:

- My Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada ("the Company") determines that I am not insurable. If the Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask the Company in writing to: (a) obtain certain information from the Application-file relating to me; (b) correct, amend or delete information in the Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the Application file relating to me is incorrect; and (d) provide me with a copy of my Application.
- The insurance I am enrolling for may have benefit limitations for pre-existing conditions. These limitations will apply even if the conditions were fully disclosed during the enrollment process and I was approved for coverage.

If I have any questions regarding my Application, I can write to Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481.

6 Acknowledgement, authorization for release and disclosure of health related information, and signature, continued

I AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager or other medical or healthcare facility that has provided payment, treatment, or services to me or on my behalf, to disclose my entire medical record and any other protected health information concerning me to the Medical Underwriting Department of Sun Life Assurance Company of Canada ("the Company") its subsidiaries, affiliates, third party administrators, and reinsurers.

I understand that such information may include records that relate to my physical or mental condition, such as diagnostic tests, physical examination notes and treatment histories, and that may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs, and tobacco, but does not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

X

Employee signature

Today's date

X

Spouse signature

Today's date

7 Statement of health and authorization information

A medical statement of health application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. A medical statement of health application may also be needed if you:

- apply for a higher coverage than the Maximum Guaranteed Issue amount
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada or a prior insurance carrier
- decline coverage and then want it at a later date

Coverage subject to a medical state of health application will not go into effect until Sun Life Assurance Company of Canada approves it.

I understand that:

- I am requesting coverage under a Group Insurance Policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit a medical statement of health application which is acceptable to Sun Life Assurance Company of Canada. I have read the Evidence of Insurability notice.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the Group Insurance Policy; such coverage will not start until the date I return to work.
- If my spouse is confined due to an injury or illness on the date that any initial or increased coverage is scheduled to start under the Group Insurance Policy, such coverage will not start until the date he/she is no longer confined and is able to perform their normal activities.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

X

Employee signature

Today's date

X

Spouse signature

Today's date

To the employee: Make a copy of this form for your records.

8 Fraud warnings

General fraud warning: Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance, 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.

For AL the following fraud warning applies: 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.

For AR, LA, MA, NM, RI, and WV the following fraud warning applies: 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 fines and confinement in prison.

For CO the following warning applies: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

For the District of Columbia the following notice applies: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

For FL the following notice applies: 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.

For KS the following notice applies: 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 may be guilty of insurance fraud as determined by a court of law.

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

For MD the following notice applies: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

For ME, TN, and WA the following notice applies: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For NJ the following notice applies: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For OH the following notice applies: Any person who, with intent to defraud or knowing that he 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.

For OK the following notice applies: 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.

8 Fraud warnings, continued

For OR and VA the following notice applies: Any person who, with intent to defraud or knowing that he 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.

For PR the following notice applies: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For VT the following notice applies: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Contact us



By mail
Sun Life Financial
One Sun Life Executive Park
Wellesley Hills, MA 02481



By e-mail
my.eoi@sunlife.com



www.sunlife.com/us



Customer Service **800-247-6875** M-F 8:00 a.m. – 8:00 p.m., ET

PREMIUM TRANSPORTATION GROUP

Insurance Department
190 Highland Drive
Medina, Ohio 44256

SUBJECT: Welcome to Sun Life Voluntary Benefits.

Dear Employee,

You are eligible for employer paid 20,000.00 life insurance, as well as other voluntary benefits.

Please see below for a short explanation of the benefits offered.

Please complete the following pages. They must be returned within 30 days of start of employment.

Section 1 – General Information

Section 2 – Employee Information – please complete this section with your information

Section 3 – Dependent Information – If you are going to purchase voluntary benefits for your dependents, please complete this section.

Section 4 – Benefit Elections – Please check off elect or Refuse

***Please note that some of the rates vary based your age and salary**

***EE voluntary life and accidental ***

***Spouse voluntary life and accidental ***

***Children voluntary life and accidental ***

***Short term disability pays out 60% of your total weekly earnings up to \$1,500 benefits begin
Within 15 days for up to 11 weeks ***

***Long term disability pays out 60% of your total weekly earnings benefits begin as soon as 90 days ***

Accident insurance

Employee only	\$10.86 per month
Employee and spouse	\$19.44 per month
Employee and children	\$22.73 per month
Employee and family	\$31.31 per month

***Please note that some of the rates vary based your age and salary.**

Critical illness

Hospital indemnity

Employee only	\$21.45 per month
Employee and spouse	\$60.71 per month
Employee and children	\$47.11 per month
Employee and family	\$79.30 per month

Employer provided benefits – this is for your no cost to you \$20,000.00 please complete your beneficiary information, if you have more than one you must split to equal 100.

Signature and Authorization information. Please do not forget to sign, date, and make a copy for your records.

COMPENSATION AND BENEFIT ACKNOWLEDGEMENT

I fully understand my compensation and benefits package that has been explained to me.

Employee

Date

Employee Acknowledgement of Receipt of Employment Handbook

I have received, read and understand this employee handbook. I have also asked for an explanation from my Supervisor as to any parts I did not understand. I understand that the contents of this Handbook are presented as a matter of information only and that the information contained in this Handbook does not constitute a condition of employment and that the information contained in this handbook does not constitute a guarantee of employment for any specific period of time. The Company reserves the right to modify, revoke, suspend, terminate or change all information contained in this Handbook in whole or in part, at any time, with or without notice to me. I recognize that the language used in this Handbook is not intended to create nor is it to be construed to constitute an express or implied contract of employment between the Company and myself or any other employee. I also understand that the employment between the Company and me may be terminated at any time, with or without cause, regardless of the time and manner of wages and salary, be terminated either by myself or by the Company at any time, with or without cause, unless the employment arrangement is modified by a written agreement signed by both me and the CEO or President. Further, I acknowledge that I do not rely and have not relied on any representation or statement made by the Company or any of its agents or representatives, whether oral or otherwise, that are inconsistent with or differ in any way from the statements presented in this Handbook. I also understand that no representative of the Company, other than the CEO or President, has any authority to enter into any agreement of employment with any employee for any specified period of time, or to make any agreement contrary to the foregoing. The contents of this Handbook may change at any time as experience indicates that changes are necessary. This Handbook replaces and supersedes all previous handbooks, booklets, or understandings that may have existed prior to my receipt and acknowledgement of this Handbook.

Employee Signature

Company Representative Signature

Date

Date

FMCSA DRUG & ALCOHOL CLEARINGHOUSE – LIMITED QUERIES

CONSENT FORM

I, _____, hereby provide consent to
(Driver's Printed Name)

(Name of Motor Carrier)

and/or their TPA to conduct a limited query of the FMCSA Commercial Driver's License Drug and Alcohol Clearinghouse on an annual basis during the duration of my employment to determine whether drug or alcohol violation information about me exists in the Clearinghouse.

I understand that if the limited query indicates that drug or alcohol violation information about me exists in the Clearinghouse, I must grant electronic consent within 24 hours, via the Clearinghouse website, for the motor carrier and/or their TPA to obtain my full Clearinghouse record. I further understand that if I refuse to provide such consent, I will be removed from performing all safety-sensitive duties including driving a commercial motor vehicle, as required by FMCSA's drug and alcohol program regulations.

Driver's Signature: _____

Date: _____

Authorization to Obtain Motor Vehicle Record

THE UNDERSIGNED DOES HEREBY ACKNOWLEDGE AND CERTIFY AS FOLLOWS:

1. Certifies that the undersigned is an employee, or has applied to become an employee of the below named employer in a position which involves the operation of a motor vehicle, and the undersigned gives his or her consent to the release of their driving record (MVR) for review by:

Name of Employer or Potential Employer

2. That the undersigned authorizes his or her driving record to be periodically obtained and reviewed for the purpose of initial and continued employment.
3. That all information presented in this form is true and correct. The undersigned makes this certification and affirmation under penalty of perjury and understands that knowingly making a false statement or representation on this form is a criminal violation.

Name of Employee/potential employee: _____
Print name as it appears on driver's license

License Number & State: _____

License Number & State: _____

License Number & State: _____

Date of Birth: ____/____/____

Signature of employee/potential employee: _____

Date: _____

Employer Authorized Representative Name: _____

Date: _____

PEI OHIO, INC.™

Driver & Logistics Staffing Specialists

WELCOME !!!!!

We would like to take this opportunity to welcome you to PEI Ohio Inc. You are a very important asset to the company. Your safety and job satisfaction are very important to us. We have put together an experienced and professional staff to meet the needs of our dedicated employees.

Although we have a large employee pool, you are not just a number with our company. We encourage you to give us a call with any concerns or comments that you may have. Believe it or not, most problems can be solved with a simple phone call. We are requesting that you use the avenues that we have created to make your employment with us successful.

Should you be injured on the job, notify your immediate supervisor where you work, as soon as possible. You will then need to contact our work comp office within 24 hours of the injury to make a report. The contact information for our work comp office is 800-762-9430 or carolb@premiumdrivers.com.

Sincerely,

PEI Ohio Inc
www.premiumdrivers.com

E-Mail: tammyh@premiumdrivers.com
hunterh@premiumdrivers.com
tierras@premiumdrivers.com
racheller@premiumdrivers.com