Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

BENEFIT ENROLLMENT AND CHANGE FORM

Plan information available at www.wwihub.com

Employee Name	
Date of Birth	
Social Security	
Mailing Address	
Phone Number	
Email	
Hire Date	
Coverage Effective	
Pay Rate	

Group Health Insurance

Tier	Cost Per Pay Period	Elect (initial)	Decline (initial)
Employee Only	$75.00		
Employee + Spouse	$375.00		
Employee + Child	$375.00		
Family	$575.00		

Group Dental Insurance

Tier	Cost Per Pay Period	Elect (initial)	Decline (initial)
Employee Only	Winning Wheels Pays		
Employee + Spouse	$29.75		
Employee + Child	$42.19		
Family	$63.18		

Group Vision Insurance

Tier	Cost Per Pay Period	Elect (initial)	Decline (initial)
Employee Only	Winning Wheels Pays		
Employee + Spouse	$5.67		
Employee + Child	$5.97		
Family	$8.87		

Life with ADD Insurance

Employee $50,000.00	Winning Wheels Pays	Elect (initial)	Decline (initial)

Short Term Disability Insurance

Employee	Winning Wheels Pays	Elect (initial	Decline (initial)

Designated Beneficiary

Name	Relation	Percentage

Dependents

Name	Relation	Gender	Date of Birth	Social Security Number
		M F		
		M F		
		M F		
		M F		

I understand:

- Benefit coverage is effective the first of the month following my hire date or qualifying event effective date.
- I must maintain my minimum employment status to remain eligible to receive employment benefits.
- If I am off of work or am unable to pay my premiums through payroll deduction I will need to reimburse Winning Wheels, Inc. for my portion of the premiums.
- Changes to selected elections can only be made with a qualifying event or during an annual enrollment period.

Signature **Name Printed** **Date**

Winning Wheels, Inc,

Comprehensive Employment Benefits

**** Benefits in Italics are company paid/**free** to the team member*

Group Health Insurance

Plan Tier	**Per Pay Period Premium**
Employee	$75.00
Employee + Spouse	$375.00
Employee + Child	$375.00
Family	$575.00
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	Blue Cross/Blue Shield of Illinois

Dental Insurance

Plan Tier	**Per Pay Period Premium**
Employee	*Winning Wheels, Inc. Pays*
Employee + Spouse	$29.75
Employee + Child	$42.19
Family	$63.18
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	Blue Cross/Blue Shield of Illinois

Vision Insurance

Plan Tier	**Per Pay Period Premium**
Employee	*Winning Wheels, Inc. Pays*
Employee + Spouse	$5.67
Employee + Child	$5.97
Family	$8.87
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	Blue Cross/Blue Shield of Illinois

Life w/ ADD Insurance

Amount of Coverage	$50,000.00 per year
Premium	*Winning Wheels, Inc. Pays*
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	Blue Cross/Blue Shield of Illinois

Short Term Disability

Amount of Coverage	Based on individual income
Premium	*Winning Wheels, Inc. Pays*
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	Blue Cross/Blue Shield of Illinois

Supplemental Coverage

Coverage Available	Supplemental Life Accident Critical Illness
Premium	Dependent upon coverage elected
Effective	First of the month following hire date
Provider	APL

Retirement Savings

Premium	Team member chooses contribution amount
Effective	First of the month following hire date
Provider	Illinois Secure Choice

Things to Note

- Under the "125 Cafeteria" Flex Plan, team member contributions to dental, supplemental, limited medical and vision plans are made pre-tax, which allows team members to save money on income and social security taxes
- Insurance premiums are prepaid by Winning Wheels, Inc. and final payroll deductions may need to be adjusted accordingly
- Once enrolled, you may only make changes during the designated annual enrollment period or in the event of a qualifying event.
- New team member enrollment paperwork must be completed within 14 days of hire.

Child Care

Amount of Benefit	75% discount at the Lyndon Play and Learn Center
Eligibility	*All team members*
Effective	Upon hire and based on service availability and openings
Provider	Lyndon Play and Learn Center

Education Assistance

Amount of Benefit	Reimbursement of up to $500.00 per semester
Eligibility	Full-time team members
Effective	First of the month following 90 days of employment

Professional Licenses and Membership Dues

Amount of Benefit	Up to $250.00 per year
Eligibility	Professionally licensed team members and memberships to professional associations
Effective	Upon Hire

Certified Nurse Aide Training Program

Eligibility	All team members
Effective	Upon Hire, must be successfully completed within 120 days of hire

Shift Differential

Nursing staff receive $3.00 per hour in addition to their regular rate of pay for 2nd and 3rd shifts.

Nursing Bonus Holiday

Full Time RNs, LPNs and C.N.A.s (minimum 72 hours per pay period) receive 8 hours of holiday pay each pay period.

Paid Time Off

Vacation Time	- Accrues as you work - Up to 48 hours per year during 1st year of service - Up to 104 hours per year 2-4 years of service - Up to 152 hours per year after 5 years of employment - Up to 192 hours per year at 15 years of employment - Benefit time carries over - Full and part-time team members are eligible after 90 days of service
Sick Time	- 40-hour maximum benefit per annual year - Benefit time does not carry over - Full and Part-time team members are eligible after 90 days of service
Bereavement	- 3 days immediate family member - 1 day for non-immediate family member - 10 days for a child
Jury Duty	- Reimbursement for service during scheduled work time
Holidays	- 6 paid holidays annually: New Year's Day, Memorial Day, Labor Day, Thanksgiving Day, Independence Day, Christmas Day - Team members working the actual holiday will be paid at time and a half of their regular pay rate - Part-time team members receive 50% of the benefit

For assistance with any of our employment benefits or programs, please contact Human Resources at 815-778-3683 extension 305 or aschaefer@aheinco.com

Detailed plan summaries, current benefit information and employment resources are available at www.wwihub.com

Winning Wheels Voluntary Benefit Election Form **Semi-Monthly Rates Page 1 of 1.**

This form must be completed in full. The below is for your accident and critical illness plans with Assurity and your life insurance with American Public Life (APL). If you have any questions regarding these plans please contact your representative, Matt Rednour, at 563-265-0122 or Matt@waregroupga.com

(Employee) Print Name (First, MI, Last) : _____ Phone: _____

If you have elected any coverage on a spouse or child please complete the below in full. If you need additional space please add an additional form

	Name (First, MI, Last)	Relationship to you (spouse or dependent child)	Gender	Date of Birth
1				
2				
3				
4				
5				

Please select only one of the accident plans boxes below or if you intend to decline both please check the decline both accident plans box.

Election Type		Accident Expense Plan 1
Employee Only	☐	$5.38
Employee + Spouse	☐	$9.31
Employee + Children	☐	$10.20
Family	☐	$15.30

Election Type		Accident Expense Plan 2
Employee Only	☐	$9.51
Employee + Spouse	☐	$16.39
Employee + Children	☐	$17.59
Family	☐	$26.40
I Decline Both Accident Plans	☐	

Critical Illness

Children are no additional cost to be added. If children are insured they will be covered at 25% of the listed benefit, if spouse are insured they will be covered at 50% of the listed benefit. Choose one of the below boxes or check the decline box.

Employee Only and Employee with Children Rates

Employee Attained Age		$10,000		$20,000		$30,000
18-24	☐	$2.18	☐	$4.36	☐	$6.53
25-29	☐	$2.56	☐	$5.10	☐	$7.62
30-34	☐	$3.11	☐	$6.21	☐	$9.29
35-39	☐	$3.91	☐	$7.80	☐	$11.67
40-44	☐	$4.96	☐	$9.89	☐	$14.80
45-49	☐	$6.81	☐	$13.54	☐	$20.24
50-54	☐	$10.09	☐	$20.05	☐	$30.00
55-59	☐	$15.72	☐	$31.24	☐	$46.76
60-64	☐	$19.93	☐	$39.62	☐	$59.31
65-69	☐	$27.15	☐	$54.05	☐	$80.95
70+	☐	$77.34	☐	$154.13	☐	$230.91
I Decline Critical Illness	☐					

Employee with Spouse and Employee with Family Rates

Employee Attained Age		$10,000		$20,000		$30,000
18-24	☐	$2.80	☐	$5.60	☐	$8.37
25-29	☐	$3.32	☐	$6.60	☐	$9.90
30-34	☐	$4.17	☐	$8.29	☐	$12.40
35-39	☐	$5.38	☐	$10.68	☐	$15.97
40-44	☐	$6.97	☐	$13.83	☐	$20.69
45-49	☐	$9.77	☐	$19.34	☐	$28.93
50-54	☐	$14.72	☐	$29.16	☐	$43.60
55-59	☐	$23.22	☐	$46.03	☐	$68.84
60-64	☐	$29.53	☐	$58.60	☐	$87.69
65-69	☐	$40.35	☐	$80.23	☐	$120.09
70+	☐	$115.73	☐	$230.34	☐	$344.95

20 Year Term Life Insurance

Choose how much life insurance you want for yourself in the empoyee volume on the left then on the right choose who is all to be covered in the coverage type. If you cover your spouse they will be 50% of the amount you select for youself and if you cover your children they will be at $10,000. If you are declining life insurance please check the decline box. The rates for this plan can be located in the life insurance brochure.

Employee Volume		
$50,000	☐	
$100,000	☐	
$150,000	☐	
I Decline Life Insurance	☐	

Coverage Type		
Employee Only	☐	
Employee + Spouse	☐	
Employee + Children	☐	
Family	☐	

If you have elected life insurance above please be sure to complete the beneficiary section below. If this section is left blank your beneficiary will be listed as being designated to your estate.

	Beneficiary (First Name and Last Name)	Relationship to you	Percent of benefit paid to beneficiary. Must equal 100%
1			
2			
3			

	Contingent Beneficiary (First Name and Last Name)	Relationship to you	Percent of benefit paid to beneficiary. Must equal 100%
1			
2			
3			

*You are electing or waiving coverage for which you are eligible or may become and, if enrolling, authorize your employer to deduct premiums via payroll deduction. The coverage requested on this election form will not be effective until approved by the carriers. If any discrepancies, the policy will control. Coverage is subject to terms, conditions, limitations, and exclusions. Exact premium will be determined at time of issue. You understand that changes may only take place during qualifying life events or during future open enrollments.

Signature:_____ **Date:**_____

Print Name (First, MI, Last):_____

Illinois Secure Choice
Retirement Savings Program

EMPLOYEE OPT OUT FORM

Illinois Secure Choice is a completely voluntary program. You can opt out at any time online, by phone, or by completing this form. If you do not opt out your employer will send payroll contributions to your Illinois Secure Choice account. Amounts you save in this account are always your money. Your account is in your control and goes with you from job to job in accordance with the Illinois Secure Choice Program terms. Every little bit you save now can potentially make a difference in retirement. To opt out of payroll contributions to Illinois Secure Choice for more than one employer you must submit a separate form for each employer.

Completed forms should be mailed back to Illinois Secure Choice.
Illinois Secure Choice
PO Box 56000
Boston, MA 02205-6000

Overnight Address:
Illinois Secure Choice
95 Wells Avenue, Suite 155
Newton, MA 02459

You may also opt out online or by phone.
855-650-6914
8 a.m. to 8 p.m. CT, Monday through Friday

saver.ilsecurechoice.com

1. EMPLOYEE INFORMATION *(All fields required)*

To verify your information, please provide either the last four digits of your Social Security Number/Taxpayer Identification Number, or your access code and date of birth. The access code can be found in the email or letter you received from Illinois Secure Choice.

Legal Name *(First)* *(M.I.)*

Legal Name *(Last)*

Address

City State Zip Code

Telephone Number *(In case we have a question)*

Last Four Digits of Social Security Number or Taxpayer Identification Number

Access Code

Birth Date *(mm/dd/yyyy)*

2. OPT OUT REASON

- ☐ I don't qualify for a Roth IRA due to my income
- ☐ I would prefer a Traditional IRA
- ☐ I have my own retirement plan
- ☐ I can't afford to save at this time
- ☐ I don't trust the financial markets
- ☐ I'm not satisfied with the investment options
- ☐ I'm not interested in contributing through this employer
- ☐ Other

3. EMPLOYER INFORMATION

Employer Name

4. SIGNATURE

I do not wish to participate in the Illinois Secure Choice Program at this time. I understand that I can change my mind at any time and begin participating in Illinois Secure Choice at a later date, subject to and in accordance with the terms of the Illinois Secure Choice Program. If I decide to opt back in, I can contact Illinois Secure Choice.

Signature of Employee

Date *(mm/dd/yyyy)*

©2018 Ascensus, LLC

Illinois Secure Choice
Retirement Savings Program

IRA ACCOUNT MAINTENANCE FORM

Complete this form to change your name, permanent and/or mailing address, phone number, email address, contribution rate, annual increase, or bank information. You may also update this information online by logging into your account at saver.ilsecurechoice.com.

If you are changing your legal name, your signature with your old name and your signature with your new name are required to be Medallion Signature Guaranteed in Section 3 by an authorized officer of a bank, broker, or other qualified financial institution. In place of a Medallion Signature Guarantee, you have the option to submit a signed letter of instruction with supporting legal documentation (i.e. marriage certificate, court order, divorce documentation) for this change.

The updates/changes on this form override all previous elections for this IRA. Contact the Client Service team if you need assistance completing this form.

Completed forms should be mailed to: Illinois Secure Choice
PO Box 56000
Boston, MA 02205-6000

Overnight Address: Illinois Secure Choice
95 Wells Avenue, Suite 155
Newton, MA 02459

855-650-6914
8 a.m. to 8 p.m. CT, Monday through Friday

saver.ilsecurechoice.com

1. IRA OWNER INFORMATION *(All fields required)*

If you are updating your information, enter the information that is currently on file in this section and the new information in Section 3.

Account Number

IRA Owner Legal Name *(First) (If you are changing your name, enter the name you have on file in this section.)* *(M.I.)*

IRA Owner Legal Name *(Last)*

Telephone Number *(In case we have a question about your Account. If you are updating your phone number, enter the number you have on file in this section and the new number in Section 3.)*

Employer Name *(If you contribute through more than one employer and want to change your contribution rate or automatic annual increase election, you must submit a separate form for each employer.)*

2. ACCOUNT UPDATES OR CHANGES

Check the box(es) to indicate which section(s) you plan to update or change.

- ☐ **IRA Owner Information** – Section 3
- ☐ **Bank Information** – Section 4
- ☐ **Contribution Rate** – Section 5
- ☐ **Automatic Annual Increase** – Section 6

©2018 Ascensus, LLC

3. UPDATE IRA OWNER INFORMATION

If you are changing your name and/or contact information, provide the new information exactly as you would like it to appear on your Illinois Secure Choice IRA.

If you are changing your name, you must also provide a Medallion Signature Guarantee below or legal document(s) verifying the name change.

IRA Owner Legal Name *(First)* *(M.I.)*

IRA Owner Legal Name *(Last)*

Email Address

Physical Address *(We cannot accept a PO Box)*

City State Zip Code

Mailing Address if different from above *(This address will be used as the address of record and for all mailings)*

City State Zip Code

Telephone Number

Medallion Signature Guarantee — REQUIRED FOR NAME CHANGES TO THE ACCOUNT OWNER OF AN EXISTING ACCOUNT ONLY

- You must provide the following information as underwritten certification that the new signature is genuine.
- You can obtain a Medallion Signature Guarantee from an authorized officer of a bank, broker, or other qualified financial institution. A notary public cannot provide a Medallion Signature Guarantee, nor can you guarantee your own signature.
- **Do not sign below until you are in the presence of the authorized officer providing the signature guarantee.**

By signing here I certify that the information provided herein is true and complete in all respects.

Former Signature of Account Owner *(For name change only)*

Current Signature of Account Owner

Signature of Guarantor

Authorized Officer to Place Stamp Here

Title

Name of Institution

Date *(mm/dd/yyyy)*

©2018 Ascensus, LLC

4. UPDATE BANK INFORMATION

Important: *By signing this form, you agree and confirm that your ACH transaction will not involve the branches or offices of a bank or other financial services company located outside the territorial jurisdiction of the United States.*

☐ Add ☐ Delete Bank Information Indicated Below ☐ Delete All Current Bank Information and Add New Bank Information Below

Financial Organization Name

Financial Organization Routing Number

Financial Organization Account Number

ACCOUNT TYPE *(Select one)*

☐ Checking ☐ Savings

Note: *The routing number is usually located on the bottom left corner of your checks. You can also ask your financial organization for the routing number.*

☐ Add ☐ Delete Bank Information Indicated Below ☐ Delete All Current Bank Information and Add New Bank Information Below

Name

Financial Organization Routing Number

Financial Organization Account Number

ACCOUNT TYPE *(Select one)*

☐ Checking ☐ Savings

Note: *The routing number is usually located on the bottom left corner of your checks. You can also ask your financial organization for the routing number.*

5. UPDATE CONTRIBUTION RATE

If you wish to change your contribution rate, enter the percentage of your pay check you wish to contribute as a whole number. ***Note:*** *Your contributions to all of your Roth IRA are limited to $5,500 ($6,500 if 50 or older) for 2018 depending on your income. See IRS Publication 590A for more information.*

New Contribution Rate ☐☐☐ %

6. AUTOMATIC ANNUAL INCREASE

Contributions for accounts open at least 180 days will automatically increase by 1% on January 1 of each year, with the first increase scheduled for January 1, 2019.

☐ I wish to have my contribution rate automatically increased by 1% each year until it reaches 10%.

☐ I DO NOT wish to have my contribution rate automatically increased each year.

7. SIGNATURE

I certify that I am the account owner and verify the information above is accurate. I assume responsibility for any consequences that may result from these changes and I agree that Illinois Secure Choice, the custodian, or the program administrator are not responsible for any consequences that may arise from executing the changes outlined in this form.

Signature of IRA Owner

Date *(mm/dd/yyyy)*

©2018 Ascensus, LLC

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Benefit Acknowledgment

I acknowledge receipt of the benefit plan summaries and have reviewed the employment benefit options and eligibility offered with employment at Winning Wheels, Inc.

I understand to enroll in, cancel or change benefit elections I must complete the enrollment forms within fourteen days of the qualifying event. Benefits are effective the first of the month following hire date. Cases of qualifying events, enrollments, terminations and changes in benefits are effective the first of the month following the effective date of change. Changes to elections can only be made in the event of qualifying events and during the annual enrollment period.

I understand I have access to all current benefit plan information, summaries, eligibility requirements and disclosures at www.wwihub.com or by contacting the Plan Administrator at 815-778-3683 or via email aschaefer@ahelpc.com.

Team Member Name Printed Signature Date