

# 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	\$100.00
Employee + Spouse	\$420.00
Employee + Child	\$505.00
Family	\$825.00
<b>Eligibility</b>	Full-time team members
<b>Effective</b>	First of the month following hire date
<b>Provider</b>	Blue Cross/Blue Shield of Illinois

### Dental Insurance

Plan Tier	Per Pay Period Premium
<i>Employee</i>	<i>Winning Wheels, Inc. Pays</i>
Employee + Spouse	\$15.33
Employee + Child	\$28.13
Family	\$49.76
<b>Eligibility</b>	Full-time team members
<b>Effective</b>	First of the month following hire date
<b>Provider</b>	Blue Cross/Blue Shield of Illinois

### Vision Insurance

Plan Tier	Per Pay Period Premium
<i>Employee</i>	<i>Winning Wheels, Inc. Pays</i>
Employee + Spouse	\$2.69
Employee + Child	\$2.99
Family	\$5.79
<b>Eligibility</b>	Full-time team members
<b>Effective</b>	First of the month following hire date
<b>Provider</b>	Blue Cross/Blue Shield of Illinois

### Life w/ ADD Insurance

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

### Short Term Disability

<b>Amount of Coverage</b>	Based on individual income
<b>Premium</b>	<i>Winning Wheels, Inc. Pays</i>
<b>Eligibility</b>	Full-time team members
<b>Effective</b>	First of the month following hire date
<b>Provider</b>	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.
- Team members on leave are responsible for premiums not able to be deducted from their pay.

## Child Care

Amount of Benefit	75% discount at the Lyndon Play and Learn Center
Eligibility	<i>Full and Part-Time Team Members</i>
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

***Please visit this link to view an information video on our benefit plans:***

**<https://flimp.live/WWBenefitReview>**

## ***Paid Time Off***

<b>Vacation Time</b>	<ul style="list-style-type: none"><li>- Accrues as you work</li><li>- Up to 48 hours per year during 1<sup>st</sup> year of service</li><li>- Up to 104 hours per year 2-4 years of service</li><li>- Up to 152 hours per year after 5 years of employment</li><li>- Up to 192 hours per year at 15 years of employment</li><li>- Benefit time carries over</li><li>- Full and part-time team members are eligible after 90 days of service</li></ul>
<b>Sick Time</b>	<ul style="list-style-type: none"><li>- Accrues as you work: 1 hour for every 40 worked up to 40 hours in a 12-month period.</li><li>- Unused sick time may carryover into the next year, up to a maximum of 40 hours.</li><li>- A maximum of 40 hours may be used in a 12-month period.</li><li>- All Team Members are eligible</li></ul>
<b>Bereavement</b>	<ul style="list-style-type: none"><li>- 3 days immediate family member</li><li>- 1 day for non-immediate family member</li><li>- 10 days for a child</li></ul>
<b>Jury Duty</b>	<ul style="list-style-type: none"><li>- Reimbursement for service during scheduled work time</li></ul>
<b>Holidays</b>	<ul style="list-style-type: none"><li>- 6 paid holidays annually: New Year's Day      Memorial Day    Labor Day              Thanksgiving Day    Independence Day      Christmas Day</li><li>- Team members working the actual holiday will be paid at time and a half of their regular pay rate</li><li>- Part-time team members receive 50% of the benefit</li></ul>

**For assistance with any of our employment benefits or programs, please contact Human Resources at 815-778-3683.**

**Detailed plan summaries, current benefit information and employment resources are available at [www.wwihub.com](http://www.wwihub.com)**





### **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](http://www.wwihub.com) or by contacting the Plan Administrator at 815-778-3683.

---

Team Member Name Printed

Signature

Date



## BENEFIT ENROLLMENT AND CHANGE FORM

Plan information available at <https://flimp.live/WWBenefitReview>

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	\$100.00		
Employee + Spouse	\$420.00		
Employee + Child	\$505.00		
Family	\$825.00		

### Group Dental Insurance

Tier	Cost Per Pay Period	Elect (initial)	Decline (initial)
Employee Only	Winning Wheels Pays		
Employee + Spouse	\$15.33		
Employee + Child	\$28.13		
Family	\$49.76		

### Group Vision Insurance

Tier	Cost Per Pay Period	Elect (initial)	Decline (initial)
Employee Only	Winning Wheels Pays		
Employee + Spouse	\$2.69		
Employee + Child	\$2.99		
Family	\$5.79		

### Life with ADD Insurance

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

### Short Term Disability Insurance

Employee	Winning Wheels	Elect (initial)	Decline (initial)
	Pays		

**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 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	Election Type	Accident Expense Plan 2
Employee Only	<input type="checkbox"/> \$5.38	Employee Only	<input type="checkbox"/> \$9.51
Employee + Spouse	<input type="checkbox"/> \$9.31	Employee + Spouse	<input type="checkbox"/> \$16.39
Employee + Children	<input type="checkbox"/> \$10.20	Employee + Children	<input type="checkbox"/> \$17.59
Family	<input type="checkbox"/> \$15.30	Family	<input type="checkbox"/> \$26.40
		I Decline Both Accident Plans	<input type="checkbox"/>

## 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 with Spouse and Employee with Family Rates			
Employee Attained Age	\$10,000	\$20,000	\$30,000	Employee Attained Age	\$10,000	\$20,000	\$30,000
18-24	<input type="checkbox"/> \$2.18	<input type="checkbox"/> \$4.36	<input type="checkbox"/> \$6.53	18-24	<input type="checkbox"/> \$2.80	<input type="checkbox"/> \$5.60	<input type="checkbox"/> \$8.37
25-29	<input type="checkbox"/> \$2.56	<input type="checkbox"/> \$5.10	<input type="checkbox"/> \$7.62	25-29	<input type="checkbox"/> \$3.32	<input type="checkbox"/> \$6.60	<input type="checkbox"/> \$9.90
30-34	<input type="checkbox"/> \$3.11	<input type="checkbox"/> \$6.21	<input type="checkbox"/> \$9.29	30-34	<input type="checkbox"/> \$4.17	<input type="checkbox"/> \$8.29	<input type="checkbox"/> \$12.40
35-39	<input type="checkbox"/> \$3.91	<input type="checkbox"/> \$7.80	<input type="checkbox"/> \$11.67	35-39	<input type="checkbox"/> \$5.38	<input type="checkbox"/> \$10.68	<input type="checkbox"/> \$15.97
40-44	<input type="checkbox"/> \$4.96	<input type="checkbox"/> \$9.89	<input type="checkbox"/> \$14.80	40-44	<input type="checkbox"/> \$6.97	<input type="checkbox"/> \$13.83	<input type="checkbox"/> \$20.69
45-49	<input type="checkbox"/> \$6.81	<input type="checkbox"/> \$13.54	<input type="checkbox"/> \$20.24	45-49	<input type="checkbox"/> \$9.77	<input type="checkbox"/> \$19.34	<input type="checkbox"/> \$28.93
50-54	<input type="checkbox"/> \$10.09	<input type="checkbox"/> \$20.05	<input type="checkbox"/> \$30.00	50-54	<input type="checkbox"/> \$14.72	<input type="checkbox"/> \$29.16	<input type="checkbox"/> \$43.60
55-59	<input type="checkbox"/> \$15.72	<input type="checkbox"/> \$31.24	<input type="checkbox"/> \$46.76	55-59	<input type="checkbox"/> \$23.22	<input type="checkbox"/> \$46.03	<input type="checkbox"/> \$68.84
60-64	<input type="checkbox"/> \$19.93	<input type="checkbox"/> \$39.62	<input type="checkbox"/> \$59.31	60-64	<input type="checkbox"/> \$29.53	<input type="checkbox"/> \$58.60	<input type="checkbox"/> \$87.69
65-69	<input type="checkbox"/> \$27.15	<input type="checkbox"/> \$54.05	<input type="checkbox"/> \$80.95	65-69	<input type="checkbox"/> \$40.35	<input type="checkbox"/> \$80.23	<input type="checkbox"/> \$120.09
70+	<input type="checkbox"/> \$77.34	<input type="checkbox"/> \$154.13	<input type="checkbox"/> \$230.91	70+	<input type="checkbox"/> \$115.73	<input type="checkbox"/> \$230.34	<input type="checkbox"/> \$344.95
I Decline Critical Illness	<input type="checkbox"/>						

## 20 Year Term Life Insurance

Choose how much life insurance you want for yourself in the employee 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 yourself 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		Coverage Type	
\$50,000	<input type="checkbox"/>	Employee Only	<input type="checkbox"/>
\$100,000	<input type="checkbox"/>	Employee + Spouse	<input type="checkbox"/>
\$150,000	<input type="checkbox"/>	Employee + Children	<input type="checkbox"/>
I Decline Life Insurance	<input type="checkbox"/>	Family	<input type="checkbox"/>

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):** \_\_\_\_\_







### 3.

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 (Last)

Physical Address (We cannot accept a PO Box)

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

-    -      
 Telephone Number

- 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.**

--

\_\_\_\_\_

--

\_\_\_\_\_

\_\_\_\_\_

-   -      
 Date (mm/dd/yyyy)

Authorized Officer to Place Stamp Here

4.

**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

[illegible]

Financial Organization Name

Financial Organization Routing Number

[illegible]

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

[illegible]

Name

--	--	--	--	--	--	--	--	--

Financial Organization Routing Number

[illegible]

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.

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.

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.

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)