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:_____

EMPLOYMENT APPLICATION

This application will help the below-named Motor Carrier determine whether or not this particular applicant qualifies to operate the motor carrier equipment according to the requirements of the Federal Motor Carrier Safety Rules and Regulations and our Company.

Company AMAZING TRUCKING & LOGISTICS, INC
Address **3025 East End Ave**
City **South Chicago Heights** **State** **IL** **Zip** **60411**

INSTRUCTIONS *Please answer ALL questions. Do not leave anything blank. Use "No", "None", or "Not Applicable" for anything that applies. Be as detailed as possible.*

Date:_____

Position applying for (check one):

- ☐ **Company Driver**
- ☐ **Owner Operator**
- ☐ **Owner Operator's Driver**
- ☐ **Other:** _____

Division applying for (check one):

- ☐ **Intermodal Division**
- ☐ **Dry Van/Reefer Division**

Name: _____
First Middle Last

Phone Number: _____
Alternate Phone Number: _____

Age: _____ **Date of Birth:** _____ **SSN:** _____

Physical Exam/Medical Card Expiration Date: _____

Current and Previous Addresses (go back three (3) years):

_____ **From:**_____ **To:**_____
_____ **From:**_____ **To:**_____
_____ **From:**_____ **To:**_____
_____ **From:**_____ **To:**_____

Have you ever worked for this company before: YES NO
If YES give dates: From_____**To:**_____
Reason for Leaving: _____

EDUCATION AND EMPLOYMENT HISTORY

Circle the highest grade completed:

Grade School	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
College	**1**	**2**	**3**	**4**								
Post Graduate	**1**	**2**	**3**	**4**								

Give a COMPLETE record of ALL employment for the past ten (10) years, including any unemployment or self-employment, and all commercial driving experience for the past ten (10) years.

Mo/Yr Mo/Yr Present or Last Employer
From________To__________ Name:__________________________
Position:_________________ Address:____
Equipment Used:_______________________ Street City State/Zip
Reason for Leaving:____________________ Phone:_________________________
Were you subject to the FMCSRs while employed here? YES NO
Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

Mo/Yr Mo/Yr Present or Last Employer
From________To__________ Name:__________________________
Position:_________________ Address:____
Equipment Used:_______________________ Street City State/Zip
Reason for Leaving:____________________ Phone:_________________________
Were you subject to the FMCSRs* while employed here? YES NO
Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

Mo/Yr Mo/Yr Present or Last Employer
From________To__________ Name:__________________________
Position:_________________ Address:____
Equipment Used:_______________________ Street City State/Zip
Reason for Leaving:____________________ Phone:_________________________
Were you subject to the FMCSRs* while employed here? YES NO
Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

Mo/Yr Mo/Yr Present or Last Employer
From________To__________ Name:__________________________
Position:_________________ Address:____
Equipment Used:_______________________ Street City State/Zip
Reason for Leaving:____________________ Phone:_________________________
Were you subject to the FMCSRs* while employed here? YES NO
Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

Mo/Yr Mo/Yr Present or Last Employer

From________To__________ Name:___________________________

Position:_________________ Address:____

Equipment Used:______________________ Street City State/Zip

Reason for Leaving:____________________ Phone:___________________________

Were you subject to the FMCSRs* while employed here? YES NO

Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

Mo/Yr Mo/Yr Present or Last Employer

From________To__________ Name:___________________________

Position:_________________ Address:____

Equipment Used:______________________ Street City State/Zip

Reason for Leaving:____________________ Phone:___________________________

Were you subject to the FMCSRs* while employed here? YES NO

Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

Mo/Yr Mo/Yr Present or Last Employer

From________To__________ Name:___________________________

Position:_________________ Address:____

Equipment Used:______________________ Street City State/Zip

Reason for Leaving:____________________ Phone:___________________________

Were you subject to the FMCSRs* while employed here? YES NO

Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

Mo/Yr Mo/Yr Present or Last Employer

From________To__________ Name:___________________________

Position:_________________ Address:____

Equipment Used:______________________ Street City State/Zip

Reason for Leaving:____________________ Phone:___________________________

Were you subject to the FMCSRs* while employed here? YES NO

Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

Mo/Yr Mo/Yr Present or Last Employer

From________To__________ Name:___________________________

Position:_________________ Address:____

Equipment Used:______________________ Street City State/Zip

Reason for Leaving:____________________ Phone:___________________________

Were you subject to the FMCSRs* while employed here? YES NO

Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the drug and alcohol testing requirements of 49 CFR Part 40? YES NO

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

DRIVING EXPERIENCE

Class of Equipment	Dates From-To	Approx. Number of Miles Driven
Straight Truck		
Tractor & Semi Trailer		
Tractor-Two Trailers		
Tractor-Three Trailers		
Other		

List ALL states operated in (go back five (5) years): _____

_____

List special courses completed (PTD/DDC, Haz Mat, etc.): _____

List any safe driving awards you hold and from whom: _____

Accident Record for past three (3) years:

Date of Accident	Type of Accident	Location	# of Fatalities	# of Injured

Traffic Convictions and Forfeitures for the last three (3) years (except parking violations):

Date	Location	Charge	Penalty

Driver's License (list each license held in the past three (3) years):

State	License #	Type	Endorsements	Expiration Date

Have you ever been denied a license, permit or privilege to operate a motor vehicle?	YES	NO
Has any license, permit or privilege ever been suspended or revoked?	YES	NO
Is there any reason you might be unable to perform the functions of the job for which you have applied?	YES	NO
Have you ever been convicted of a felony?	YES	NO

Please give details if answered YES in any of the above questions: _____

_____

_____

PERSONAL REFERENCES

List three (3) persons for references, other than family members, **who have knowledge of your safety habits**:

1) Name: _____
Address: _____
_____
Phone: _____

2) Name: _____
Address: _____
_____
Phone: _____

3) Name: _____
Address: _____
_____
Phone: _____

UNDERSTANDING THE APPLICATION

To Be Read And Signed By The Applicant

It is agreed and understood that any misrepresentation given on this application shall be considered an act of dishonesty. It is agreed and understood that the motor carrier or his agents may investigate the applicant's background to ascertain any and all information of concern to applicant's record, whether same of record or not, and applicant releases employers and persons named herein from all liabilities for any damages on account of his furnishing such information. It is also agreed and understood that under the Fair Credit Reporting Act, Public Law 91-508, I have been told that this investigation may include an investigating Consumer Report, including information regarding my character, general reputation, personal characteristics, and mode of living. I agree to furnish such additional information and complete such examinations as may be required to complete my application file. It is agreed and understood that this Employment Application in no way obligates the motor carrier to employ or hire the applicant. It is agreed and understood that if qualified and hired, I may be on a probationary period during which time I may be disqualified without recourse. 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.

_____ _____

Applicant's Signature Date

Remarks (for office use only)

DISCLOSURE AND AUTHORIZATION

In connection with my application for employment (or contract for services) with you, I understand that consumer reports which may contain public record information may be requested. These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, etc. I further understand that such reports may contain public record information concerning my driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records; as well as information concerning previous driving record requests made by others from such sate agencies, and state provided driving records.

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I have the right, upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including the source of information; and the recipients of any reports on me, which have been previously furnished within the two-year period preceding my request. I hereby consent to your obtaining the above information, and I agree that such information which may be obtained, and my employment history with you if I am hired, may be supplied to other companies.

I hereby authorize procurement of consumer report(s) if hired (or contracted); this authorization shall remain on file and shall serve as an ongoing authorization for you to procure consumer reports at any time during my employment (or contract) period.

Applicant Name, Please Print	Applicant Social Security Number
Applicant's Signature	Date

IMPORTANT NOTICE
REGARDING BACKGROUND REPORTS
FROM THE *PSP Online Service*

In connection with your application for employment with Amazing Trucking & Logistics ("Prospective Employer"), it may obtain one or more reports regarding your driving, and safety inspection history from the Federal Motor Carrier Safety Administration (FMCSA). If the Prospective Employer uses any information it obtains from FMCSA in a decision to not hire you or to make any other adverse employment decision regarding you, the Prospective Employer will provide you with a copy of the report upon which its decision was based and a written summary of your rights under the Fair Credit Reporting Act before taking any final adverse action. If any final adverse action is taken against you based upon your driving history or safety report, the Prospective Employer will notify you that the action has been taken and that the action was based in part or in whole on this report. The Prospective Employer cannot obtain background reports from FMCSA unless you consent in writing. If you agree that the Prospective Employer may obtain such background reports, please read the following and sign below:

I authorize Amazing Trucking & Logistics ("Prospective Employer") to access the FMCSA Pre-Employment Screening Program (PSP) system to seek information regarding my commercial driving safety record and information regarding my safety inspection history. I understand that I am consenting to the release of safety performance information including crash data from the previous five (5) years and inspection history from the previous three (3) years. I understand and acknowledge that this release of information may assist the Prospective Employer to make a determination regarding my suitability as an employee.

I further understand that neither the Prospective Employer nor the FMCSA contractor supplying the crash and safety information has the capability to correct any safety data that appears to be incorrect. I understand I may challenge the accuracy of the data by submitting a request to https://dataqs.fmcsa.dot.gov. If I am challenging crash or inspection information reported by a State, FMCSA cannot change or correct this data. I understand my request will be forwarded by the DataQs system to the appropriate State for adjudication.

I have read the above Notice Regarding Background Reports provided to me by Prospective Employer and I understand that if I sign this consent form, Prospective Employer may obtain a report of my crash and inspection history. I hereby authorize Prospective Employer and its employees, authorized agents, and/or affiliates to obtain the information authorized above.

Date: _____ _____

Signature

_____

Name (Please Print)

Company Name: _____

Richmond Office
Ph 800.367.2875 Fax 765.966.6279

Date	_____	Reply to	Rachelle
Company	_____	Email	racheller@premiumdrivers.com
City, State	_____	Phone	800-367-2875
Phone	_____	Fax	866-406-0191 or 765-966-6279
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:

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:**

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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 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. *(See instructions)*

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.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

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

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				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Section 2
Do Not Write In This Space

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
		Premium Enterprises, Inc.

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code
615 Commerce Road	Richmond	IN	47374

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

A. New Name *(if applicable)*			B. Date of Rehire *(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
1. U.S. Passport or U.S. Passport Card		**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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (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.		**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		**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
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		**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		

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

Refer to the instructions for more information about acceptable receipts.

CERTIFICATE OF COMPLIANCE WITH DRIVER LICENSE REQUIREMENTS

NOTICE TO DRIVERS:

The Motor Carrier Safety Regulations part 383, applies to every person who operates a commercial motor vehicle in interstate, foreign or intrastate commerce, who operates a vehicle with a gross weight rating of 26,001 pounds or more, can transport 16 or more passengers including the driver, or transports hazardous materials that require placarding.

If the above applies you must comply with the following:

1. A driver may not possess more than one license. A motor carrier may not use a driver with more than one license. The driver's license must be from the driver's state of domicile.

2. A driver who violates state and/or local traffic laws (other than parking) must notify the motor carrier and the state that issued the license, within thirty days after the violation occurred.

3. A driver who receives either a revocation or suspension of their license must notify the motor carrier the next business day after receiving the notice.

4. A driver must provide previous work history when applying to operate a commercial motor vehicle.

DRIVER CERTIFICATION

I hereby agree that I have read and understand the above requirements issued in the Federal Motor Carrier Safety Regulations. The following license is the only one I possess.

Driver's Name _____ Social Security # _____-_____-_____
(please print)

Driver's Address_____
(street address (P.O. box) city state zip)

Driver's License No. _____State _____ Exp. Date ___/___/___

Driver's Signature _____

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 WOR

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( ).

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 re uirements: If yes to either uestion – 5 year retention.
If no to both uestions – 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: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

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.

OMB No. 1545-0074

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) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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)

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

Illinois Department of Revenue

Form IL-W-4

Employee's and other Payee's Illinois Withholding Allowance Certificate and Instructions

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

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

Printed by the authority of the State of Illinois -
PO Number: 2200208 - 500 copies
IL-W-4 (R-05/20)

This form is authorized under the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in this form not being processed and may result in a penalty.

PRINT NAME _____

CLIENT NAME/LOCATION_____

Premium Enterprises, Inc.

190 Highland Dr., Medina, OH 44256

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

DIRECT DEPOSIT AUTHORIZATION

I hereby authorize Premium Enterprises, 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 #** _____

……**Note:** *Cannot begin with a 5*

BANK NAME_____ **CITY, STATE** _____

CHECKING _____ or SAVINGS _____ AMOUNT $_____ or ENTIRE CHECK _____

TRANSIT/ROUTING # (9 DIGITS) _ _ _ _ _ _ _ _ _ **ACCOUNT #** _____

……. **Note**: *Cannot begin with a 5*

For accuracy, attach copy of void check below

PREMIUM TRANSPORTATION GROUP, INC.

Employee Quick-Start

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

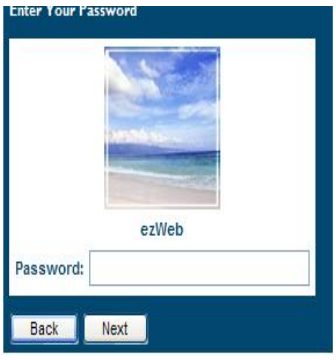
Follow the "create a new login" prompts. You ***will receive an email to finalize the process.*** If you do not see the email in your inbox, check your junk or quarantine folders. Due to the confidential nature of the information available in the system, leading industry security standards are used to 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.



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

CLICK THE FOLLOWING LINK TO RECREATE YOUR PASSWORD

PREMIUM
TRANSPORTATION GROUP, INC.

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

Ameritas.

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 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	☐	☐	☐	☐					☐
2	☐	☐	☐	☐					☐
3	☐	☐	☐	☐					☐
4	☐	☐	☐	☐					☐
5	☐	☐	☐	☐					☐

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 _____ X _____

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

Dependent late entrant date_____

Effective Date	Class	Dep. Code

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 of 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.

PREMIUM™
TRANSPORTATION GROUP, INC.
Driver & Logistics Staffing Specialists™

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

Sun Life

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	**Account / Policy Number**	**Location**
Premium Transportation Group, Inc.	956091	

2. Employee Information

Employee's Full Legal Name (First, M.I., Last)	☐ Male ☐ Female	**Date of Birth**	
Street Address	**City**	**State**	**Zip Code**
Occupation	**Eligibility Class** (if applicable)	**Social Security Number**	**Phone Number**

Date employed: ☐ Full-Time Date: ☐ Return from layoff Date:
☐ Part-Time Date: ☐ Rehire

Current Active Employment Type
_____ # of hours ☐ Full-Time ☐ Part-Time

Earnings $
☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ 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**

Elect	Refuse	Coverage
☐	☐	Employee Voluntary Life and Accidental Death & Dismemberment (AD&D) $ _____
☐	☐	Spouse Voluntary Life and Accidental Death & Dismemberment (AD&D) $ _____
☐	☐	Child(ren) Voluntary Life and Accidental Death & Dismemberment (AD&D) $ _____

4. Benefit Elections (continued)

Elect	Refuse	Coverage
☐	☐	Short-Term Disability (STD) $ _____
☐	☐	Long-Term Disability (LTD) $ _____
☐	☐	Accident: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family
☐	☐	Critical Illness: Employee amount $ _____ Spouse amount $ _____ Child(ren) amount $ _____
☐	☐	Hospital Indemnity: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family Have you used tobacco in any form in the past 12 months? ..... ☐ Yes ☐ 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

Sun Life Financial®

1 General information

Employer name	Account/policy number	Location	Date effective

Street address	City	State	Zip code

Type of activity: ☐ New Enrollment ☐ Change Reason:	Occupation

2 Employee information

Employee's Full Legal Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth

Street Address	City	State	Zip Code

Marital Status	Social Security Number	Phone number

Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Rehire ☐ Return from layoff Date:

Current Active Employment Type	Employee Status: ☐ Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired	Salary
_____ # of hours ☐ Full-Time ☐ Part-Time		

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: ☐ Male ☐ Female	Height: _____ Ft. _____ In.	Weight: _____ lbs.
Spouse: ☐ Male ☐ 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:	☐	☐	☐	☐
A. Cirrhosis of the liver or chronic hepatitis, kidney disease or abnormal kidney function, diabetes, chronic disease of the pancreas?	☐	☐	☐	☐
B. Stroke, transient ischemic attack (TIA), aneurysm, paralysis, optic neuritis, disorder of the brain or spinal cord, circulatory disease or disorder, heart attack, angina?	☐	☐	☐	☐
C. Chronic Obstructive Pulmonary Disease (COPD), emphysema, cystic fibrosis, status asthmaticus?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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)?	☐	☐	☐	☐
2. In the last 3 years, have any of the proposed Insureds had an in-situ tumor?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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)?	☐	☐	☐	☐

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.

PREMIUM ONLY PLAN (POP)

-Ability to Elect to Pay Your Health Premium with Pre-Tax Dollars-

Enrollment Form

Employer Name	Department
Employee Name	Social Security Number -- --
Address	Plan Year (from – to – mm/dd) / To /
City State Zip	Hours regularly worked each week

PRETAX Premium Elections

Listed below are the benefits that may be available under the POP. Please indicate which benefits you elect to deduct PRETAX by checking the box next to the applicable benefit.

- ☐ Medical $ _____
- ☐ Dental $ _____
- ☐ Vision $ _____
- ☐ Group Term Life $ _____
- ☐ Disability $ _____
- ☐ Other _____ $ _____
- ☐ Other _____ $ _____
- ☐ Other _____ $ _____

AUTHORIZATION (Benefits Deductions will be PRETAX)

I authorize the deductions elected above to be made on a **PRETAX** basis for the plan year as stated.

Signature _____ **Date** _____

DECLINATION (Benefits Deductions will be POST TAX)

The benefits of the Premium Only Plan (POP) have been thoroughly explained – I understand that by DECLINING, the deductions for my elected benefits will be **POST TAX** for the plan year as stated.

Signature _____ **Date** _____

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▶ Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850*.

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

First name | Social security number ▶ ___ - ___ - ___

Last name

Street address where you live

City or town, state, and ZIP code | State | Zip Code

County | Telephone number ( ) -

If you are under age 40, enter your date of birth (month, day, year) m m / d d / y y y y

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  - **a.** Received SNAP benefits (food stamps) for the past 6 months; **or**
  - **b.** Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature – All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ **Date** m m / d d / y y y y

04192016

Request for Verification

This company participates in various federal and state tax credit programs. The information you provide will be used to determine eligibility for these programs and will in no way negatively impact any hiring, retention, or promotion decisions. Your responses will only be shared with your employer's management and federal, state and local governmental agencies as needed in the administration of these programs. By completing this form, you knowingly and voluntarily waive any objection to providing your Social Security Number. Any information provided will be used in a manner consistent with the Americans with Disabilities Act (ADA).

Section 1: Please print carefully in blue or black ink.

First Name

Last Name

Job Title: _____

Starting Hourly Wage: _____

Home Address: _____ City: _____ State: _____

Section 2: Please provide the following information by completing the boxes and filling in the corresponding circles.

Social Security Number

Date of Birth (mm-dd-yyyy)

Zip Code

Job Start Date (mm-dd-yyyy)

Under penalty of perjury, I state that the information I provided is, to the best of my knowledge, true, correct and complete. I hereby authorize this company's management, and federal, state, Tribal, and local government agencies to provide information to ADP and/or State Workforce Agencies (SWA), to determine and document eligibility for federal and state tax credit programs.

Employee Signature: _____ Date: _____

Section 3: Please fill in the appropriate Yes or No circle for each of the following questions. Please complete additional information as required.

	YES	NO
Have you worked for this company before?	○	○
Are you a Veteran of the US Armed Forces?	○	○
If Yes to Veteran: Which Branch? _____		
Are you receiving compensation for a service-connected disability?	○	○
Were you discharged or released from active duty in the past year?	○	○
Have you been unemployed for at least 4 weeks but less than 6 months in the past year?	○	○
Have you been unemployed for 6 months or more in the past year?	○	○
Have you, or a household family member, received Food Stamps anytime within the last 15 months?	○	○
Are you a member of a family that received Welfare (AFDC or TANF) or Assistance (child care, housing or transportation) in the last 2 years or are you no longer eligible because you have collected for the maximum time period?	○	○
If yes to either: What city and state were benefits received? City: _____ State Abbreviation: ☐☐ If someone other than you received benefits, please list their name: _____		
Have you been continuously unemployed for the last 27 weeks?	○	○
If yes, During your period of unemployment, did you, at any time, receive State or Federal unemployment compensation?	○	○
If yes, in which State did you receive compensation? State Abbreviation: ☐☐		

	YES	NO
Have you participated in a vocational rehab program?	○	○
If yes: Which one? ○ Veteran Administration ○ Ticket to Work ○ State or Local Agency City: _____ State Abbreviation: ☐☐ Counselor's Name: _____		
Did you receive Supplemental Security Income (SSI) in the last 90 days?	○	○
Have you been convicted of a felony or received deferred adjudication for a felony charge?	○	○
If yes: What type of conviction? ○ Federal ○ State ○ None (Deferred Adjudication)		
Were you released or did you start a work release program or transition center within the past year?	○	○
Conviction Date (mm/yyyy): ☐☐ ☐☐☐☐ Release Date (mm-yyyy): ☐☐ ☐☐☐☐ Inmate #: _____ City: _____ State Abbreviation: ☐☐ Probation Officer: _____ Probation Officer Phone #: _____		

13188C18801

AMAZING TRUCKING & LOGISTICS, INC
5203 W. 65th St. – Bedford Park, IL 60638
Ph: (773) 459 2331 Fax: (773) 337 1113
6139 "O" St. Ste B. – Omaha, NE 68117
Ph: (402) 932 6541 Fax: (402) 932 6841

CONTRACT OF RESPONSIBILITIES

Between

AMAZING TRUCKING & LOGISTICS, INC. (ATL)

AND _____ (DRIVER)

Amazing Trucking s obligations:

- Amazing Trucking will pay the driver every 7 days after valid proof of delivery (Bill of Lading, J1 slip) is received from the driver. Unjustified delays in the delivery of paperwork may result in delay in payment as well.
- Amazing Trucking will pay all state permits, tolls, and scales.
- Amazing Trucking will provide a fuel card as necessary for normal operations.
- Amazing Trucking will NOT pay penalties and/or fines incurred by the driver such as traffic tickets, damaged loads, damage to others' proprieties, and/or shortage of the load.
- Amazing Trucking will NOT pay the load if logbooks, miles report, and trip cost reports are inaccurate or not turned in with the bill of lading.
- Amazing Trucking will NOT pay for loads which are damaged or missing until the situation is resolved.
- Drivers are guaranteed a minimum of one day off every 7 days of driving.

- Amazing Trucking has the right to rescind this contract with the driver with or without notice in all cases when the driver is not in compliance with DOT and FMCSA dispositions regulating inter/intrastate commerce, and safety.

Compensation Schedule:

- $.35/mile on all trips considered road (non-cross town and shuttle specific).
- 32 - 40% of Netted Contractor-based Rate for intermodal rates.
- Pay on local, shuttle, cross-town moves is to be defined on a case by case basis, depending on the customer, but in no occasion can it be less than $15.00 per trip.
- These prices are for contractual agreement and the individual driver is responsible as far as income tax reporting is concerned.
- Driver agrees to pick up the check by USPS or by picking it up in the office every Friday. A separate arrangement can be made (with charges to be quantified) if direct deposit or another payment form is requested on the part of the driver.

Drivers Obligations:

- Maintenance of trucks and other equipment must be in compliance with DOT safety regulations. Amazing Trucking MUST approve all costs before reimbursements.
- Driver must speak and understand English in a satisfactory level to be able to understand and communicate with law enforcement officials and/or customers.
- Driver must comply with terms of contract and act in a professional manner when dealing with all parties involved in transactions. He must represent the company in a professional manner. Failure to do so may result in immediate termination.
- Driver must call dispatcher when loading and/or unloading. Driver is also required to call every morning (Mon-Fri) at 08:00 – 08:30 in the office to check in with dispatch if he is not loading/unloading at the time, as well as every time a move is finished prior to returning to the terminal.

- Driver must pay all fines and damages incurred, including but not limited to: traffic violations, damage to loads and/or damage to vehicle. Insurance has a $1,000.00 deductible per occurrence.
- Two week notice is required and mandatory for a driver prior to leaving the company. If the driver leaves the job without giving two weeks notice he/she will not collect his/her last paycheck. **There will be absolutely zero tolerance on this matter.**
- Driver must deliver loads up to 80,000 lb. legal limit, unless a separate arrangement is made as far as overweight permits are concerned.
- Driver must carry DOT Federal Motor Carrier Safety Regulations book in vehicle at all times. Driver must know rules and regulations as outlined by the Department of Transportation.
- Driver's logbook, miles report, and trip cost report must be filled out accurately, legibly, and neatly.
- Driver is responsible for accurate delivery of good from point of origin to point of delivery. After driver signs that he received load, driver is responsible for shortage or damage to the load**. If driver is late (not due to ma or cause) and there is e pense involved the e pense will be deducted from the driver s paycheck (25.00 minimum).** Driver must deliver load to consignee and get signature from consignee that load is delivered on time without shortages or damages. When possible and applicable, the driver needs to get seal for the load and/or signed paperwork with SLC (shipper loaded and counted).
- **Driver MUST NOTIFY company if he is going to be late, before his appointment time. Should we find that driver is late from the customer, driver forfeits at least 70 of trip pay. Two such occurrences can and will lead to termination without prospect of re-hire.**

Above agreement, in a total of 4 pages, any addendums related to it, and other material, is a valid and binding contract for both parties. The parties involved agree to abide by and follow the rules and terms outlined in this contract. Each party has the right to terminate the contract within 30 days of signing it. If a situation or problem arises which is not covered in the contract the problem may be resolved amicably between the parties involved.

Date: _____

Driver (print): _____

Driver (sign): _____

Amazing Trucking Officer: _____

Appendix A: Drivers late for their appointments & related consequences.

Amazing Trucking & Logistics, INC. owes its existence and success to a strict ethical and correct behavior. We always strive to give all our customers the best possible service, by avoiding late appointments and the like. There have been instances of unjustified and un-notified delays at appointments, and we have found that out from our customers.
THIS IS UNACCEPTABLE, furthermore considering that there was no equipment or other safety issues. As a result, ATL risked losing the customer which was most loyal to us, and We will not allow that.
For this reason, effective immediately, the following will be our policy:

- **Just like your wait time is rewarded, your delay without ustification will be as well. Should you be over 15 minutes late at a customer and not notify us IN ADVANCE, a penalty of 40 of your daily earnings will be applied. On a second occurrence, 0 of daily earnings will be applied. Third occurrence, we cannot work together anymore. Should you not agree with above policy, please notify us, and in no later than 2 weeks we can part ways in an amicable way. At the same token, we will reward accuracy and correctness at appointments for all customers.**

If you know that you will be late, no matter what the reason, you are REQUIRED to notify dispatch. No e ceptions are allowed to this simple rule.

Should there be any questions regarding this point, contact our office.

Amazing Trucking & Logistics, Inc.

Gjaneto Harusha
President

Appendix B: Operational Guidelines

The Intermodal Business is a time and security sensitive one. This notwithstanding, safety is our primary concern at all times. The general rule of thumb we expect you to apply in all daily operations is: *"You don't think it is safe; don't do it and tell us about it"* Our next concern is cargo and equipment security. For this, it is mandatory to understand that **YOU ARE NOT ALLOWED TO EVER, EVER PREPULL LOADED CARGO TO ANY OF OUR TERMINALS OR ANY OTHER LOCATION. YOU ARE ALSO NOT ALLOWED TO DEVIATE FROM MAIN ROUTE UNLESS INSTRUCTED BY AUTHORITIES** Should you do it, you will be terminated right away and your escrow will NOT be refunded.

Also, you may not:

a) Pull the load and stop at home / parking lot / any other location.
b) Leave the unit / container unattended, at any time.
c) Act in any other way that might jeopardize cargo and equipment security.

It is strongly recommended that unless circumstances do not allow and it is not safe to do so, when you are loaded stop the least times possible.

When you pull a load out of a Container Yard / Rail Terminal:

a) Verify Equipment Physical Integrity IN PERSON.
b) Verify Seal Integrity IN PERSON. Should seal or equipment appear tampered with, NOTIFY SECURITY PERSONNEL RIGHT AWAY. NEVER PULL A LOAD WITH A TAMPERED SEAL!!!

When you pull a load out of a customer (export moves):

a) Inspect seal number in container to correspond with paperwork received.
b) Notate seal number in our BoL as well.
c) Do not leave the dock if there is any discrepancy. Courteously point it out to the customer and notify dispatch immediately
d) Extra attention is to be paid in refrigerated cargo, and you are required to inspect reefer unit is working properly.

Should there be any questions, please notify us.

Amazing Trucking & Logistics, Inc.

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

Amazing Trucking & Logistics
3025 South End Ave
South Chicago Heights, IL, 60411
TEL: (773) 459-2331
FAX: (773) 337-1113

Alcohol and Drug Testing Policy

I. POLICY

It is the Policy of Amazing Trucking & Logistics, Inc. (hereinafter the Company) that the use, sale, purchase, transfer, possession, or presence in one's system of any prohibited drug or other substances (except medications prescribed by one's physician and taken pursuant to the prescription), including alcohol, by any employee while on the Company's premises, engaged in the Company's business, operating the Company's equipment, or while operating under the authority of the Company, is strictly prohibited.

All employees subject to the rules and regulations of the U.S. Department of Transportation (USDOT) must be drug and alcohol free, and be and remain in full compliance with all USDOT drug and alcohol testing regulations. All persons subject to USDOT drug and alcohol testing regulations are required to read this Policy and acknowledge, by their signature, that they have read and understand the Policy, and to conform with all requirements set forth in the Policy.

II. EMPLOYEES SUBJECT TO THE POLICY

All Covered Employees as defined in paragraph IIIA below must be and remain in full compliance with this Policy.

III. DEFINITIONS

A. Covered Employee(s) – All employees who, under the operating authority of the company, drive commercial motor vehicles with gross vehicle weight ratings or gross combination weight ratings in excess of 26,000 pounds, or who transport placardable quantities of hazardous materials.

B. Safety Sensitive Functions – All Covered Employees are deemed to be performing safety sensitive functions as follows:

1. All time at a carrier or shipper plant, terminal, facility, or other property, waiting to be dispatched, unless the covered person has been relieved from duty by the Company.

2. All time inspecting equipment as required by the Federal Motor Carrier Safety Regulations (FMCSRs) or otherwise inspecting, servicing, or conditioning any commercial motor vehicle at anytime.

3. All time spent at the driving controls of a commercial motor vehicle.

4. All time, other than driving time, spent on or in a commercial motor vehicle (except for time spent resting in the sleeper berth).

5. All time loading or unloading a commercial motor vehicle, supervising, or assisting in the loading or unloading, attending a vehicle being loaded or unloaded, remaining in readiness to operate the vehicle, or in giving or receiving receipts for shipments loaded or unloaded.

6. All time spent performing the requirements associated with an accident.

7. All time repairing, obtaining assistance, or reaming in attendance upon disabled vehicle.

C. <u>On Duty</u> – All Covered Employees are considered to be on-duty when they are performing safety sensitive functions as defined above.

D. <u>Refusing to Submit</u> – A Covered Employee is deemed to have refused to submit to an alcohol or drug test when that person:

1. Fails to provide a adequate sample of breath for alcohol testing without a valid medical explanation after he or she has received notice of the requirement to submit to breath testing.

2. Fails to provide an adequate urine sample for drug testing without a valid medical explanation after he or she has received notice of the requirement to submit to urine testing.

3. Engages in conduct that clearly obstructs the testing process.

4. Fails to properly notify the Company of their involvement in a commercial motor vehicle accident meeting the criteria for a post-accident alcohol and drug test.

5. Fails to remain available for alcohol and drug testing after a commercial motor vehicle accident meeting the criteria for a post-accident alcohol and drug test.

E. <u>Substance Abuse Professional</u> – A licensed physician (medical doctor or doctor of osteopathy) or a licensed or certified psychologist, social worker, employee assistance professional, or addiction counselor (certified by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission) with knowledge of or clinical experience in the diagnosis and treatment of alcohol and controlled substance-related disorders.

IV. PROHIBITED CONDUCT

A. Alcohol Use and Testing

1. Covered Employees are prohibited from consuming any alcoholic beverage or other product containing alcohol within 4 hours of reporting for duty or performing safety sensitive functions.

2. Covered Employees are prohibited from reporting for duty or remaining on duty with an alcohol concentration of .02 BAC or greater.

3. Covered Employees are prohibited from refusing to submit to alcohol testing when requested to by the Company and/or required to by the regulations of the U.S. Department of Transportation.

B. Drug Use and Testing

1. Covered Employees are prohibited from illegally consuming or using any drugs at any time.

2. Covered Employees are prohibited from refusing to submit to drug testing when requested to by the Company and/or required to by the regulations of the U.S. Department of Transportation.

V. WHEN COVERED EMPLOYEES WILL BE SUBJECT TO ALCOHOL AND/OR DRUG TESTING

A. Pre-Employment Drug Testing

1. All offers of employment for positions that require the possession of a valid Commercial Driver's License (CDL) are contingent upon the following:

   a. Submitting to and passing a pre-employment drug test.

   b. Executing a Consent for Release of Alcohol and Drug Test Results (Appendix "A").

   c. Completion of a background check of previous employers that reveals no history of failing USDOT required alcohol or drug tests – unless the applicant is able to produce proof satisfactory to the Company that the applicant has fully complied with all of the return to duty requirements of 49 CFR Part 382 and is otherwise qualified.

2. Failure to comply with one or more of the above listed contingencies shall result in the withdrawal of any offer of employment.

B. Random Alcohol and Drug Testing – All Covered Employees shall submit to alcohol and drug testing when randomly selected to do so.

1. All Covered Employees currently employed by the Company will be placed in the random selection pool. Covered Employees will be selected for testing in a manner that ensures that each Covered Employee has an equal opportunity to be selected for a random test. The Company will randomly select Covered Employees for random testing once every three months (quarterly). Because Covered Employees who have been selected return to the random testing pool for the next selection, it is possible that some Covered Employees will be selected more than once. The Company will select a sufficient number of Covered Employees each quarter to ensure that the number of random drug tests conducted each year equals or exceeds fifty (50) percent of the number of driver positions, and that the number of random alcohol tests conducted each year equals or exceeds ten (10) percent of the number of driver positions.

2. A Covered Employee, upon notification that they have been randomly selected to submit to testing, shall immediately proceed to the location designated by the Company for the testing.

3. If a Covered Employee is randomly selected to submit to an alcohol test, the Company will notify the Covered Employee either just before the Covered Employee is to perform a safety sensitive function, while the Covered Employee is performing a safety sensitive function, or just after the Covered Employee has performed a safety sensitive function.

C. Post-Accident Drug and Alcohol Testing

1. A Covered Employee is required to submit to a post-accident alcohol and drug test if they are involved in a Commercial Motor Vehicle Accident that meets any one of the following criteria:

a. Someone is killed.

b. Someone is injured such that medical treatment is required away from the scene of the accident, and the Covered Employee receives a moving traffic citation or ticket arising from the accident.

c. One of the vehicles involved in the accident is towed away from the scene because of disabling damage, and the Covered Employee receives a moving traffic citation or ticket arising from the accident.

2. A Covered Employee shall notify the Company that they have been involved in an accident meeting one of the above listed criteria as soon as practically possible.

3. The Company shall provide the Covered Employee with all necessary post-accident information, procedures, and instructions so that the Covered Employee can comply with all post-accident testing requirements. The Covered Employee shall remain available so that the Company is able to convey all required information and instructions to the Covered Employee.

4. Upon receipt of post-accident testing procedures and instructions from the Company, the Covered Employee shall promptly comply with the testing procedures and instructions provided.

5. Covered Employees subject to post-accident alcohol and drug testing shall not consume any alcohol for 8 hours following the accident or until he or she submits to a post-accident alcohol test.

6. In addition to that stated above in paragraph III.D, the following shall also be deemed a refusal to submit to post-accident alcohol and/or drug testing:

a. Failing to inform the Company as soon as practically possible that the Covered Employee was involved in an accident that meets one or more of the criteria listed above in paragraphs V.C.1(a-c).

b. Failing to remain available so that the Company is able to convey the required procedures and instructions.

c. Failing to comply with the Company's instructions regarding the testing procedures.

d. Failing to refrain from the consumption of alcohol for 8 hours following the accident or until he or she has submitted to a post-accident alcohol test.

7. If a Covered Employee does not submit to an alcohol test within two hours of the accident, the Company shall document the reason for the delay. If a Covered Employee does not submit to the alcohol test within 8 hours of the accident, the post-accident alcohol test will not be conducted, and the Company shall document the reason(s) why the alcohol test was not performed.

8. If a Covered Employee does not submit to a drug test within 32 hours of the accident, the post-accident drug test will not be conducted and the Company shall document the reason(s) why the drug test was not conducted.

9. Nothing in this policy shall be deemed to justify or authorize delaying necessary medical treatment being provided to any person.

D. <u>Reasonable Cause Alcohol and Drug Testing</u>

1. A Covered Employee shall submit to an alcohol test when a duly trained supervisor or other trained Company official has reasonable cause to believe that the Covered Employee is under the influence of alcohol. The reasonable cause required before a Covered Employee is required to submit to an alcohol test must be present either just before the Covered Employee is to engage in a safety sensitive function, while the Covered Employee is engaging in a safety sensitive function, or just after the Covered Employee has engaged in a safety sensitive function.

2. A Covered Employee shall submit to a drug test when a duly trained supervisor or other Company official has reasonable cause to believe that the Covered Employee is under the influence of drugs.

3. The reasonable cause required for alcohol or drug testing shall be based on specific, contemporaneous, and articulatable observations made by a trained supervisor regarding the Covered Employee's appearance, behavior, speech, or body odors.

4. If a trained supervisor or other trained Company official has reasonable cause to believe that a Covered Employee is under the influence of alcohol or drugs, the supervisor or Company official shall immediately relieve the Covered Employee from the performance of all safety sensitive functions and immediately make arrangements for the Covered Employee to submit to the alcohol and/or drug test.

5. If there is reasonable cause to believe that a covered employee is under the influence of alcohol, and the Covered employee does not submit to an alcohol test within 2 hours of the observation, the Company shall document the reason for the delay. If the Covered Employee does not submit to a reasonable cause alcohol test within 8 hours of the observation, the reasonable cause alcohol test will not be conducted, and the Company shall document the reason(s) why the alcohol test was not conducted.

6. If a duly trained supervisor or Company official has reasonable cause to believe that a Covered Employee is under the influence of alcohol or drugs, the supervisor or Company official shall promptly prepare and sign a written record of the observations.

7. The Company shall designate certain supervisors and/or Company officials to receive at least 60 minutes of training on alcohol misuse and 60 minutes of training on drug abuse. The training shall include how to recognize the signs and symptoms of alcohol and drug use. Such duly trained supervisors and Company officials are the only Company officials qualified to make reasonable cause determinations.

VI. <u>PROCEDURES FOR ALCOHOL AND DRUG TESTING</u> – The procedures for conducting all alcohol and drug testing shall be the policies and procedures set forth in 49 C.F.R. Part 40. An amendment or revision to 49 C.F.R. Part 40 shall be considered an amendment or revision to this section of the Policy. A current copy of 49 C.F.R. Part 40 is available for your review upon contacting Alen Potkrajac or Gjaneto Harusha.

VII. CONSEQUENCES OF VIOLATING THE POLICY

A. Termination for Cause - The following violations of this policy shall result in immediate removal from the performance of safety sensitive functions and termination of employment for cause:

1. Failing an alcohol test (.04 BAC or greater).

2. Failing a drug test.

3. Refusing to submit to an alcohol test.

4, Refusing to submit to a drug test.

5. Engaging in the illegal sale, transfer, use, or possession of drugs while on duty, on Company property, or in possession of Company property.

B. Immediate Removal From Safety Sensitive Functions and Possible Termination for Cause – Reporting for duty or remaining on duty with an alcohol concentration of .02 BAC or greater shall result in immediate removal from the performance of safety sensitive functions for at least 24 hours and may result in termination for cause or other disciplinary action.

C. Substance Abuse Professional Referral – The Company shall refer any Covered Employee who fails an alcohol or drug test to a Substance Abuse Professional**.**

D. Return to Duty Testing – At the sole discretion of the Company, a Covered Employee who fails an alcohol or drug test may return to performing safety sensitive functions only after satisfactory completion of each of the following:

1. Evaluation by a Substance Abuse Professional.

2. Certification by the Substance Abuse Professional that the Covered Employee has satisfactorily completed all rehabilitation, substance abuse counseling, or other treatment or interventions recommended by the Substance Abuse Professional.

3. Submitting to and passing a Return to Work Alcohol or Drug Test.

E. Follow-up Testing. – A Covered Employee who is permitted to return to performing safety sensitive functions after failing an Alcohol or Drug Test shall also be subject to, in addition to the other required alcohol and drug testing, unannounced follow-up testing.

1. The follow-up testing shall be at a frequency determined by the Substance Abuse Professional, but in no case shall be less than six unannounced follow-up tests in the first twelve months after returning to duty.

2. The follow-up testing shall not continue for a period longer than 60 months.

3. Follow-up alcohol testing shall be conducted either just before, during, or just after the Covered Employee has performed a safety sensitive function.

VIII. THE AVAILABILITY AND DISCLOSURE OF ALCOHOL AND DRUG TEST RESULTS AND OTHER INFORMATION

A. Alcohol and drug test results and other information or documentation relating to alcohol or drug testing conducted pursuant to this policy shall not be disclosed to others except under the following circumstances:

1. The Company receives the signed written consent of the Covered Employee or former Covered Employee authorizing the Company to release the information to a specified third party.

2. The Company is required by statute, regulation, judicial decision, or other legal authority to release the results or information.

3. A legal action or other claim has been brought against the Company by the Covered Employee or former Covered Employee, or someone acting on behalf of the Covered Employee or former Covered Employee, or his or her estate, and the results or information are deemed by the Company or its attorneys to be necessary for the Company to defend itself in the proceedings.

B. All Covered Employees and Former Covered Employees are entitled to the records or information relating to their alcohol or drug tests upon written request to the Company.

C. The custodians of the alcohol and drug test results and other information are Alen Potkrajac, Gjaneto Harusha, and Klemens Kuqi. No employee or other official of the Company other than Alen Potkrajec, Gjaneto Harusha, and Klemens Kuqi shall have access to the alcohol or drug tests results or other documentation of any Covered Employee.

IX. Reservation of Rights – The Company reserves the right to amend, change, modify, or rescind this Policy at any time and in any manner it chooses, in its sole discretion, and with or without notice to any affected employees or others. This Policy does not, in any way, create any contractual rights between the Company and its employees or others. This Policy supersedes all previous Alcohol and/or Drug Testing policies.

X. SUBSTANCE ABUSE INFORMATION

A. Signs and Symptoms of a Substance Abuse Problem

1. Family or social problems caused by substance abuse.

2. Job or financial difficulties related to substance abuse.

3. Loss of a consistent ability to control substance abuse.

4. "Blackouts" or the inability to remember what happened while drinking.

5. Distressing physical and/or psychological reactions while trying to stop drinking or drug abuse.

6. A need to drink increasing amounts of alcohol or increase drug use to get the desired effect.

7. Marked changes in behavior or personality when drinking or abusing drugs.

8. Getting "drunk" or "high" on alcohol and/or drugs frequently.

9. Injuring yourself – or someone else – while intoxicated or abusing drugs.

10. Breaking the law while intoxicated or abusing drugs.

11. Starting the day with a drink or taking illegal drugs.

B. <u>Effects Of a Substance Abuse Problem on Health, Work, and Personal Life</u>

1. Alcohol is a central nervous system depressant. Taken in large quantities it causes the euphoria associated with "being drunk" and adversely affects your judgment, your ability to think, and your motor functions. Drink alcohol fast enough and it can kill you.

2. Long term overuse of alcohol can cause liver damage, heart problems, sexual dysfunction and other serious medical problems.

3. In some cases, alcohol use can lead to physical and psychological dependence on alcohol. Alcoholism is a serious chronic disease. Left untreated it gets worse.

4. Workers who use alcohol and illegal drugs affect everyone. Studies show that compared to alcohol-free and drug-free workers, substance abusers are far less productive, miss more workdays, are more likely to injure themselves or someone else, and file more workers' compensation claims.

5. The measurable dollar costs of workplace substance abuse from absenteeism, overtime pay, tardiness, sick leave, insurance claims, and workers' compensation can be substantial. However, the hidden costs resulting from diverted supervisory and managerial time, friction among workers, damage to equipment, and damage to the Company's public image mean that workplace substance abuse can further cut profits and competitiveness.

6. Substance abusers can also destroy relationships, lead to serious problems with the law (e.g. drunk driving) and even cause harm to the people you love.

7. If substance abuse affects your work life, it could lead to job loss and all of the financial problems that would follow.

C. Evaluating and Resolving Substance Abuse Problems

1. Outpatient programs exist in a variety of settings:

   a. Community mental health centers

   b. Family service agencies

   c. Private physicians' and therapists' offices

   d. Occupational settings

   e. Specialized alcoholism treatment facilities.

2. Inpatient services, designed for those with more serious substance abuse problems, can be found in:

   a. Hospitals

   b. Residential care facilities

   c. Community halfway houses

   d. Some alcoholism clinics.

3. Your local phone directory will list helpful referral organizations such as:

   a. Local council on alcoholism and drug abuse

   b. Alcoholics Anonymous

   c. Community alcoholism or mental health clinics

d. Social service or human resources departments

e. Community medical society

D. The Importance of Intervention

1. The Company recognizes that alcoholism, alcohol misuse, and drug abuse are problems throughout America.

2. There are three good reasons why you should be concerned if any of your co-workers is using drugs or alcohol on the job:

a. Your health and safety may be at risk.

b. Drug abuse and alcohol misuse costs you money.

c. Drug abuse and alcohol misuse creates a negative work environment.

3. The U.S. Department of Labor has determined that drug and alcohol use on the job costs society an estimated $102 billion a year. Since most of this cost is passed on to you in the form of higher health insurance rates or in the prices you pay for things, drug and alcohol use on the job costs you and your fellow workers.

4. The U.S. Department of Labor has also determined that absenteeism among problem drug abusers, drinkers, or alcoholics is 3.8 to 8.3 times greater than normal. If your fellow workers don't come to work, you may have to do their jobs in addition to your own.

5. Workers who misuse alcohol and drugs don't function at their full potential. Not only is absenteeism a problem, when they are at work these employees may have reduced capabilities and productivity. Since our product is the safe transportation of the public, alcohol and drug misuse is an especially serious issue.

6. No matter what your position is in the organization, there is something you can do to ensure that drug and alcohol use on the job never becomes a problem at the Company. Acceptance of any misuse puts you, this Company, and the public at risk.

I _____, acknowledge receipt of Amazing Trucking & Logistics, Inc.'s Alcohol and Drug Testing Policy and agree to abide by its terms and conditions.

_____

Employee Signature

Dated:_____

_____

ATL Representative Signature

Dated:_____

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: _____

MVR CONSENT FORM

I, _____, hereby provide consent to
(Driver's Name – Please print)

_____
(Company Name)

to make an inquiry to obtain my motor vehicle record (MVR) throughout the duration of my employment. This is to ensure the motor carrier is aware of any and all traffic convictions for each driver it employs from every State in which the driver holds or has held a CMV operator's license or permit in the past year and that the driver is compliant with all Federal and State regulations.

_____
Driver's Signature

_____
Date

PREMIUM™
ENTERPRISES, INC.
Driver & Logistics Staffing Specialists

WELCOME ! ! ! ! !

We would like to take this opportunity to welcome you to Premium Enterprises 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,

Premium Enterprises Inc
www.premiumdrivers.com

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