

TOTAL HR SOLUTIONS, L.L.C.
Tony Cook Construction, LLC
Employee Worksheet

Employee # _____

Add _____

Change _____

Employee Information

Name _____

Start Date _____

Address _____

Re-Hire Date _____

City _____

Please Circle Applicable Choice

State _____

Full Time Part Time Seasonal

Zip _____

Pay Period: **Wkly**

SS# _____

Pay Type: Hourly

Phone Number _____

Pay Amount: _____

Email Address _____

Tax Information

State Exemptions None Single Married

State Dependents _____

Extra State Withholding _____ \$ or %

SUI State _____

Human Resource Information

Sex Male Female Division _____

Race _____ Department _____

Birth Date _____ Job Title _____

Direct Deposit **Yes** No Dept _____

100 Oil & Gas

110 Sales

120 Clerical

Other Information

TONY COOK CONSTRUCTION, LLC
402 Service Road
Rayne, Louisiana 70578
(337) 873-8698

Application for Employment

Name: _____ Date: _____

Address: _____

Telephone Number: _____ Email Address: _____

Social Security No: _____ Date of Birth: _____

Are you 18 years of age or older?

Yes No

Are you either a U.S. citizen or an alien authorized to work in the U.S.?

Yes No

Have you ever worked or attended school under another name? If so, under what name?

Position Desired

Position: _____ Start date available: _____

Wage rate desired: \$ _____ Hourly Monthly Annually

Do you prefer: Full-time Part-time If part-time, hours per week desired: _____

Hours you are available to work: _____

Days of week you are available to work: _____

Are you able to work: Weekends
 Holidays
 Nights
 Overtime

Have you previously worked for Tony Cook Construction, LLC? Yes No

Dates of employment with Tony Cook Construction, LLC : from _____ to _____

Reason(s) for leaving: _____

Former supervisor(s) at this company: _____

How did you learn about this opening? _____

Education

High School:	Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Course of Study:
Technical School:	Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Course of Study:
College/University:	Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Course of Study:
Post-Graduate Education:	Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Course of Study:
Other education, training or special skills:		

Skills

Are you experienced in using personal computers? Yes No PC Mac

Are you able to use Microsoft Word, Excel and/or other programs? What other programs are you capable of using?

In case of emergency notify:

Name: _____

Address: _____ Phone: _____

Work Experience

Please list all previous employment, beginning with the most recent. If you need more room, you may attach another sheet of paper.

Employer:		Address:	
From	To	Position Held:	Reason for Leaving:
Supervisor's Name & Title:		May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Description of Duties:			
Starting Compensation:		Final Compensation:	
Employer:		Address:	
From	To	Position Held:	Reason for Leaving:
Supervisor's Name & Title:		May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Description of Duties:			
Starting Compensation:		Final Compensation:	

References

Identify three persons who know your work, beginning with the most recent.

Name: _____ Phone Number: _____ Email: _____

Address: _____ City, State, Zip: _____

Position or Title: _____ Years Known: _____

Name: _____ Phone Number: _____ Email: _____

Address: _____ City, State, Zip: _____

Position or Title: _____ Years Known: _____

Name: _____ Phone Number: _____ Email: _____

Address: _____ City, State, Zip: _____

Position or Title: _____ Years Known: _____

Authorization and Acknowledgements

I affirm that the information I have provided in this application is true to the best of my knowledge, information and belief, and I have not knowingly withheld any information requested. I understand that withholding or misstating any information requested in this application is grounds for rejection of my application, and that providing false or misleading information in this application is grounds for discharge.

I authorize the company to verify my references, record of employment, education record, and any other information I have provided. Unless otherwise noted, I authorize the references I have listed to disclose any information related to my work record and my professional experiences with them, without giving me prior notice of such disclosure. In addition, I release the company, my former employers and all other persons and entities, from any and all claims, demands or liabilities arising out of or in any way related to such inquiry or disclosure.

Applicant's Signature

Date

APPLICATION FOR EMPLOYMENT

COMPANY _____ STREET ADDRESS _____
 CITY, STATE AND ZIP CODE _____
 NAME _____ (FIRST) (MIDDLE) (Maiden Name, if any) (LAST)
 ADDRESS _____ (STREET) (CITY) (STATE & ZIP CODE) HOW LONG? _____
 DATE OF BIRTH _____ SOCIAL SECURITY NO. _____ HIRE DATE _____
 TELEPHONE NUMBER _____ E-MAIL ADDRESS _____

PREVIOUS THREE YEARS RESIDENCY

(STREET)	(CITY)	(STATE & ZIP CODE)	# YEARS _____
(STREET)	(CITY)	(STATE & ZIP CODE)	# YEARS _____
(STREET)	(CITY)	(STATE & ZIP CODE)	# YEARS _____

(ATTACH SHEET IF MORE SPACE IS NEEDED)

LICENSE INFORMATION

Section 383.21 FMCSR states "No person who operates a commercial motor vehicle shall at any time have more than one driver's license". I certify that I do not have more than one motor vehicle license, the information for which is listed below.

STATE	LICENSE NO.	TYPE	EXPIRATION DATE

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.)	DATES FROM	TO	APPROX. NO. OF MILES (TOTAL)
STRAIGHT TRUCK				
TRACTOR AND SEMI-TRAILER				
TRACTOR - TWO TRAILERS				
OTHER				

(ATTACH SHEET IF MORE SPACE IS NEEDED)

DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	NUMBER FATALITIES	NUMBER INJURIES	CHEMICAL SPILLS
				YES NO
				YES NO
				YES NO

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

DATE CONVICTED (month/year)	VIOLATION	STATE OF VIOLATION LOCATION	PENALTY (forfeited bond, collateral and/or points)

(ATTACH SHEET IF MORE SPACE IS NEEDED)

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES _____ NO _____

If yes, explain _____

B. Has any license, permit or privilege ever been suspended or revoked? YES _____ NO _____

If yes, explain _____

EMPLOYMENT RECORD
(ATTACH SHEET IF MORE SPACE IS NEEDED)

Applicants that desire to drive in intrastate/interstate commerce must provide the following information on all employers during the previous three years. You must give the same information for all employers you have driven a commercial motor vehicle for the seven years prior to the initial three years (total of ten years employment record).

Must list the complete mailing address: street number and name, city, state and zip code.

LAST EMPLOYER: NAME _____

ADDRESS _____ PHONE _____

POSITION HELD _____ FROM _____ TO _____ SALARY _____

REASONS FOR LEAVING _____

ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON. _____

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes No

Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes No

SECOND LAST EMPLOYER: NAME _____

ADDRESS _____ PHONE _____

POSITION HELD _____ FROM _____ TO _____ SALARY _____

REASONS FOR LEAVING _____

ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON. _____

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes No

Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes No

THIRD LAST EMPLOYER: NAME _____

ADDRESS _____ PHONE _____

POSITION HELD _____ FROM _____ TO _____ SALARY _____

REASONS FOR LEAVING _____

ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON. _____

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes No

Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes No

TO BE READ AND SIGNED BY APPLICANT

I authorize you to make sure investigations and inquiries to my personal, employment, financial or medical history and other related matters as may be necessary in arriving at an employment decision. (Generally, inquiries regarding medical history will be made only if and after a conditional offer of employment has been extended.) I hereby release employers, schools, health care providers and other persons from all liability in responding to inquiries and releasing information in connection with my application.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Company.

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

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

DATE _____

APPLICANT'S SIGNATURE _____

This certifies that I completed this application, and that all entries on it and information in it are true and complete to the best of my knowledge.

DATE _____

APPLICANT'S SIGNATURE _____

Note: A motor carrier may require an applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.

"SUMMARY OF RIGHTS UNDER THE FAIR CREDIT REPORTING ACT"
MVR

(Name of Job Applicant/Employee)

(Street Address)

(City, State, Zip Code)

(Date)

Consumer reports may be obtained as part of the company circled above evaluation on my job application/employment. The reports may be procured by United Employers Insurance Agency, Inc., and may include my driving record, an assessment of my insurability under the Company's insurance coverages or other consumer reports. By signing this disclosure, I hereby authorize the Company to procure such reports and additional reports about me from time to time, as it deems appropriate, to evaluate my insurability or for other permissible purposes.

I have been provided a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act".

(Signature of Job Applicant/Employee)

(Typed Name of Job Applicant/Employee)

(Date of Birth)

(Drivers License #)

(State)



PAYROLL DEDUCTION AUTHORIZATION

If I were to terminate my employment at Tony Cook Construction within 90 days of my hire date for any reason, I hereby authorize Tony Cook Construction to offset any amounts owed by me to the company. I likewise authorize the company to make automatic payroll deductions at its sole discretion during or following employment to satisfy any deductions owed from me to the company or any other indebtedness.

Employee Name (printed): _____

Employee Signature: _____ Date: _____

Witness Name (printed): _____ Nadine Gary _____

Witness Signature: Nadine Gary _____ Date: _____


**Employee's Withholding
Certificate (L-4)**
This form must be filed with your employer.
For Questions:

Phone: (855) 307-3893

Send an email by visiting www.revenue.louisiana.gov/Contact/ContactUs.
Purpose: Complete Form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding must provide their expected tax return filing status in Block A.

- Employees must file a new certificate within 10 days if the number of their deductions decreases, except if the change is the result of the death of a spouse.
- Employees may file a new certificate any time the number of their deductions increases.
- Line 7 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willfully failing to supply information that would reduce the withholding amount.

This form must be filed with your employer. If an employee fails to complete this withholding certificate, the employer must withhold Louisiana income tax from the employee's wages without any standard deduction.

Note to Employer: Keep this certificate with your records.

Block A

- Enter "0" to claim no standard deduction and check the appropriate box under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim a standard deduction if your filing status is single or married filing separate and check the appropriate box under number 3 below if you did not claim this deduction in connection with other employment or if your spouse has not claimed a deduction.
- Enter "2" to claim a standard deduction if your filing status is married filing jointly, head of household, or qualifying surviving spouse and check the appropriate box under number 3 below.

A.


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

Form L-4

 Louisiana
Department of
Revenue

Employee's Withholding Certificate

1. First name and middle initial

Last name

2. Social security number

3. Select one:

 No deduction Single or married filing separately Married filing jointly, qualifying surviving spouse, or head of household

4. Home address (number and street or rural route)

5. City

State

ZIP

6. Total number of deductions claimed in Block A

6.

7. Adjustments. Enter any increase or decrease in the amount of tax to be withheld each pay period. Decreases should be indicated as a negative amount and cannot result in an amount less than zero to be withheld each pay period.

7.

I declare under the penalties imposed for filing false reports that the number of deductions claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature

Date

The following is to be completed by employer.

8. Employer's name and address

Tony Cook Construction 402 Service Road Rayne LA 70578

9. Employer's state withholding account number

Employee's Withholding Certificate

OMB No. 1545-0074

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.

2026

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
	Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at www.irs.gov/W4App.

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) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; or
	(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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate <input type="checkbox"/>

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):			
	(a) Multiply the number of qualifying children under age 17 by \$2,200	3(a) \$		
	(b) Multiply the number of other dependents by \$500	3(b) \$		
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here	3 \$		
Step 4: 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			
	(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here	4(b) \$		
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c) \$		

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 . <input type="checkbox"/>		
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 Tony Cook Construction LLC 402 Service Road Rayne, LA 70578	First date of employment	Employer identification number (EIN) 86-2917297

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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 these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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. Submit a separate Form W-4 for each job.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

Instead, 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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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; or, you can use the online withholding estimator at www.irs.gov/W4App.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld)

4 \$ _____

Step 4(b) – Deductions Worksheet (Keep for your records.)



See the instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

- 1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.
 - a **Qualified tips.** If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000 **1a** \$ _____
 - b **Qualified overtime compensation.** If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the “and-a-half” portion of time-and-a-half compensation **1b** \$ _____
 - c **Qualified passenger vehicle loan interest.** If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000 **1c** \$ _____
- 2 Add lines 1a, 1b, and 1c. Enter the result here **2** \$ _____
- 3 **Seniors age 65 or older.** If your total income is less than \$75,000 (\$150,000 if married filing jointly):
 - a Enter \$6,000 if you are age 65 or older before the end of the year **3a** \$ _____
 - b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment **3b** \$ _____
- 4 Add lines 3a and 3b. Enter the result here **4** \$ _____
- 5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information **5** \$ _____
- 6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:
 - a **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income **6a** \$ _____
 - b **State and local taxes.** If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately) **6b** \$ _____
 - c **Home mortgage interest.** If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) **6c** \$ _____
 - d **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income **6d** \$ _____
 - e **Other itemized deductions.** Enter the amount for other itemized deductions **6e** \$ _____
- 7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here **7** \$ _____
- 8 **Limitation on itemized deductions.**
 - a Enter your total income **8a** \$ _____
 - b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** \$ _____
- 9 Enter:
$$\left\{ \begin{array}{l} \bullet \$768,700 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$640,600 \text{ if you're single or head of household} \\ \bullet \$384,350 \text{ if you're married filing separately} \end{array} \right\} **9** $ _____$$
- 10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here **10** \$ _____
- 11 **Standard deduction.**
 - Enter:
$$\left\{ \begin{array}{l} \bullet \$32,200 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$24,150 \text{ if you're head of household} \\ \bullet \$16,100 \text{ if you're single or married filing separately} \end{array} \right\} **11** $ _____$$
- 12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly) **12** \$ _____
- 13 Add lines 11 and 12. Enter the result here **13** \$ _____
- 14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 **14** \$ _____
- 15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 **15** \$ _____

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	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,420	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	18,710	20,320	21,620
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	18,710	20,320	22,920
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS

Form I-9

OMB No.1615-0047

Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or **Supplement B, Reverification and Rehire**. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number (if any)	City or Town	
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address		Employee's Telephone Number
<p>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</p>	Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):			
	<input type="checkbox"/> 1. A citizen of the United States			
	<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)			
	<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)			
	<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)			
If you check Item Number 4., enter one of these:				
USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee		Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the **Preparer and/or Translator Certification on Page 3**.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the **Additional Information** box; see Instructions.

List A	OR	List B	AND	List C
Document Title 1				
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				
Document Title 2 (if any)		Additional Information		
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				
Document Title 3 (if any)				
Issuing Authority				
Document Number (if any)				
Expiration Date (if any)				

Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment
(mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative Gary, Nadine Accounting Assistant	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name Tony Cook Construction, LLC	Employer's Business or Organization Address, City or Town, State, ZIP Code 402 Service Road Rayne LA 70578	

For reverification or rehire, complete **Supplement B, Reverification and Rehire on Page 4**.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity AND Documents that Establish Employment Authorization
<p>1. U.S. Passport or U.S. Passport Card</p> <p>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</p> <p>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</p> <p>4. Employment Authorization Document that contains a photograph (Form I-766)</p> <p>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:</p> <p>a. Foreign passport; and</p> <p>b. Form I-94 or Form I-94A that has the following:</p> <p>(1) The same name as the passport; and</p> <p>(2) An endorsement of the individual's status or parole 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.</p> <p>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</p>	OR	<p>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</p> <p>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</p> <p>3. School ID card with a photograph</p> <p>4. Voter's registration card</p> <p>5. U.S. Military card or draft record</p> <p>6. Military dependent's ID card</p> <p>7. U.S. Coast Guard Merchant Mariner Card</p> <p>8. Native American tribal document</p> <p>9. Driver's license issued by a Canadian government authority</p> <p>For persons under age 18 who are unable to present a document listed above:</p> <p>10. School record or report card</p> <p>11. Clinic, doctor, or hospital record</p> <p>12. Day-care or nursery school record</p> <p>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</p> <p>(1) NOT VALID FOR EMPLOYMENT</p> <p>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</p> <p>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</p> <p>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</p> <p>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</p> <p>4. Native American tribal document</p> <p>5. U.S. Citizen ID Card (Form I-197)</p> <p>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</p> <p>7. Employment authorization document issued by the Department of Homeland Security</p> <p>For examples, see <u>Section 7</u> and <u>Section 13</u> of the M-274 on uscis.gov/i-9-central.</p> <p>The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.</p>

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

<ul style="list-style-type: none"> Receipt for a replacement of a lost, stolen, or damaged List A document. Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>
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*Refer to the Employment Authorization Extensions page on I-9 Central for more information.



Supplement A, Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle initial (if any) from Section 1.
---	---	---

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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	Date (mm/dd/yyyy)		
Last Name (Family Name)	First Name (Given Name)		Middle Initial (if any)
Address (Street Number and Name)	City or Town	State	ZIP Code

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	Date (mm/dd/yyyy)		
Last Name (Family Name)	First Name (Given Name)		Middle Initial (if any)
Address (Street Number and Name)	City or Town	State	ZIP Code

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	Date (mm/dd/yyyy)		
Last Name (Family Name)	First Name (Given Name)		Middle Initial (if any)
Address (Street Number and Name)	City or Town	State	ZIP Code

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	Date (mm/dd/yyyy)		
Last Name (Family Name)	First Name (Given Name)		Middle Initial (if any)
Address (Street Number and Name)	City or Town	State	ZIP Code



Supplement B, Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name (Family Name) from Section 1 .	First Name (Given Name) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)
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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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
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Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
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Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

Attention New Hires

All employees of Tony Cook Constructions are paid by Direct Deposit.

Exception to this is the first check. **All first checks are mailed**, this is done through our payroll service. If your second check does not go Direct Deposit, please contact the office.

PLEASE INCLUDE A
VOIDED PERSONAL CHECK
TO THIS AUTHORIZATION
FOR VERIFICATION OF ALL
CHECKING ACCOUNT
INFORMATION.



Tony Cook Construction, LLC

Benefits Effective: 12/01/2025 - 11/30/2026

United Healthcare | Group# 1554664

Guardian Life Insurance Company of America | Group #00025056

Choice Plus P2500i80LX21B (Level Funded)

Benefit Period	Calendar Year	
Plan Status	Non-Grandfathered	
Maximum Lifetime Benefits	None	
In Network Deductible Per Calendar Year	\$2,500 Individual / \$5,000 Family Aggregate (Not Applicable for Eligible Wellness/Preventive Care Services)	
Out of Network Deductible Per Calendar Year	\$5,000 Individual / \$10,000 Family Aggregate	
Coinsurance	80% Preferred Care / 50% Non-Preferred Care	
In Network - Out of Pocket	\$8,150 Individual / \$16,300 Family	
Out of Network - Out of Pocket	\$12,000 Individual / \$24,000 Family	
Physician Copayment	\$25 PCP / \$75 Specialist	
Urgent Care Copayment	\$50	
Emergency Room Services	\$300 Copay Per Visit + Deductible and Coinsurance	
Pregnancy Coverage	Included	
Wellness Benefits	Please Refer to Policy Details - 100% of Specified Services (PPO Only)	
Prescription Drug Card (Retail & Mail Order)	Retail: Up to 30 Day Supply Rx Drug Product Tier: \$10 / \$35 / \$75 / \$250 Preferred Specialty Rx Drug Product Tier Level: \$10 / \$150 / \$350 / \$500	Mail Order: Up to 90 Day Supply Rx Drug Product Tier: \$25 / \$87.50 / \$187.50 / \$625 Preferred Specialty Rx Drug Product Tier Level: Not Applicable

The above information is not a United Healthcare contract, nor does it guarantee payment of benefits. This describes the main features of the offered insurance for employees who are enrolled. It does not waive or alter any of the terms of the Benefit Plan.

The employer is contributing 75% to the Employee Only Rate.

Coverage Tier	Weekly Employee Deduction
Employee	\$43.92
Employee & Spouse	\$227.02
Employee & Child(ren)	\$185.40
Family	\$360.17

Contact Information:

UHC Customer Service	1-877-797-8812 / Website: www.myuhc.com	
Guardian Customer Service	1-800-627-4200 / Website: www.guardiananytime.com	
Brown & Brown of Louisiana	Elizabeth Minvielle Executive Vice President, Employee Benefits Phone: (337) 266-5624 Email: elizabeth.minvielle@bbrown.com	Della LaRive Account Manager, Employee Benefits Phone: (337) 266-5711 Email: della.larive@bbrown.com

This Benefit Summary designed to provide basic information regarding benefit plans and programs available to eligible employees of Tony Cook Construction, LLC. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee of Tony Cook Construction, LLC, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Tony Cook Construction, LLC reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.



Tony Cook Construction, LLC

Benefits Effective: 12/01/2025 - 11/30/2026

United Healthcare | Group# 1554664

Guardian Life Insurance Company of America | Group #00025056

Guardian: Voluntary Dental			Cost Breakdown:	
Network	DentalGuard Preferred Network		<u>Coverage Tier</u>	<u>Weekly</u>
Deductible	\$50 Individual / \$150 Family		Employee Only	\$5.80
Calendar Year Max	\$1,000 + Rollover		Employee + Spouse	\$11.78
Coinsurance PPO (See Policy for Complete List of Services)	In Network Preventive: 100% Basic: 100% Major: 60% Orthodontia: NA	Out of Network Preventive: 100% Basic: 80% Major: 50% Orthodontia: NA	Employee + Child(ren)	\$14.75
			Employee + Family	\$22.11
Guardian: Voluntary Vision			Cost Breakdown:	
Network	VSP Full Feature – Choice B Network		<u>Coverage Tier</u>	<u>Weekly</u>
Eye Exams / Frequency	\$10 Copay / Calendar Year		Employee Only	\$1.24
Materials / Lens Allowance / Frequency	\$25 Copay / Covered After Copay / Calendar Year		Employee + Spouse	\$2.35
Contact Lenses / Frequency (See Policy for Complete List of Services)	Evaluation & Fitting: Included in the Contact Lens Allowance. 15% Off Professional Fees Elective Allowance: \$130, Copay Waived Medically Necessary: 100%, After Copay Frequency: Calendar Year <i>*Contacts are in lieu of a complete set of glasses.</i>		Employee + Child(ren)	\$2.40
			Employee + Family	\$3.79
Frames / Frequency	\$130 Retail Allowance + 20% Off Remaining Balance Costco, Walmart, Sam's Club: \$70 Retail Max Every Other Calendar Year			

Guardian: Voluntary Life w/ AD&D	
Employee Life Benefit	Flat Amounts: \$25K, \$50K, \$75K, \$100K, \$125K, \$150K, \$200K
Spouse Life Benefit	Flat Amounts: \$10K, \$20K, \$25K - (Not to Exceed 100% EE Amount)
Child Life Benefit	\$1K Increments (Minimum \$5K): \$10K Max - (Not to Exceed 100% EE Amount)
Guarantee Issue	EE: Age<65 \$50K, Age 65<70 \$50K, Age 70+ \$10K SP: Age<65 \$25K, Age 65<70 \$25K, Age 70+ \$0 Ch: \$10K
AD&D	Same as Life Amount
Benefit Reduction	35% at age 65 / 60% at age 70 / 75% at age 75 / 85% at age 80
Portability/Conversion	Portability: Included w/Evidence of Insurability / Conversion: Included

Employee's Age	Employee Coverage - Weekly Premium For:								
	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
\$25,000	\$1.26	\$1.30	\$1.56	\$2.04	\$3.14	\$4.86	\$7.31	\$9.40	\$14.08
\$50,000	\$2.52	\$2.61	\$3.12	\$4.07	\$6.29	\$9.73	\$14.62	\$18.81	\$28.17
\$75,000	\$3.77	\$3.91	\$4.67	\$6.11	\$9.43	\$14.59	\$21.93	\$28.21	\$42.25
\$100,000	\$5.03	\$5.22	\$6.23	\$8.15	\$12.58	\$19.45	\$29.24	\$37.62	\$56.33
\$125,000	\$6.29	\$6.52	\$7.79	\$10.18	\$15.72	\$24.32	\$36.55	\$47.02	\$70.41
\$150,000	\$7.55	\$7.82	\$9.35	\$12.22	\$18.87	\$29.18	\$43.86	\$56.42	\$84.50
\$200,000	\$10.06	\$10.43	\$12.46	\$16.29	\$25.15	\$38.91	\$58.48	\$75.23	\$112.66

Employee's Age	Spouse Coverage - Weekly Premium For:								
	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
\$10,000	\$0.50	\$0.52	\$0.62	\$0.82	\$1.26	\$1.95	\$2.92	\$3.76	\$5.63
\$20,000	\$1.01	\$1.04	\$1.25	\$1.63	\$2.52	\$3.89	\$5.85	\$7.52	\$11.27
\$25,000	\$1.26	\$1.30	\$1.56	\$2.04	\$3.14	\$4.86	\$7.31	\$9.40	\$14.08



Level Funded plan participant enrollment application form

UnitedHealthcare Level Funded

Send correspondence to: P.O. Box 31394, Salt Lake City, UT 84131 • Phone: 1-877-797-8812

Tony Cook Construction, LLC

Fill out the entire enrollment application form to avoid processing delay. Please clearly print all information.

Enrollee Social Security Number

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

Group No.

1	5	5	4	6	6	4	
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Enrollee Information

Plan Sponsor Name

Plan Sponsor Address (If more than one location)

Last Name

First Name

Initial

Single Address
 Married

Apt #

City

State

ZIP

County

Phone #

Email Address

Cell
Phone #

Occupation

Date Employed Full Time

Average Hours
Worked Per Week

Are you an independent contractor?

Yes No

Enrollee and Dependent Information (only for those applying)

If you need to list additional dependents, please use lined paper, sign and date it, and check this box:

	Enrollee	Spouse	Child 1	Child 2	Child 3
First Name					
Last Name					
Gender	<input type="checkbox"/> M <input type="checkbox"/> F				
Date of Birth					
Height					
Weight					
Tobacco or nicotine use including e-cigarette or similar devices in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Social Security Number					

Primary Care Physician's Name

Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)

Currently Working Full Time	<input type="checkbox"/> Yes				
Plan to Keep Other Insurance Coverage	<input type="checkbox"/> Yes				
Other Insurance Policy Number					
Name of Other Insurance Company(ies)					
Covered by Medicare/Medicaid	<input type="checkbox"/> Yes				
Medicare/Medicaid Coverage Effective Date					

Coverage and Change Request Information

Medical: Plan Participant Family Plan Participant/Spouse Plan Participant/Dependent Child(ren)

Name of Medical Plan You Have Selected: _____

Change Request: Marriage Divorce Adoption Returning to School Full Time Court Order

Date of Event: _____ (you may be required to provide proof of event)

Attach a written and signed statement by the plan sponsor for a requested coverage effective date other than plan participant effective date. Effective date may not be guaranteed.

Medical History

Please answer the following questions for yourself and each person listed on the Enrollee and Dependent Information Section on page 2 of this form. Please answer completely and truthfully. Please note that, if you fraudulently leave out or fraudulently misrepresent information, we may terminate or not renew your coverage, or we may change your monthly payment retroactive to the date your coverage became effective.

All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.

1. In the last 5 years, has anyone on this application been diagnosed with, or been examined/treated by a health care professional for any illness, injury, or health condition in any of the categories listed below?

- a. Cancer/Tumor (indicate type of cancer and location of tumor below) Yes No
- b. Mental Health/Substance Abuse Yes No
- c. Blood Disorders/Hemophilia Yes No
- d. Congenital Disorder/Disability Yes No
- e. Heart/High Blood Pressure/Circulatory Disease/Stroke Yes No
- f. Kidney/Bladder/Urinary Disorders/ESRD Yes No
- g. Transplant – prior, pending or recommended (indicate organ) Yes No
- h. Digestive Disorder/Crohns Disease/Ulcerative Colitis Yes No
- i. Liver Disease/Cirrhosis/Hepatitis (indicate type below) Yes No
- j. Endocrine/Diabetes/Growth Hormone/Thyroid Yes No
- k. Immune System/Lupus/Psoriasis/HIV/AIDS Yes No
- l. Nervous System Disorder/Multiple Sclerosis/Seizure/Epilepsy/Paralysis Yes No
- m. Lung/Respiratory/Cystic Fibrosis/COPD Yes No
- n. Back/Bones/Joints/Muscles/Arthritis Yes No
- o. Reproductive/Infertility/Breast Disorders/PCOS Yes No

If your answer to any of the above categories is "yes" please provide detailed information below for each person involved.

2. Is anyone on this application currently pregnant? If "yes," please provide detailed information including anticipated delivery date, any pregnancy complications, anticipation of multiple births, and/or Cesarean Section. Yes No

3. In the past 12 months, has anyone on this application been hospitalized (inpatient or outpatient) or had surgery? If your answer is "yes," please provide detailed information below including surgery (if applicable), diagnosis, current and future treatment recommended for each person involved. Yes No

4. In the past 12 months, has anyone on this application been recommended or prescribed medications, or is anyone currently taking prescription medications? If your answer is "yes," please provide detailed information below for each person involved. Yes No

5. In the past 5 years, has anyone on this application been tested for or diagnosed with, received medical treatment, or had medical treatment recommended, or been hospitalized for any illness, injury or health condition not previously mentioned? If your answer is "yes," please provide detailed information below for each person involved. Yes No

Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and date and sign that sheet.)

Prior Medical Coverage Information

Yes No Have you or any dependents applying for coverage been covered by this plan sponsor's prior group medical plan?

Yes No Have you or any dependents applying for coverage been covered by any medical plan other than this plan sponsor's prior group plan?

If yes:

Insurance Company Name _____ Phone # _____ Policy/Group # _____

Termination Date _____ Effective Date _____ Reason for Termination _____

Who was covered? _____

Type of Plan: Prior Plan Sponsor Group Plan Spouse's Plan Sponsor Group Plan Individual Policy

Other _____

Signature

I declare that all statements and responses contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 120 days that was provided to UnitedHealthcare, are true and correct and that no material information has been withheld or omitted. I also understand that the information provided on this form is used to make decisions regarding eligibility and pricing. I understand that misrepresentation, concealment or omission of fact, or a mistake of fact (whether or not a mutual mistake), could materially affect the underwriting, premium, rating or terms and conditions of my plan sponsor's Excess Loss Insurance Policy ("Policy") which could result in changes to the terms and conditions of my plan sponsor's Excess Loss Insurance Policy, including retroactive increased premium rates and attachment points, or termination of that Policy. I also understand that willful or intentional misrepresentation, concealment or omission of any material fact affecting terms, conditions, or underwriting of my plan sponsor's Excess Loss Insurance Policy could result in that Policy being null and void in its inception.

I understand and I agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no medical benefits will be effective until the date specified in the Summary Plan Description. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date. Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment application form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

All pages must be attached and complete, including this authorization, for the enrollment application form to be considered complete. Incomplete enrollment application forms may be rejected.

I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

Authorization to Disclose Medical Information for Enrollment

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, pharmacy benefit managers, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents proposed for coverage to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize.

Enrollee Signature X _____

Date _____

If signed by a representative of enrollee, please indicate the representative's legal authority to act on behalf of enrollee.

Waiver (please complete if you are waiving medical coverage)

I waive medical coverage for: Self (and dependents)
 Spouse Dependent Children

Please state reason for waiving coverage:

Qualifying Coverage: _____

Other: _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Applicant Signature X _____ Date _____

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION – The results of any genetic test, including genetic test information, shall not be used as the basis to: (1) terminate, restrict, limit or otherwise apply conditions to the coverage of an individual or family member under the plan, or restrict the sale of the plan to an individual or family member; (2) cancel or refuse to renew the coverage of an individual or family member under the plan; (3) deny coverage or exclude an individual or family member from coverage under the plan; (4) impose a rider that excludes coverage for certain benefits or services under the plan; (5) establish differentials in monthly costs or cost-sharing for coverage under the plan; (6) otherwise discriminate against an individual or family member in the provision of insurance.

Guardian Life, P.O. Box 14319,
 Lexington, KY 40512

Please print clearly and mark carefully.

Employer/Planholder Name: TONY COOK CONSTRUCTION, LLC		Group Plan Number: 00025056	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Member Dependents/Family Members <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change			
In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term, and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.			

Class: _____	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer/Planholder)
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About You: Full Legal Name-First, MI, Last Name: What is the name you go by? (optional)	Employer/Planholder Provided Identification: _____	Social Security Number _____ - _____ - _____ Your Social Security Number must be provided if enrolling for Life Coverage, Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address	City	State	Zip
Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): _____ - _____ - _____		
Phone (indicate primary): <input type="checkbox"/> Home (_____) - ____ - ____ <input type="checkbox"/> Work (_____) - ____ - ____ <input type="checkbox"/> Mobile (_____) - ____ - ____			
Email Address (indicate primary) <input type="checkbox"/> Home _____		<input type="checkbox"/> Work _____	
Are you married or in a civil union? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of marriage/civil union: _____ - _____ - _____	
Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No Placement date of adopted child: _____ - _____ - _____			

About Your Job:	Job Title: _____	
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation Hours worked per week: _____	Date of full time hire: _____ - _____ - _____	Annual Salary: \$ _____

About Your Family: Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse Address/City/State/Zip: Phone: () - _____	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) _____ - _____ - _____
---	---	--

Child/Dependent 1: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> M <input type="checkbox"/> F	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> M <input type="checkbox"/> F	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> M <input type="checkbox"/> F	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> M <input type="checkbox"/> F	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Drop Coverage: <input type="checkbox"/> Drop Employee/Member <input type="checkbox"/> Drop Dependents/Family Members The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: ____ - ____ - ____ <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____	Coverage Being Dropped: <input type="checkbox"/> Dental <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Vision <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Basic Term Life <input type="checkbox"/> Voluntary Term Life <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
Loss Of Other Coverage: I and/or my dependents were previously covered under Loss of coverage was due to: <input type="checkbox"/> Termination of Employment: ____ - ____ - ____ <input type="checkbox"/> Divorce/Separation: ____ - ____ - ____ <input type="checkbox"/> Death of Spouse: ____ - ____ - ____ <input type="checkbox"/> Termination/Expiration of Coverage: ____ - ____ - ____ Coverage Lost <input type="checkbox"/> Dental <input type="checkbox"/> Vision	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ <small>(additional information may be required)</small>

Dental Coverage: You must be enrolled to cover your dependents/family members. Check only one box.					
Your Weekly Premium	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)	
PPO	<input type="checkbox"/> \$5.80	<input type="checkbox"/> \$11.78	<input type="checkbox"/> \$14.75	<input type="checkbox"/> \$22.11	
<input type="checkbox"/> I do not want Dental Coverage because (Check as applicable): <input type="checkbox"/> I am covered under another Dental plan <input type="checkbox"/> My spouse is covered under another Dental plan <input type="checkbox"/> My dependents/family members are covered under another Dental plan					

Vision Coverage: You must be enrolled to cover your dependents/family members. Check only one box.

Your Weekly Premium	Employee/Member Only	Employee/Member & Employee/Member & Spouse	Employee/Member, Spouse & Dependent/Child(ren)
Full Feature	<input type="checkbox"/> \$1.24	<input type="checkbox"/> \$2.35	<input type="checkbox"/> \$2.39

I do not want this Vision coverage because (Check as applicable):

- I am covered under another Vision plan
- My spouse is covered under another Vision plan
- My dependents/family members are covered under another Vision plan

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): You must be enrolled to cover your dependents/family members. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Employee/Member

Policy Amount	<i>Check one box only</i>					
<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$50,000*	<input type="checkbox"/> \$75,000**	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$125,000	<input type="checkbox"/> \$150,000	
<input type="checkbox"/> \$200,000						

Guarantee Issue up to: Employee Less than age 65 \$50,000*, \$0, 70+ \$10,000. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected. Additional Amount: per employee \$25,000**. The Additional amount is available for ages Less than age 65. An Evidence of Insurability form must be completed if any amount above the Guarantee Issue Amount plus Additional Amount is elected.

I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount					
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$25,000*			

**Guarantee Issue Amount*

**The amount may not be more than 50% of the employee amount for Voluntary Life.*

I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount					
<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000	<input type="checkbox"/> \$8,000	<input type="checkbox"/> \$9,000	<input type="checkbox"/> \$10,000*

**Guarantee Issue Amount*

**The amount may not be more than 10% of the employee amount for Voluntary Life.*

I do not want this coverage

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

LIFE INSURANCE *continued*

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____ - _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Health History

Complete the following question(s) if you are enrolling for one or more of the following benefits listed below and you are electing an amount above coverage that is Guaranteed Issue. NOTE: Additional information may be required.

Voluntary Life

In the last 6 months have you received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to Acquired Immune Deficiency Disorder (AIDS); or any other chronic condition?

Yes, I have. No, I haven't. Yes, my spouse has. No, my spouse hasn't. Yes, my dependent child(ren) have. No, my dependent child(ren) haven't.

An Evidence of Insurability form must be completed for any person with a "Yes" answer to the question(s) above.

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

SIGNATURE OF EMPLOYEE/MEMBER X

DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Delaware, Indiana and Oklahoma: **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.

District of Columbia: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: 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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana and Texas: Any person 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 confinements in state prison.

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

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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.

Ohio: Any person who with intent to defraud or knowing that he/she 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.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Virginia: Any person who with intent to defraud or knowing that he/she 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.



NEW HIRE SHEET
TONY COOK CONSTRUCTION

Benefits Offered



Disability



Cancer



Critical Illness



Accident



Life Insurance



Hospital

Name

Hire Date:

Date of Birth:

Phone

Address

State

Zip Code

Social Security Number

NEED TO COVER YOUR SPOUSE?

Name

Date of Birth:

Signature

Date

Next Steps

1. Select the policies that you need by checking the box next to your associated age/premium.
2. Premiums are on a weekly payroll basis.
3. Coverage will start the 1st of the month
4. Return this form to Nadine Gary or Tyler Breaud
5. Sign Waiver if declining coverage



NEW HIRE SHEET
TONY COOK CONSTRUCTION



Disability

Benefit Period: 6 Months	Elimination Period: 0-Days for Injury, 14-Days for Illness
--------------------------	--

Income	\$36,000	\$38,000	\$40,000	\$42,000	\$44,000	\$46,000	\$48,000	\$50,000	\$52,000	\$54,000
Benefit	\$1,800	\$1,900	\$2,000	\$2,100	\$2,200	\$2,300	\$2,400	\$2,500	\$2,600	\$2,700

Age

18-49	<input type="checkbox"/> \$13.50	<input type="checkbox"/> \$14.25	<input type="checkbox"/> \$15.00	<input type="checkbox"/> \$15.75	<input type="checkbox"/> \$16.50	<input type="checkbox"/> \$17.25	<input type="checkbox"/> \$18.00	<input type="checkbox"/> \$18.75	<input type="checkbox"/> \$19.50	<input type="checkbox"/> \$20.25
50-59	<input type="checkbox"/> \$17.82	<input type="checkbox"/> \$18.81	<input type="checkbox"/> \$19.80	<input type="checkbox"/> \$20.79	<input type="checkbox"/> \$21.78	<input type="checkbox"/> \$22.77	<input type="checkbox"/> \$23.76	<input type="checkbox"/> \$24.75	<input type="checkbox"/> \$25.74	<input type="checkbox"/> \$26.73
60-75	<input type="checkbox"/> \$22.14	<input type="checkbox"/> \$23.37	<input type="checkbox"/> \$24.60	<input type="checkbox"/> \$25.83	<input type="checkbox"/> \$27.06	<input type="checkbox"/> \$28.29	<input type="checkbox"/> \$29.52	<input type="checkbox"/> \$30.75	<input type="checkbox"/> \$31.98	<input type="checkbox"/> \$33.21

Income	\$56,000	\$58,000	\$60,000	\$61,000	\$63,000	\$68,000	\$73,000	\$78,000	\$82,000	\$87,000
Benefit	\$2,800	\$2,900	\$3,000	\$3,100	\$3,200	\$3,300	\$3,400	\$3,500	\$3,600	\$3,700

Age

18-49	<input type="checkbox"/> \$21.00	<input type="checkbox"/> \$21.75	<input type="checkbox"/> \$22.50	<input type="checkbox"/> \$23.25	<input type="checkbox"/> \$24.00	<input type="checkbox"/> \$24.75	<input type="checkbox"/> \$25.50	<input type="checkbox"/> \$26.25	<input type="checkbox"/> \$27.00	<input type="checkbox"/> \$27.75
50-59	<input type="checkbox"/> \$27.72	<input type="checkbox"/> \$28.71	<input type="checkbox"/> \$29.70	<input type="checkbox"/> \$30.69	<input type="checkbox"/> \$31.68	<input type="checkbox"/> \$32.67	<input type="checkbox"/> \$33.66	<input type="checkbox"/> \$34.65	<input type="checkbox"/> \$35.64	<input type="checkbox"/> \$36.63
60-75	<input type="checkbox"/> \$34.44	<input type="checkbox"/> \$35.67	<input type="checkbox"/> \$36.90	<input type="checkbox"/> \$38.13	<input type="checkbox"/> \$39.36	<input type="checkbox"/> \$40.59	<input type="checkbox"/> \$41.82	<input type="checkbox"/> \$43.05	<input type="checkbox"/> \$44.28	<input type="checkbox"/> \$45.51

Income	\$92,000	\$97,000	\$102,000	\$106,000	\$111,000	\$116,000	\$121,000	\$126,000	\$130,000	\$135,000
Benefit	\$3,800	\$3,900	\$4,000	\$4,100	\$4,200	\$4,300	\$4,400	\$4,500	\$4,600	\$4,700

Age

18-49	<input type="checkbox"/> \$28.50	<input type="checkbox"/> \$29.25	<input type="checkbox"/> \$30.00	<input type="checkbox"/> \$30.75	<input type="checkbox"/> \$31.50	<input type="checkbox"/> \$32.25	<input type="checkbox"/> \$33.00	<input type="checkbox"/> \$33.75	<input type="checkbox"/> \$34.50	<input type="checkbox"/> \$35.25
50-59	<input type="checkbox"/> \$37.62	<input type="checkbox"/> \$38.61	<input type="checkbox"/> \$39.60	<input type="checkbox"/> \$40.59	<input type="checkbox"/> \$41.58	<input type="checkbox"/> \$42.57	<input type="checkbox"/> \$43.56	<input type="checkbox"/> \$44.55	<input type="checkbox"/> \$45.54	<input type="checkbox"/> \$46.53
60-75	<input type="checkbox"/> \$46.74	<input type="checkbox"/> \$47.97	<input type="checkbox"/> \$49.20	<input type="checkbox"/> \$50.43	<input type="checkbox"/> \$51.66	<input type="checkbox"/> \$52.12	<input type="checkbox"/> \$54.12	<input type="checkbox"/> \$55.35	<input type="checkbox"/> \$56.58	<input type="checkbox"/> \$57.81



Accident On/Off Job

Initial Hospitalization	\$1,500 for Hospital Confinement of at least 18 hours or \$2,500 for ICU		
Hospital Confinement	\$250 per day, 365 days per accident, \$400 per day for ICU		
Emergency Room / Urgent Care	\$200		
Ambulance Benefit	\$200 Ground / \$1,500 Air		
Diagnostic & Imaging	\$200		
Physical/Occupation Therapy	\$35 per day		
Appliance Benefit (Wheelchair, crutches, boot, etc.)	\$25-\$300		
Specific-Sum Injuries	Dislocations \$100-\$3,750 Lacerations \$35-\$500 Surgery \$200-\$1,250	Burns \$125-\$12,500 Fractures \$125-\$3,500 Coma \$12,500	Eye Injuries \$65-\$300 Dental Work \$130-\$400 Paralysis \$4,750-\$12,500
Accidental Death	\$40,000 - \$200,000		
Wellness Benefits	\$100		

Individual
\$6.78



Individual+All Children
\$15.48



Individual+Spouse
\$13.14



Family
\$19.50





TONY COOK CONSTRUCTION



CANCER

Initial Diagnosis	\$5,000, builds by \$500 every year (\$10,000 for a diagnosis of children)
Chemotherapy & Radiation	\$1,600 per month
Stem Cell & Bone Marrow	\$7,000 (+ Doner Gets Paid as well)
Hospitalization	\$200 (Day 1-30) \$400 (Day 31 - 365)
Diagnostic & Imaging	\$200
Home Health & Nursing Services	\$100 per day
Hospice Care	\$1,000, \$50 per day thereafter
Surgery	\$100 - \$3,400
Lodging & Transportation	\$65 per day & \$.40 per mile
Wellness Benefits	\$75

Individual
\$9.10

Individual+All Children
(Children covered for FREE)
\$9.10

Individual+Spouse
\$16.54

Family
\$16.54



Critical Illness

Critical Illness Event Heart Attack, Stoke, Coma, Paralysis, Organ Transplant, Renal Failure, Cardiac Arrest	\$10,000, payable once per lifetime
Subsequent Critical Illness Event	\$5,000 for every event
Coronary Artery Bypass	\$3,000
Spouse / Dependent Benefit	Pays 50% of individual benefit

AGE	Individual	Individual+All Children (Children Covered for FREE)	Individual+Spouse	Family		
18-24	\$1.02	<input type="checkbox"/>	\$1.02	<input type="checkbox"/>	\$1.65	<input type="checkbox"/>
25-29	\$1.14	<input type="checkbox"/>	\$1.14	<input type="checkbox"/>	\$1.86	<input type="checkbox"/>
30-34	\$1.50	<input type="checkbox"/>	\$1.50	<input type="checkbox"/>	\$2.43	<input type="checkbox"/>
35-39	\$2.04	<input type="checkbox"/>	\$2.04	<input type="checkbox"/>	\$3.21	<input type="checkbox"/>
40-44	\$2.64	<input type="checkbox"/>	\$2.64	<input type="checkbox"/>	\$4.02	<input type="checkbox"/>
45-49	\$3.21	<input type="checkbox"/>	\$3.21	<input type="checkbox"/>	\$4.89	<input type="checkbox"/>
50-54	\$3.75	<input type="checkbox"/>	\$3.75	<input type="checkbox"/>	\$5.88	<input type="checkbox"/>
55-59	\$4.25	<input type="checkbox"/>	\$4.25	<input type="checkbox"/>	\$6.90	<input type="checkbox"/>
60-70	\$5.01	<input type="checkbox"/>	\$5.01	<input type="checkbox"/>	\$8.49	<input type="checkbox"/>



TONY COOK CONSTRUCTION



HOSPITAL

Initial Hospitalization or Mental Health Facility	\$1,000
Intensive Care	\$500 / Day
Consecutive Days in Hospital	\$100 / Day
Emergency Room / Urgent Care	\$100
Diagnostic & Imaging	\$150
Lab Test / X-Ray	\$35
Physician Visit	\$25 / Visit
Surgery	\$50-\$1,000
Ambulance	\$200 (Ground) \$2,000 (Air)
Initial Assistance / Short Hospital Stay	\$100

AGE	Individual	Individual+All Children	Individual+ Spouse	Family
18-49	\$13.41 <input type="checkbox"/>	\$19.52 <input type="checkbox"/>	\$22.71 <input type="checkbox"/>	\$24.63 <input type="checkbox"/>
50-59	\$15.15 <input type="checkbox"/>	\$20.61 <input type="checkbox"/>	\$27.03 <input type="checkbox"/>	\$28.35 <input type="checkbox"/>
60-75	\$17.07 <input type="checkbox"/>	\$23.01 <input type="checkbox"/>	\$30.57 <input type="checkbox"/>	\$32.52 <input type="checkbox"/>



Amounts from \$20,000 - \$500,000
 Term Life = will expire after 10, 20, or 30 years
 Whole Life = Lasts whole entire life
 You can have combination of both types
 Can cover yourself, spouse, and children
 Quotes below are estimate

20 Year Term		
Age	\$25,000	\$50,000
50	\$4.94	\$7.80
51	\$5.30	\$8.49
52	\$5.68	\$9.28
53	\$6.12	\$10.15
54	\$6.61	\$11.12
55	\$7.17	\$12.16
56	\$7.80	\$13.32
57	\$8.53	\$14.61
58	\$9.37	\$15.95
59	\$10.32	\$17.38
60	\$11.38	\$18.90

Juvenile Whole Life \$20,000	
Age	Premium
1	\$2.98
2	\$3.02
3	\$3.16
4	\$3.28
5	\$3.32
6	\$3.44
7	\$3.58
8	\$3.69
9	\$3.81
10	\$3.92
11	\$4.11
12	\$4.22
13	\$4.41
14	\$4.52
15	\$4.71
16	\$4.89
17	\$5.08

30 Year Term				
Age	\$25,000	\$50,000	\$75,000	\$100,000
18	\$2.05	\$2.70	\$3.59	\$4.48
19	\$2.05	\$2.70	\$3.59	\$4.48
20	\$2.05	\$2.70	\$3.59	\$4.48
21	\$2.05	\$2.70	\$3.59	\$4.48
22	\$2.05	\$2.70	\$3.59	\$4.48
23	\$2.05	\$2.70	\$3.59	\$4.48
24	\$2.05	\$2.70	\$3.59	\$4.48
25	\$2.05	\$2.70	\$3.59	\$4.48
26	\$2.09	\$2.75	\$3.66	\$4.57
27	\$2.11	\$2.79	\$3.73	\$4.66
28	\$2.13	\$2.84	\$3.80	\$4.75
29	\$2.18	\$2.91	\$3.90	\$4.89
30	\$2.22	\$2.98	\$4.00	\$5.03
31	\$2.27	\$3.07	\$4.14	\$5.22
32	\$2.33	\$3.18	\$4.32	\$5.45
33	\$2.40	\$3.37	\$4.59	\$5.82
34	\$2.47	\$3.62	\$4.97	\$6.32
35	\$2.55	\$3.92	\$5.42	\$6.92
36	\$2.69	\$4.25	\$5.91	\$7.57
37	\$2.84	\$4.59	\$6.43	\$8.26
38	\$3.02	\$4.98	\$7.02	\$9.05
39	\$3.22	\$5.40	\$7.64	\$9.88
40	\$3.45	\$5.86	\$8.33	\$10.80
41	\$3.68	\$6.37	\$9.09	\$11.82
42	\$3.92	\$6.92	\$9.92	\$12.92
43	\$4.22	\$7.50	\$10.79	\$14.08
44	\$4.55	\$8.15	\$11.76	\$15.37
45	\$4.92	\$8.84	\$12.80	\$16.75
46	\$6.21	\$9.92	\$14.42	\$18.92
47	\$6.73	\$10.82	\$15.77	\$20.72
48	\$7.25	\$11.72	\$17.12	\$22.52
49	\$7.77	\$12.62	\$18.47	\$24.32
50	\$8.28	\$13.52	\$19.82	\$26.12

Whole Life			
Age	\$25,000	\$50,000	\$75,000
18	\$3.92	\$7.15	\$10.38
19	\$3.92	\$7.15	\$10.38
20	\$3.92	\$7.15	\$10.38
21	\$3.98	\$7.15	\$10.38
22	\$4.04	\$7.27	\$10.56
23	\$4.10	\$7.38	\$10.73
24	\$4.15	\$7.50	\$10.90
25	\$4.27	\$7.75	\$11.28
26	\$4.44	\$8.05	\$11.73
27	\$4.56	\$8.35	\$12.18
28	\$4.73	\$8.68	\$12.67
29	\$4.88	\$9.00	\$13.15
30	\$5.07	\$9.35	\$13.67
31	\$5.25	\$9.72	\$14.23
32	\$5.43	\$10.08	\$14.78
33	\$5.64	\$10.45	\$15.33
34	\$5.86	\$10.87	\$15.96
35	\$6.08	\$11.31	\$16.62
36	\$6.31	\$11.75	\$17.27
37	\$6.58	\$12.21	\$17.97
38	\$6.92	\$12.72	\$18.73
39	\$7.27	\$13.22	\$19.49
40	\$7.67	\$13.85	\$20.42
41	\$8.02	\$14.65	\$21.63
42	\$8.48	\$15.35	\$22.67
43	\$8.88	\$16.27	\$24.06
44	\$9.35	\$17.08	\$25.27
45	\$9.81	\$18.00	\$26.65
46	\$10.33	\$18.92	\$28.04
47	\$10.90	\$19.96	\$29.60
48	\$11.48	\$21.12	\$31.33
49	\$12.06	\$22.27	\$33.06
50	\$12.75	\$23.42	\$34.79
51	\$13.38	\$24.81	\$36.87
52	\$14.13	\$26.08	\$38.77
53	\$14.88	\$27.58	\$41.02
54	\$15.69	\$29.08	\$43.27
55	\$16.79	\$30.69	\$45.69
56	\$17.94	\$32.88	\$48.98
57	\$19.15	\$35.19	\$52.44
58	\$20.48	\$37.62	\$56.08
59	\$21.92	\$40.27	\$60.06
60	\$36.82	\$43.15	\$64.38



WAIVER OF PARTICIPATION (IF NOT APPLYING, SIGN HERE)

I UNDERSTAND THAT THESE POLICIES ARE OFFERED THROUGH MY EMPLOYER BY PAYROLL DEDUCTION AND I AM WAIVING MY PARTICIPATION BASED ON ONE OF THE FOLLOWING:

I AM NOT CURRENTLY PARTICIPATING IN THE OFFERINGS BY MY EMPLOYER, INCLUDING PRODUCTS OFFERED BY AFLAC, AND WAIVE MY OPPORTUNITY TO PARTICIPATE AT THIS TIME.

EMPLOYEE NAME

LAST

FIRST

MI

EMPLOYEE SIGNATURE:

DATE: _____ / _____ / _____

I CERTIFY THAT THE FEATURES AND BENEFITS OF AFLAC'S GUARANTEED - RENEWABLE INSURANCE POLICIES AND OTHER PRODUCTS OFFERED TO ME BY MY EMPLOYER HAVE BEEN EXPLAINED TO ME COMPLETELY.

BENEFITS CONSULTANT

TYLER BREAUD

Cell: (504) 201-4114

Fax: (337) 295-9927

tyler_breaud@us.aflac.com

Insurance Agent/Prod Tyler Breaud	Insurance Agent/Producer Writing No. AHV29	Insurance Agent/Producer Phone No. (504) 201-4114
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**LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE**

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.¹ This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY
RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.**

Employee Signature: _____ Date: _____

Employer Representative Signature: Nadine Gary Date: _____

Employer Name: _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: Female:

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

¹ Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> <input checked="" type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> <input checked="" type="checkbox"/> Arthritis	<input type="checkbox"/> <input checked="" type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> <input checked="" type="checkbox"/> Silicosis	<input type="checkbox"/> <input checked="" type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input checked="" type="checkbox"/> Parkinson's	<input type="checkbox"/> <input checked="" type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> <input checked="" type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input checked="" type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> <input checked="" type="checkbox"/> Brain Damage	<input type="checkbox"/> <input checked="" type="checkbox"/> Vision Loss, one or both eyes
<input type="checkbox"/> <input checked="" type="checkbox"/> Asbestosis	<input type="checkbox"/> <input checked="" type="checkbox"/> Post-Traumatic Stress	<input type="checkbox"/> <input checked="" type="checkbox"/> Asthma	<input type="checkbox"/> <input checked="" type="checkbox"/> Disability from Polio
<input type="checkbox"/> <input checked="" type="checkbox"/> Hyperinsulinism	<input type="checkbox"/> <input checked="" type="checkbox"/> Osteomyelitis	<input type="checkbox"/> <input checked="" type="checkbox"/> Dementia	<input type="checkbox"/> <input checked="" type="checkbox"/> Psychoneurotic Disability
<input type="checkbox"/> <input checked="" type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input checked="" type="checkbox"/> Nervous Disorder	<input type="checkbox"/> <input checked="" type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> <input checked="" type="checkbox"/> Ruptured or Herniated Disc
<input type="checkbox"/> <input checked="" type="checkbox"/> Emphysema	<input type="checkbox"/> <input checked="" type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <input checked="" type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input checked="" type="checkbox"/> Ankylosis or Joint Stiffening
<input type="checkbox"/> <input checked="" type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input checked="" type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input checked="" type="checkbox"/> Hodgkin's	<input type="checkbox"/> <input checked="" type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> <input checked="" type="checkbox"/> COPD	<input type="checkbox"/> <input checked="" type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input checked="" type="checkbox"/> Cancer	<input type="checkbox"/> <input checked="" type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> <input checked="" type="checkbox"/> Hypertension	<input type="checkbox"/> <input checked="" type="checkbox"/> Kidney Disorder	<input type="checkbox"/> <input checked="" type="checkbox"/> Double Vision	<input type="checkbox"/> <input checked="" type="checkbox"/> Compressed Air Sequelae
<input type="checkbox"/> <input checked="" type="checkbox"/> Head Injury	<input type="checkbox"/> <input checked="" type="checkbox"/> Loss of Use of Limb	<input type="checkbox"/> <input checked="" type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input checked="" type="checkbox"/> Disease of the Lung
<input type="checkbox"/> <input checked="" type="checkbox"/> Epilepsy	<input type="checkbox"/> <input checked="" type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input checked="" type="checkbox"/> Hemophilia	<input type="checkbox"/> <input checked="" type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> <input checked="" type="checkbox"/> Stroke	<input type="checkbox"/> <input checked="" type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input checked="" type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> <input checked="" type="checkbox"/> Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

 Spinal Disc Surgery

Year (approximate if unsure) _____

 Spinal Fusion Surgery

Year (approximate if unsure) _____

 Amputated FootLeft Right Year (approx. if unsure) _____ Amputated LegLeft Right Year (approx. if unsure) _____ Amputated ArmLeft Right Year (approx. if unsure) _____ Amputated HandLeft Right Year (approx. if unsure) _____ Knee ReplacementLeft Right Year (approx. if unsure) _____ Hip ReplacementLeft Right Year (approx. if unsure) _____ Other Joint Replacement

Joint _____ Year _____

 Other Surgical Procedure

Procedure _____ Year _____

Employee Signature: _____

Date: _____

Employer Representative: Nadine Gary

Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

Employee Signature: _____ Date: _____

Employer Representative: *Nadine Gary* Date: _____

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes No

If "Yes," please list the restrictions: _____

Were the restrictions: Permanent Temporary

Are your activities currently restricted? Yes No

What is the medical condition for which you have restrictions? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes No

Please list the medical condition being treated: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: _____ Prescribing Doctor: _____

Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes No

If you answered "YES," please provide the date for each injury and the nature of the injury:

How long were you on compensation? _____

Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes No

If you answered YES, please provide:

Recommended surgery: _____

Approximate date of recommendation: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Representative: Nadine Gary Date: _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature: _____ Date: _____

Employee Printed Name: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;
2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;
3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;
4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and
5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;
6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature: Nadine Gary Date: _____

Employer Representative Printed Name: Nadine Gary

Title: Accounting Assistant