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		**Status:**	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? ❑ Yes ❑ No	Course of Study:
Technical School:	Graduated? ❑ Yes ❑ No	Course of Study:
College/University:	Graduated? ❑ Yes ❑ No	Course of Study:
Post-Graduate Education:	Graduated? ❑ Yes ❑ 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? ❑ Yes ❑ No
Description of Duties:		
Starting Compensation:	Final Compensation:	
Employer:	Address:	
From To	Position Held:	Reason for Leaving:
Supervisor's Name & Title:		May we contact? ❑ Yes ❑ 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 _____ HOW LONG? _____
(STREET) (CITY) (STATE & ZIP CODE)

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____ HIRE DATE _____

TELEPHONE NUMBER _____ E-MAIL ADDRESS _____

PREVIOUS THREE YEARS RESIDENCY

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

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

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

(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			

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (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 may 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)

TONY COOK
CONSTRUCTION

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:_____

R-1300 (1/25)

LOUISIANA DEPARTMENT of REVENUE

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly or Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Tony Cook Construction 402 Service Rd Rayne LA 70578		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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

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 will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; 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 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

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

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

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	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

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.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 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)					
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)					

Additional Information

☐ 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	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Gary, Nadine Accounting Assistant		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Tony Cook Construction, LLC	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	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the 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.		**5.** U.S. Military card or draft record **6.** Military dependent's ID card **7.** U.S. Coast Guard Merchant Mariner Card **8.** Native American tribal document **9.** Driver's license issued by a Canadian government authority		**5.** U.S. Citizen ID Card (Form I-197) **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) **7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**For persons under age 18 who are unable to present a document listed above:** **10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• 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	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*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.**

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)

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)*

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.

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 dose not go Direct Deposit, please contact the office.

kotapay

A Division of First International Bank & Trust

Employer/Company Information (required):		***KOTAPAY***
Name:	Tony Cook Construction, LLC	*1700 42nd St. S, Suite 2000*
Street Address:	402 Service Road	*Fargo, ND 58103*
City, State, Zip:	Rayne LA 70578	*(800) 378-3328*
Telephone:	337-873-8698	

Authorization for Debit and Credit Electronic Funds Transfers

On this _____ day of _____, _____, I hereby authorize Kotapay, a division of First International Bank & Trust ("KP") as well as the employer or company described above, and its agents (collectively, "Company/Employer"), to initiate electronic withdrawals and/or deposits from/to the bank account provided below, and any subsequent bank accounts identified by me in writing. I understand that adjustment and/or reversing entries may be made to these accounts to ensure an accurate and balanced accounting of all transactions. This authorization will remain in effect until:

a) I notify the financial institution provided below ("Bank") and KP in writing to terminate this authorization and the Bank and KP have been afforded reasonable time to comply, or

b) The Bank, Company/Employer, and/or KP have provided me with five (5) business days advance written notice of their decision not to initiate electronic withdrawals and/or deposits from/to the bank account provided below.

Notwithstanding the foregoing authorization termination provisions, I understand that any written termination of this authorization will become effective no earlier than five (5) business days after the day the last transaction has cleared and there are no outstanding balances to the account.

I UNDERSTAND THAT KP PROVIDES ELECTRONIC FUND TRANSFER SERVICES TO THE COMPANY/EMPLOYER DESCRIBED ABOVE AND THEIR AGENTS, INCLUDING PAYMENT AND PAYROLL PROCESSORS, IF USED. THE FUNDS TO BE TRANSFERRED MUST BE COLLATERALLY FUNDED AND ARE FULLY GUARANTEED BY THE EMPLOYER/COMPANY LISTED ABOVE, THEIR AGENTS, INCLUDING ANY PAYROLL OR PAYMENT PROCESSOR, IF USED, AND/OR MYSELF. IN THE EVENT THAT THE FUNDING FOR A TRANSFER IS RETURNED FOR ANY REASON, KP HAS BEEN PROVIDED WITH INCORRECT INFORMATION, AND/OR KP HAS ERRONEOUSLY TRANSFERRED FUNDS TO MY ACCOUNT, I AUTHORIZE KP TO CORRECT/WITHDRAW FROM MY ACCOUNT THE AMOUNT OF FUNDS TRANSFERRED IN ERROR. I ALSO UNDERSTAND THAT KP MAY WITHDRAW AND/OR DEPOSIT TO MY ACCOUNT VARIOUS FUNDS RELATING TO MY PARTICIPATION IN A FLEXIBLE BENEFIT/CAFETERIA PLAN/ERISA PLAN. I HEREBY HOLD KP HARMLESS FROM ALL CLAIMS AND CAUSES OF ACTION RESULTING FROM KP'S TRANSFER OF SUCH FUNDS UPON THE DIRECTION OF MY EMPLOYER OR ITS PROCESSOR, AGREE THAT MY REMEDY FOR ANY ERRONEOUS TRANSFERS IS SOLELY AGAINST THE PROCESSOR AND/OR MY EMPLOYER, AND FURTHER AGREE THAT I WILL HOLD KP HARMLESS FROM ANY LIABILITY AND DAMAGES RESULTING THEREFROM, INCLUDING COURT COSTS AND REASONABLE ATTORNEY'S FEES.

Electronic Funds Transfer (15 U.S.C. § 1693): I hereby acknowledge receipt of notice from my Bank of my responsibilities under the Electronic Funds Transfer Act ("Act"), my potential liability for certain unauthorized electronic fund transfers, my duty to promptly report unauthorized transfers, any charges for electronic fund transfers, if applicable, the right to stop payment of pre-authorized electronic fund transfers, the procedure to initiate such stop payment orders, my right to receive documentation of electronic fund transfers, and the Bank's liability pursuant to the Act.

Limitation of Action: I acknowledge that I will have 60 days from the date of a withdrawal or deposit to my Bank account to dispute the withdrawal or deposit. I further acknowledge that I shall dispute a withdrawal or deposit by providing the Company/Employer and KP with written notification of any discrepancies, errors or disputes concerning any transfer of funds to or from any account processed by KP. I acknowledge that all written notices must include the following information:

a) The name of the Company/Employer authorized to make the transaction;
b) The federal taxpayer ID number of the Company/Employer;
c) My full name;
d) My contact information;
e) The name, account number and ABA number of the transaction in question;
f) The dollar amount of the transaction in question; and
g) A description and explanation of the error.

I acknowledge that, if possible, the Company/Employer , its agent, or KP will inform me of the results of their investigation into the disputed transaction within ten (10) days of the receipt of my complaint, and will attempt to correct any identified error promptly. However, if my employer, its agent, and/or KP need additional time, I understand that they may take up to 45 days to investigate my complaint. For transfers initiated outside the United States or transfers resulting from point of sale or debit/access cards, I understand that the time periods for investigating and resolving errors will be 45/90 days, respectively.

Undersigned's Name (printed) _____ Date _____

Financial Institution _____ Branch name _____

City _____ Branch Phone Number _____

Routing (ABA) Number Account Type: Checking ☐ Savings ☐

Please designate if you wish a specific dollar amount or percentage deposited: $_____ / _____%

Routing (ABA) Number Account Type: Checking ☐ Savings ☐

Please designate if you wish a specific dollar amount or percentage deposited: $_____ / _____%

Undersigned's Signature _____ Employee ID # *(if applicable)* _____

Please attach a voided personal check to this authorization for verification of all checking account information.

Created 4/18

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 waiver 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		**Coverage Tier**	**Weekly**
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) Employee + Family	$14.75 $22.11

Guardian: Voluntary Vision		Cost Breakdown:	
Network	VSP Full Feature – Choice B Network	**Coverage Tier**	**Weekly**
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 **Contacts are in lieu of a complete set of glasses.*	Employee + Child(ren) Employee + Family	$2.40 $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

Employee's Age	Child Coverage - Weekly Premium For:								
	Under 30	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**
$5,000	$0.21	$0.21	$0.21	$0.21	$0.21	$0.21	$0.21	$0.21	$0.21
$6,000	$0.25	$0.25	$0.25	$0.25	$0.25	$0.25	$0.25	$0.25	$0.25
$7,000	$0.29	$0.29	$0.29	$0.29	$0.29	$0.29	$0.29	$0.29	$0.29
$8,000	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34
$9,000	$0.38	$0.38	$0.38	$0.38	$0.38	$0.38	$0.38	$0.38	$0.38
$10,000	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42

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

Enrollee Information

Plan Sponsor Name

Plan Sponsor Address (If more than one location)

Last Name | First Name | Initial

☐ Single ☐ Married | Address | 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

continued

United Healthcare

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	☐M ☐F	☐M ☐F	☐M ☐F	☐M ☐F	☐M ☐F
Date of Birth					
Height					
Weight					
Tobacco or nicotine use including e-cigarette or similar devices in the past 12 months?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐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	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes
Plan to Keep Other Insurance Coverage	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes
Other Insurance Policy Number					
Name of Other Insurance Company(ies)					
Covered by Medicare/ Medicaid	☐Yes	☐Yes	☐Yes	☐Yes	☐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.

continued

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.)

Question #	Person	Condition/Diagnosis	Treatment/Meds	Dates Treated	Prognosis

continued

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.

_____

continued

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.

United Healthcare

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 ❑ Initial Enrollment ❑ Add Employee/Member Dependents/Family Members ❑ Drop/Refuse Coverage ❑ 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)

About You:	Employer/Planholder Provided Identification:	Social Security Number	
Full Legal Name-First, MI, Last Name: What is the name you go by? (optional)	_____	___ ___ ___ - ___ ___ - ___ ___ ___ ___ 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: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): ❑ Home (____) ____ - ____
❑ Work (____) ____ - ____
❑ Mobile (____) ____ - ____

Email Address (indicate primary) ❑ Home _____ ❑ Work _____

Are you married or in a civil union? ❑ Yes ❑ No Date of marriage/civil union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job: Job Title:

Work Status: ❑ Active ❑ Retired ❑ 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: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Sep 12, 2025

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

Drop Coverage:

❑ Drop Employee/Member ❑ Drop Dependents/Family Members

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Dental	❑ Employee/Member	❑ Spouse	❑ Child(ren)
❑ Vision	❑ Employee/Member	❑ Spouse	❑ Child(ren)
❑ Basic Term Life			
❑ Voluntary Term Life	❑ Employee/Member	❑ Spouse	❑ Child(ren)

Loss Of Other Coverage:

I and/or my dependents were previously covered under Loss of coverage was due to:

❑ Termination of Employment: _____-_____-_____

❑ Divorce/Separation _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ Dental ❑ Vision

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

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	❑ $5.80	❑ $11.78	❑ $14.75	❑ $22.11

❑ I do not want Dental Coverage because (Check as applicable):

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

Guardian Group Plan Number: 00025056 Please print employee name:

Vision 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)
Full Feature	❑ $1.24	❑ $2.35	❑ $2.39	❑ $3.79

❑ 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 *Check one box only*

❑ $25,000 ❑ **$50,000*** ❑ **$75,000**** ❑ $100,000 ❑ $125,000 ❑ $150,000
❑ $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

❑ $10,000 ❑ $20,000 ❑ **$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

❑ $5,000 ❑ $6,000 ❑ $7,000 ❑ $8,000 ❑ $9,000 ❑ **$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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

Guardian Group Plan Number: 00025056 Please print employee name:

- 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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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	☐ $13.50	☐ $14.25	☐ $15.00	☐ $15.75	☐ $16.50	☐ $17.25	☐ $18.00	☐ $18.75	☐ $19.50	☐ $20.25
50-59	☐ $17.82	☐ $18.81	☐ $19.80	☐ $20.79	☐ $21.78	☐ $22.77	☐ $23.76	☐ $24.75	☐ $25,74	☐ $26.73
60-75	☐ $22.14	☐ $23.37	☐ $24.60	☐ $25.83	☐ $27.06	☐ $28.29	☐ $29.52	☐ $30.75	☐ $31.98	☐ $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	☐ $21.00	☐ $21.75	☐ $22.50	☐ $23.25	☐ $24.00	☐ $24.75	☐ $25.50	☐ $26.25	☐ $27.00	☐ $27.75
50-59	☐ $27.72	☐ $28.71	☐ $29.70	☐ $30.69	☐ $31.68	☐ $32.67	☐ $33.66	☐ $34.65	☐ $35.64	☐ $36.63
60-75	☐ $34.44	☐ $35.67	☐ $36.90	☐ $38.13	☐ $39.36	☐ $40.59	☐ $41.82	☐ $43.05	☐ $44.28	☐ $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	☐ $28.50	☐ $29.25	☐ $30.00	☐ $30.75	☐ $31.50	☐ $32.25	☐ $33.00	☐ $33.75	☐ $34.50	☐ $35.25
50-59	☐ $37.62	☐ $38.61	☐ $39.60	☐ $40.59	☐ $41.58	☐ $42.57	☐ $43.56	☐ $44.55	☐ $45.54	☐ $46.53
60-75	☐ $46.74	☐ $47.97	☐ $49.20	☐ $50.43	☐ $51.66	☐ $52.12	☐ $54.12	☐ $55.35	☐ $56.58	☐ $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	Individual+All Children	Individual+Spouse	Family
$6.78	**$15.48**	**$13.14**	**$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)
Hospitilzation	$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	Individual+All Children (Children covered for FREE)	Individual+Spouse	Family
$9.10	**$9.10**	**$16.54**	**$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 ☐	$1.02 ☐	$1.65 ☐	$1.65 ☐
25-29	$1.14 ☐	$1.14 ☐	$1.86 ☐	$1.86 ☐
30-34	$1.50 ☐	$1.50 ☐	$2.43 ☐	$2.43 ☐
35-39	$2.04 ☐	$2.04 ☐	$3.21 ☐	$3.21 ☐
40-44	$2.64 ☐	$2.64 ☐	$4.02 ☐	$4.02 ☐
45-49	$3.21 ☐	$3.21 ☐	$4.89 ☐	$4.89 ☐
50-54	$3.75 ☐	$3.75 ☐	$5.88 ☐	$5.88 ☐
55-59	$4.25 ☐	$4.25 ☐	$6.90 ☐	$6.90 ☐
60-70	$5.01 ☐	$5.01 ☐	$8.49 ☐	$8.49 ☐

Aflac

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 Assisitance / Short Hospital Stay	$100

AGE	Individual	Individual+All Children	Individual+ Spouse	Family
18-49	$13.41 ☐	$19.52 ☐	$22.71 ☐	$24.63 ☐
50-59	$15.15 ☐	$20.61 ☐	$27.03 ☐	$28.35 ☐
60-75	$17.07 ☐	$23.01 ☐	$30.57 ☐	$32.52 ☐

LIFE

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	Insurance Agent/Producer Writing No.	Insurance Agent/Producer Phone No.
Tyler Breaud	AHV29	(504) 201-4114

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
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystrophy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertension	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ 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 Foot — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Leg — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Arm — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Hand — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Knee Replacement — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Hip Replacement — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Other Joint Replacement — Joint _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ 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**