

Employee Information Sheet and Insurance Waiver

Lee's Food Mart # \_\_\_\_\_ New \_\_\_\_\_ Change \_\_\_\_\_ Date \_\_\_\_\_

Employee Information:

First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Last Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

Social Security # \_\_\_\_\_

Gender Male \_\_\_\_\_ Female \_\_\_\_\_

Hire Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Compensation:

Federal Information:

Hourly Rate \_\_\_\_\_

State Subject to W/H Taxes:

Filing Status:

Tennessee \_\_\_\_\_

\_\_\_\_ Single

Kentucky \_\_\_\_\_

\_\_\_\_ Married

Virginia \_\_\_\_\_

\_\_\_\_ Married Withhold Single Rate

State Subject to UNEMPLOYMENT TAXES:

\_\_\_\_ Allowances Extra W/H\$ \_\_\_\_\_

Tennessee \_\_\_\_\_

Kentucky \_\_\_\_\_

Virginia \_\_\_\_\_

Bank Information:

City Taxes (WHERE APPLICABLE):

Checking \_\_\_\_\_ Savings \_\_\_\_\_

Middlesboro \_\_\_\_\_

Bank Name \_\_\_\_\_

Pineville \_\_\_\_\_

ABA Routing # \_\_\_\_\_

Barbourville \_\_\_\_\_

Account # \_\_\_\_\_

TO WHOM IT MAY CONCERN:

This is to certify that I do not wish to enroll in the Company's health insurance coverage, due to the fact that I am covered under health insurance policy # \_\_\_\_\_ with (name of insurance company) \_\_\_\_\_ from another source or I prefer to waive my right to any and all Company provided health insurance coverage. I understand this fully releases the Company (Lee Oil Company, Inc./Lee's Food Mart/Lee Enterprises/Heartland, Inc.) of any and all liability for providing health insurance.

\_\_\_\_\_  
Employee Print Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

# LEE OIL COMPANY---LEE FOOD MARTS

## Insurance Election Form

### WEEKLY-DEDUCTIONS

#### PLAN 1 BW4i

##### MEDICAL \$3,000 deductible

<input type="checkbox"/> Employee	\$ 65.49
<input type="checkbox"/> Employee & Spouse	\$ 184.31
<input type="checkbox"/> Employee & Children	\$ 172.43
<input type="checkbox"/> Family	\$ 326.90

##### DENTAL

<input type="checkbox"/> Single	\$ 8.24
<input type="checkbox"/> Employee & Spouse	\$ 18.78
<input type="checkbox"/> Employee & Children	\$ 15.81
<input type="checkbox"/> Family	\$ 26.69

##### VISION

<input type="checkbox"/> Single	\$ 2.01
<input type="checkbox"/> Employee & Spouse	\$ 4.02
<input type="checkbox"/> Employee & Children	\$ 3.82
<input type="checkbox"/> Family	\$ 5.99

##### BASIC LIFE (First time enrolles for Medical only)

<input type="checkbox"/> Single	\$ 0.00	<input type="checkbox"/> Single	\$ 0.00
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VOLUNTARY LIFE  Cost varies based on age, gender and coverage selected underwritten

\_\_\_\_\_ I DECLINE ALL COVERAGE

\_\_\_\_\_ NO CHANGE

Employee Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*New Employees added 1<sup>st</sup> of month after 60 days

\*Application must be completed to elect new coverage or to change existing coverage