Oak Harbor Freight Lines, Inc.

New Hire Union 2018 Benefits Summary

Welcome to Oak Harbor Freight Lines! As valued Employee, we are pleased to offer a comprehensive benefits program. As a Full Time Employee, you may enroll yourself, your Children up to age 26 and your Spouse or Domestic Partner. Benefits will begin on the first of the month after 60 days of employment.

What do I need to do?
Log on to www.oakharborbenefits.com to view a complete list of all benefits available. Please watch the benefit webinar, view your offerings and decide which benefits you would like to elect. Once you have made your decisions, please complete and return the applicable enrollment forms, please note the forms that are **REQUIRED**:

Below is a list of benefits offered by Oak Harbor Freight Lines:

- ☐ **(REQUIRED) Medical Benefits: 2018 Health Enrollment Form.** There are two options: PPO Health Care Plan or High Deductible Health Care Plan with a company contribution to a Health Savings Account. *This form must be completed even if you are opting out of coverage.*
  - Oak Harbor pays 100% of the premiums for Union Employees.
  - Dental and Vision Benefits are included.
  - If you are OPTING OUT of coverage, you must fill out the first 2 pages of the enrollment form. Check the box indicating you are opting out and provide a copy of your current medical benefit card.
- ☐ **(REQUIRED) Life & Accidental Death and Dismemberment Insurance: UNUM Beneficiary Form** OHFL fully pays the premium in providing a $15,000 life insurance policy for you. This is paid 100% by OHFL, you do not have to contribute anything. All we need is your beneficiary form!
- ☐ **Navia Flexible Spending Account: 2018 Enrollment Form.** There are two FSA options: a Medical FSA with a maximum of $2,650 or Dependent Care FSA with a maximum $5,000 contribution. FSA contributions are fully paid by the Employee and strictly voluntary.
- ☐ **401(k) Enrollment Form (eligible from date of hire):** There is both a traditional and Roth (after tax) option. You may start and stop your 401k participation at any time. After 90 days OHFL matches 50% for every dollar contributed up to 5%.
- ☐ **Employee Assistance Plan (Wellspring EAP):** Provides up to 3 free visits for consultation services and referral information nationwide on a wide variety of topics. This is open to you and your family.
- ☐ **Wellness Incentive Program:** You and/or your spouse/domestic partner (if enrolled in a medical plan) can receive $50 each as a bonus for completing a routine health exam each year!
- ☐ **AFLAC:** An AFLAC Representative will be in touch with you within 90 days of your hire date to talk about the different supplemental benefits we offer.
- ☐ **(Open Enrollment Only) UNUM Short Term Disability:** You are eligible to enroll in short term disability benefits during open enrollment at the end of the year.
- ☐ **(Open Enrollment Only) UNUM Supplemental Life Insurance:** You are eligible to enroll in supplemental life insurance for yourself or dependents during open enrollment at the end of the year.
- ☐ **Costco Mail Order for Prescriptions:** Included in your medical benefits; you are required to use the Costco mail order program to have your maintenance medications delivered to your home or workplace.

Please Note: All applicable enrollment forms must be completed and returned to Human Resources before your coverage begins. If you fail to return the forms by the deadline given by your manager, you will not be able to enroll again until Open Enrollment.

Who can I go to if I have questions?
Please visit www.oakharborbenefits.com for more information and to view our FAQ section or email benefits@oakh.com

Regence Group Administrators

Oak Harbor Freight Lines, Inc. EST. 1916

OAK HARBOR FREIGHT LINES
2018 EMPLOYEE HEALTH CARE ENROLLMENT FORM
Group Number: 020189

❑ **Open Enrollment** ❑ **New Enrollee** ❑ **Coverage Change** ❑ **Name Change** ❑ **Address Change**

❑ ADD Spouse/Domestic Partner/Dependent Reason: ________________ ❑ DROP Spouse/Domestic Partner/Dependent Reason: ______________

If Adding Spouse/Domestic Partner, Date of Marriage: ________________________
(If adding dependent(s) due to adoption, court order, or legal guardianship, you must provide legal documentation.)

❑ Rehire Date: _____/____/_____ ❑Leave of Absence Date returned from LOA: ____/____/____

Hire Date: ________/____/_____ **Employee #** ________________________

Soc. Sec. # ___________________ **Date of Birth** _____/____/______ **Sex**: ❑ M ❑ F **Telephone Number** (____) ______________

Participant Last Name ______________________________ **First Name** ______________________________ **M.I.** _________

Mailing Address ________________________________ **City** _____________________ **State** _____ **Zip Code** ________

Benefit Election Information

Plan Election (must select one option)

❑ Base Health Plan ❑ High Deductible Health Plan

Medical/Rx Election(s) (Required)

- ☐ Employee
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Employee & Family
- ☐ Waive

Dental Election(s) (Required)

- ☐ Employee
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Employee & Family
- ☐ Waive

Vision Election(s) (Required)

- ☐ Employee
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Employee & Family
- ☐ Waive

First Name	M.I.	Last Name	Sex	Date of Birth	Relationship SP= Spouse D=Daughter S=Son	Social Security # *Required

If dropping dependents please list name(s):

Name: ______________________________ Termination date: __________ Reason: ____________________________

Name: ______________________________ Termination date: __________ Reason: ____________________________

Disabled Child Eligibility

List dependent who is developmentally disabled or physically handicapped who is over age 25:

Name: ____________________________ Medical documentation must be submitted within 31 days of the effective date of coverage

Note: Enrollment in the plan will not be processed if this enrollment form is submitted incomplete, including the applicant's signature and date signed. Notify the plan immediately of a change in address, or within 31 days of a change in status, over age dependent addition, or special enrollment opportunity, or within 60 days of a birth, adoption or placement for adoption

MUST be completed in order for your enrollment to be processed.

Coordination of Benefits Information

Is there anyone enrolling on the plan who currently has coverage through another insurance plan? ☐ Yes ☐ No

If yes, please complete the following:

Marital Status: ☐ Single ☐ Married_______________________________ ☐ Widowed ☐ Legally Separated ☐ Divorced

Name of Spouse/Domestic Partner

If divorced, is there a court order for provision of the child? ☐ Yes ☐ No If yes, please attach a copy of the court decree. Per court decree:

Who has custody of child? _________________________________ who provides insurance for child? ________________________________

Please list the full name of the child (ren) ____

____

Please list both the natural parents name and date of birth:

Natural Father _______________________ / DOB ______________ Natural Mother __________________________ / DOB _______________

List all family member(s), including yourself, who are included on this enrollment form and are currently covered through another plan.

Name of covered members:	Type of Coverage: (M) edical (D)ental (V)ision	Type of Policy: (G)roup (I)ndividual	Effective date of coverage:	Carrier Name:
________________________	___________	__________	____/____/____	________________________
________________________	___________	__________	____/____/____	________________________
________________________	___________	__________	____/____/____	________________________
________________________	___________	__________	____/____/____	________________________

Provide the following information on the carriers listed above:

Carrier Name: ____ Policy Number: _____________________________

Street Address: ____ City: _________________ State __________ Zip ____________

Carrier phone #: _______________________________

Subscriber's Name: _____________________ Social Security Number: _____________________________ Date of birth: ___________________

Employer's Name and Address (if group coverage) ____

Is Employee, Spouse/Domestic Partner covered under this medical plan eligible for Medicare benefits? ☐ Yes ☐ No

If yes, enter date of eligibility for Medicare Part A ____________________date of eligibility for Medicare Part B ____________________

Social Security No.________________________________

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent. I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. *

Health information requested or disclosed may be related to treatment or services performed by: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) An insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available from the Human Resources Department upon request.

Employee's Signature____ **Date Signed** ________/______/______

EMPLOYER SECTION

Date Hired: ________/________/______ Seniority Date: ______/_____/__________ Coverage Effective Date: _______/_______/______

Certified by: ______________________________________ Today's Date: _______/_____/_______ Terminal: ________________________

❑ **Union** ❑ **Non-Union** ❑ **COBRA**

Note: Enrollment in the plan will not be processed if this enrollment form is submitted incomplete, including the applicant's signature and date signed. Notify the plan immediately of a change in address, or within 31 days of a change in status, over age dependent addition, or special enrollment opportunity, or within 60 days of a birth, adoption or placement for adoption

Oak Harbor Freight Lines
Declaration For Dependent(s)
Health Care Coverage

Oak Harbor Freight Lines, Inc.
Corporate Office
P.O. Box 1469 • Auburn, Washington 98071-1469
1339 West Valley Hwy. • Auburn, Washington 98001
(253) 288-8300 • (800) 858-8815

This is an official declaration by an Oak Harbor Freight Lines employee regarding benefits governed by Pub.L. 93-406, 88 Stat. 829

Name: ______________________________ Employee Number: ____________

Dependents eligible for coverage under the Oak Harbor Freight Lines Health Care Plan are:

- An employee's legal spouse or when required by law, registered domestic partner.
- An employee's dependent child(ren) to age 26.
  - Dependent children are
    - any of the employee's natural children
    - legally adopted children
    - children who have been placed for adoption with the employee
    - step-children who depend on the employee for support
    - children who have been placed under the legal guardianship of employee by court decree
- An employee's unmarried dependent child(ren) who is incapable of self-support because of mental or physical incapacity.

To enroll a dependent or dependents onto your health insurance plan you will need to provide proof of the dependent's eligibility. Without proof of dependency, your dependents will not have health coverage through Oak Harbor Freight Lines. Proof of dependency can be accomplished only in the following manner:

- Spouse: A copy of marriage certificate (not marriage license)
- Child: A copy of the child's birth certificate.
- Step Children: A copy of marriage certificate (not marriage license)
- Adopted Child or Child under the Employee's Legal Guardianship: A copy of the adoption records or court decree.

I understand enrolling anyone into the Oak Harbor Freight Lines Health Care Plan who does not meet one of the above definitions is considered fraud. Any claims paid out on behalf of falsely enrolled dependents would be subject to reimbursement by me and would be grounds for termination of employment as this is considered falsification of employment records. Additionally, false statements may constitute insurance fraud punishable under state and/or federal law.

____
Initial Here

I understand it is my responsibility to un-enroll any dependent who no longer meets eligibility requirements.

____
Initial Here

I understand my dependents cannot be enrolled unless I have submitted the applicable proof of dependency as described below.

____
Initial Here

I declare under penalty of making a false statement that all dependents enrolled in the Oak Harbor Freight Lines health care plan under my name are qualified under one of the above definitions.

Employee Signature: ______________________________ Date: ____________________________

BENEFICIARY DESIGNATION FORM
GROUP LIFE AND GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
Unum Life Insurance Company of America
Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)	Social Security Number

Policy Number(s)	Division Number(s)
617170	

Employer Name	Check the coverages listed below to which this beneficiary designation applies:
Oak Harbor Freight Lines	☑ Basic Life ☐ Supplemental Life ☑ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 4: Signature

X

Employee Signature **Date**

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Important Information About Designation of Beneficiaries

Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits only if **all** primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- **Minor Beneficiary(ies) –** When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- **Trust –** You may designate a valid trust as a beneficiary.

Types of Coverage Information

- **Basic Life** is life insurance provided by your employer for which they pay the premiums.

- **Supplemental Life** is life insurance elected by you for which you pay the premiums.

- **AD&D** is Accidental Death & Dismemberment coverage.

- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- **Updates to Your Beneficiary Designation –** You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- **Consult an Attorney –** This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.