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.

RECORDS REQUEST FOR
DRIVER/APPLICANT SAFETY PERFORMANCE HISTORY

This request is made by the driver/applicant in compliance with the Department of Transportation regulations.

§391.23(i)(2) Drivers who have previous Department of Transportation regulated employment history in the preceding three years, and wish to review previous employer-provided investigative information must submit a written request to the prospective employer, which may be done at any time, including when applying, or as late as thirty (30) days after being employed or being notified of denial of employment. The prospective employer must provide this information to the applicant within five (5) business days of receiving the written request. If the prospective employer has not yet received the requested information from the previous employer(s), then the five-business-days deadline will begin when the prospective employer receives the requested safety-performance history information. If the driver has not arranged to pick up or receive the requested records within thirty (30) days of the prospective employer making them available, the prospective motor carrier may consider the driver to have waived his/her request to review the records.

PART 1: COMPLETED BY THE DRIVER/APPLICANT

TO:

Prospective Employer: _____

Street/P.O. Box: _____

City, State, Zip: _____ Telephone # _____

FROM:

Driver/Applicant: _____ Social Security/I.D. # _____

Street: _____

City, State, Zip: _____ Telephone # _____

I am submitting this written request to obtain copies of my Department of Transportation Safety Performance History for the preceding three years. I understand, for records requested from a prospective employer, that I must arrange to pick up or receive the requested records within thirty (30) days of the records being made available or I have waived my request to review the records.

This information should be: ☐ sent to me at the above address.
☐ I will arrange to pick up.

Driver/Applicant Signature: _____ Date: ____/____/____
M D Y

PART 2: COMPLETED BY THE PROSPECTIVE EMPLOYER

The information must be provided to the applicant within five (5) business days of receiving the written request. If the prospective employer has not yet received the requested information form the previous employer(s), then the five-business-days deadline will begin when the prospective employer receives the requested safety performance history information.

Information supplied to:

Name: _____

Street: _____

City, State, Zip: _____

Comments: _____

_____

By:

_____ _____ Release Date: ____/____/____
Signature/person providing information Telephone # M D Y

COPY 1 PROSPECTIVE EMPLOYER

PREVIOUS EMPLOYER – COMPLETE PAGE 2 PART 3

PART 3:	TO BE COMPLETED BY PREVIOUS EMPLOYER

DRUG AND ALCOHOL HISTORY

If driver was not subject to Department of Transportation testing requirements while employed by this employer, please check here ☐, fill in the dates of employment from _____ to _____, complete bottom of Part 3, sign, and return.

Driver was subject to Department of Transportation testing requirements from _____ to _____.

1. Has this person had an alcohol test with the result of 0.04 or higher alcohol concentration?
   YES ☐ NO ☐
2. Has this person tested positive or adulterated or substituted a test specimen for controlled substances?
   YES ☐ NO ☐
3. Has this person refused to submit to a post-accident, random, reasonable suspicion, or follow-up alcohol or controlled substance test?
   YES ☐ NO ☐
4. Has this person committed other violations of Subpart B of Part 382, or Part 40?
   YES ☐ NO ☐
5. If this person has violated a DOT drug and alcohol regulation, did this person complete a SAP-prescribed rehabilitation program in your employ, including return-to-duty and follow-up tests? If yes, please send documentation back with this form.
   YES ☐ NO ☐
6. For a driver who successfully completed a SAP's rehabilitation referral and remained in your employ, did this driver subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refuse to be tested?
   YES ☐ NO ☐

In answering these questions, include any required DOT drug or alcohol testing information obtained from prior previous employers in the previous 3 years prior to the application date shown on page 1.

Name: _____

Company: _____

Street: _____

City, State, Zip: _____ Telephone: _____

Part 3 Completed by (Signature): _____ Date: _____

PART 4a:	TO BE COMPLETED BY PROSPECTIVE EMPLOYER

This form was (check one) ☐ Faxed to previous employer ☐ Mailed ☐ Emailed ☐ Other _____

By: _____ Date: _____

PART 4b:	TO BE COMPLETED BY PROSPECTIVE EMPLOYER

Complete below when information is obtained.

Information received from: _____

Recorded by: _____ Method: ☐ Fax ☐ Mail ☐ Email ☐ Telephone

Date: _____ ☐ Other _____

INSTRUCTIONS TO COMPLETE THE SAFETY PERFORMANCE HISTORY RECORDS REQUEST

PAGE 1 PART 1: Prospective Employee
- Complete the information required in this section
- Sign and date
- Submit to the Prospective Employer

PAGE 2 PART 4a: Prospective Employer
- Complete the information
- Send to Previous Employer

PAGE 1 PART 2: Previous Employer
- Complete the information required in this section
- Sign and date
- Turn form over to complete SIDE 2 SECTION 3

PAGE 2 PART 3: Previous Employer
- Complete the information required in this section
- Sign and date
- Return to Prospective Employer

PAGE 2 PART 4b: Prospective Employer
- Record receipt of the information
- Retain the form

4 Warriors
HYDRO EXCAVATING

EMPLOYEE EMERGENCY CONTACT FORM

Employee Full Name: _____

PERSONAL CONTACT INFO:

Home Address: _____

City, State, ZIP: _____

Cell Phone: _____ Home Phone: _____

EMERGENCY CONTACT (1)

Name: _____ Relationship: _____

Address: _____

City, State, ZIP: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Employer: _____

EMERGENCY CONTACT (2)

Name: _____ Relationship: _____

Address: _____

City, State, ZIP: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Employer: _____

4 Warriors
HYDRO EXCAVATING

Dear

We are pleased that you have chosen to accept our offer of employment for **OPERATOR** and look forward to your first day. We believe you will find working at 4 Warriors Hydro Excavating to be a rewarding experience.

4 Warriors Hydro Excavating uses a 60/90/120-day probation time frame for new employees. This time frame lets you assess your readiness for the position as well as allows us to determine your ability to do the job. You will be provided an employee handbook, documentation, training and performance feedback during that time frame as part of your on-boarding.

We wish you great success in your new position.

_____
Executive Signature

_____
Date

I, _____, have read and understood the probationary policy.
Print full name

_____
Signature

_____
Date

Authorization to Obtain Motor Vehicle Record

THE UNDERSIGNED DOES HEREBY ACKNOWLEDGE AND CERTIFY AS FOLLOWS:

1. Certifies that the undersigned is an employee, or has applied to become an employee of the below named employer in a position which involves the operation of a motor vehicle and the undersigned gives his or her consent to the release of their driving record (MVR) for review by:

   _____
   Name of Employer or Potential Employer

2. That the undersigned authorizes his or her driving record to be periodically obtained and reviewed for the purpose of initial and continued employment.

3. That all information presented in this form is true and correct. The undersigned makes this certification and affirmation under penalty of perjury and understands that knowingly making a false statement or representation on this form is a criminal violation.

Name of Employee/potential employee: _____
Print name as it appears on driver's license

License Number & State: _____

Date of Birth: _____/_____/_____

Signature of employee/potential employee: _____

Date: _____

Employer Authorized Representative Name: _____

Authorized Representative Signature: _____

Date: _____

PREVIOUS PRE-EMPLOYMENT EMPLOYEE ALCOHOL AND DRUG TEST STATEMENT

Section 40.25(j) As the employer, you must also ask the employee whether he or she has tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which the employee applied for, but did not obtain, safety-sensitive transportation work covered by DOT Agency drug and alcohol testing rules during the past two years. If the employee admits that he or she had a positive test or a refusal to test, you must not use the employee to perform safety-sensitive functions for you, until and unless the employee documents successful completion of return-to-duty process. (see Section 40.25(b)(5) and (e))

Driver's Name (Printed):_____

In accordance with Federal Motor Carrier Regulations Section 40.25(j), the driver must respond to the following questions.

1. Have you tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which you applied for; but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol testing rules during the past two years?
   Check one: ☐ Yes ☐ No
2. If you answered yes, can you provide/obtain proof that you've successfully completed the DOT return-to-duty requirements?
   Check one: ☐ Yes ☐ No ☐ Not Applicable

I certify that the information provided on this document is true and correct.

Driver's Signature:_____ Date:_____

Witnessed by:

Signature:_____ Date:_____

U.S. DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SAFETY PROGRAM
INQUIRY TO STATE AGENCY FOR
DRIVER'S RECORD
391.23

_____
(Driver's Name)

_____
(Driver's Operator's Lic. No.)

_____
(Driver's Social Sec. No.)

Dear _____,

The above listed individual has made application with us for employment as a driver. Applicant has indicated that the above numbered operator's license or permit has been issued by your State to applicant and it is in good standing.

In accordance with Section 391.23(a)(1) and (b) of the Federal Motor Carrier Safety Regulations, we are required to make inquiry into the driving record during the preceding 3 years of every State in which an applicant-driver has held a motor vehicle operator's license or permit during those 3 years.

Therefore, please certify to us what the individual's driving record is for the preceding 3 years, or certify that no record exists if that be the case.

In the event that this inquiry does not satisfy your requirements for making such inquiries, please send us such forms of yours as are necessary for us to complete our inquiry into the driving record of this individual.

Respectfully yours,

_____
Signature of individual making inquiry

_____
(printed) Name of person making inquiry

_____
Title of person making inquiry

_____
Motor Carrier Name

_____
Street Address City State Zip

DRIVER STATEMENT OF ON-DUTY HOURS
(For Newly Hired Drivers)

INSTRUCTION: Motor carriers when using a driver for the first time shall obtain from the driver a signed statement giving the total time on-duty during the immediately preceding 7 days and time at which such driver was last relieved from duty prior to beginning work for such carrier. Rule 395.8(j)(2) Federal Motor Carrier Safety Regulations. NOTE: Hours for any compensated work during the preceding 7 days, including work for a non-motor carrier entity, must be recorded on this form.

Driver Name (Print) _____

Social Security Number _____

Driver's License: State _____ Number _____ Class _____ Endorsement(s) _____ Restriction(s) _____

Type of License _____ Issuing State _____

DAY	1 (yesterday)	2	3	4	5	6	7	
DATE								
HOURS WORKED								TOTAL HOURS

I hereby certify that the information given above is correct to the best of my knowledge and belief, and that I was last relieved from work at

_____ A.M. / P.M. On _____
Time Day Month Year

_____ _____
Driver's Signature Date

DRIVER CERTIFICATION FOR OTHER COMPENSATED WORK

INSTRUCTIONS: When employed by a motor carrier, a driver must report to the carrier all on-duty time including time working for other employers. The definition of on-duty time found in Section 395.2 paragraphs (8) and (9) of the Federal Motor Carrier Safety Regulations includes time performing any other work in the capacity of, or in the employ or service of, a common, contract or private motor carrier, also performing any compensated work for any nonmotor carrier entity.

(check one)

Are you currently working for another employer? ☐ Yes ☐ No

At this time do you intend to work for another employer while still employed by this company? ☐ Yes ☐ No

I hereby certify that the information given above is true and I understand that once I become employed with this company, if I begin working for any additional employer(s) for compensation that I must inform this company immediately of such employment activity.

_____ _____
Driver's Signature Date

Witness: _____ _____
Company Representative Date

RELEASE OF CDL HOLDER'S REPORTED POSITIVE ALCOHOL OR CONTROLLED SUBSTANCE TEST RESULTS

Use this form to obtain the CDL holder's reported positive alcohol or controlled substance test results information.

This form should ONLY be used if you wish to inquire whether or not a prospective driver (CDL Holder) has had a positive alcohol or controlled substance test result reported to the Texas Department of Public Safety in compliance with state law.

THIS FORM IS NOT REQUIRED FOR REPORTING A POSITIVE ALCOHOL OR CONTROLLED SUBSTANCE TEST.

1. This form must be completed in full and include the driver's original signature.
2. Deliver or mail the completed form to:

Texas Department of Public Safety
Motor Carrier Bureau, MSC# 0522
6200 Guadalupe, Building P
Austin, Texas 78752-4019

I, _____ ,
Print Name of CDL Holder

of _____ ,
Print Address of CDL Holder

authorize release of the CDL holder's reported positive alcohol or controlled substance test results reported under state law

to _____ ,
Print Name

of _____ ,
Print Address

Driver License Number: _____ State: _____ Date of Birth: _____

Signature of Driver	Date:
X	

DO NOT SEND THIS FORM BY FACSIMILE

MCS-21 (REV 09/01/05)

Revision Date: January 2012

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

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

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		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		
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				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

4 Warriors
HYDRO EXCAVATING

Employee Criminal Background Check

I give 4 Warriors Hydro Excavating permission to complete a criminal background check.

Full Name: _____

Social Security Number: _____

Date of Birth: _____

_____ _____

Signature of Applicant Date

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by 4 Warriors Hydro Excavating at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PeopleFacts. at 7127 Riverside Parkway, Tulsa, OK 74136 800-772-0130 **www.peoplefacts.com** and/or _____ I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

California applicants only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.
- A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.
- By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. A CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person's presence.
Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Signature: _____ Date: _____

*This form is intended for use with the PeopleFacts Quick Invite Feature for the consumer's review of the Disclosure and Authorization and collection of an electronic signature. No other use of this form is permitted.

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

4 Warriors Hydro Excavating may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by PeopleFacts, 7127 Riverside Parkway, Tulsa, OK 74136 800-772-0130 **www.peoplefacts.com**. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

*This form is intended for use with the PeopleFacts Quick Invite Feature for the collection of an electronic signature. No other use of this form is permitted.

4 Warriors
HYDRO EXCAVATING

Training Cost Agreement

This agreement is dated _____ and is made between;
4 Warriors Hydro Excavating and _____.

Whereas: The Employee is employed by the employer as either a Driver or Tech.

It is hereby agreed and declared that:

1. In consideration of the employer meeting the costs of the training courses, the employee undertakes the responsibility to reimburse the employer for the costs if:

    - He/She voluntarily withdraws from or terminates the course early without the employer's consent.

    - He/She is dismissed or otherwise is compulsorily discharged from the course unless the dismissal or discharge arises out of the discontinuance generally of the course.

    - He/She resigns from the employment of 4 Warriors either prior to completion of the course, or within the 90 days after the end of the course.

4 Warriors
HYDRO EXCAVATING

2. To the extent permitted by law, the employee agrees that 4 Warriors may deduct a sum equal to the whole part of the online training due in accordance with Clause 1 (III) under the term of this agreement from his/her wages (As defined in section 27 of the Employment Rights Act 1996) or from any other allowances, expenses, or other payments due to the employee.

3. The amount due to the employer under the terms of this agreement is a genuine attempt by the employer to assess its loss as a result of the termination of the employee's employment and takes in to account the derived benefit to the employer. This agreement is not intended to act as a penalty on the employee upon termination of his/her agreement.

SIGNED:

_____

Employee

_____

Employer

_____

Date

4 Warriors
HYDRO EXCAVATING

I, _____; hereby Understand that I am responsible for my pre-employment DOT Drug Screening if:

- I choose to end employment before it begins
- Employment does not last longer than my 60-day probation period
- I choose to end employment before my 60-day probation period

Cost of pre-employment DOT Drug Screen will either be billed or taken out of my last paycheck.

_____ _____

Employee Signature Date

4Warriors
Hydro Excavation

PO Box 189
Saint Hedwig TX, 78

I, _____; hereby understand that the following equipment is assigned to my unit _____. I also understand that it is my responsibility to take car the equipment assigned in order to perform the duties as an operator. I assume resp sibility for the equipment, and will accept any charges that go towards the replaceme or repair in the event that the safety equipment is lost or damaged due to my negligence.

NOTE: ALL EQUIPMENT WILL BE TURNED IN WHEN YOU ARE NO LONGER EI PLOYED BY 4 WARRIORS HYDRO EXCAVATION LLC.

Employees failing to return the equipment will be charged the full amount out of thei paycheck. If there is no paycheck to deduct charges you will pay the company. Refu could result in criminal charges.

_____ _____

Employee Signature Date

4Warriors
Hydro Excavation

PO Box 189
Saint Hedwig TX, 78

I, _____; hereby understand that I am being as
signed to unit _____. I also understand that by signing out the keys
this unit I assume responsibility for the keys, and will accept any charge
that go towards the replacement or repair in the event that the keys are l
or damaged.

NOTE: ALL KEYS WILL BE TURNED IN WHEN YOU ARE NO LONGE
ASSIGNED THAT UNIT OR NO LONGER EMPLOYED BY 4 WARRIOF
HYDRO EXCAVATION LLC.

Employees failing to return the keys will be charged the full amount of th
keys out of your paycheck. Refusal to return the keys could result in crin
nal charges.

_____ _____

EMPLOYEE SIGNATURE DATE

4Warriors
Hydro Excavation

PO Box 189
Saint Hedwig TX, 78

You must comply with the regulations for fuel card and purchasing as part of the terms conditions of your employment.

1. You are to only make fuel purchases with the fuel card at accepting locatic
2. No non-fuel items are to be purchased with the fuel card unless it has beer proved by your supervisor.
3. Not all non-fuel items will be approved.
4. A receipt WILL be turned in for every non-fuel purchase. If not it will be ject for payroll deduction.
5. Any non-approved non-fuel purchases WILL be deducted from your paycl and you will be subject to termination.

EMPLOYEE SIGNATURE

DATE

4 Warriors
HYDRO EXCAVATING

H2S Monitor Compliance Form

I hereby acknowledge that I have been trained properly and understand the rules and procedures of the H2S monitor. This equipment is the property of 4 Warriors Hydro Excavation, LLC & the unit I will be occupying. I acknowledge that I am responsible for this equipment & the cost if it is damaged due to my negligence. I also agree that I am responsible for the cost if I am terminated/quit, and do not return the equipment to 4 Warriors Hydro Excavating.

_____ _____

Employee Signature Date

Intuit QuickBooks Payroll

Employee Direct Deposit Authorization

Instructions

Employee: Fill out and return to your employer.

Employer: Save for your files only.

This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Do **not** send this form to Intuit. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

Account 1

Account 1 type: ◯ Checking ◯ Savings

Bank routing number (ABA number): _____

Account number: _____

Percentage or dollar amount to be deposited to this account: _____

Account 2 (remainder to be deposited to this account)

Account 2 type: ◯ Checking ◯ Savings

Bank routing number (ABA number): _____

Account number: _____

attach a voided check for each account here

Authorization (enter your company name in the blank space below) _____

This authorizes _____ (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Authorized signature: _____ Employee ID #: _____

Print name: _____ Date: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

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 widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

If your 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 and 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)

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.

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 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). 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:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1. 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 or 1040-SR)). 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 possessions 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.

General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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.

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

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

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

Step 3. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2020 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.

Married Filing Jointly or Qualifying Widow(er)

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	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

4Warriors Hydro Excavation

Election / Change Page

EMPLOYEE INFORMATION

Print Name:_____ Social Security# ___-___-____

Address: _____ Date of Birth: ___/___/___ Gender: M / F Date of Hire: ___/___/___

City: _____ State: ___ Zip: _____

Employee Phone Number: _____

Enrollment Type:

☐ Open Enrollment	☐ New Hire	☐ Rehire/Reinstate	☐ Late Enrollee	☐ Event Date	
Remove/ Terminate	☐ Remove Spouse / Child	☐ EE Termination	☐ New Hire	☐ Cancel Coverage	_____
Change	☐ Add Spouse / Child	☐ Name Change	☐ Address Change		

MEDICAL AND PRESCRIPTION DRUG BENEFITS

MEDICAL PLAN – BlueCross BlueShield - B661CHC – **BASE PLAN**					
Cost Per Pay Period	Employee Only ☐ Age Rated	Employee + Spouse ☐ Age Rated	Employee + Child(ren) ☐ Age Rated	Employee + Family ☐ Age Rated	Decline Coverage ☐
MEDICAL PLAN – BlueCross BlueShield – S665CHC – CORE PLAN					
Cost Per Pay Period	Employee Only ☐ Age Rated	Employee + Spouse ☐ Age Rated	Employee + Child(ren) ☐ Age Rated	Employee + Family ☐ Age Rated	Decline Coverage ☐
MEDICAL PLAN – BlueCross BlueShield – G652CHC – BUY UP PLAN					
Cost Per Pay Period	Employee Only ☐ Age Rated	Employee + Spouse ☐ Age Rated	Employee + Child(ren) ☐ Age Rated	Employee + Family ☐ Age Rated	Decline Coverage ☐

IS THIS A CHANGE FROM LAST YEAR? YES or NO

DEPENDENT INFORMATION

Spouse's Name: (Last, First, M) _____	☐ M ☐ F	Social Security Number: _____	Date of Birth: _____
Dependent Name: (Last, First, M) _____	☐ M ☐ F	Social Security Number: _____	Date of Birth: _____
Dependent Name: (Last, First, M) _____	☐ M ☐ F	Social Security Number: _____	Date of Birth: _____
Dependent Name: (Last, First, M) _____	☐ M ☐ F	Social Security Number: _____	Date of Birth: _____

Continue

DENTAL BENEFITS

DENTAL PLAN – BlueCross BlueShield- DTXHR02 - BASE PLAN					
Cost Per Pay Period	Employee Only ☐ Age Rated	Employee + Spouse ☐ Age Rated	Employee + Child(ren) ☐ Age Rated	Employee + Family ☐ Age Rated	Decline Coverage ☐

IS THIS A CHANGE FROM LAST YEAR? YES or NO

DEPENDENT INFORMATION- SAME AS MEDICAL: YES / NO

Spouse's Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

VISION BENEFITS

VISION PLAN – VSP					
Cost Per Pay Period	Employee Only ☐ $0.00	Employee + Spouse ☐ $4.20	Employee + Child(ren) ☐ $4.43	Employee + Family ☐ $11.43	Decline Coverage ☐

IS THIS A CHANGE FROM LAST YEAR? YES or NO

DEPENDENT INFORMATION- SAME AS MEDICAL: YES / NO

Spouse's Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

IF CANCELING A DEPENDENT(S), PLEASE LIST BELOW:

Spouse's Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Dependent Name: (Last, First, M) _____ ☐M ☐F Social Security Number: _____ Date of Birth: _____

Print Name	Employee Signature	Date

4Warriors Hydro Excavation

Employee Benefit Summary – May 15, 2021

Effective May 15, 2021 full-time, eligible employees will be offered Medical and Prescription Drug benefits from BlueCross BlueShield of Texas. Employees may choose between three different plan options, and may elect coverage for themselves and their dependents with the payroll deduction amounts shown below.

MEDICAL AND PRESCRIPTION DRUG BENEFIT

BlueCross BlueShield of Texas

	LOW PLAN B661CHC		MIDDLE PLAN S665CHC		HIGH PLAN G652CHC	
Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physician Office Visit	You pay nothing after deductible	You pay nothing after deductible	**$50** Primary Care **$80** Specialist	You pay 40% after deductible	**$40** Primary Care **$80** Specialist	You pay 40% after deductible
Calendar Year Deductible	**$6,900** individual **$13,800** family	**$13,500** individual **$27,000** family	**$3,250** individual **$9,750** family	**$6,500** individual **$19,500** family	**$1,500** individual **$4,500** family	**$3,000** individual **$9,000** family
Coinsurance	Plan pays **100%** after deductible	Plan pays 100% after deductible	Plan pays **60%** after deductible	Plan pays 60% after deductible	Plan pays **80%** after deductible	Plan pays 60% after deductible
Out of Pocket Maximum	**$6,900** individual **$13,800** family	**$13,500** individual **$27,000** family	**$8,550** individual **$17,100** family	Unlimited individual Unlimited family	**$5,000** individual **$10,000** family	Unlimited individual Unlimited family
Inpatient Hospital	You pay nothing after deductible	You pay nothing after deductible	You pay **$250** then 40% after deductible	You pay $350 then 40% after deductible	You pay **20%** after deductible	You pay 40% after deductible
Diagnostic (x-ray, labs)	You pay nothing after deductible	You pay nothing after deductible	You pay 40% after deductible	You pay 40% after deductible	You pay **20%** after deductible	You pay 40% after deductible
Imaging CT/PET scan, MRI	You pay nothing after deductible	You pay nothing after deductible	You pay 40% after deductible	You pay 40% after deductible	You pay $250	You pay 40% after deductible
Emergency Room (Facility)	You pay $650	You pay $650	You pay **$500** then 40% after deductible	You pay $500 then 40% after deductible	You pay **$500** then 20% after deductible	You pay $500 then 20% after deductible
Urgent Care	You pay nothing after deductible	You pay nothing after deductible	You pay $100	You pay 40% after deductible	You pay $100	You pay 40% after deductible
Prescription Drugs Discount at Preferred Pharmacies (HEB, Albertsons, Wal-Mart, Walgreens)	You pay nothing after deductible	In-Network copay plus 50%	**$10-$20** Generic $70 Preferred Brand $120 NonPreferred $150-$250 Specialty	In-Network copay plus 50%	**$10-$20** Generic $70 Preferred Brand $120 NonPreferred $150-$250 Specialty	In-Network copay plus 50%
Provider Network	BlueChoice PPO / www.bcbstx.com		BlueChoice PPO/ www.bcbstx.com		BlueChoice PPO/ www.bcbstx.com	

Payroll Deductions (Bi-Weekly)	
Employee and Dependents	See Attached Rate Grid

4Warriors Hydro Excavation G652CHC Buy-Up Gold Plan Payroll Deductions - BI-WEEKLY			
Age	MONTHLY Rate (Employee)	EMPLOYEE	SPOUSE (or CHILD)
< 15	336.90	0.00	155.49
15	366.85	0.00	169.32
16	378.30	0.00	174.60
17	389.75	0.00	179.88
18	402.08	0.00	185.58
19	414.41	0.00	191.27
20	427.18	0.00	197.16
21	440.39	0.00	203.26
22	440.39	0.00	203.26
23	440.39	0.00	203.26
24	440.39	0.00	203.26
25	442.16	0.00	204.07
26	450.96	0.00	208.14
27	461.53	0.00	213.01
28	478.71	0.00	220.94
29	492.80	0.00	227.45
30	499.85	0.00	230.70
31	510.42	0.00	235.58
32	520.99	0.00	240.46
33	527.59	0.00	243.50
34	534.64	0.00	246.76
35	538.16	0.00	248.38
36	541.68	0.00	250.01
37	545.21	0.00	251.64
38	548.73	0.00	253.26
39	555.78	0.00	256.51
40	562.82	0.00	259.76
41	573.39	0.00	264.64
42	583.52	0.00	269.32
43	597.61	0.00	275.82
44	615.23	0.00	283.95
45	635.93	0.00	293.51
46	660.59	0.00	304.89
47	688.34	0.00	317.70
48	720.04	0.00	332.33
49	751.31	0.00	346.76
50	786.54	0.00	363.02
51	821.33	0.00	379.08
52	859.65	0.00	396.76
53	898.40	0.00	414.65
54	940.24	0.00	433.96
55	982.08	0.00	453.27
56	1027.44	0.00	474.20
57	1073.24	0.00	495.34
58	1122.12	0.00	517.90
59	1146.34	0.00	529.08
60	1195.23	0.00	551.64
61	1237.51	0.00	571.16
62	1265.25	0.00	583.96
63	1300.04	0.00	600.02
64+	1321.17	0.00	609.77

Dental Payroll Deductions - BI-WEEKLY			
		EMPLOYEE	SPOUSE (or CHILD)
> 21 Years of Age	$34.64	$0.00	$15.99
21 Years or Older	$34.94	$0.00	$16.13

Child(ren) under 15 - BI-WEEKLY	
1 Child < 15	$155.49
2 Children < 15	$310.98
3 + Children < 15	$466.48

4Warriors Hydro Excavation S665CHC Core Plan Payroll Deductions - BI-WEEKLY				
Age	MONTHLY Rate (Employee)	Difference	EMPLOYEE	SPOUSE (or CHILD)
<15	288.77	288.77	0.00	133.28
15	314.43	314.43	0.00	145.12
16	324.25	324.25	0.00	149.65
17	334.06	334.06	0.00	154.18
18	344.63	344.63	0.00	159.06
19	355.20	355.20	0.00	163.94
20	366.15	366.15	0.00	168.99
21	377.47	377.47	0.00	174.22
22	377.47	377.47	0.00	174.22
23	377.47	377.47	0.00	174.22
24	377.47	377.47	0.00	174.22
25	378.98	378.98	0.00	174.91
26	386.53	386.53	0.00	178.40
27	395.59	395.59	0.00	182.58
28	410.31	410.31	0.00	189.37
29	422.39	422.39	0.00	194.95
30	428.43	428.43	0.00	197.74
31	437.49	437.49	0.00	201.92
32	446.55	446.55	0.00	206.10
33	452.21	452.21	0.00	208.71
34	458.25	458.25	0.00	211.50
35	461.27	461.27	0.00	212.89
36	464.29	464.29	0.00	214.29
37	467.31	467.31	0.00	215.68
38	470.33	470.33	0.00	217.08
39	476.37	476.37	0.00	219.86
40	482.41	482.41	0.00	222.65
41	491.47	491.47	0.00	226.83
42	500.15	500.15	0.00	230.84
43	512.23	512.23	0.00	236.41
44	527.33	527.33	0.00	243.38
45	545.07	545.07	0.00	251.57
46	566.21	566.21	0.00	261.33
47	589.99	589.99	0.00	272.30
48	617.17	617.17	0.00	284.85
49	643.97	643.97	0.00	297.22
50	674.17	674.17	0.00	311.16
51	703.99	703.99	0.00	324.92
52	736.83	736.83	0.00	340.08
53	770.04	770.04	0.00	355.40
54	805.90	805.90	0.00	371.95
55	841.76	841.76	0.00	388.50
56	880.64	880.64	0.00	406.45
57	919.90	919.90	0.00	424.57
58	961.80	961.80	0.00	443.91
59	982.56	982.56	0.00	453.49
60	1024.46	1024.46	0.00	472.83
61	1060.70	1060.70	0.00	489.55
62	1084.48	1084.48	0.00	500.53
63	1114.30	1114.30	0.00	514.29
64+	1132.41	1132.41	0.00	522.65

Dental Payroll Deductions - BI-WEEKLY			
		EMPLOYEE	SPOUSE (or CHILD)
> 21 Years of Age	$34.64	$0.00	$15.99
21 Years or Older	$34.94	$0.00	$16.13

Child(ren) under 15 - BI-WEEKLY	
1 Child < 15	$133.28
2 Children < 15	$266.56
3 + Children < 15	$399.84

4Warriors Hydro Excavation B661CHC Bronze Base Plan Payroll Deductions - BI-WEEKLY			
Age	MONTHLY Rate (Employee)	EMPLOYEE	SPOUSE (or CHILD)
< 15	259.38	0.00	119.71
15	282.43	0.00	130.35
16	291.25	0.00	134.42
17	300.06	0.00	138.49
18	309.56	0.00	142.87
19	319.05	0.00	147.25
20	328.88	0.00	151.79
21	339.05	0.00	156.48
22	339.05	0.00	156.48
23	339.05	0.00	156.48
24	339.05	0.00	156.48
25	340.41	0.00	157.11
26	347.19	0.00	160.24
27	355.33	0.00	164.00
28	368.55	0.00	170.10
29	379.40	0.00	175.11
30	384.83	0.00	177.61
31	392.96	0.00	181.37
32	401.10	0.00	185.12
33	406.19	0.00	187.47
34	411.61	0.00	189.97
35	414.32	0.00	191.22
36	417.04	0.00	192.48
37	419.75	0.00	193.73
38	422.46	0.00	194.98
39	427.89	0.00	197.49
40	433.31	0.00	199.99
41	441.45	0.00	203.75
42	449.25	0.00	207.35
43	460.10	0.00	212.35
44	473.66	0.00	218.61
45	489.59	0.00	225.96
46	508.58	0.00	234.73
47	529.94	0.00	244.59
48	554.35	0.00	255.85
49	578.43	0.00	266.97
50	605.55	0.00	279.48
51	632.34	0.00	291.85
52	661.83	0.00	305.46
53	691.67	0.00	319.23
54	723.88	0.00	334.10
55	756.09	0.00	348.96
56	791.01	0.00	365.08
57	829.27	0.00	382.74
58	863.91	0.00	398.73
59	882.56	0.00	407.34
60	920.19	0.00	424.70
61	952.74	0.00	439.73
62	974.10	0.00	449.58
63	1000.89	0.00	461.95
64+	1017.15	0.00	469.45

Dental Payroll Deductions - BI-WEEKLY			
		EMPLOYEE	SPOUSE (or CHILD)
> 21 Years of Age	$34.64	$0.00	$15.99
21 Years or Older	$34.94	$0.00	$16.13

Child(ren) under 15 - BI-WEEKLY	
1 Child < 15	$119.71
2 Children < 15	$239.43
3 + Children < 15	$359.14

GROUP DENTAL BENEFITS

BlueCross BlueShield of Texas

	In-Network
Calendar Year Deductible	$50 Individual / $150 Family
Calendar Year Maximum	$2,000
Preventive & Diagnostic Services (exams, cleanings, x-rays, sealants, space maintainers)	100%
Basic Services (general anesthesia, extractions, composite/fillings,)	70%
Major Services (adjustments, implants, bridges, gum disease, dentures, crowns)	50%
Orthodontia	50% / $2,000 maximum
Out-of-Network Reimbursement	Pays at 90% of Reasonable & Customary Charge
Provider Network	BlueCare Dental / www.bcbstx.com/dental

PAYROLL DEDUCTIONS (Bi-Weekly)	EMPLOYEE	SPOUSE / DEPENDENT
Less than 21 Years of Age	$0.00	$15.99
21 Years or Older	$0.00	$16.13

GROUP VISION BENEFITS

VSP Vision care for life

	In-Network	Out-of-Network
Office Copay	**$10** Exam / **$25** Materials	See below
Benefit Frequency	Exam & Lenses – Once every 12 months Frames OR Contacts – Once every 12 months	
Routine Eye Exam	$10 Copay	Pays up to $50
Single Vision Lenses	$25 Copay	Pays up to $50
Lined Bifocal Lenses	$25 Copay	Pays up to $75
Lined Trifocal Lenses	$25 Copay	Pays up to $100
Frames	Pays up to $150	Pays up to $70
Contact Exam	Up to $60 copay	Included in contact allowance
Contact Lens (medically necessary)	$25 Copay	Pays up to $210
Contact Lens (elective)	Pays up to $150	Pays up to $105
Laser Vision Correction	Discounts Only	
Provider Network	VSP Choice / www.vsp.com	

PAYROLL DEDUCTIONS (Bi-Weekly)	
Employee Only	$ 0.00
Employee & Spouse	$ 4.20
Employee & Child(ren)	$ 4.43
Employee & Family	$ 11.43