TO BE FILLED OUT BY MANAGER ONLY

Employee Information Sheet and Insurance Waiver

Lee's Food Mart #_____________ New _________ Change _________ Date __________

Employee Information:

First Name _________________________ M.I. _________

Last Name _________________________ Email ____

Address ____

City ________________________________ State ___________ Zip Code ___________________

Phone ______________________________

Social Security # _________________________________

Gender Male __________ Female ___________

Hire Date _________________________

Date of Birth ____

Compensation:

Hourly Rate __________________

State Subject to W/H Taxes:

Tennessee ________

Kentucky ________

Virginia _________

State Subject to UNEMPLOYMENT TAXES:

Tennessee ________

Kentucky ________

Virginia ________

City Taxes (WHERE APPLICABLE):

Middlesboro ________

Pineville ________

Barbourville ________

Federal Information:

Filing Status:

____ Single

____ Married

____ Married Withhold Single Rate

____ Allowances Extra W/H$ __________

Bank Information:

Checking ______ Savings ______

Bank Name __________________________________

ABA Routing # ________________________________

Account # ____________________________________

TO WHOM IT MAY CONCERN:

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

____ ______________________________________

Employee Print Name **Employee Signature**

____

Date

LEE OIL COMPANY---LEE FOOD MARTS **PAGE 2 OF 2**

2024 INSURANCE ELECTION FORM

WEEKLY-DEDUCTIONS

PLAN 1 BW4i		**PLAN 2 DF85**	
MEDICAL $3,000 deductible		**MEDICAL $5500 deductible**	
□ **Employee**	**$ 65.49**	□ Employee	$ 32.32
□ **Employee & Spouse**	**$ 184.31**	□ **Employee & Spouse**	**$130.60**
□ **Employee & Children**	**$ 172.43**	□ **Employee & Children**	**$120.77**
□ **Family**	**$ 326.90**	□ **Family**	**$248.54**

DENTAL

□ **Single**	**$ 8.24**
□ **Employee & Spouse**	**$ 18.78**
□ **Employee & Children**	**$ 15.81**
□ **Family**	**$ 26.69**

VISION

□ **Single**	**$ 2.01**
□ **Employee & Spouse**	**$ 4.02**
□ **Employee & Children**	**$ 3.82**
□ **Family**	**$ 5.996**

□ **BASIC LIFE (First time enrolles for Medical only)** **Single Only** **$ 0.00**

□ **VOLUNTARY LIFE** Cost varies based on age, gender and coverage selected (underwritten)

_____ **I DECLINE ALL COVERAGE**

_____ **NO CHANGE**

Employee Name____

Signature____Date_________________

*New Employees added 1st of month after 60 days

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