RLS Logistics
COLD CHAIN EXPERTS

2024 BENEFITS OPEN ENROLLMENT FORM

For benefits effective January 1, 2024 - December 31, 2024
Medical, Dental & Vision

A. EMPLOYEE INFORMATION (PLEASE PRINT)

Name (Last, First, MI):		Social Security Number:		Date of Hire (MM/DD/YYYY): / /
Street Address:		City:	State:	Zip:
Home Phone:	Work Phone:	Gender: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated	Date of Birth (MM/DD/YYYY): / /

Location:

☐ L111 - Cold Storage Newfield ☐ L312 - Cold Storage Vineland ☐ L411 - Cold Storage Delanco ☐ P111 - Fulfillment Newfield ☐ Q115 - Freight Brokerage (Nashville)
☐ P113 - Fulfillment Salt Lake City ☐ Q111 - Freight Consolidation ☐ Q113 - Freight Brokerage (Mt. Laurel) ☐ R111 - Transportation ☐ S111 - Shared Services
☐ P115 - Fulfillment Kansas City ☐ L251 - Cold Storage Hauppauge

B. MEDICAL PLAN OPTIONS (WEEKLY CONTRIBUTIONS)

Please check (✓) one box
Medical Coverage includes Prescription Drug Coverage

	Meritain PPO Base Plan		Meritain PPO Middle Plan		Meritain PPO Buy-Up Plan	
	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
Employee Only	☐ $26.63	☐ $43.94	☐ $72.06	☐ $89.37	☐ $105.15	☐ $122.46
Employee + Child(ren)	☐ $97.32	☐ $114.62	☐ $177.67	☐ $194.98	☐ $285.63	☐ $302.93
Employee + Spouse	☐ $159.01	☐ $176.32	☐ $260.31	☐ $277.62	☐ $419.62	☐ $436.92
Employee + Family	☐ $229.32	☐ $246.63	☐ $360.59	☐ $377.90	☐ $580.95	☐ $598.26

☐ **Waive Medical Coverage**

C. DENTAL PLAN OPTIONS (WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	Principal PPO Base Plan	Principal PPO Buy-Up Plan
Employee Only	☐ $1.02	☐ $2.79
Employee + Child(ren)	☐ $5.30	☐ $12.21
Employee + Spouse	☐ $3.87	☐ $7.50
Employee + Family	☐ $8.67	☐ $18.05

☐ **Waive Dental Coverage**

D. VISION PLAN OPTION (WEEKLY CONTRIBUTIONS)

Please check (✓) one box

	Aetna Vision Plan
Employee Only	☐ $1.53
Employee + Child(ren)	☐ $3.06
Employee + Spouse	☐ $2.90
Employee + Family	☐ $4.50

☐ **Waive Vision Coverage**

DEPENDENT INFORMATION - ALL FIELDS REQUIRED

(Indicate dependents that you want covered by your Medical, Dental and/or Vision plans)

LAST NAME, FIRST NAME, MI	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	COVERAGE
Spouse/Partner	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision

If enrolling more than four children, please attach a separate sheet of paper with the above information.

F. EMPLOYEE ACKNOWLEDGEMENT

I apply for coverage, as indicated, for which I am or may become eligible through my employment with RLS Logistics. I have read the above statements and represent they are true to the best of my knowledge. If applicable, the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I authorize my employer to deduct from my pay the necessary premiums (if any) to be withheld through payroll deduction and, where allowed, on a pre-tax basis, in equal installments throughout the plan year.

IMPORTANT: DON'T FORGET!

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status.

The elections on this form are effective for the plan year of January 1, 2024 – December 31, 2024.

WAIVER OF INSURANCE

I _____, hereby certify that the insurance plans offered by RLS Logistics have been explained and offered to me. However, by my own free will and without coercion, I have decided to waive my enrollment and refuse insurance coverage for myself and my eligible dependents. I further understand that should I want to enroll myself or my eligible dependents for medical, dental and/or vision coverage in the future, I and/or my eligible dependents will be required to submit proof of coverage loss through another insurance carrier. If documentation is not submitted, enrollment requests will only be accepted during annual open enrollment each year.

EMPLOYEE SIGNATURE

Print Name

Signature Date

EMPLOYER VERIFICATION (To be completed by employer. Employer signature required.)

Signature	Date
Effective Date	

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COLD CHAIN EXPERTS

TOBACCO USE CERTIFICATION FORM

As part of our tobacco cessation program, we will need your current tobacco use status. This form must be completed and returned to Human Resources if you are part of the Company sponsored Health Insurance plan **two weeks prior to your eligibility date**.

If you are a tobacco user (including use of electronic cigarettes), you will incur a tobacco user surcharge. If you are a non-tobacco user, you will not incur this surcharge.

If you complete a tobacco cessation program and provide proof (printout of completion) sixty days from your eligibility date, you will be credited for the surcharge incurred back to your effective date and will not incur the surcharge the rest of the plan year. For a list of smoking cessation programs and resources, go to **https://nj.gov/health/fhs/tobacco**.

Falsification of this record can lead to disciplinary action including termination of employment at the company's discretion. We ask that everyone please complete this affidavit honestly.

- ☐ **I certify that I currently do use tobacco.**
- ☐ **I certify that I currently do not use tobacco.**
- ☐ **I certify I have completed a smoking cessation program (provide proof).**

_____
Print Name

_____
Address

_____
Phone Number

_____
Signature Date