DRIVER EMPLOYEE BENEFITS ENROLLMENT FORM
Weekly | 2026 -2027

TRANSPORTATION INC. AUGUSTA GA.

✓__Select Type	__New Coverage	__Open Enrollment	__Change to Existing	__Special Enrollment	__Waive Coverage	Remove / Term	__Qualifying Event Date of QE_____

Proposed Effective Date*	Date of Hire*	Reason for Change:

About You

Last Name*	First Name*	Middle Initial	Social Security Number*

Street Address*	City*	State*	Zip Code*	Gender* ☐M / ☐F	Date of Birth*

Salary* $	Phone*	Email Address*	Marital Status* ☐Single ☐Married ☐Divorced ☐Other_____

About Your Dependents *(* indicates required information)*

	Last Name*	First Name* | Middle	Social Security Number*	Date of Birth*	Gender*	Medical / Dental / Vision
Spouse					☐M / ☐F	☐ ☐ ☐
Child					☐M ☐F	☐ ☐ ☐
Child					☐M ☐F	☐ ☐ ☐
Child					☐M / ☐F	☐ ☐ ☐

MEDICAL

__ Accept __ Decline

Reason if declining:	Gravie ComfortFit 7,900	Gravie Copay 1,600	Gravie Copay 6,500
__ Have other coverage	EMPLOYEE (EE) ☐$84.00	☐$96.05	☐$45.00
__ Do not wish to enroll	EE + Spouse ☐$283.00	☐$304.02	☐$253.37
	EE + Child(ren) ☐$198.00	☐$227.30	☐$173.81
	EE + Family ☐$494.16	☐$508.78	☐$430.01

DENTAL

__ Accept __ Decline

Reason if declining:	Low Plan	High Plan
__ Have other coverage	EMPLOYEE (EE) ☐$4.54	☐$5.33
__ Do not wish to enroll	EE + Spouse ☐$9.10	☐$10.67
	EE + Child(ren) ☐$12.63	☐$14.81
	EE + Family ☐$17.19	☐$20.15

VISION

__ Accept __ Decline

Reason if declining:	Vision Plan
__ Have other coverage	EMPLOYEE (EE) ☐$1.44
__ Do not wish to enroll	EE + Spouse ☐$2.82
	EE + Child(ren) ☐$2.43
	EE + Family ☐$3.81

GROUP LIFE AND AD&D

Coverage Level (Group Employee Life = 100% Employer Paid)
_X_ Accept _X_ $15,000

FLEXIBLE SPENDING ACCOUNT

	Annual Contribution	Weekly Deduction Calculation
__ Medical	$_____(Max $3,400)	Annual Contribution $$ ÷ 52 = Weekly Deduction
__ Dependent	$_____(Max $7,500)	

Beneficiary Designation

Primary Beneficiary Designate who will receive the Life Insurance benefit amount in the event of your death.

1. Name:	Relationship:	Percentage:
2. Name:	Relationship:	Percentage:

Contingent Beneficiary Designate who will receive the Life Insurance benefit amount in the event of your primary beneficiary's death.

1. Name:	Relationship:	Percentage:
2. Name:	Relationship:	Percentage:

Dependent Eligibility Verification

Newly enrolled dependents will be required to provide documentation to participate in the insurance plans offered through F&W. You could be held responsible for 100% of insurance costs if your enrolled dependent is not eligible. To protect you as an employee from future legal and financial risk, F&W requires dependent eligibility information to verify that the dependents you wish to enroll are eligible to participate in the insurance plans.

Authorization

I hereby apply for the group benefit(s) indicated above and understand that I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full-time service. I further authorize my employer to take deductions from my pay if they are required for insurance. The information provided herein is true to the best of my knowledge. Any person who with the intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I understand that deductions will be withheld from my paycheck for eligible employer-sponsored insurance premiums on a pretax (before tax) basis. I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description.

Print Name

Signature	Date

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