2027 BENEFITS WAIVER FORM

Medical, Dental, & Vision

PLEASE CHECK: ☐ **WAIVE ALL INSURANCE PLAN COVERAGE (MEDICAL, DENTAL, VISION)**

REASON FOR WAIVING: _____

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: ☐ Male ☐ Female | Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated | Date of Birth (mm/dd/yyyy):

Location:

☐ L111 - Cold Storage Newfield ☐ L312 - Cold Storage Vineland ☐ L411 - Cold Storage Delanco ☐ P111 - Fulfillment Newfield ☐ P113 - Fulfillment Salt Lake City
☐ Q111 - Freight Consolidation ☐ Q113 - Freight Brokerage (Mt. Laurel) ☐ S111 - Shared Services ☐ P120 - Dry Ice Fulfillment
☐ L211 - Cold Storage Pittstown PA ☐ L250 - Cold Storage Lebanon PA

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 my 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, 2027 - December 31, 2027.

Employee's Signature | **Date**

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's Signature | **Date**

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

Signature | Date

Effective Date