Livonia Chrysler Jeep

New Employee Information

Fill out ONLY this page then click the print button

First Name: Middle Initial

Last Name:

Job Title:

Address:

City: State: Zip Code:

SS Number:

Home Phone: Cell Phone:

Drivers License:

Birth Date: Email:

Tax Exemptions:

Notify in Case of Emergency: Phone #:

Spouse Name:

New Hire Check List

Employee Name_____ _____

1.	Application FULLY COMPLETED	_____
2.	A.V.O --Rate of Pay	_____
	Hourly,Salary,Commission, etc….	
	Date of Hire	
	Position	_____
3.	W-4 Form	_____
4.	Working Papers (Under age 18)	_____
5.	Employee Handbook Acknowledgement	_____
6.	Pre Employment Physical	_____
7.	Safety Training-Employee Verification (included in handbook)	_____
8.	Form I-9 Citizenship Verification	_____
9.	Sexual Harassment Training (included in handbook)	_____
10.	Right to Know Training (included in handbook)	_____
11.	Job Description	_____
12.	Orientation	_____
13.	Copy of Drivers License	_____
13.5	Run employee on State of MI OTIS	_____
14.	Copy of Social Security Card	_____
15.	Direct Deposit Form	_____
16.	Insurance Application (Medical or Life) if Applicable	
16.5	A. Pre–tax Medical Deduction	_____
17.	Employee receives copies of everything they sign	_____
18.	401k Sign up (when available)	
	_____	

Dept. Manager_____ Date_____

A.V.O

Employee N_____ _____

Department: _____

Hire Date: _____ - _____ - _____

Position Hired for: _____

Rate of Pay

Hourly: _____

Salary: _____

Commission / Bonus:

_____
_____
_____

Special Conditions (part time / full time / job restrictions / health restrictions / under 17)
_____
_____
_____

Hours: _____

State License Number: _____

Assigned Employee Number: _____

Does Employee need (Circle for YES) ? MPK DealerConnect Email

Manager X_____ Employee X_____

Date ____- ___ - ____ Date ____- ___ - ____

Livonia Chrysler Jeep

New Hire Orientation

Have ***new employee*** initial each line.

_____ 1. Location of customer and employee bathrooms.

_____ 2. Location of customer and employee parking.

_____ 3. Employee pay cycle / 1 week delay / commissions

_____ 4. Dealer History.

_____ 5. Introduce to department personnel and relating departments.

_____ 6. Assigned mentor_____.

_____ 7. hours : Service / Parts / Body Shop / Sales.

_____ 8. Training policy / Requirements.

_____ 9. Dress Code.

_____ 10. Lunch / Breaks/ Smoking.

_____ 11. Car wash instruction / use.

_____ _____

Employee Date

_____ _____

Department Manager Date

Purchasers receive copies of everything they sign

Since 1990 Michigan law has required Dealers to give the buyer of a vehicle a copy of every document the buyer signs at the time of signing.

Copies of RD-108s required

A dealer must give the buyer two copies of the RD-108: one at the time of signing and the pink copy after the RD-108 is validated. The copy given at the time of signing should be a photocopy of the original. If the dealer uses RD-108s which have a legible “Dealers extra copy” as the last copy, the “extra” copy may be given to the customer at the time of signing. The validated pink copy, which also serves at the buyer’s registration document, must be given to the buyer before the 20 day time period for providing a registration expires.

Copies of odometer disclosure statements required

Michigan dealers are required to get and give their official odometer disclosure statements on conforming titles. When a conforming title has been issued, the only official place is on the title itself. The odometer law requires a dealer who sells a used vehicle to:

1) Present the conforming title to the buyer with the odometer disclosure statement completed before delivery of the vehicle.
2) Obtain the buyer’s signature on the reverse side of the title document.
3) Provide the buyer with a copy of both the front and back of the title at the time the title is signed by the buyer.

If a vehicle does not have a conforming title, a separate odometer statement must be given. The dealer must provide the buyer with a copy of the separate statement at the time of signing. Copies of official odometer statements must be maintained in the dealer’s records for five years. Copies of all other documents that a dealer requires a buyer to sign must be given to the buyer at the time of signing. When in doubt, give a copy.

Signature

Enclosed forms: ***New Subscriber Enrollment form*** **(Page 2)** ***Blue Cross Physician Choice/BCN Primary Care Physician Selection form*** **(Page 4)** ***Change of Status form*** **(Page 6)** ***Health Savings and Flexible Spending Account Options form*** **(Page 8)**

Please read the following information before completing the attached forms. The information on these forms and the following conditions are part of your contract with Blue Cross Blue Shield of Michigan or Blue Care Network of Michigan.

I am applying for health care coverage with Blue Cross Blue Shield of Michigan or Blue Care Network, or I am modifying existing coverage for me or my dependents. Coverage begins on the date determined by Blue Cross or BCN. When Blue Cross or BCN accepts my application or changes, my covered dependents and I are bound by the terms of the Blue Cross or BCN certificates, riders, other coverage documents, policies and these forms. I understand that submitting false or misleading information or omitting material information on these forms may result in rejection of my changes or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependents' eligibility for coverage when requested by Blue Cross or BCN.

Authorization: I appoint my employer or association to handle all matters of coverage. My employer may forward any agreed deductions for coverage from my wages. I am responsible for notifying my employer or association of changes in my status or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements or death of someone covered under the policy. I authorize Blue Cross or BCN or my primary care physician to obtain the medical records relating to me and my enrolled family members needed to coordinate our medical care, administer my Blue Cross or BCN coverage and for other purposes necessary for Blue Cross or BCN to fulfill its contractual and statutory obligations.

Health Insurance Portability and Accountability Act: If I lose my eligibility for coverage, I may be entitled to special enrollment rights under HIPAA. Blue Cross or BCN reserves the right to request written verification of the date of the event and reason for loss of eligibility from my previous group or carrier. HIPAA special enrollment rights do not pre-empt a new-hire waiting period, which must first be satisfied. Termination of employment may qualify for special enrollment rights, but voluntary terminations of other health care coverage do not.

Release of health care information: I acknowledge that Blue Cross or BCN requires me to provide my Social Security number. In applying for coverage, I and my enrolled dependents agree to permit health care providers and others to release "protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996) to Blue Cross or BCN for administering our coverage. Upon my request, Blue Cross or BCN will tell me where the information was sent. If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer, I authorize Blue Cross or BCN to provide claim information pertaining to me and my covered dependents to the account administrator to facilitate reimbursement.

Group representative information: The group confirms that the status change requested complies with and is permitted under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Blue Care Network only

I and my enrolled family members agree that all our medical services may be performed, prescribed, directed or authorized by our designated BCN primary care physician except in the case of an immediate and unforeseen medical emergency when the time needed to contact our primary care physician may mean permanent damage to our health. Unauthorized services that are not an emergency as described above, received from non-BCN providers, will not be covered.

I agree to assign to BCN the right to recover from any person or organization the cost of hospital, medical and prescription services delivered by or paid for by BCN as a result of accident or disease, including injuries or disease claimed under workers' compensation laws or acts, whether by redemption award, voluntary payment or otherwise.

I authorize any holder of medical or other information about me or my enrolled family members to release any information needed to determine benefits coverage to the Centers for Medicare and Medicaid Services, any insurance company or any HMO and their agents. I request that payment of authorized Medicare, Medicaid, insurance company or HMO benefits be made payable to BCN on my behalf for any services that BCN provides to me and my enrolled family members.

Send completed forms to:

(For Blue Cross Blue Shield of Michigan)
Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 610G
P.O. Box 2260
Detroit, MI 48226 Fax: 1-866-900-2619 or 1-866-900-2829

(For Blue Care Network)
Blue Care Network
Membership and Billing – M.C. H300
P.O. Box 5043
Southfield, MI 48086

Fax: 1-877-218-1466

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

New Subscriber Enrollment (See Page 3 for instructions)

☐ Blue Cross Blue Shield of Michigan ☐ Blue Care Network

(Also complete Page 4 for Physician Choice or primary care physician selection)

Blue Cross group number	Division	BCN group number	Subgroup number	Class number	Employer representative signature

Subscriber information

Date	☐ Non U.S. citizen	Social Security/TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.	Marital status	Gender
						☐ S ☐ M	☐ M ☐ F

Subscriber birth date	Home street address	City	State	ZIP code

County	Country – if other than USA	Primary telephone number		Secondary telephone number		Email
			☐ Home ☐ Work ☐ Cell		☐ Home ☐ Work ☐ Cell	

List all persons to be covered:

	Legal last name	Legal first name	MI	Gender	Date of birth	Non U.S. citizen	Social Security/TIN number (required)	*Relationship code (see instructions for codes)
Spouse				☐ M ☐ F		☐		
Dep. 1				☐ M ☐ F		☐		
Dep. 2				☐ M ☐ F		☐		
Dep. 3				☐ M ☐ F		☐		
Dep. 4				☐ M ☐ F		☐		

If the permanent address of the spouse or dependent is different from the address above, please complete the information below:

Spouse or dependent (full name)	Street address	City	State	ZIP code

Coordination of benefits information

Do you, your spouse or dependents have other health care coverage? ☐ Yes ☐ No

If "Yes," complete below: ☐ Check here if this applies to all members on the contract.

Person covered (full name)	Employer or group name	Policy number	Carrier	Address

I have read and understand the conditions of this form. Subscriber signature: Date:

Health savings, health reimbursement and flexible spending account options for only Blue Cross coverage: See Page 8 for product selections

☐ FSA ☐ HRA ☐ HSA ☐ HSA Opt out Blue Cross product indicator code ☐ Add ☐ Change ☐ Cancel Goal amount:

Employer/group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Date of hire	Effective date

Check coverage if applicable: ☐ Medical ☐ Vision ☐ Dental ☐ Pharmacy

Check type of enrollment: ☐ New ☐ Rehire ☐ Full time ☐ Part time ☐ Transfer ☐ Return from layoff ☐ Loss of eligibility (prior coverage) ☐ Salary ☐ Retiree ☐ Surviving spouse ☐ Hourly ☐ Open enrollment

Old group division/subgroup _____

New group division/subgroup _____

Average hours worked per week (required): _____

Job title (required) _____

COBRA enrollment Check reason:	☐ Termination ☐ Layoff	☐ Reduction of hours ☐ Loss of dependent status	☐ Divorce or legal separation ☐ Deceased subscriber	Previous contract number	Original qualifying date

Loss of eligibility (prior coverage)	☐ Yes ☐ No	If "Yes," complete:	Carrier's name (including Blue Cross and BCN)	Contract holder name	Policy number	Termination date

Are any members listed enrolled in Medicare? ☐ Yes ☐ No If "Yes," check reason category ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD HIC number:

☐ Medicare primary ☐ Subscriber ☐ Spouse Medicare A effective date Medicare B effective date Medicare Part D effective date

☐ Blue Cross or BCN primary ☐ Dependent name:

Instructions for completing *New Subscriber Enrollment* form on Page 2

- Indicate if enrolling in Blue Cross or Blue Care Network. If enrolling with Blue Cross Physician Choice or with BCN, you are also required to complete the *Blue Cross Physician Choice/BCN Primary Care Physician* form on Page 4 to designate your primary care physician.
- Enter Blue Cross group and division number (for example, suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the "Employer Signature" section.

Subscriber information:

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter home address beginning with street address, city, state and ZIP code. Enter email address to receive health and wellness information.
- Enter county name for home address and country name (if other than USA). Enter primary and secondary phone number and indicate if home, work or cell.
- List all persons to be enrolled. Enter names on appropriate line – Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if you have more than four dependents.
- Enter last name, middle initial, male or female and date of birth. If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx). Enter the relationship code of the member (see below).

Relationship codes:

N – Child (by birth or adoption)	A – Child adoption in process**	C – Court order coverage (QMCSO)**	SP – Spouse
S – Stepchild	L – Legal guardianship**	D – Disabled child***	DP – Domestic partner
P – Principal support (BCN only)*	SD – Sponsored dependent*	M – Medicare	

* = Attached documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Coordination of benefits information:

- Indicate "Yes" or "No" if you, your spouse or dependent have other health care coverage. If "Yes," lit complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Health savings, health reimbursement and flexible spending account options:

- Check all applicable options. Blue Cross only: See Page 8 for four-digit product indicator code. Return to Page 2 or 6 and enter the four-digit Blue Cross product indicator code.

Employer/group use only:

- Enter employer or group name and employee reference ID or department number, if applicable. Enter benefit code (service code, package code). For the plan code field, enter "710" to represent Blue Cross Blue Shield of Michigan. Enter date of hire and effective date.
- Please check all applicable boxes to indicate coverage selected.
- Check type of enrolment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If enrolled in COBRA, check the reason for COBRA. Indicate the previous contract number and the original qualifying date. If transfer, please indicate the old group/division/subgroup and new group division/subgroup numbers.
- For loss of eligibility (prior coverage), indicate "Yes" or "No." If "Yes," please indicate the carrier name, contract holder name, policy number and termination date. If coverage is lost from an insurance carrier other than Blue Cross or BCN, then a letter of credible coverage is required.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If "Yes," check the reason category to explain the member's enrollment in Medicare. Indicate if Medicare is primary or if Blue Cross or BC is primary and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation for enrollment.

Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Physician Choice PPO/BCN Primary Care Physician Selection (see Page 5 for instructions)

☐ Non U.S. citizen	Subscriber Social Security number/TIN (required)	Blue Cross/BCN group number	Blue Cross division/BCN subgroup number	BCN class number

If you are enrolling in Blue Cross Blue Shield of Michigan Physician Choice PPO or Blue Care Network, you need to select a primary care physician for you and each person on your contract. List your selections on this form.

You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a primary care physician. You also need to fill out this form if you are already enrolled in Blue Cross or BCN and have decided to change your primary care physician.

Need information about available primary care physicians?
Our website, **bcbsm.com/find-a-doctor**, provides the most current information on Blue Cross and BCN-affiliated primary care physicians. You can search for a family practice, general medicine, internal medicine, pediatrics, preventive medicine, city or hospital group.

Member information						
	Member's last name, first name	Physician last name, first name	Physician's NPI#	Physician address	If change PCPs, list reason	Seen in the last 12 months?
Subscriber						☐ Yes ☐ No
Spouse						☐ Yes ☐ No
Dep. 1						☐ Yes ☐ No
Dep. 2						☐ Yes ☐ No
Dep. 3						☐ Yes ☐ No
Dep. 4						☐ Yes ☐ No
Group/Employer's name:					Effective date of change:	
I have read and understand the conditions of this form.		Subscriber signature			Date:	

Return this form to start your heath care partnership
We encourage you to return this form as soon as you enroll so we can notify hour doctor of your membership.

For Blue Cross Blue Shield of Michigan:

Fax your complete form to 1-866-900-2619 or 1-866-900-2829
Or mail to:
Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 610G
P.O. Box 2260
Detroit, MI 48226

For Blue Care Network:

Fax your complete form to 1-877-218-1466
Or mail to:
Blue Care Network
Membership and Billing – M.C. H300
P.O. Box 5043
Southfield, MI 48086-5043

All changes become effective two business days after we receive this form – unless you request a later effective date.
You cannot select an earlier date when you change your primary care physician. If you change your primary care physician while you are being treated by a specialist, your new primary care physician must reauthorize the treatment you are receiving. Your treatment may not be covered until that occurs. You may request to change your primary care physician effective immediately by calling the Customer Service number on the back of your Blue Cross or BCN ID card.

Instructions for completing the *Blue Cross Physician Choice/BCN Primary Care Physician Selection* form on Page 4

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen, enter a taxpayer identification number in the Social Security number field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter each member's last and first name, physician's last name and first name, physician's NPI number, physician's address and the reason for changing your primary care physician, if applicable. Indicate if the primary care physician has been seen in the last 12 months. You can find the physician's NPI number when searching for a doctor on **bcbsm.com/find-a-doctor**.
- Enter the employer's name and the date you changed to this physician.
- In the signature section, sign your full name and enter the date that you signed the form.

Note: Submit the *Blue Cross Physician Choice/BCN Primary Care Physician* form with your *New Subscriber Enrollment* form when enrolling with Blue Cross or BCN.

Blue Cross Blue Shield Blue Care Network of Michigan

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Change of Status

☐ Blue Cross Blue Shield of Michigan ☐ Blue Care Network (see instructions on Page 7)

Blue Cross group number	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date

Subscriber information (*Indicate changes only)

☐ Non U.S. citizen	Social Security/TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.*	Date of birth*	Marital status* ☐ S ☐ M	Gender* ☐ M ☐ F

New home street address*	City*	State*	ZIP code*	Email*

County*	Country – if other than USA*	New primary phone* ☐ Home ☐ Work ☐ Cell	New secondary phone* ☐ Home ☐ Work ☐ Cell

List all persons to be added or deleted:

	Legal last name	Legal first name	M.	Gender	Date of birth	Non U.S. citizen	Social Security/TIN number (required)	*Relationship code (see instructions for codes)
Spouse ☐ Add ☐ Delete				☐ M ☐ F		☐		
Dep. 1 ☐ Add ☐ Delete				☐ M ☐ F		☐		
Dep. 2 ☐ Add ☐ Delete				☐ M ☐ F		☐		
Dep. 3 ☐ Add ☐ Delete				☐ M ☐ F		☐		
Dep. 4 ☐ Add ☐ Delete				☐ M ☐ F		☐		

If the permanent address of the spouse or dependent is different from the address above, please complete the following information:	Spouse or dependent (full name)	Home street address	City	State	ZIP code

Coordination of benefits information

Do you, your spouse or dependents have other health care coverage? ☐ Yes ☐ No	If "Yes," complete below:	☐ Check here if this applies to all members on the contract.

Person covered (full name)	Employer or group name	Policy number	Carrier	Address

I have read and understand the conditions of this form.	Subscriber signature:	Date:

Health savings, health reimbursement and flexible spending account options for only Blue Cross coverage: See Page 8 for product selections

☐ FSA ☐ HRA ☐ HSA ☐ HSA Opt out Blue Cross product indicator code ☐ Add ☐ Change ☐ Cancel Goal amount:

Employer/group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code

Check reason for change below:

☐ Marriage ☐ Loss of eligibility (prior coverage) ☐ COBRA enrollment
☐ Dependents ☐ Name change ☐ Open enrollment ☐ Address change
☐ Transfer old group division/subgroup _____ New group division/subgroup _____

Date of event: _____ Effective date: _____

Check type of cancellation and reason below. Type: ☐ Contract ☐ Spouse ☐ Dependents

Reason: ☐ COBRA ☐ Death ☐ Left employment
☐ Divorce ☐ Dependent over age ☐ Other
☐ Retired ☐ Other insurance
☐ Last date of coverage: _____

Loss of eligibility (prior coverage)	☐ Yes ☐ No	If "Yes," complete below:

Carrier's name (including Blue Cross and BCN)	Contract holder name	Policy number	Termination date

Are any members listed enrolled in Medicare? ☐ Yes ☐ No If "Yes," check reason category ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD

☐ Medicare primary ☐ Subscriber ☐ Spouse Medicare A effective date _____ Medicare B effective date _____ Medicare Part D effective date _____ HIC number: _____

☐ Blue Cross or BCN primary ☐ Dependent name:

Instructions for completing *Change of Status* form on Page 6

- Indicate if enrolling in Blue Cross or Blue Care Network. If enrolling with Blue Cross Physician Choice or with BCN, you are also required to complete the *Blue Cross Physician Choice/BCN Primary Care Physician* form on Page 4 to designate your primary care physician.
- Enter Blue Cross group and division number (for example, suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the "Employer Signature" section.

Subscriber information:

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter new home address beginning with street address, city, state and ZIP code. Enter email address to receive health and wellness information.
- Enter new county name for home address and country name (if other than USA). Enter new primary phone, if changing, and indicate if home, work or cell. Enter new secondary phone number and indicate if home, work or cell.
- List all persons to be added or deleted. Enter name(s) on appropriate line – Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if all your dependents do not fit on this form.
- Enter last name, middle initial, male or female and date of birth. If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx). Enter the relationship code of the member (see below).

Relationship codes:

N – Child (by birth or adoption)	A – Child adoption in process**	C – Court order coverage (QMCSO)**	SP – Spouse
S – Stepchild	L – Legal guardianship**	D – Disabled child***	DP – Domestic partner
P – Principal support (BCN only)*	SD – Sponsored dependent*	M – Medicare	

* = Attached documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Coordination of benefits information:

- Indicate "Yes" or "No" if you, your spouse or dependent have other health care coverage. If "Yes," lit complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Health savings, health reimbursement and flexible spending account options:

- Check all applicable options. Blue Cross only: See Page 8 for four-digit product indicator code. Return to Page 2 or 6 and enter the four-digit Blue Cross product indicator code.

Employer/group use only:

- Enter employer or group name and employee reference ID or department number, if applicable. Enter benefit code (service code, package code). For the plan code field, enter "710" to represent Blue Cross Blue Shield of Michigan. Enter date of hire and effective date.
- Please check all applicable boxes to indicate coverage selected.
- Check type of enrolment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If enrolled in COBRA, check the reason for COBRA. Indicate the previous contract number and the original qualifying date. If transfer, please indicate the old group/division/subgroup and new group division/subgroup numbers.
- For loss of eligibility (prior coverage), indicate "Yes" or "No." If "Yes," please indicate the carrier name, contract holder name, policy number and termination date. If coverage is lost from an insurance carrier other than Blue Cross or BCN, then a letter of credible coverage is required.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If "Yes," check the reason category to explain the member's enrollment in Medicare. Indicate if Medicare is primary or if Blue Cross or BC is primary and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation for enrollment.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Blue Cross Blue Shield of Michigan Health Savings and Flexible Spending Account Options

If you are enrolling in a health savings and flexible spending account, please indicate below which options you are selecting by checking all appropriate boxes. Record your selections and the corresponding product indicator code on Page 2 for new enrollments or on Page 6 for a change of status in the "Health savings and flexible spending account options" section of the form. If you have selected as FSA product, please indicate your designated goal amount on Page 2 or Page 6 of the form.

Product selections

Product selected (Check box)	Product name	Product indicator code
☐	Health Savings Account (HSA)	1000
☐	HSA with limited purpose Flexible Spending Account (FSA)	1070
☐	HSA with dependent care FSA	1004
☐	HSA with limited purpose FSA and dependent care FSA	1074
☐	Health Reimbursement Arrangement (HRA)	0100
☐	HRA with limited purpose FSA	0170
☐	HRA with dependent care FSA	0104
☐	HRA with limited purpose FSA and dependent care FSA	0174
☐	HRA with FSA	0110
☐	HRA with FSA and dependent care FSA	0114
☐	Health care FSA	0010
☐	Dependent care FSA	0004
☐	Health care FSA and dependent care FSA	0014
☐	Limited Purpose FSA	0070

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話

ܐܶܢ ܐܰܢ̄ܬ݁ܽܘܢ، ܝܰܢ ܚܰܕ ܦܰܪܨܽܘܦܳܐ ܕܗܰܝܪܽܘܬ݂ܽܘܢ، ܣܢܺܝܩܺܝ ܠܗܽܘܢ ܗܰܝܰܪܬ݂ܳܐ ، ܐܰܢ̄ܬ݁ܽܘܢ ܐܺܝܬ݂ܠܳܟ݂ܽܘܢ ܫܽܘܠܛܳܢܳܐ ܕܡܩܰܒ݁ܠܺܝܬ݂ܽܘܢ ܗܰܝܰܪܬ݂ܳܐ ܘܡܰܕ݂ܥܳܢܽܘܬ݂ܳܐ ܒܠܶܫܳܢܽܘܟ݂ܽܘܢ ܕܠܳܐ ܡܶܢܝܳܢܳܐ. ܠܡܗܰܡܙܰܡܬ݂ܳܐ ܥܰܡ ܚܰܕ ܡܬܰܪܓܡܳܢܳܐ، ܩܪܽܘܢ ܥܰܠ ܡܶܢܝܳܢܳܐ ܕܚܶܫܡܶܫܬ݂ܳܐ ܥܰܠ ܚܨܳܐ ܕܟ݂ܰܪܛܺܝܣܽܘܟ݂ܽܘܢ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711,
fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697,
email: OCRComplaint@hhs.gov. Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Blue Cross Blue Shield Blue Care Network of Michigan

EMPLOYEE WAIVER FORM

Company name: _____
(Please print)

Employee Name: _____ _____
(Please print)

I understand that by waiving coverage I will not be eligible to enroll until the group's next open enrollment.

Please check the appropriate box below and provide all applicable information.

If your employer offers multiple choices of health insurance plans, please complete the following section:

☐ I am waiving BCN coverage from my employer because I am currently enrolled in BCBSM.

BCBSM Group Number _____

☐ I am waiving BCBSM coverage from my employer because I am currently enrolled in BCN.

BCN Group Number _____

☐ I have coverage other than BCBSM or BCN, offered by my employer.

Carrier Name: _____ Policy/Contract Number: _____

☐ Carrier Coverage indicated is through Marketplace Exchange.

If you are waiving coverage offered by your employer for another reason, please complete the following section:

☐ I have my own individual coverage that my employer does not provide any contribution or reimbursement of premiums.

Carrier Name:_____ Policy/Contract Number: _____

☐ Carrier Coverage indicated is through Marketplace Exchange.

☐ I am covered under another group health plan, vision plan or dental plan not offered by this employer (through spouse, self, parent, etc):

Carrier Name: _____ Policy/Contract Number: _____

Policyholder Name: _____ Relationship to Employee: _____

☐ Carrier Coverage indicated is through Marketplace Exchange.

☐ I was not offered health care coverage, vision coverage or dental coverage by this employer.

☐ I do not want coverage offered through this employer (Reason must be provided):_____

_____

The information provided above is true and accurate to the best of my knowledge.

_____ _____
Employee Date of Hire Employee Job Title

_____ _____
Employee signature Date

_____ _____
Employer signature Date

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

RIGHT TO KNOW ACT AND SAFTY TRAINING PRELIMINARY ACKNOWLEDGMENT STATEMENT

I, _____ _____, an employee of a Livonia Chrysler Jeep ("Dealership"), do acknowledge that as required under the Michigan Right to Know law and Federal Hazard Communication Standards, I understand I will be given complete and formal training on the above laws at the next company wide training session held on those laws by this dealership. In the interim I have been told what a Material Safety Data Sheet (MSDS) is and where it can be located at this company. I have been told the location of this companionless written Hazard Communication and Safety Training Programs. I have been shown how to read labels on chemicals I use in my work area which tell how to properly use the chemicals, and how to protect myself while using them. I have been instructed that when my job demands it I must where proper safety equipment which would reduce the hazards of my assigned task. I understand safety equipment must be worn and safety procedures performed or punitive action may be taken against me, by the company. I further acknowledge receipt of the following safety equipment.

(Please initial next to each piece of equipment received)

Safety Glasses _____ Gloves_____ Respirator_____ Chemical Goggles ____

Signed X_____ Date _____

_____ _____

Company Rep X_____ Date _____

Form **W-4**
(Rev. December 2020)
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

2021

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | **(b) Social security number**

Address

City or town, state, and ZIP code

► **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*.

(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 estimator at *www.irs.gov/W4App*, 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 2021 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 total 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)

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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), 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 2021 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 15, 2022.

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 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. This step 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 2021 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.

Reset Form

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. ***Read instructions on page 2 before completing this form.***

Issued under P.A. 281 of 1967.

▸ 1. Full Social Security Number	▸ 2. Date of Birth
▸ 3. Name (First, Middle Initial, Last)	4. Driver's License Number or State ID
Home Address (No., Street, P.O. Box or Rural Route)	▸ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire..... (mm/dd/yyyy) ☐ No
City or Town / State / ZIP Code	

6. Enter the number of personal and dependent exemptions (see instructions) ..... ▸ 6.

7. Additional amount you want deducted from each pay (if employer agrees) .....7. $ .00

8. I claim exemption from withholding because (see instructions):

a. ☐ A Michigan income tax liability is not expected this year.

b. ☐ Wages are exempt from withholding. Explain: _____

c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	▸ Date

EMPLOYER: Complete the below section.

10. Employer's Name	▸ 11. Federal Employer Identification Number		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
Name of Contact Person	Contact Phone Number		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See **www.mi-newhire.com** for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

Michigan Department of Treasury
3281 (07-11)

STATE OF MICHIGAN
NEW HIRE REPORTING FORM

Federal legislation, effective October 1, 1997, requires all Michigan employers, both public and private, to report all newly hired, rehired, or returning to work employees to the State of Michigan. This form is recommended for use by all employers who do not report electronically.

*** Internet reporting is available online at the new website: www.mi-newhire.com

This form may be photocopied as necessary.
Many employers preprint employer information on the form and have the employee complete the necessary information during the hiring process.

For optimum accuracy, please print neatly in capital letters and avoid contact with the edge of the box. The following will serve as an example:

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

(Note: When reporting new hires with special exemptions, please use the MI-W4 to report.)

EMPLOYEE INFORMATION (Mandatory):

Social Security Number:

First Name:

M.I.

Last Name:

Address:

City:

State:

Zip Code: -

Date of Hire: - -

EMPLOYER INFORMATION (Mandatory):

Federal EIN: -

Employer:

Address:

City:

State:

Zip Code: -

OPTIONAL EMPLOYEE INFORMATION:

Date of Birth:

Driver's License No.:

Reports must be submitted within 20 calendar days of date of hire (i.e., the date services are first performed for pay.)

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

Send Reports To:
Michigan New Hire Operations Center
P.O. Box 85010
Lansing, MI 48908-5010
Fax: 877-318-1659

Questions?
Call: 1-800-524-9846

20738

Driving, Parking and Care of Customers and Dealership Vehicles.

I upon accepting employment with Livonia Chrysler Jeep I agree to practice the following policies. I further understand that failure to follow these practices can result in termination of employment.

1. No smoking, eating or drinking in any vehicles (customer or Dealership).
2. All vehicles are parked in proper locations, windows up and locked.
3. Keys are never left in a vehicle unless inside the building.
4. When driving vehicles all traffic signals and speed restriction must be obeyed.
5. Never squeal tires, turn on customer radios or in any way miss-treat a vehicle.

X_____ X_____

Employee Date

DIRECT DEPOSIT OF PAY AUTHORIZATION

We've arranged to make DIRECT DEPOSIT OF PAY available as an employee benefit. There is no cost to you, just convenience.

.

DIRECT DEPOSIT OF PAY EMPLOYEES AUTHORIZATION

I authorize you and the financial institution listed below to deposit my pay automatically to my ___CHECKING ACCOUNT ___SAVINGS ACCOUNT each payday. Adjusting entries to correct errors are also authorized. This authority will remain in effect until I have cancelled in writing.

_____ _____

Financial Institution Name Date

_____ _____

Address (if known) Employee Name (please print)

_____ _____

City State Signature

_____

Bank Name

_____ _____

Transit Routing Number Checking Acct. Number Info.

_____ _____

Transit Routing Number Savings Acct. Number Info.

_____

Authorized Signature for Financial Institution

Credit Report Notice and Authorization

Pursuant to the U.S. Fair Credit Reporting Act, as amended, 15 USC 1681 et seq., notice is hereby given that the employer may obtain a consumer credit report regarding the Applicant or the Employee and may use this report in making employment decisions that affect the Applicant or the Employee.

The Applicant / Employee authorized the Employer to a consumer credit report regarding the Applicant / Employee from a consumer reporting agency pursuant to the U.S. Fair Credit Reporting Act, as amended, 15 USC 1681 et seq.

Print Employee Name: _____

Employee Signature: X _____

Date: _____

ACKNOWLEDGMENT OF RECEIPT

I understand that this handbook is a guideline to which I may refer if I have any questions about my employment with Livonia Chrysler Jeep I understand that the information and statements contained in this handbook are presented as a matter of information only and are not intended to create, or is the handbook or any information or statements to be construed to constitute, a contract for employment for any specified time between Livonia Chrysler Jeep and myself. I further understand that this handbook will be reviewed periodically by the company and that the company reserves the right to alter, amend, modify or terminate any benefits, provisions, policies or procedures, including those contained in this handbook at any time it so chooses. Those changes may take the form of revisions to the handbook postings on the bulletin board or other communications to employees and once changed, employees are expected to follow the revised policies.

I acknowledge and understand that no one except the President of Livonia Chrysler Jeep can alter or change any of the provisions contained in this handbook and that any changes to the handbook can only be made in writing signed by both the President and myself. I further understand and agree that no representative of Livonia Chrysler Jeep has the authority to make enforceable oral promises about Livonia Chrysler Jeep policies, guidelines, standards or benefits. I further understand and agree that this handbook supersedes all prior and subsequent statements made to me about my employment.

In consideration of my employment, I agree to conform to the rules and regulations of Livonia Chrysler Jeep and understand that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at the option of either Livonia Chrysler Jeep or myself.

I have received the employee handbook and agree to abide by the policies contained herein.

_____ _____

Employee's signature **Date**

_____ _____

Employees' Acknowledgment of **Date**
Arbitration Policy

LOOK -> TWO SIGNATURES ARE REQUIRED

CELL PHONE POLICY

This policy applies to any device that makes or receives phone calls, leaves messages, sends text messages, sends photographic material, surfs the Internet, or allows for reading and/or sending email messages. The use of cell phones or similar devices for personal reasons is strictly prohibited during working hours. This includes sending or receiving personal text messages or email and visiting social media networking sites. Unless you use personal cell phone or similar device to conduct business, your cell must be set on silent or vibrate only mode during working hours.

The use of cell phones or similar devices, including ear buds are not permitted in the auto shop or body shop. Working on vehicles takes 100% concentration and your undivided attention is mandatory. Employees may use their personal cell phones or similar devices during their lunch period or during authorized breaks. If you choose to use your cell phone or similar device during a break or lunch, please use discretion and be conscious of and courteous to those around you. In some cases, we may require you to leave your phone in your vehicle during working hours.

In the event of an emergency or anticipated emergency that requires immediate attention, an employee may request permission to make or receive personal phone calls or messages during working hours. If such a need arises, speak to your supervisor.

CELL PHONE/TEXTING/EMAIL/DISTRACTED DRIVING IS PROHIBITED

Research indicates that cell phone use while driving is dangerous and in specific circumstances is considered a violation of Michigan law. Accordingly, employees are strictly prohibited from using cellular phone or similar devices while operating company owned vehicles or customer-owned vehicles. This includes texting messaging, surfing the internet, receiving or responding to email, checking for messages, or any other purpose, including purposes relating to your employment or company business. In the event it is necessary to use your cell phone or similar device pull over in a safe location. Employees who violate this policy will be subject to disciplinary action, up to and including termination of employment.

Sign: _____ Date: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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

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

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:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.