Direct Deposit Form

PROLINE

Concrete Construction

DIRECT DEPOSIT AUTHORIZATION
THIS IS MANDATORY
WE DO NOT PRINT PAYROLL CHECKS OR STUBS

I _____ authorize Proline Concrete to direct deposit my payroll check in the follow accounts.

_____ _____

Signature **Date**

Email address for paystub: _____

_____ _____ Checking/Savings $_____

Routing # Account # Amount to deposit

_____ _____ Checking/Savings $_____

Routing # Account # Amount to deposit

_____ _____ Checking/Savings $_____

Routing # Account # Amount to deposit

_____ _____ Checking/Savings $_____

Routing # Account # Amount to deposit

4185 Proline Court, Suite A Dorr, MI 49323 (616) 877-5212 (616) 877-7408 Fax

401k Enrollment Form

Enrollment Form

Case Number: 395–85321
Proline Equipment Company 401(k) Plan

Beene Garter LLP

Yes, sign me up.

Follow these four easy steps:

Please clearly print current and accurate information below. Please note that this enrollment form is for your initial enrollment only. For future changes, refer to the account access card on the back cover. All employees who have met the plan's eligibility requirements, regardless of whether you choose to participate, must complete all applicable sections of the form.

STEP ONE: COMPLETE YOUR PERSONAL INFORMATION

Social Security Number: _____ Name: _____
Last First MI

Address: _____
Street & Apt#/PO Box City State ZIP Code

__/__/__ __/__/__ _____ _____ _____
Date of Birth Date of Hire Gender (M or F) Marital Status Phone Number

STEP TWO: COMPLETE YOUR CONTRIBUTION ELECTION(S)

ELECTIVE DEFERRALS

☐ I elect to participate and contribute _____% or $ _____ of compensation per pay period on a ***pre–tax*** basis. (Maximum plan limit for pre–tax contributions: $17,500 for 2014 or $23,000, if you are age 50 or older in 2014).

☐ I elect not to make *elective deferrals* until further notice. I understand that if I do not participate now, or discontinue participation, I must wait until the next available enrollment date. Although I elect not to save through payroll deduction, I understand my employer may elect to contribute a discretionary contribution to the plan, and I authorize such a contribution to be invested as indicated below. If I elect to roll over money into the plan I also authorize my rollover to be invested as indicated below.

Please turn to the next page and proceed to Step Three.
PLEASE BE SURE TO RETURN ALL PAGES OF THIS FORM

Social Security Number: Name: Last First MI

Case Number: 395–85321
Proline Equipment Company 401(k) Plan

Beene Garter LLP

STEP THREE: CHOOSE YOUR INVESTMENT OPTION BY CHECKING A BOX BELOW

The following investment allocation will apply to all new money deposited into an existing group annuity or trust contract unle .s otherwise directed. Monies previously deposited to this contract will not be changed to reflect the selections below. If you do not select a fund on this form or if the form is not completed by the time the first deposit to your account is received, and your plan has a default fund, then deposits will be made to the plan's default fund.

Please complete one of the "Help Me Do It" or "I'll Do It Myself" sections based on your investment style and goals.

HELP ME DO IT

I prefer to pick just one fund, based on my investor profile.

✓ Select the fund below that matches your profile, then go to the next step and sign your name.

	Fund Name:	Inquire Code:	Allocation Percentage:
☐	NW Inv Dest Aggr Svc	970	100%
☐	NW Inv Dest Cnsrv Svc	974	100%
☐	NW Inv Dest Mod Svc	972	100%
☐	NW Inv Dest Mod Aggr Svc	971	100%
☐	NW Inv Dest Mod Cnsrv Svc	973	100%

I'LL DO IT MYSELF

✓ ☐ I elect to invest as follows:

Select investments below based on your profile, then go to the next step and sign your name. All allocations must be made in whole percentages, and the total must equal 100%.

Asset Class	Fund Name	Percentage	Inquire Code	Asset Class	Fund Name	Percentage	Inquire Code
SP	Invsco RealEst A	____%	576	LC	NW Inv Dest Aggr Svc	____%	970
IS	AmFds Cap Wld Gr Inc R5	____%	1395	BA	AmFds Cap Inc Bldr R5	____%	1494
IS	Opp Glbl Oppr A	____%	849	BA	AmFds Inc Fd Am R5	____%	1398
MC	Fed Kaufman A	____%	489	BA	NW Inv Dest Cnsrv Svc	____%	974
MC	GdmnScs MdCap Val A	____%	775	BA	NW Inv Dest Mod Aggr Svc	____%	971
MC	Opp Mn St SmMdCap A	____%	377	BA	NW Inv Dest Mod Cnsrv Svc	____%	973
LC	AmFds Fdmntl Inv R5	____%	1496	BA	NW Inv Dest Mod Svc	____%	972
LC	AmFds Gr Fd Am R5	____%	1397	BD	PIMCO Real Rtn A	____%	676
LC	AmFds Invmt Co Am R5	____%	1399	BD	Pionr Strat Inc A	____%	382
LC	Invsco Gr Inc A	____%	306	CA	NW Mny Mkt Inst	____%	688

Total Percentage **100%**
Double–check that your selections equal 100%

Asset Class Legend: IS – International Stocks, SC – Small–Cap Stocks, MC – Mid–Cap Stocks, LC – Large–Cap Stocks, BA – Balanced, BD – US Bonds SB – Short–Term Bonds, CA – Cash, SP – Specialty, AA – Asset Allocation

Additional funds are available to you after this enrollment process is completed by visiting nationwide.com.

PLEASE BE SURE TO RETURN ALL PAGES OF THIS FORM

Social Security Number: Name: Last First MI

Case Number: 395– 85321
Proline Equipment Company 401(k) Plan

Beene Garter LLP

STEP FOUR: SIGN AND DATE

Please return this completed form to YOUR HUMAN RESOURCE REPRESENTATIVE.

Signature: **X** Date:

Welcome to your plan!

Don't forget to set up your online access at nationwide.com.

PLEASE BE SURE TO RETURN ALL PAGES OF THIS FORM

Beneficiary Designation Form

Case Number: 395–85321
Proline Equipment Company 401(k) Plan

Beene Garter LLP

This form is used to designate the payment of your account balance upon your death. Follow these easy steps.

Social Security Number: _____ Name: _____
Last First MI

STEP ONE: Enter Primary Beneficiary Information. **Percentages must total 100%.**

If you are married, your spouse must be the sole primary beneficiary unless your spouse approves otherwise and signs the waiver below.

Last Name_____ First Name_____ Relationship_____

Address _____ Percentage _____%

Social Security Number _____ Date of Birth ____ /____ /_____ Phone Number _____

Last Name _____First Name_____ Relationship_____

Address _____ Percentage _____%

Social Security Number _____ Date of Birth ____ /____ /_____ Phone Number _____

STEP TWO: Enter Contingent Beneficiary Information. **Percentages must total 100%.**

In the event that your primary beneficiaries do not survive you, your vested account balance will be divided among your contingent beneficiaries in the percentages specified below.

Last Name_____ First Name_____ Relationship_____

Address _____ Percentage _____%

Social Security Number _____ Date of Birth ____ /____ /_____ Phone Number _____

Last Name _____First Name_____ Relationship_____

Address _____ Percentage _____%

Social Security Number _____ Date of Birth ____ /____ /_____ Phone Number _____

STEP THREE: Complete and Sign.

I certify that I am: ☐ Married ☐ Not Married ☐ Legally Separated

Participant Signature_____ Date_____

STEP FOUR: This section must be completed if your spouse is not the sole primary beneficiary.

I consent to the primary beneficiary designation(s) made by my spouse. I understand that I have the right to all of my spouse's vested account under this plan after my spouse dies. I understand that by signing this consent, I am giving up my right to some or all of the benefits under this plan, that the designation is not valid unless I consent to it, and that my consent is irrevocable unless my spouse revokes the beneficiary designation.

Spouse's Name _____

Spouse Signature _____ Date _____

This consent must be witnessed by either a plan representative or a notary public.

STATE OF _____ COUNTY OF _____

I certify that before me personally appeared the above-named spouse who signed the above spousal consent and acknowledged the same to be his/her free act and deed.

_____ _____
Plan Representative or Notary Public Date

Notary Public Commission expires: _____ (Notary Seal)

Return form to: YOUR HUMAN RESOURCE REPRESENTATIVE.

Health Insurance Enrollment Form

Blue Cross Blue Shield Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

SUBSCRIBER NEW ENROLLMENT

(see Page 3 for instructions) ☐ BCBSM ☐ BCN Members - Complete Page 4 for PCP Selection

BCBSM group number	Division	BCN group ID	Subgroup	Class ID	Employer representative signature

Subscriber information

Date	Social Security number (required)	Subscriber last name	Subscriber 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		E-mail
			☐ Home ☐ Work ☐ Cell		☐ Home ☐ Work ☐ Cell	

List all persons to be covered:

	Last name	First name	MI	Gender	Date of birth	Social Security number	*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 dependents maintain other 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 and flexible spending account options

☐ HSA ☐ HSA Opt out ☐ BCBSM Product indicator code: ☐ Add ☐ Change ☐ Cancel ☐ FSAMED Goal amount: ☐ FSADEPCA Goal amount:

Employer/Group use only

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

Check coverge if applicable: ☐ Medical ☐ Vision ☐ Dental

Check type of enrollment: ☐ Transfer ☐ Return from layoff ☐ Loss of eligibility (prior coverge) ☐ Salary ☐ New ☐ Full time ☐ Rehire ☐ Part time Old group division/subgroup _____ New group division/subgroup _____ ☐ Retiree ☐ Surviving spouse ☐ Hourly ☐ Open enrollment

Average hours worked per week (required): _____

Job title (required): _____

COBRA enrollment Check reason: ☐ Termination ☐ Reduction of hours ☐ Divorce or legal separation ☐ Layoff ☐ Loss of dependent status ☐ Deceased subscriber

Previous contract number

Original qualifying date

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

Are any members listed enrolled in Medicare? ☐ No ☐ Yes If Yes, check reason category ☐ Working Aged ☐ Retired ☐ Disabled ☐ ESRD HIC number:

☐ Medicare primary ☐ BCBSM or BCN primary	Medicare A effective date	Medicare B effective date	Medicare Part D effective date

Blue Cross Blue Shield Blue Care Network of Michigan

Change of Status

☐ BCBSM ☐ BCN Member (see instructions on Page 7)

BCBSM group	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date

Subscriber information *Required field

Subscriber Social Security number (*Required)	Subscriber last name*	Subscriber first name*	M.I.*	Marital status*	Gender
				☐S ☐M	☐M ☐F

New home street address*	City*	State*	ZIP code*	E-mail*

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

List all persons to be added or deleted:

	Last name	First name	M.I.	Gender	Date of birth	Social Security number	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 maintain other health 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 and flexible spending account options

☐FSAMED Effective date: _____ Goal amount: _____ ☐HSA

☐FSADEPCA Effective date: _____ Goal amount: _____ ☐HSA opt out

BCBSM Product indicator code ☐ Add ☐ Change ☐ Cancel

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)

☐Dependents ☐Name change ☐Open enrollment

☐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 (includes BCBSM or BCN)	Contract holder name	Policy #	Termination date

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

☐Medicare primary per MSP laws

☐BCBSM or BCN primary per MSP laws

Medicare A effective date: _____ Medicare B effective date: _____ Medicare D effective date: _____ HIC #: _____

Dental Insurance Enrollment Form

Administered by: AlwaysCare

Enrollment Form for Group Insurance

Underwritten by: National Guardian Life Insurance Company
Administered by: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
P.O. Box 98100 Baton Rouge, LA 70898-9100, (225)926-2888 or 1-888-729-5433

1. MEMBER INFORMATION — A: Add (enroll) T: Terminate C: Change (change of name or coverage)

Group/Policyholder Name	Group Number	Location	Effective Date

☐ A ☐ T ☐ C	Gender ☐ M ☐ F	Last Name (Member)	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone	Work Phone	Cell Phone
		Email:		

COMPLETED BY EMPLOYER

Date of Hire	☐ Full time ☐ Part time If part time: Hrs worked per week: _____	Occupation	Class

Salary $: _____ ☐ Yearly ☐ monthly ☐ bi-monthly ☐ weekly ☐ bi-weekly ☐ hourly

2. FAMILY INFORMATION (Only those eligible may be enrolled. Use additional paper if needed) (Relationship – If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.)

	Gender	Relationship	Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)	
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Husband ☐ Wife	(Spouse)				
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other_____	(Dependent)				Unmarried child/ FT student/handicapped? Yes No
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other_____	(Dependent)				Yes No
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other_____	(Dependent)				Yes No

3. BENEFIT ELECTIONS (Employer determines benefits available for election):

	Member Only	Member & Spouse	Member & Child(ren)	Member & Family	Waive	Mode Premium
Dental	☐	☐	☐	☐	☐	$

STATEMENTS AND AGREEMENTS:

- My dependents are not eligible for coverages I don't have. If I refuse dental or vision coverage, I and/or my dependents may enroll later but this will affect the level of benefits. If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health. If I refuse coverage, I cannot enroll after retirement. If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution: (1) I authorize my employer to deduct from my pay; and (2) I understand that no insurance is in force until the first premium is paid.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage.
- I agree National Guardian Life Insurance Company is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- I authorize National Guardian Life Insurance Company to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date of signature. I may revoke authorization for information not yet obtained. I understand data obtained will be used by National Guardian Life Insurance Company for claims administration and determining eligibility for life and disability insurance. Information will not be used for any purpose prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers from myself and/or my dependents will be used by National Guardian Life Insurance Company only as allowed by law.
- NOTE for Dental: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under Coverage A in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date.
- NOTE for Vision: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. These limited coverages also apply to the Late Entrant's or Re-enrollee's Dependents, if enrolled.

In the past 12 months, have you had continuous group coverage providing like or similar benefits (for yourself and/or your dependents) with a prior carrier? ☐ Yes ☐ No

If yes, please provide: Policyholder _____ and Insurance Company _____

Important! If declining any coverage for yourself or any dependent, give reason. Covered under: ☐ Spouse's group coverage

☐ Individual insurance ☐ other coverage offered by my employer ☐ other_____

AUTHORIZATION AND AGREEMENT: I hereby declare that all the statements made in this application are, to the best of my knowledge and belief, true and complete, and that they are the basis on which insurance requested by me may be issued. I understand that coverage will not become effective until NATIONAL GUARDIAN LIFE INSURANCE COMPANY grants its underwriting approval if required. I understand that there is no coverage for a Pre-existing Condition except as described in the Certificate of Insurance.

I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, or other medically related facility, insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, or that of any member of my family whose name appears in the application to which this is attached, to give NATIONAL GUARDIAN LIFE INSURANCE COMPANY and its affiliates or authorized representative any such information. This information will be used to determine eligibility for insurance. I understand that I may revoke this authorization at any time by sending a written revocation to NATIONAL GUARDIAN LIFE INSURANCE COMPANY at the address above. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right NATIONAL GUARDIAN LIFE INSURANCE COMPANY has to contest an insurance policy / certificate, or to contest a claim under an insurance policy / certificate. I understand that if I revoke this authorization, NATIONAL GUARDIAN LIFE INSURANCE COMPANY may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement. I understand that once this information is received by the authorized person/organization, then this information may be subject to redisclosure, and may no longer be protected by federal privacy laws. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation. I also certify that the producer and I, if applicable, also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Information Practices Notice.

I declare that the information I have completed on this enrollment form is complete and true. I have read and understand the statements and understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from National Guardian Life Insurance Company.

Your Signature: x_____ Date signed _____

A copy of this form will be as valid as the original. After this form is completed and signed, make one copy for the Policyholder and a copy of page one only for the Member.