2025 JJET Leasing, Inc. Eligibility Form

Please complete the following form for your 2025 benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by Bolin Enterprises and are therefore waiving all coverage, please check the appropriate box for waiving coverage in each section.

☐ Open Enrollment	☐ New Hire	☐ Qualifying Event	Effective Date:
	Termination ☐	Reason: _____ Date of event: _____	/ /

Company Name	**Bolin Autos Trucks Tires**	Employee Number	
Employee First Name		Middle Initial	Employee Last Name
Employee Home Address		SSN	
City, State, Zip		Date of Hire	
Employee Phone Number		Date of Birth	
Marital Status		Gender	Male / Female

Medical-Weekly

Carrier: BlueCross BlueShield

Waive/Decline	☐	I do not choose to participate in Health Insurance
Enroll—Employee Only	☐	$58.00
Enroll—Employee + Spouse*	☐	Adding a Spouse will require an additional contribution based upon age in the bracket below
Enroll—Employee + Child(ren)*	☐	Adding a Child/Children will require an additional contribution based upon age in the bracket below
Enroll—Family*	☐	Adding Family Mebers will require an additional contribution based upon age in the bracket below

NOTE: Employees active on our health insurance plan that do not participate in the wellness program will be responsible for an additional 10% of their individual premium.

Employee Only Coverage	Weekly Per Pay Period Contribution
Any Age	$58.00

Age	Weekly Per Pay Period Contribution	Age	Weekly Per Pay Period Contribution	Age	Weekly Per Pay Period Contribution
<14	$88.78	33	$139.03	49	$197.99
15	$96.67	34	$140.89	50	$207.27
16	$99.69	35	$141.82	51	$216.44
17	$102.71	36	$142.75	52	$226.54
18	$105.96	37	$143.67	53	$236.75
19	$109.21	38	$144.60	54	$247.77
20	$112.57	39	$146.46	55	$258.80
21-24	$116.05	40	$148.32	56	$270.75
25	$116.52	41	$151.10	57	$282.82
26	$118.84	42	$153.77	58	$295.71
27	$121.62	43	$157.49	59	$302.09
28	$126.15	44	$162.13	60	$314.97
29	$129.87	45	$167.58	61	$326.11
30	$131.72	46	$174.08	62	$333.42
31	$134.51	47	$181.39	63	$342.59
32	$137.29	48	$189.75	64+	$348.16

* If any election other than employee only is selected please complete dependent information

Dental Weekly		Carrier: BlueCross BlueShield
Employee Only	☐	$5.78
Employee + Spouse*	☐	$11.56
Employee + Child(ren)*	☐	$14.16
Family*	☐	$22.83
☐ I do not choose to participate in Dental Insurance		

Vision–Weekly		Carrier: BlueCross BlueShield
Employee Only	☐	$1.75
Employee + Spouse*	☐	$3.33
Employee + Child(ren)*	☐	$3.51
Family*	☐	$5.16
☐ I do not choose to participate in Vision Insurance		

Dependent Information

Name	Date of Birth	Social Security Number	Gender	Relationship	Medical	Dental	Vision

2025 Changes	YES	NO
Is the address that you supplied on the front a new address?		
Is the phone number that you supplied on the front a new phone number?		
Did you have a marital status change in 2024?		
Do you need to change your life insurance beneficiary information? (See HR for new form)		
Did you have any dependents born in 2024? (If YES, please make sure to provide name, birthdate and gender above with any other dependents so that HR can update their database)		

Authorization and Signature

Every employee is required to complete this form in its entirety, either electing group benefit coverage or waiving group benefit coverage. By signing this form you are authorizing pre-tax deduction under the cafeteria plan, your next opportunity to make changes will be during the next open enrollment period unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth of a child or adoption of a child. Please contact your Human Resources representative if you experience a qualifying life event within 30 days of the life event.

Print Name	Signature	Date

* If any election other than employee only is selected please complete dependent information