GRAND RAPIDS TRANSPORT INC.
EMPLOYEE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

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TO OUR EMPLOYEES

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of the **Grand Rapids Transport Inc. Employee Benefit Plan** ("Plan"). You should carefully read this Summary Plan Description, acquaint your family with its provisions and keep it for future reference.

The Plan is comprised of various fully insured benefits. Generally, the terms and conditions under which you may be eligible for and receive the benefits are set forth in the terms of each applicable insurance policy. Since the benefits under the Plan are provided solely through insurance coverages, Grand Rapids Transport Inc. ("Employer") is not an insurer of any benefits. The insurance companies are the sole source for benefits.

This document does not replace the provisions of the policy and other documents governing each insured benefit (collectively, the "policy"). Every effort has been made to make this Summary Plan Description as complete and accurate as possible. In the event of any difference between the Summary Plan Description and one of the insurance policies, the terms of the policy will control.

If you have any questions about your benefits under the Plan, please contact Employer.

GRAND RAPIDS TRANSPORT INC.

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GROUP INSURANCE PLAN

Employer provides the following types of insurance benefits:

- Group medical/prescription drug insurance coverage for you and your eligible dependents.
- Group dental insurance coverage for you and your eligible dependents.
- Group vision insurance coverage for you and your eligible dependents.

These insurance benefits are provided through a policy with each insurance carrier. Each insurance carrier will provide you with a booklet or certificate describing the insurance benefits provided by that carrier.

The booklet or certificate will contain the following information:

- The eligibility and participation conditions for any dependent coverage.
- A summary of benefits.
- A description of any deductibles, coinsurance or copayment amounts.
- A description of any annual or lifetime caps or other limits on benefits.
- Whether and under what circumstances preventive services are covered.
- Whether and under what circumstances prescription drugs are covered.
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures.
- Provisions governing the use of network providers (if any). If there is a network, the booklet or certificate will contain a general description of the provider network and you will be entitled to obtain a list of providers in the network from the insurer.
- Whether and under what circumstances coverage is provided for any out-of-network services.
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- Any conditions or limits applicable to obtaining emergency medical care.
- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit.

- A description of the circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that you might otherwise reasonably expect the Plan to provide.

ELIGIBILITY AND PARTICIPATION

Each insurance carrier is responsible for determining eligibility for, and the amount of, any benefits payable under its respective insurance policy.

Each booklet and/or certificate from the insurance carriers contains a description of the employees who are eligible to participate in the applicable insurance coverage, along with the rules concerning when and how an eligible employee may become a participant.

SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE

Employer makes contributions under the Plan on your behalf if you participate in the Plan. Employer applies its contributions under the Plan to purchase insurance coverage. You may be required to contribute to the cost of coverage. If you are required to contribute to the cost of coverage, Employer will notify you of the required contribution. If Employer maintains a Section 125 plan, your required premiums may be paid on a pre-tax basis.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding any contrary provision in any group health insurance policy under the Plan, an eligible dependent child may include a child for whom you are required to provide coverage pursuant to a qualified medical child support order ("QMCSO"). You may obtain, without charge, a copy of the Plan's QMCSO procedures from the plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

HEALTH CARE REFORM

The health benefits under the Plan will be amended as necessary to comply the new insurance market reforms under the federal Health Care Reform legislation enacted in March 2010. (The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act of 2010.) The insurance market reforms include, for example, new restrictions on maximum lifetime and annual benefits and pre-existing condition exclusions. Further, effective no later than the first day of the first plan year beginning on or after September 23, 2010, older children will be eligible for health coverage under the Plan until at least their 26th birthday.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, provides participants with the following rights:

Pre-Existing Conditions/Certificates of Creditable Coverage

Group health plans may not impose pre-existing condition exclusions with respect to individuals beyond 12 months (18 months for late enrollees). Further, an individual's period of creditable coverage under another health plan must reduce the pre-existing condition exclusion. Group health plans and health insurance issuers must provide individuals with a certificate of creditable coverage following termination of coverage. Individuals may also request a certificate of creditable coverage if the request is made within 24 months after coverage ends. Such a request should be made to the insurance carrier or Employer.

Special Enrollment Rights

If an individual experiences a loss of coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in medical coverage under the group health plan immediately without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), a benefit package option is terminated unless the individual is provided a current right to enroll in alternative health coverage, or coverage is lost due to the application of the other plan's maximum lifetime limit on all benefits. A loss of other coverage for this purpose does not include, however, termination due to the nonpayment of required contributions, for cause due to the filing of a fraudulent application or claim, or where the individual voluntarily terminates other coverage.

- The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.

- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of an individual who loses other coverage due to the application of a plan's lifetime limit on all benefits, special enrollment rights continue until 30 days after the earliest date that a claim is denied due to the operation of the lifetime limit. Further, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

Privacy and Security

Group health plans and health insurance issuers must make sure that medical information identifying a participant is kept private, must maintain and follow privacy policies and procedures and must notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form. Further, group health plans and health insurance issuers must comply with the changes made to the HIPAA privacy and security rules under the federal law known as HITECH, including, but not limited to, the new breach notification requirements.

TERMINATION OF COVERAGE

Each booklet and/or certificate from the insurance carriers contains a description of the rules concerning termination of an individual's participation in the insurance coverage.

In certain circumstances, the employee and/or his or her eligible dependents may be eligible for COBRA continuation coverage and/or a conversion policy, as explained in the following sections.

MICHELLE'S LAW

Effective as of September 1, 2010, pursuant to a new federal law known as Michelle's law, if a serious illness or injury requires a dependent child to change from full-time to part-time student status or take a leave of absence from a college, university or other accredited educational institution, medical coverage may be temporarily extended if all of the following requirements are satisfied:

- The dependent child was enrolled in the Plan on or before the reduction in status or leave of absence began;
- The reduction in status or leave of absence would have otherwise caused the dependent child's medical coverage under the Plan to terminate; and
- The dependent child's attending physician provides a written certification which states that the reduction in status or leave of absence is medically necessary and due to a serious illness or injury.

If all of the above requirements are satisfied, medical coverage will be extended until the earliest of the following dates:

- One year after the date on which student status was reduced from full-time to part-time;
- One year after the date on which the leave of absence began;
- The date on which the reduction in status or leave of absence is no longer medically necessary; or
- The date on which the child's medical coverage would otherwise terminate under the Plan (for example, due to the attainment of the limiting age).

After this temporary extension period ends COBRA continuation coverage may be available.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 ("FMLA") applies to the Plan during any calendar year when Employer employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible employees (i.e., participating employees who have been employed by Employer for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave).

A participant on an FMLA leave may continue health coverage during the leave on the same basis and at the same participant contribution rate as if the employee had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by Employer). However, if an employee takes a leave under the FMLA to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA is 26 weeks per 12-month period. If health coverage ends at the end of an FMLA leave, COBRA continuation coverage is available.

COBRA CONTINUATION COVERAGE

Continuation coverage is required under the federal law known as COBRA. COBRA continuation coverage allows you and/or your dependents (including a child for whom you are required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end.

The plan administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator, InfiniSource. You and your spouse (if any) will be informed which responsibilities InfiniSource has assumed, including whether notices required to be provided to the plan administrator should be sent to InfiniSource.

Eligibility

You and/or your dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with the employee during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)*
Reduced hours** or termination of employment***	Employee and Dependents	18
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation****	Dependents	36
Commencement of Bankruptcy proceeding under Title 11 of the United States Code with respect to Employer	Retiree and Dependents	For a qualified beneficiary who is the retiree - until the qualified beneficiary's death. For qualified beneficiaries who are the spouse, surviving spouse, or dependent children of the retiree upon the occurrence of the qualifying event - the earlier of the date of the qualified beneficiary's death or 36 months after the retiree's death.

* However, to the extent required by law, the maximum continuation period may be temporarily extended while a covered employee is receiving trade assistance benefits or benefits from the Pension Benefit Guaranty Corporation. Such an extension shall not continue past December 31, 2010.

** A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause your participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if you do not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

*** Continuation coverage is not available if employment is terminated for gross misconduct.

**** Elimination of your spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example) is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation.

Extension of Continuation Coverage

If you and/or your dependents become entitled to continuation coverage as a result of your termination of employment or reduction in hours, the 18-month continuation period may be extended for you and/or your dependents in the three circumstances described below ("extension events").

Second Qualifying Event

If a second qualifying event that is a divorce, legal separation, your death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), your dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of your termination of employment or reduction in hours. ***Notice of this second qualifying event must be provided to the plan administrator within 60 days of the date of the second qualifying event.***

Employee's Entitlement to Medicare

If you become entitled to Medicare benefits during the initial 18-month period, your dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, your entitlement to Medicare would have been a qualifying event under the Plan. The 36-month continuation period begins on the date of your termination of employment or reduction in hours. ***Notice of your entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the date on which you became entitled to Medicare.***

A special rule applies if you became entitled to Medicare before your termination of employment or reduction in hours. In that situation, the maximum continuation period for your dependents may be extended, and may end on the later of: 36 months after the date of your Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of your termination of employment or reduction in hours. ***Notice of your entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of your termination of employment or reduction in hours.***

Social Security Disability Determination

If it is determined that you or one of your dependents is entitled to Social Security disability benefits either before your termination of employment or reduction in hours or within 60 days after your termination of employment or reduction in hours, the disabled individual and the qualified beneficiaries who are his or her family members will be entitled to an additional 11 months of continuation coverage (29 months total). ***Notice of the Social Security disability determination must be provided to the plan administrator within 60 days of the date of the disability determination (or within 60 days of your termination of***

employment or reduction in hours, if later) and before the end of the 18-month continuation period.

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary ***must notify the plan administrator of that determination within 30 days of the date of the final determination.*** In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The plan administrator will provide you and your spouse (if any) with certain information regarding your rights under COBRA in the following situations:

Notice of Eligibility to Elect COBRA

The plan administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

However, a special rule applies where the qualified beneficiary is required to provide the plan administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the plan administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was timely submitted in accordance with the requirements described in the "Notice Procedures" subsection.

Notice of Unavailability of Continuation Coverage

The plan administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the plan administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event that is a divorce, legal separation, or a dependent child's loss of eligibility for health coverage under the Plan.

- Where the plan administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the plan administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be

defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "Notice Procedures" subsection.

The plan administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the plan administrator receives the notice of the potential qualifying event or extension event, or if later, the deadline for submission of additional information requested by the plan administrator to supplement a defective notice. The notice of the unavailability of continuation coverage will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, you and/or your dependents have the obligation to provide notice of a qualifying event or extension event to the plan administrator in order to trigger eligibility for continuation coverage or an extension of continuation coverage. You and/or your dependents have this obligation in the following situations:

Notice of Certain Initial Qualifying Events

You, one of your dependents, or an individual acting on behalf of you and/or your dependents must inform the plan administrator of a qualifying event that is a divorce or legal separation, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

Notice of an Extension Event

In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, you, one of your dependents, or an individual acting on behalf of you and/or your dependent must notify the plan administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided in accordance with the requirements of the "Notice Procedures" subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the plan administrator of qualifying events and extension events.

The plan administrator has a form which may be used to provide the required notice. The form may be obtained by contacting the plan administrator at the address or telephone number on the last page of this Summary Plan Description. While use of the notice form will help ensure that the qualified beneficiary provides all of the required information, use of the notice form is not required. Written notification that contains all of the following information will also be accepted:

- Your name.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current address of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court documents establishing the legal separation.
- If the notice relates to your entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline, is not made in writing and/or does not contain all of the required information is deemed to be defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

If the plan administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the plan administrator will request the missing information. If the defective notice was provided by the representative of a qualified beneficiary or a potential qualified beneficiary, the plan administrator will send the request to the representative and each individual who is a qualified beneficiary or a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the plan administrator requests the additional information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The plan administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the plan administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the plan administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or

- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

Notification is made by timely returning the election form to the plan administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

Special Trade Adjustment Assistance Election

Special COBRA rights may apply to you if you terminate employment or experience a reduction of hours and qualify for a "trade adjustment allowance" or "alternative trade adjustment assistance" under federal trade laws. In this situation, you are entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if they did not already elect COBRA continuation coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after group health plan coverage ended. In certain circumstances, you may also be eligible to continue COBRA beyond the normal 18 or 36-month maximum continuation period (see the plan administrator for details).

If you qualify or may qualify for assistance under the federal trade laws, contact the plan administrator for additional information. You must contact the plan administrator

promptly after qualifying for assistance under the federal trade laws or you will lose these special COBRA election rights.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage. Alternatively, the qualified beneficiary may initially elect to purchase one or more of the medical/prescription drug, dental and vision coverages which are provided by Employer pursuant to any separate group health plans and/or which may be separately elected pursuant to Employer's Section 125 plan, if applicable. However, each coverage is initially available only if the qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost of Continuation Coverage

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

New COBRA Subsidy Laws

Effective as of March 1, 2009, if a qualified beneficiary (employee or dependent) becomes entitled to COBRA as a result of an employee's involuntary termination of employment (except where due to gross misconduct) and the involuntary termination of employment and loss of coverage/eligibility for COBRA occur on or after September 1, 2008 and before January 1, 2010, the qualified beneficiary may be entitled to a subsidy.

The subsidy will reduce the cost of the qualified beneficiary's premium by 65% for a period of up to nine months. Qualified beneficiaries will be provided with notice of the availability of the subsidy and the requirements to qualify for it and any related available election opportunities. A qualified beneficiary must submit a request for the subsidy within 60 days of being provided with the notice described in the immediately preceding sentence.

The Department of Defense Appropriations Act, 2010 ("2010 DOD Act") makes two changes to the rules described in the immediately preceding paragraph. First, it extends the window during which the involuntary termination of employment may occur from before January 1, 2010 to before March 1, 2010. Second, it extends the maximum subsidy period from 9 months to 15 months.

The Temporary Extension Act of 2010 extended the window described in the immediately preceding paragraph to include an involuntary termination of employment occurring before April 1, 2010 and for certain reductions in hours followed by an involuntary termination of employment. The Continuation Extension Act of 2010 further extended the window in the immediately preceding paragraph to include an involuntary termination of employment occurring before June 1, 2010. The Plan will comply with all of the COBRA subsidy laws described above as well as any subsequently enacted COBRA subsidy laws.

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

Coverage Terminated

Employer no longer offers a group health plan to any of its employees.

Unpaid Premium

The premium for continuation coverage is not timely paid, to the extent payment is required.

Other Coverage

A qualified beneficiary becomes covered under another group health plan. Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision will not apply during any time period the other group health plan contains an exclusion or limitation with respect to any pre-existing conditions, other than an exclusion or limitation which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to HIPAA.

Medicare

A qualified beneficiary becomes entitled to Medicare (Part A or Part B). Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).

Cause

A qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits). Continuation coverage will end as of the date on which the qualified beneficiary's coverage is terminated for cause.

The plan administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the qualified beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the plan administrator's determination that continuation coverage will terminate.

Questions

You and/or your dependents should contact the plan administrator at the address or telephone number listed at the end of this Summary Plan Description with any questions regarding COBRA that are not answered in this Summary Plan Description. You and/or your dependents may also contact the nearest District or Regional office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA's website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Plan Administrator Informed of Address Changes

To protect your rights under COBRA, it is important that you and your dependents keep the plan administrator informed of any changes in address. You should also keep a copy, for your records, of any notices that are sent to the plan administrator.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE

If you cease to be eligible for health coverage under the Plan due to service in the U.S. military, you and your eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). You and your dependents may also be entitled to elect to continue your health coverage under COBRA if you cease to be eligible for health coverage due to your military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

You may elect to continue health coverage under the Plan for yourself and your eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day you are absent from work to perform military service; or

- The period beginning on the first day you are absent from work to perform military service and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If you give Employer advance notice of a period of military service that will be 30 days or less, the plan administrator will treat your notice as an election to continue your health coverage during your military service unless you specifically inform Employer, in writing, that you want to cancel your health coverage during your military leave. You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms or paperwork to continue your health coverage during your military service.

If you give Employer advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. Unlike COBRA, your dependents do not have a separate right to elect USERRA coverage. If you want USERRA continuation coverage for any member of your family, you must elect it for yourself and all eligible dependents who are covered under the Plan when your military service begins.

If you choose USERRA continuation coverage, you must return the USERRA election form to the plan administrator within 60 days of the date it was provided to you. If you do not timely return the election form, USERRA continuation coverage will not be available to you and your eligible dependents.

A special rule applies if you do not give Employer advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your health coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

- You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity);

- You affirmatively elect to reinstate the coverage; and
- You pay all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If your period of military service is more than 30 days, beginning on the 31st day of your military service your required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if you do not timely pay any required premiums for that coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elect USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

CONVERSION PRIVILEGES

When you or one of your dependents are no longer eligible under the Plan (either as an active participant, the eligible dependent of an active participant or as a qualified beneficiary receiving continuation coverage), you and/or your dependents may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility are set forth in the policy with each insurance carrier.

RETIREE COVERAGE

Employees may be eligible for retiree health insurance coverage in accordance with Employer's policy for retiree health insurance. The terms and conditions of the retiree group health insurance policy will be determined by Employer. Employer reserves the right to amend or terminate the retiree group health insurance at any time.

CLAIMS

Each insurance carrier is responsible for prescribing the claims procedures to be followed with regard to the benefits provided pursuant to that carrier's policy. The insurance certificate(s) or booklet(s) from the insurer(s) that are coupled with this Summary Plan Description contain a summary of the claims procedures. However, the claims procedures must provide you with claims and appeal rights at least as favorable as the following:

Initial Decision

A claimant will be notified of a benefit determination as follows:

Urgent Care Health Claims

An urgent care health claim is a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A claimant will be notified of a benefit determination regarding an urgent care health claim within 72 hours after the Plan's receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the claimant will be notified within 24 hours after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant will be granted 48 hours to provide the information. The claimant will then be notified of the benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.

Pre-Service Health Claims

A pre-service health claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. A claimant will be notified of a benefit determination regarding a pre-service health claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control

of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be granted 45 days from receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Post-Service Health Claims

A post-service health claim is a claim for a health benefit which is not a pre-service claim or an urgent care claim. If a post-service health claim is denied, in whole or in part, the claimant will be notified of the adverse determination within 30 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Concurrent Care Health Claims

If the Plan has approved an ongoing course of health treatment to be provided over a period of time or over a number of treatments, any reduction or termination by the Plan of that course of treatment (other than by Plan amendment or termination) will constitute an adverse benefit determination. Notice will be provided in accordance with the "Benefit Determination Notice" subsection below and will be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care will be decided as soon as possible and the claimant will be notified of the determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

Benefit Determination Notice

The claimant will be provided with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, refer to the Plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The notice will also describe the Plan's review procedures and related time limits and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA (a federal law) following an adverse benefit determination on review.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain a statement that such an explanation will be provided free of charge to the claimant upon request.

Appeal of Denial

The claimant may request a review of an adverse benefit determination regarding a health claim by submitting a written application to the Plan within 180 days following the denial of the claim. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claimant's claim for benefits. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan will identify any medical or vocational experts whose advice was

obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon.

In the case of an appeal of an adverse benefit determination regarding an urgent care health claim, a request for an expedited appeal may be made orally or in writing and all necessary information including the Plan's determination on review may be transmitted between the Plan and the claimant by telephone, facsimile or any other available similarly expeditious method.

Final Decision

The Plan will make a decision regarding a request for review as follows:

Urgent Care Health Claims

The claimant will be notified of the Plan's determination on review regarding an urgent care health claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.

Pre-Service Health Claims

There will be one or two levels of appeal for pre-service health claims. In either case, the appeal process must be completed within 30 days and notification must be provided to the claimant.

Post-Service Health Claims

There will be one or two levels of appeal for post-service health claims. In either case, the appeal process must be completed within 60 days and notification must be provided to the claimant.

ADMINISTRATION

Employer is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. However, because all benefits under the Plan are fully insured, each benefit is provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy.

AMENDMENT OR TERMINATION

Although Employer intends to maintain the Plan indefinitely, Employer has the authority to amend or terminate the Plan at any time. However, no amendment or termination can

retroactively diminish a participant's right to obtain Plan benefits. You will be informed of any material amendment affecting your coverages or changing the operation of the Plan.

GOVERNING LAW

The Plan is primarily subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as well as other various federal laws, including, but not limited to, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, HIPAA, Michelle's Law, FMLA, COBRA, and USERRA, as well as certain state insurance laws. However, the Plan may include certain benefits (such as a dependent care flexible spending account) that are not subject to ERISA.

YOUR RIGHTS AS A PLAN PARTICIPANT

Notwithstanding anything to the contrary in a booklet or certificate, as a participant in the Plan, you are entitled to certain rights and protections under ERISA with respect to the benefits under the Plan that are subject to ERISA.

Information About the Plan and its Benefits

ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the plan administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, any updated Summary Plan Description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report if there are 100 or more participants in the Plan and the Plan is not funded solely through Employer's general assets. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review the rules governing your COBRA

continuation coverage rights described elsewhere in this Summary Plan Description.

- A reduction or elimination of any exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to any plan pre-existing condition exclusion which may be up to 12 months (or 18 months for late enrollees) after your enrollment date in your coverage.

Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other Plan participants and beneficiaries. No one, including Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds the participant's claim is frivolous.

Assistance With Questions

If you have any questions about the Plan, you should contact the plan administrator. If you have any questions about this statement ("YOUR RIGHTS AS A PLAN PARTICIPANT") or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or viewing its website at www.dol.gov/ebsa.

OTHER BASIC INFORMATION ABOUT THE PLAN

Name of Plan:	Grand Rapids Transport Inc. Employee Benefit Plan
Name, Address, Telephone Number and Taxpayer Identification Number of Employer/Plan Sponsor:	Grand Rapids Transport Inc. 2778 Port Sheldon St. Jenison, MI 49428 **Mailing Address:** **P.O. Box D** **Grand Rapids, MI 49501** (616) 669-8822 38-2672595
Plan Number:	501
Type of Plan:	Group insurance plan providing medical/ prescription drug, dental and vision benefits
Type of Administration:	Insurer Administration
Plan Administrator:	Employer/Plan Sponsor
Agent for Service of Legal Process:	Robert Fedewa, President Grand Rapids Transport Inc. P.O. Box D Grand Rapids, MI 49501 Service of legal process may also be made on the plan administrator.
COBRA Administrator:	Small Business Association of Michigan (SBAM) 120 N Washington Square Ste 1000 Lansing, MI 48933 (800) 362-5461

Name, Address and Telephone Numbers of Insurer(s):	Blue Care Network (BCN) (Medical/Prescription Drug) P.O. Box 68767 Grand Rapids, MI 49516-8767 (800) 662-6667 Blue Cross Blue Shield of Michigan (BCBSM) (Medical/Prescription Drug) 86 Monroe Center St NW Grand Rapids, MI 49503-2930 (800) 972-9797 Companion Life (Dental) P.O. Box 100102 Columbia, SC 29202-3102 (800) 753-0404 VSP Vision Service Plan (Vision) 3333 Quality Dr. MS 131 Rancho Cordova, CA 95670 (800) 877-7195 Benefits are guaranteed under the policy(ies) with each insurer.
Plan Year for Fiscal Record Purposes:	September 1 through August 31 However, the Plan may maintain a different 12-month period for other purposes. For example, insurance policies may renew based on a different 12-month cycle, participants may make annual benefit elections on a different 12-month cycle and the period of coverage for deductibles, annual out-of-pocket limits and other annual benefit provisions may operate on a different 12-month period.

QUALIFIED BENEFICIARY'S NOTICE OF QUALIFYING EVENT/EXTENSION EVENT/CESSATION OF DISABLED STATUS

Qualified beneficiaries must notify the Plan Administrator of certain qualifying events in order to be eligible for COBRA continuation coverage under the Grand Rapids Transport Inc. Employee Benefit Plan ("Plan"). Notification of events that could extend the COBRA continuation period ("extension events") is also required. This form may be used to notify the Plan Administrator of these events.

You should review the Plan's summary plan description for information regarding COBRA continuation coverage, the qualifying events and extension events for which notification is required, and the procedures for submitting these notices, including the applicable time limit for submission of each notice. If you need a copy of the summary plan description, contact the Plan Administrator at the address or telephone number on the second page of this form.

Instructions

Complete this form, attach any required documentation and return it to the Plan Administrator at the address on the second page of this form. If you are unable to provide any required documentation, include an explanation regarding why the documentation is not available and the date when you anticipate it will be available. **Failure to complete all applicable sections of this form and/or to attach the appropriate documentation or explanation may affect your eligibility for COBRA continuation coverage.**

1. **Employee's Name (print):** _____

2. **Event Identification:** (check applicable box and provide the requested information)

☐ **Divorce/Legal Separation of Employee**

Date of Divorce/Legal Separation: _____

Attach copy of the judgment of divorce or other applicable court documents

NOTE: Legal separation is where a court enters an order of separate maintenance. A couple who separates and files for divorce is not legally separated for COBRA purposes.

☐ **A Child No Longer Meets the Definition of a Dependent Under the Plan**

Name of Affected Child: _____

Date of Loss of Dependent Status: _____
(for example, date of 19th birthday)

☐ **Death of Employee**

Date of Employee's Death: _____

☐ **Employee's Entitlement to Medicare**

Effective Date of Entitlement: _____

Attach a copy of the document(s) establishing the Medicare entitlement/Medicare enrollment

☐ **A Determination that a Qualified Beneficiary is Entitled to Social Security Disability Benefits**

Name of Qualified Beneficiary Entitled to Disability Benefits: _____

Effective Date of Disability Determination: _____

Attach a copy of the determination from the Social Security Administration

☐ **A Final Determination that a Qualified Beneficiary is No Longer Entitled to Social Security Disability Benefits**

Name of Affected Qualified Beneficiary: _____

Effective Date of Final Determination: _____

Attach a copy of the determination from the Social Security Administration

3. **Name and Current Address of All Individuals for Whom COBRA or an Extension of COBRA is Being Requested:** (Attach additional names/addresses if necessary)

Name: _____

Current Address: _____

_____

Name: _____

Current Address: _____

_____

4. **Signature/Certification:** I certify that all the above information is true.

_____ _____

Signature Date

_____

Print Name

Relationship to Employee: (check one) ☐ Self ☐ Spouse/Former Spouse
☐ Dependent Child ☐ Other (explain):_____

Send this completed form and required attachments to:

Grand Rapids Transport Inc.
P.O. Box D
Grand Rapids, MI 49501
Telephone Number: (616) 669-8822