Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	**7**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your social security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Complete the worksheet on page 3 before making any entries.

1 Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 17)*	**1**	
2 Total number of allowances for New York City *(from line 28)*	**2**	

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3 New York State amount	**3**	
4 New York City amount	**4**	
5 Yonkers amount	**5**	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an ***X*** in box A and/or box B to indicate why you are sending a copy of this form to New York State *(see instructions)*:

A Employee claimed more than 14 exemption allowances for NYS ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see instr.)*:

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*:

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)*	Employer identification number

Instructions

Changes effective for 2016

Form IT-2104 has been revised for tax year 2016. The worksheet on page 3 and the charts beginning on page 4, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2016 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn $106,950 or more during the tax year.
- The total income of you and your spouse has increased to $106,950 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address (*Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____ . Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A OR **List B** AND **List C**		
Identity and Employment Authorization	**Identity**	**Employment Authorization**
Document Title:	Document Title:	Document Title:
Issuing Authority:	Issuing Authority:	Issuing Authority:
Document Number:	Document Number:	Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions*.)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy):*

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

EXCEL PARTNERS

DIRECT DEPOSIT AGREEMENT FORM

Providing Professional Staffing Services Specializing in Administrative, Office, Accounting & Finance Support

Excel Partners realizes the importance of receiving your pay as quickly and conveniently as possible. In order to achieve this, we accept two forms of electronic payment which are described below. Please choose which method you prefer and return this form to us prior to starting your assignment. You may change your selection at any time.

Direct deposits occur every Thursday morning for time cards received prior to 10am the previous Monday, regardless of holidays.

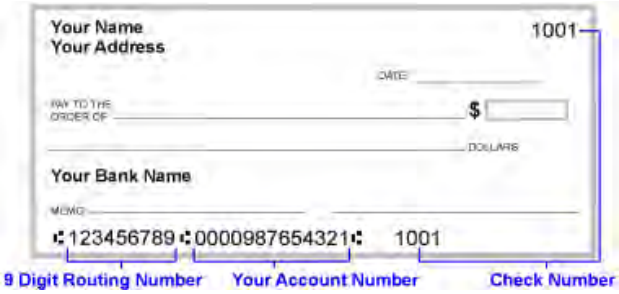
Option 1 - Direct Deposit Account Information

Name of Financial Institution: _____

Routing Number (9 digits): _____

Account Number: _____

Account Type (Select one): ☐ Checking ☐ Savings



Direct deposit forms will not be accepted without a letter from your bank or a voided check. You send a scan/photo separately to payroll@excel-partners.com or fax to (203) 978-6203.

Option 2 – WEX rapid! Paycard

rapid! PayCard®

rapid! PayCard® MasterCard®

- Use rapid! Paycard at ATMs to get cash whenever you need it. Free withdrawals from Allpoint network ATMs. Convenient locations include CVS, Walgreens, Target, Costco and 7 Eleven. Go to www.allpointnetwork.com for a complete list.
- Use as a debit card and receive cash back with purchases.
- Take to any bank that displays the MasterCard logo and withdraw the entire balance to avoid check cashing fees.

Card ID Number: _____

For internal use only: Routing # 124085244 Account Number: _____ Date: _____

Authorization Agreement

I hereby authorize Excel Partners, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Excel Partners, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Excel Partners, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Excel Partners, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Name: _____ Date of Birth: _____ Social Security #: _____

Street Address (no PO Box): _____ Phone: _____

City: _____ State: _____ Zip: _____

_____ _____

Authorized Signature *Date*

Limited Benefit & Self-Funded Minimum Essential Coverage (MEC) Enrollment Guide

Complete the Enrollment Form to Elect or Decline Coverage

IMPORTANT PLAN INFORMATION: You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

Advantages of the Fixed Indemnity Medical Plan

- ☑ Covers Day to Day Medical Expenses
- ☐ Satisfies the Individual Mandate
- ☑ Allows you to receive a subsidy from the Health Insurance Exchange
- ☑ Offers Dental, Vision, Term Life and STD

Advantages of the MEC Wellness/Preventive Plan

- ☐ Covers Day to Day Medical Expenses
- ☑ Satisfies the Individual Mandate
- ☐ Allows you to receive a subsidy from the Health Insurance Exchange
- ☐ Offers Dental, Vision, Term Life and STD

1. You **MUST** complete the Enrollment Form as part of your New Hire Process.
2. Elect or decline all benefits on the Enrollment Form.
3. You **MUST** Sign and Date the bottom of the form, even if you decline coverage.
4. Return the Enrollment Form to your Branch Manager.
5. Keep the Benefits at a Glance page for your records.

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

THE FIXED INDEMNITY MEDICAL PLAN IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED UNDER THE AFFORDABLE CARE ACT (ACA).

The Essential StaffCARE Fixed Indemnity Medical/Rx, Accidental Loss of Life, Limb & Sight, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.204, 26.212, and 26.213. The Term Life and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

LIMITED BENEFIT MEDICAL PLAN DISCLOSURE — CONNECTICUT EMPLOYEES
THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES, WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY, NOT THE INSURER, IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE LISTED IN THE MEDICAL SCHEDULE OF BENEFITS SECTION OF YOUR SUMMARY PLAN DESCRIPTION.

The MEC Wellness/Preventive Plan is an employer-sponsored, self-funded plan that has been deemed to be in compliance with ACA rules and regulations. More information about Preventive Services may be found on the government website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

Availability of Summary Health Information for MEC/Wellness Preventive Plan

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: *essentialstaffcare.com/sbcmec*. A paper copy is also available, free of charge, by calling Essential StaffCARE Customer Service 1-866-798-0803.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

Essential StaffCARE

VSI **2907300-ECP** | OFFICE USE ONLY | LOCATION _____ | Rehire Date __ __ /__ __ /__ __ __ __

ENROLLMENT FORM

ESC/MEC 4SO P1M v18.1

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name	Home Phone	
Social Security #	Date of Birth / /	Sex M F
Address		Apt. #
City	Zip	State

B. MEDICARE INFORMATION

Do you or any of your dependents receive medicare benefits?
☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. This plan is underwritten by BCS Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only	☐ **$19.98**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + Child(ren)	☐ **$33.17**	**$14.58**	**$6.54**	**$0.90**	
Employee + Spouse	☐ **$37.96**	**$10.80**	**$4.84**	**$0.90**	
Employee + Family	☐ **$50.55**	**$20.52**	**$9.20**	**$1.80**	
	☐ **NO** to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Sex M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82907300-M-ECP **Monthly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. This plan satisfies the federal healthcare reform Individual Mandate. This is an offer of ACA compliant coverage and by purchasing this plan, you will not be taxed for failing to purchase insurance required by the Affordable Care Act. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ **$60.00** Employee Only ☐ **$79.80** Employee + Child(ren) ☐ **$87.00** Employee + Spouse ☐ **$105.90** Employee + Family

☐ **NO** to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage. I understand that open enrollment is only available for a limited time, and I understand that making no benefit selection is a declination of coverage.

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**

This is an Essential StaffCARE Enrollment Form.

Policy Number **2907300-ECP**

LIMITED BENEFITS SUMMARY

FIXED INDEMNITY MEDICAL BENEFIT

The Fixed Indemnity Medical Plan pays a flat amount for each covered event caused by an accident or illness. If the covered event costs more, you pay the difference. But if the covered event costs less, you keep the difference.

Outpatient Benefits [1]		**Inpatient Benefits**	
Physician Office Visit	$100 per day	Standard Care	$300 per day
Diagnostic (Lab)	$75 per day	Intensive Care Unit Maximum [4]	$400 per day
Diagnostic (X-Ray)	$200 per day	Inpatient Surgery	$2,000 per day
Ambulance Services	$300 per day	Anesthesiology	$400 per day
Physical, Speech, or Occupational Therapy	$50 per day	Skilled Nursing [5]	$100 per day
Emergency Room Benefit - Sickness	$200 per day	First Hospital Admission (1 per year)	$250
Emergency Room Benefit - Accident	$500 per day	Annual Inpatient Maximum [6]	No Limit
Outpatient Surgery	$500 per day	**Accidental Loss of Life, Limb & Sight**	
Anesthesiology	$200 per day	Employee/Spouse	$20,000
Annual Outpatient Maximum	$2,000	Dependent (6 months to 26 years)	$5,000
Prescription Drugs (via reimbursement) [2,3]		Dependent (15 days to 6 months)	$2,500
Annual Maximum	$600	**Wellness Care**	
Per Day	$20	Wellness Care (one per year)	$100

[1] all outpatient benefits are subject to the outpatient maximum [2] not subject to outpatient maximum [3] To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc. [4] pays in addition to standard care benefit [5] for stays in a skilled nursing facility after a hospital stay [6] Subject to internal limits of plan

DENTAL BENEFIT

Waiting Period/Coinsurance | **Annual Maximum Benefit** $750 | **Deductible** $50

Coverage A	None / 80%	Exams, Cleanings, Intraoral Films and Bitewings
Coverage B	3 Months / 60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures
Coverage C	12 Months / 50%	Periodontics, Crowns, Bridges, Endodontics and Dentures

VISION BENEFIT [1]

	In-Network		**Out-of-Network**	
	You Pay	Plan Pays	You Pay	Plan Pays
Eye Examination [2] (including dilation)	$10 Copay	100%	100%	$35
Exam Options (Standard or Premium Contact Lens Fit)	Up to $55 or 10% off Retail Price	$0	100%	$0
Frames [3]	80%, after $110 allowance	$110, plus 20% of remaining	100%	$55
Standard Plastic Lenses (single, bifocal, trifocal) [2]	$25 Copay	100%	100%	$25-$55
Lens Options	$15-$45 or 20% discount	$0	100%	$0
Contact Lenses (Conventional) [2]	$0 Copay	$110, plus 15% of remaining	100%	$88
Disposable Contact Lenses [2]	$0 Copay	$110, plus balance	100%	$88
Medically Necessary Contact Lenses [2]	$0 Copay	100%	$0	$200

[1] For complete plan details, please visit www.essentialstaffcare.com/vision [2] Once every 12 months [3] Once every 24 months

TERM LIFE BENEFIT

Employee Amount	$10,000 (reduces to $7,500 at 65; $5,000 at 70)	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$5,000 (terminates at age 70)	**Infant Amount (15 days to 6 mos)**	$1,000

SHORT-TERM DISABILITY BENEFIT

Benefit Amount	60% of Salary up to $150 per week
Waiting Period/Maximum Benefit Period	7 days, up to 26 weeks

OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT [1]

Policy Number **82907300-M-ECP**

The optional MEC Wellness/Preventive Benefit **DOES NOT** cover medical services. This plan provides coverage for preventive services such as immunization and routine health screening. It does not cover conditions caused by accident or illness.

Benefit	**In-Network**	**Non-Network**	**MONTHLY MEC PREMIUM**	**MEC**
15 Preventive Services for Adults	100%	40%	**Employee Only**	$60.00
22 Preventive Services for Women	100%	40%	**Employee + Child(ren)**	$79.80
26 Covered Preventive Services for Children	100%	40%	**Employee + Spouse**	$87.00
			Employee + Family	$105.90

[1] For more information about preventive services, please visit www.healthcare.gov.

WEEKLY LIMITED BENEFITS PREMIUM	**Medical**	**Dental**	**Vision**	**Term Life**	**STD**
Employee Only	$19.98	$5.40	$2.42	$0.60	$4.20
Employee + Child(ren)	$33.17	$14.58	$6.54	$0.90	-
Employee + Spouse	$37.96	$10.80	$4.84	$0.90	-
Employee + Family	$50.55	$20.52	$9.20	$1.80	-

LIMITED BENEFIT EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

FIXED INDEMNITY MEDICAL AND ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT BENEFIT

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
- Declared or undeclared war
- Serving on full-time active duty in the armed forces
- The covered person's commission of a felony
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law or
- With regard to the accidental loss of life, limb or sight benefit - sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions
- Hearing examinations or hearing aids
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force
- Services provided by a member of the covered person's immediate family.

The fixed indemnity medical plan is not available to residents of Hawaii, New Hampshire or Puerto Rico.

PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

VISION

No benefits will be paid for any materials, procedures or services provided under worker's compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent, or a person who resides in your home
- Declared or undeclared war or act of war
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony
- Your participation in a riot
- If you engage in an illegal occupation
- Release of nuclear energy
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

Short-Term Disability benefits are not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

TERM LIFE

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

Member Services:

For frequently asked questions and network information for the the Fixed Indemnity Medical Plan, please go to *www.essentialstaffcare.com/FAQVSI*. For frequently ask questions regarding the MEC Wellness Preventive Benefit, as well as a full list of preventive services covered, please go to *www.essentialstaffcare.com/FAQMEC*.

PLEASE NOTE: To make changes or cancel coverage by telephone call (800) 269-7783. Your pin code for enrolling/making changes is **400** + _ _ _ _ (last four digits of your SSN). Your Company has chosen to take your payroll deductions on a **Post-Tax** basis.

Essential StaffCARE Customer Service: 1-866-798-0803

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets and to add, change, or cancel coverage.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit www.paisc.com and click on "Your Plan" and enter your group number.