

***EMPLOYEE BENEFIT GUIDEBOOK
&
ENROLLMENT FORMS***



Welcome!

Acro HR Solutions, Inc. has been contracted by your company to provide professional human resource and employee administration services. These services include payroll processing, tax filing, employee benefit administration, human resource services and more. Our mission is to provide you with the best benefits and employee services possible. Acro is a human resources management firm commonly referred to as a Professional Employer Organization (PEO).

This booklet will provide you with information on the benefits available to you through our program - all administered by trained specialists who are here to assist you in any way possible.

INSTRUCTIONS:

Completely fill out all forms in the booklet unless the area is marked "optional". **This booklet must be completed and processed before you can receive your first pay-check.**

This booklet includes detailed information on your benefit program with us including:

- ◆ *Flexible Spending Account (FSA)*
- ◆ *401(k) retirement savings plan*
- ◆ *Employee Assistance Plan*
- ◆ *Direct deposit of your paycheck*
- ◆ *Supplemental insurance coverage options*
- ◆ *Group Life Insurance*
- ◆ *Medical Insurance*

You may also access an electronic version of this booklet, other forms and other helpful information on the internet at www.acrohrsolutions.com. Click on "Employee Center" and follow the prompts. We are here to help and assist you, as your co-employer, with any payroll, human resource/personnel or benefit-related issues. Please feel free to call on us with any questions or concerns you may have at (734) 591-1100 or (800) 844-ACRO (2276).



Flexible Spending Accounts (Section 125)

What's in it for you???

The Acro flexible spending account allows you to pay for medical expenses as well as dependent /childcare expenses with pre-tax dollars. You pay for these expenses **before** your earnings are taxed – saving you money. The result is more net income for you, as illustrated below. Note: normally you may deduct medical expenses from your taxes only when they exceed 7.5% of your adjusted gross income, this program has no such limitations. It is especially useful for childcare expenses used with licensed day care providers whom provide you a tax id number or social security number for tax purposes. It cannot be used with your babysitter. Please see the enrollment packet for more detailed information.

	Before Flexible Spending	After Flexible Spending
Monthly Wage	\$1,300.00	\$1,300.00
Flex deduction	0.00	-100.00
Monthly Taxable Wages	1,300.00	1,200.00
Total tax Withheld	229.00	202.00
Spendable Income	1071.00	998.00
After tax expense (medical dependent care)	-100.00	0.00
TAKE HOME PAY	<u>\$971.00</u>	<u>\$998.00</u>

In the above example, contributing just \$100.00 per month would save you **\$27.00 per month or \$324.00 annually.**

How Does It Work?

1. You determine the annual amount you will be spending on unreimbursed medical expenses (see Acro for annual maximum) and dependent/childcare expenses (annual maximum of \$5,000) for the plan year – we have included a worksheet on the following page to assist you with this. The plan year is a calendar year.
2. That amount is pro-rated per pay period and is deducted out of your check before taxes are calculated. These funds are then “deposited” into an account for you.
3. When you incur an expense, simply complete a reimbursement request form and submit it with your receipts. We will reimburse you for that expense out of your account.
4. While this plan has many advantages you need to keep in mind that you cannot change your deduction amounts until open enrollment and the IRS requires you to forfeit any unused deposits 90 days after the end of the calendar year. The key to effectively using this program is to conservatively estimate your expenses.

Open enrollment is every January 1 and upon initial eligibility. Annual elections cannot be changed and are irrevocable until open enrollment, unless there is a “change in Family Status”, such as: marriage, birth, death, divorce etc. If you are interested in participating in this program or would like more information, please contact Acro HR Solutions for a Section 125-enrollment kit.



Medical Reimbursement Worksheet

Use this worksheet to calculate your anticipated out-of-pocket medical expenses.

Annual deductible for your family under your company medical and dental plans	\$ _____
Co-Payments for office visits or prescription drugs	\$ _____
Office visits and routine physical exam co-payments	\$ _____
Vision: eye exams, glasses, contacts, laser surgery	\$ _____
Uninsured dental, orthodontia	\$ _____
Hearing care, hearing aids	\$ _____
Psychotherapy, Chiropractic	\$ _____
Prescription drugs, birth control	\$ _____
Dental expenses not covered by insurance	\$ _____

TOTAL ESTIMATED HEALTH CARE EXPENSES \$ _____
 (See Acro for Maximum amount allowed for the current year)

Dependent Care

Day Care	\$ _____
Nursery Schools	\$ _____
Other Eligible Care	\$ _____

TOTAL DEPENDENT CARE \$ _____

ELIGIBLE MEDICAL EXPENSES

Acupuncture
 Ambulance hire
 Artificial limbs
 Artificial teeth
 Birth control pills
 Braces (orthodontics)
 Car controls for handicap
 Chiropractors
 Christian Science practitioners'
 Co-insurance amounts you pay
 Diagnostic fees
 Drug and medical supplies
 Eyeglasses, including exam
 Fee for practical nurse
 Fees for healing services
 Hearing aids and batteries
 Braille - books & magazines
 Hospital bills
 Hypnosis for treatment of illness
 Laboratory Fees
 Laser vision correction
 Special education for the blind
 Transportation expenses primarily in the rendering of medical services
 Life fee to a retirement home for medical care
 Television audio display equipment for the hearing impaired
 Therapeutic care for drug and alcohol addiction
 Over the counter medication (not including vitamins, dietary supplements or products for cosmetic reasons such as Rogaine).

INELIGIBLE MEDICAL EXPENSES

Membership fees or dues at health clubs or spas
 Exercise equipment or saunas
 Swimming lessons
 Elective cosmetic surgery
 Medical insurance premiums
 Smoking cessation programs



Acro HR Solutions 401(K) Savings Plan

A great way to save for your retirement is with investments made to a 401(k) plan with deductions from your paycheck BEFORE taxes. The money continues to grow in your account without being taxed until you withdraw. A 401(k) plan allows you to shelter up to 75% of your income from current federal income taxation and builds a long-term savings account for retirement using pre-tax dollars.

Your investments are self-directed, meaning you select from a list of mutual funds that are professionally managed on your behalf.

- You may contribute 1% to 75% of your income up to a maximum determined annually by the government. You are able to select each fund based upon your individual needs
- Additional “qualified” funds or your current 401(k) may be rolled over into the plan at any time
- Access to your account information as well as fund switching, etc. can be done via toll-free phone or Internet access 24 hours a day.

- Quarterly statements and newsletters keep you informed as to your account value and changing market conditions
- Access to your savings through loans for financial hardship withdrawals, if you are eligible
- You may select from a number of different investment options that best meet your individual needs.
- Eligibility varies – please check the details of your plan.
- You can access your fund information; make trades etc. over the internet or via toll-free phone access.

Financial experts agree that the earlier you start to save for your retirement income needs the better. **MAKE THE INVESTMENT IN YOUR FUTURE - STARTING TODAY!!!**

Co/op Optical

Vision Designs



EMPLOYEE & FAMILY VISION DISCOUNT
Account # 994-01

Co/op Optical Vision Designs a not-for-profit cooperative, is pleased to offer to all ACRO HR Solutions employees and their families a discount on optical services.

Co/op Optical Vision Designs will provide a 20% discount on regular dress eyewear (frames, lenses, and eye exams) and 5% discount on contacts (exams, lenses, and follow-up care).

Please request the discount at the time of service. THIS DISCOUNT CANNOT BE USED IN CONJUNCTION WITH ANY SAFETY PROGRAM, INSURANCE, COUPON, SALE OR OTHER DISCOUNTS. *Please bring this form along to your examination appointment*

Several Locations across Michigan to choose from:

PLEASE CALL AHEAD TO SCHEDULE EXAMINATION APPOINTMENTS

ANN ARBOR	4649 Washtenaw	(734) 434-3030
AUBURN HILLS	2763 University	(248) 377-4270
CENTER LINE	25027 Van Dyke	(810) 758-0700
DEARBORN	1740 N. Telegraph	(313) 278-0525
DETROIT	7408 Woodward (Grand Blvd)	(313) 871-0220
	2424 E. 8 Mile (Dequindre)	(313) 366-3290
EASTPOINTE	18193 E. 8 Mile	(810) 771-7720
FARMINGTON HILLS	Hunters' Square,31225 Orchard Lake.....	(248) 737-1880
GRAND RAPIDS	2897 Radcliff SE	(616) 942-2710
	4270 Plainfield Ave. NE	(616) 363-9041
LIVONIA	Livonia Mall, 7 Mile & Middlebelt.....	(248) 476-5350
MADISON HEIGHTS	Madison Place, 32041 John R	(248) 585-1205
MT. CLEMENS	Clinton Pt. Shopping Center,3820 Gratiot	(810) 791-3100
SOUTHGATE	13465 Dix-Toledo	(734) 285-7650
STERLING HEIGHTS.....	Clinton Valley Mall-Hall Road at Schoenherr	(810) 254-5000

Watch for advertised specials during the year.

Questions? Call Co/op Optical Customer Service (313) 366-5104

COBRA NOTICE

A federal law [Public Law 99-272, Title X, commonly known as COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end ("Qualifying Events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

WHO IS COVERED

Employees. If you are an employee of *Acro HR Solutions* covered by *Acro HR Solutions Health Plan*, **and your worksite employer has over 20 worksite employees** on a typical business day in the preceding calendar year, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Spouses of employees. If you are the spouse of an employee covered by *Acro HR Solutions Health Plan*, you are a "Qualified Beneficiary" and have the right to choose continuation coverage for yourself if you lose group health coverage under *Acro HR Solutions Health Plan* for any of the following five reasons:

1. the death of your spouse;
2. termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. divorce or legal separation from your spouse;
4. your spouse becoming entitled to Medicare; or
5. the commencement of certain bankruptcy proceedings, if your spouse is retired.

Dependent children. A dependent child of an employee covered by *Acro HR Solutions Health Plan* also is a "Qualified Beneficiary" and has the right to continuation coverage if group health coverage under *Acro HR Solutions Health Plan* is lost for any of the following six reasons:

1. the death of a parent;
2. the termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with *Acro HR Solutions*;
3. parents' divorce or legal separation;
4. a parent becoming entitled to Medicare;
5. the dependent ceasing to be a "dependent child" under *Acro HR Solutions Health Plan*; or
6. a proceeding in a bankruptcy reorganization case, if the parent is retired.

A child born to, or placed for adoption with, the covered employee during a period of continuation coverage also is a Qualified Beneficiary.

Separate elections. If there is a choice among types of coverage under the plan, each of you who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation of coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect a different coverage from the coverage that the employee elects.

YOUR DUTIES UNDER THE LAW

Under the law, the employee or a family member has the responsibility to inform *Acro HR Solutions* of a divorce, legal separation, or a child losing dependent status under *Acro HR Solutions Health Plan*, within 60 days of the date of the event. In addition, the employee or a family member must inform *Acro HR Solutions* of a determination by the Social Security Administration that the employee or covered family member was disabled during the 60 day period after the employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month continuation coverage period. (See "Special rules for disability," below.) If, during continued coverage, the Social Security Administration determines that the employee or family member is no longer disabled, the individual must inform *Acro HR Solutions* of this redetermination within 30 days of the date it is made.

EMPLOYER'S DUTIES UNDER THE LAW

Acro HR Solutions has the responsibility to notify *the administrator* of the employee's death, termination of employment or reduction in hours, or Medicare eligibility. Notice must be given to *Acro HR Solutions* within 60 days of the happening of the event. When *Acro HR Solutions* is notified that one of these events has happened, *Acro HR Solutions* will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform *Acro HR Solutions* that you want continuation coverage.

CHOOSING CONTINUATION COVERAGE

If you do not choose continuation coverage within the time period described above, your group health insurance coverage will end. If you choose continuation coverage, *Acro HR Solutions* is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. ("Similarly situated" refers to current employees or their dependents who have not had a qualifying event.)

HOW LONG WILL COVERAGE LAST?

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect. Such events may extend an 18 month continuation period to 36 months, but in no event will coverage extend beyond 36 months from the date of the event that originally made the employee or a qualified beneficiary eligible to elect coverage. You should notify *Acro HR Solutions* if a second qualifying event occurs during your continuation coverage period.

Special rules for disability. If the employee or covered family member is disabled at any time during the first 60 days of continuation coverage, the continuation coverage period is 29 months for all family members, even those who are not disabled. The disability that extends the continuation coverage period must be determined by the Social Security Administration. The employee or family member must inform *Acro HR Solutions* within 60 days of the date of disability determination and before the end of the original 18 month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the employee or family member is no longer disabled, the individual must inform *Acro HR Solutions* of this re-determination within 30 days of the date it is made. If an employee or family member is disabled and another qualifying event (other than bankruptcy of *Acro HR Solutions*) occurs within the 29 month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

Special rule for Retirees. In the case of a Retiree or an individual who was a covered surviving spouse of a Retiree on the day before the filing of a Title 11 bankruptcy proceeding by *Acro HR Solutions*, coverage may continue until death and, in the case of the spouse or dependent child of a Retiree, 36 months after the date of death of a Retiree.

Continuation coverage may be cut short. The law provides that your continuation coverage may be cut short prior to the expiration of the 18, 29, or 36 month period for *any* of the following five reasons:

1. *Acro HR Solutions* no longer provides group health coverage to any of its employees.
2. The premium for continuation coverage is not paid in a timely manner (with in the applicable grace period).
3. The individual becomes covered under another group health plan (whether or not as an employee) that does not contain any exclusion or limitation with respect to any preexisting condition of the individual (other than an exclusion or limitation that, after July 1, 1997, does not apply to, or is satisfied by, the individual under the provisions of the Health Insurance Portability and Accountability Act of 1996).
4. The individual becomes entitled to Medicare.
5. Coverage has been extended for up to 29 months due to disability (see "Special rules for disability") and there has been a final determination that the individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. (The law also says that, at the end of the 18, 29, or 36 month continuation coverage period, you must be allowed to enroll in any individual conversion health plan provided under *Acro HR Solutions* Health Plan)

Once your continuation coverage terminates for any reason, it cannot be reinstated. This notice is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance.

Questions?

If you have questions about the law, please contact *Acro HR Solutions* at 17187 N. Laurel Park Drive, Suite 165, Livonia, MI 48152. 734-591-1100. Also if you have changed marital status or you or your spouse has changed addresses, please notify *Acro* at the above address.

Application for Employment (please print clearly)

EMPLOYER SECTION (to be completed by your worksite employer)

Company Name _____

Employees Dept. Code _____ Job Title/Duties _____

Pay information Rate/Salary \$ _____ (check one) Hourly ___ Annual Salary ___

Start Date: _____ Status: ___ Full Time ___ Part Time ___ Contingent

EMPLOYEE SECTION

A). GENERAL INFORMATION

Name _____
Last First Middle

Address _____

City _____ State _____ Zip Code _____ Phone Number _____

Social Security Number _____ - _____ - _____ Drivers License # _____

Date started with current company: _____

If under 18 years old please indicate your age _____ (if under 18, please attach work permit)

Have you ever been convicted of a felony or are there any felony charges pending against you?

___ No ___ Yes (if yes please explain) _____

Who should we contact in case of an emergency?

Name: _____ Phone Number – Daytime: _____ Evening: _____

Address: _____

City _____ State _____ Zip Code _____

The company, it's affiliate corporations and clients (the "co-employers") are an Equal Opportunity employer and therefore comply with the law prohibiting discrimination on such factors as race, color, religion, sex, national origin, marital or veteran status, or disability.

Under the Michigan Handicappers' Civil Rights Act, an employer has a legal obligation to accommodate an employee's or job applicant's handicap unless the accommodation would impose an undue hardship on the employer. A handicapper may allege a violation against an employer regarding a failure to accommodate his or her handicap only if the handicapper notifies the employer in writing of the need for accommodation with 182 days after the date the handicapper knew or reasonably should have known that an accommodation was needed.

-Over-

B). Employment History: *List most recent employer first*

Dates (Month & Year)	Employer's name, address, phone number	Supervisors name Position(s)
From:		
To:		
Reason for leaving:	<input type="checkbox"/> Resigned <input type="checkbox"/> Discharged <input type="checkbox"/> Laid Off <input type="checkbox"/> Other	
From:		
To:		
Reason for leaving:	<input type="checkbox"/> Resigned <input type="checkbox"/> Discharged <input type="checkbox"/> Laid Off <input type="checkbox"/> Other	
From:		
To:		
Reason for leaving:	<input type="checkbox"/> Resigned <input type="checkbox"/> Discharged <input type="checkbox"/> Laid Off <input type="checkbox"/> Other	

C. EDUCATION:
High School Attended: _____ **Diploma:** yes no
College /Trade School Attended: _____ **Degree/Diploma:** yes no
Address: _____ **Date graduated:** _____

AUTHORIZATION AND UNDERSTANDING

1. I certify that the information given herein is true and complete without qualification. I understand that the Company may investigate my work and personal history and verify all data given on this application, on related papers, and in interviews, and I authorize the Company to do the same. This inquiry may include information as to my character, general reputation, credit history and personal characteristics, and I consent to the conduct of this inquiry and to the consideration of any statements of references or former employers that are given in response to the inquiry. I authorize all individuals, companies, institutions, schools and employers named therein, except as specifically limited on this application, to provide information requested about me, and I release them from liability for damages in providing this information. I understand and acknowledge that the Company can terminate my employment if I have provided incomplete, inaccurate, untrue or misleading information in this application or on any other document or form at any time during my employment.
2. If terminated, I authorize the Company to use any information in its possession concerning me for reference purposes and/or if legally required to furnish any information, including disclosure of information to any third party, future employer or prospective employer, without receiving any prior notice, and I release the Company from any liability in connection with such use or disclosure. I further agree to return all company owned/issued property, uniforms, equipment, etc.
3. In consideration of my employment, I agree to conform to the rules and regulations of the Company and the directions of its Supervisors. I understand and acknowledge that, if employed, unless my employment becomes subject to a collective bargaining agreement, my employment and compensation will be at the will of the Company and can be terminated, with or without cause, and with or without notice, at anytime at the option of either the Company or myself. I further understand and agree that no manager, representative, agent or employee of the Company, has now or has had in the past any authority to enter into any agreement for employment for any specified period of time or to make any agreement which is contrary to or a modification of the above described employment relationship, and that any such agreement or representation must be in writing and signed by both myself and the President of the Company in order to be effective.
4. I further understand that my employment is conditional until such time as the results of any pre-employment drug testing, if any is required, are known. I also understand and acknowledge that, as a part of the hiring process and throughout my employment, if hired, I may be required to submit to medical/physical examinations at the employer's discretion and expense.
5. Trade Secrets: The term "Confidential Information" means all information belonging to or used by the company or its clients related to procedures, policies, business strategies, pricing, customer information, billing, employee lists, technology, software source codes, programs, costs, marketing plans, proprietary information and trade secrets of every kind and character. By virtue of being employed by the Company, certain confidential information has and will be disclosed to me. These disclosures are made solely to assist me in the performance of my duties and responsibilities. My right to use confidential information and tot the extent thereof is at the Company's sole discretion and such rights shall expire immediately upon the termination of my employment. I shall not, either during or after my employment with the Company, disclose any confidential information for any reason or purpose contrary to the interest of the Company of the client to which I am assigned. Upon termination of employment, I shall immediately return all property in my possession relating to the Company or the client's business.

I have read and agree to the terms of each and all of the above five- (5) individual statements:

Applicant Signature: _____ Date of Signature: _____



AUTHORIZATION FORM FOR DIRECT DEPOSIT (optional)

Name _____ Social Security Number _____

Worksite Employer _____

___ This is a NEW direct deposit request

___ This form REPLACES all previous forms

Note: You may choose from one to three separate accounts for your deposits. Pre-note process will take up to two weeks to implement

First Account - Bank Name:	Savings <input type="checkbox"/>	Checking <input type="checkbox"/>
Routing Number: <small>(first nine digits at bottom of check)</small>		
Account Number:		
Amount or Percentage:		
Second Account - Bank Name:	Savings <input type="checkbox"/>	Checking <input type="checkbox"/>
Routing Number:		
Account Number:		
Amount or Percentage:		
Third Account - Bank Name:	Savings <input type="checkbox"/>	Checking <input type="checkbox"/>
Routing Number:		
Account Number:		
Amount or Percentage:		

PLEASE ATTACH A VOIDED CHECK

If your direct deposit is inactive after 60 days due to a break in employment you must go through the pre-note process when your employment is reinstated and you wish to continue directly depositing your pay. I authorize the Company to deposit all paychecks automatically to my account as indicated above. Adjusting entries to correct errors is also authorized. This authority remains in effect until cancelled in writing.

Signature _____ Date: _____



BENEFIT ELECTION FORM

COMPANY NAME

EMPLOYEE NAME

HIRE DATE

BENEFIT EFFECTIVE DATE

Please indicate which benefits you wish to elect or waive by marking an "X" in the appropriate space. Please mark on EACH area – do not leave any blank.

	Enrolling	Waiving
Medical	_____	_____
Dental	_____	_____
Vision	_____	_____
Section 125 Flexible Spending Account	_____	_____

If I am waiving any of the benefits, I understand that the next opportunity to enroll will be open enrollment of the following year. I also understand that if I have a life event change (i.e. marriage, divorce, birth/adoption of a child, COBRA expiration), I will be able to enroll at that time. Employer must be notified within 30 days of the qualifying event. Dental and vision insurance plans require 12 month enrollment, once enrolled, you cannot cancel for a minimum of 12 months.

Pre-tax Premium Pay Plan

I will participate in the Pre-tax Premium Pay Plan so as to be able to pay my health, dental, and Sec. 125 Benefit Plan insurance premiums using pre-tax dollars. The program has been explained to me and I understand that if I elect to participate I am making a binding election to reduce my paychecks by the dollar amount necessary to pay my portion of the premiums charged to cover me, my spouse (if any), and dependents (if any).

I hereby authorize my employer to reduce my paychecks to pro rata throughout the year by the amount necessary to pay such premiums. I understand that my election will remain in place for the plan year and I cannot increase, decrease, or suspend the salary reductions to be made hereunder except in connection with a qualifying life event change.

Employee Signature

Date

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM (optional)

(Please Print All Information)

Company Name: _____

Participant Name: _____

Social Security Number _____ - _____ - _____

Date of Birth: _____

Phone Number: _____

Address: _____

Pay Period: Weekly Semi-Monthly
 Bi-Weekly Monthly

City, State, Zip _____

E-Mail Address: _____

New Hire Key Employee (Officer or Owner) Open Enrollment

Change in Status Explanation: _____

MEDICAL REIMBURSEMENT ACCOUNT

1

I elect to participate. Yes No

(not to exceed Employer Limit – See Acro for current maximum)

\$ _____ per pay X _____ (# of pays) = \$ _____ Annually (do not round)

**EMPLOYER MUST COMPLETE
FOR MID YEAR ENROLLMENT**

Date of First Deduction: _____

Eligibility Date: _____

2

DEPENDENT CARE ACCOUNT

I elect to participate. Yes No

(Not to exceed \$5000, or \$2500 if married filing separately)

\$ _____ per pay X _____ (# of pays) = \$ _____ Annually (do not round)

**EMPLOYER MUST COMPLETE
FOR MID YEAR ENROLLMENT**

Date of First Deduction: _____

Eligibility Date: _____

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

COMPLETE AND RETURN TO YOUR BENEFITS COORDINATOR



9246 Portage Industrial Drive

Portage, MI 49024

1-800-444-1922 • 269-327-1922 • FAX 269-327-0716

E-Mail: basic@basicflex.com • Web Site: <http://www.basicr.nu>

**Admin Use
Only**

Ent _____

File _____

Rev 9/03



The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.

Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012

Northeast Regional Office
P.O. Box 28040
Lehigh Valley, PA 18002-6040

Bridgewater Office
P.O. Box 425
E. Bridgewater, MA
02333-04251

Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

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Enrollm
For Non-Medical Co

Planholder Name (Company Name) Acro HR Solutions		Group Plan No. 414050		Division	Class
Planholder Street Address 17187 N. Laurel Park Dr., Ste. 165			City Livonia	State MI	Zip 48
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced					
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION					
CHANGE: <input type="checkbox"/> ADD DEPENDENT(S) <input type="checkbox"/> TERMINATE A FAMILY MEMBER <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME <input type="checkbox"/> DELETE COVERAGE					
DATE OF CHANGE ___/___/___ REASON FOR CHANGE _____					
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED					
Name (Last, First, Middle Initial)		Sex	Birthdate	Employee's Social Se	
Employee:		<input type="checkbox"/> M <input type="checkbox"/> F			
Spouse:		<input type="checkbox"/> M <input type="checkbox"/> F		Date of Marriage / /	
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Y	
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Y	
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Y	
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Y	
(1) Are any dependent children adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name and date of placement					
(2) Have you included stepchildren? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name(s):					
(3) Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date of Full Time Employment	Hrs. Worked /Week	Annual Salary \$	Occupation /Job Title		
Employee's Street Address			City		
State	Zip	Business Phone #	Home Phone #		
DENTAL					
Employee:		Spouse:		Child(ren):	
<input type="checkbox"/> I elect coverage.		<input type="checkbox"/> Yes <input type="checkbox"/> No***		<input type="checkbox"/> Yes <input type="checkbox"/> No***	
<input type="checkbox"/> I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. **					
*** If declining coverage, are you covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
*** If declining dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
DECLINATION OF COVERAGE:					
* If I have waived the insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my expense, proof of each person's insurability, and Guardian reserves the right to reject my request.					
<ul style="list-style-type: none"> I hereby apply for the group benefit(s) indicated above. I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. I understand that insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex. I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance. The information provided above is true and correct to the best of my knowledge. Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. 					
X SIGNATURE OF EMPLOYEE				DATE	

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN

CEF-1999 ESU 11.14.05

ACRO HR SOLUTIONS DENTAL BENEFIT SUMMARY	
ITEM	GUARDIAN DENTAL INSURANCE
	Payment /Percentage covered
Annual Deductible	Single \$75 Family \$225 Deductible is waived for Class I (Preventive Services)
Class I Preventive Services	100%
Class II Basic Services	80%
Class III Major Services	50%
Orthodontia	Not Covered
Benefit Year Maximum	\$1,000
New Hire/New Enrollee Waiting Period	No wait for Class I and Class II services. There is a 12-month wait for Class III services.
Reasonable and Customary	90 th percentile
Pre-Determination Review	If the charge for any treatment is expected to exceed \$300, a dental treatment plan needs to be submitted for review before the treatment begins.
Missing Teeth Limitation	Benefits will not be paid for replacement of teeth missing on the Participant's or a covered dependent's effective date of participation under the plan for the purpose of the initial placement of a full denture, partial denture, or fixed bridge.
EXAMPLES OF SERVICES	
Type I	Oral evaluation – 1 every 6 months Full mouth x-ray series every 60 months Bitewing x-rays – 4 every 12 months Prophylaxis (cleaning) – 1 every 6 months Topical fluoride treatment – 1 every 6 months through age 14 Sealants – 1 time per tooth every 36 months through age 14
Type II	Emergency palliative treatment Amalgam restorations Composite restorations
Type III	Root canal therapy, Periodontal services Oral surgery – uncomplicated extractions General anesthesia – surgical procedures only Inlays and onlays, Posts, Dentures, Bridges, Crowns Repairs of dentures, bridgework, and crowns Space maintainers for children through age 14

This benefit outline is intended only as a source of reference. Official benefits, conditions, limitations, and exclusions are documented in plan contracts.



LIFE/ACCIDENTAL DEATH BENEFITARY CARD

Please complete this beneficiary card for your \$10,000.00 life insurance policy. This is available to all full time employees (30+ hours/week). Please return this form with your other new employee paperwork. Thank you!

**POLICY HOLDER NAME: ACRO HR SOLUTIONS/
Policy Number : 0552111-001**

Insured's Name _____ Birth date _____

Social Security Number _____

Beneficiary 1 _____ % of Benefit _____

Social Security Number _____ Relationship _____

Beneficiary 2 _____ % of Benefit _____

Social Security Number _____ Relationship _____

Beneficiary 3 _____ % of Benefit _____

Social Security Number _____ Relationship _____

Beneficiary 4 _____ % of Benefit _____

Social Security Number _____ Relationship _____

Contingent Beneficiary (used only if the above beneficiary dies before you do)

Insured's Signature _____ Date _____

Contact Information:

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