KV 10.15

Smart Solutions for managing benefits and more

Idilus Flex Series PPO

Utilizes CIGNA Network

Enrollment Worksheet

www.idilustotalsolution.com

(Effective through 12/31/2016)

For Groups 1+

Includes medical contribution, PEO fees and administrative costs

Plan Selection: ***(check one)*** ☐ **Flex 1000** ☐ **Flex 2500** ☐ **Flex 5000**

Flex 1000	**Single**	**$ 754.00**
	E+Spouse	**$ 1377.00**
	E+Child(ren)	**$ 1289.00**
	Family	**$ 1643.00**

Flex 2500	**Single**	**$ 709.00**
	E+Spouse	**$ 1281.00**
	E+Child(ren)	**$ 1200.00**
	Family	**$ 1528.00**

Flex 5000	**Single**	**$ 648.00**
	E+Spouse	**$ 1164.00**
	E+Child(ren)	**$ 1092.00**
	Family	**$ 1387.00**

- One Time Processing Per Employee Fee: $ 125.00
- Cost at Enrollment: $_____

☐ **Recurring billing is done via Electronic (EFT) Billing Only.**
☐ **Applicant must complete Billing & Enrollment forms.**
☐ **Applications must be received by 25th of the month prior to the start date.**

Payment Instructions; 1 Check (or EFT info) required at enrollment, See below.

- **Medical Plan & processing fee payable to:** ***Nu Era Benefits Agency***

To Search providers go to www.cigna.com

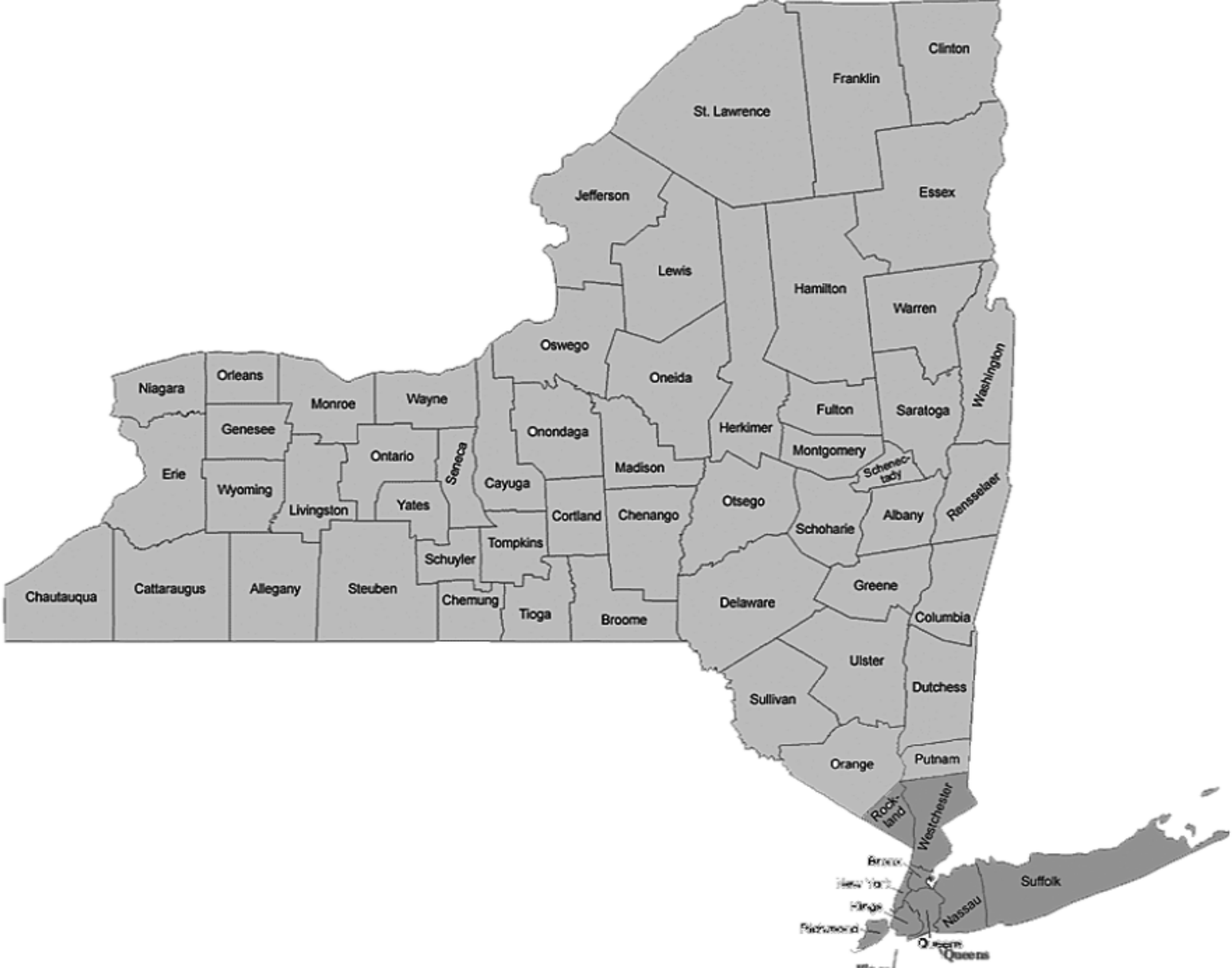
Member Name _____ Rep. Name _____

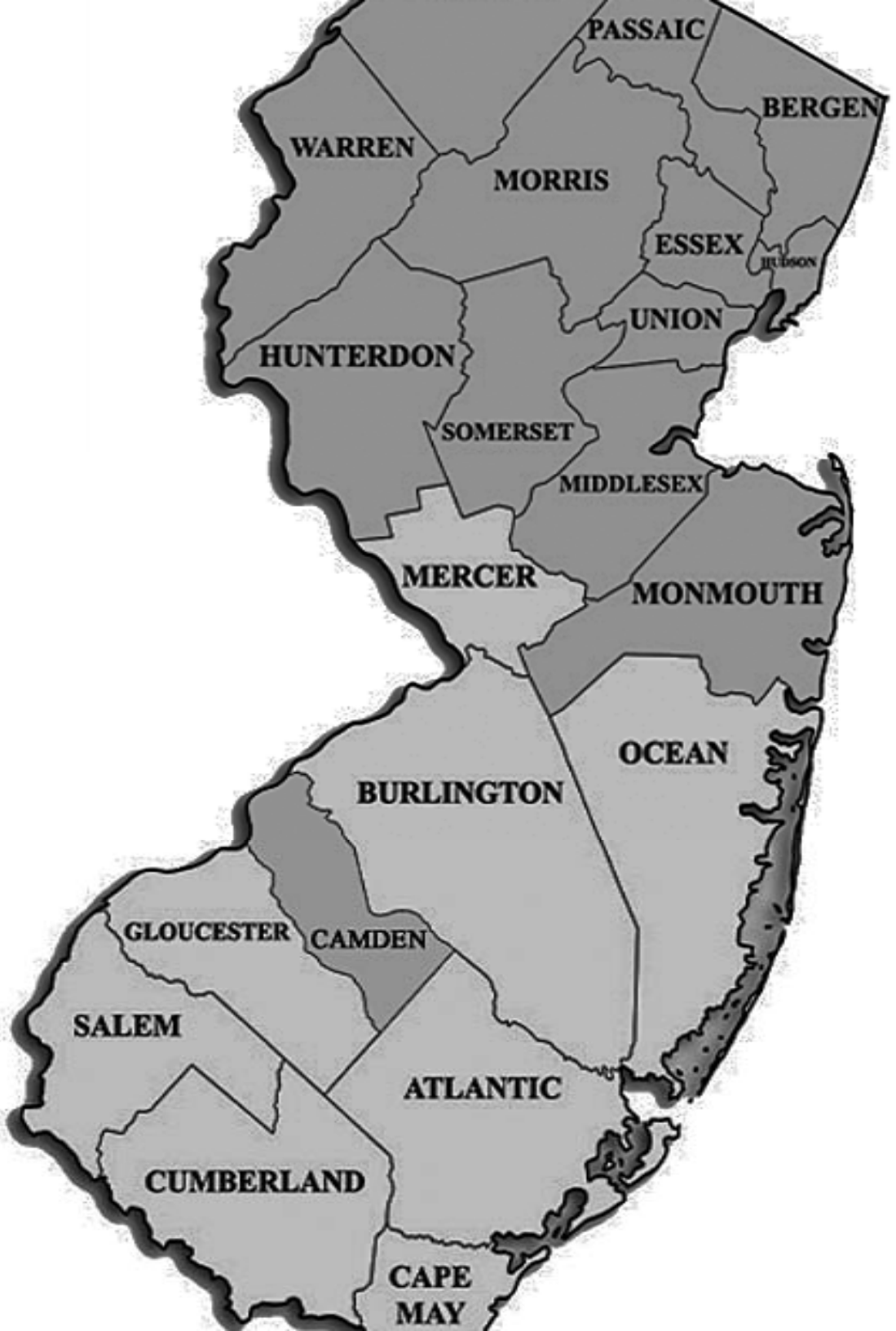
Member Signature _____ Rep. Signature _____

Date _____ Rep. Phone Number _(_____)_____

Please note it will take 15-20 Business days after your effective date for your ID cards to arrive from the carrier.

Initial _____


Clinton
Franklin
St. Lawrence
Essex
Jefferson
Lewis
Hamilton
Warren
Washington
Oswego
Oneida
Herkimer
Fulton
Saratoga
Niagara
Orleans
Monroe
Wayne
Onondaga
Montgomery
Schenectady
Genesee
Ontario
Seneca
Madison
Erie
Wyoming
Livingston
Yates
Cayuga
Otsego
Albany
Rensselaer
Cortland
Chenango
Schoharie
Tompkins
Schuyler
Greene
Columbia
Chautauqua
Cattaraugus
Allegany
Steuben
Chemung
Tioga
Broome
Delaware
Ulster
Dutchess
Sullivan
Orange
Putnam
Rock-
land
Westchester
Suffolk
Nassau
Queens


PASSAIC
BERGEN
WARREN
MORRIS
ESSEX
HUDSON
UNION
HUNTERDON
SOMERSET
MIDDLESEX
MERCER
MONMOUTH
OCEAN
BURLINGTON
GLOUCESTER
CAMDEN
SALEM
ATLANTIC
CUMBERLAND
CAPE
MAY

Flex Series 1000		
	In-Network	**Out of Network**
Deductible	$1,000 Single/$2,000 Family	$2,000 Single/$4,000 Family
Co-Insurance	20%	50%
Co-Insurance Maximum	$6,350 Single/$12,700 Family	$7,000 Single/$14,000 Family
Preventive Services	100%	100%
Professional Office Visits	$30 Copay Primary Care $50 Copay Specialist	Deductible/Co-insurance
Outpatient Lab	$35 Copay	Deductible/Co-insurance
Outpatient Radiology	Deductible/Co-insurance	Deductible/Co-insurance
Diabetic Supplies	Deductible/Co-insurance	Deductible/Co-insurance
Allergy Treatment	$25 Copay, then 100% to $100 per visit	Deductible/Co-insurance
Outpatient Rehab & Therapy **Chiropractic Services**	Deductible/Co-insurance Deductible/Co-insurance	Deductible/Co-insurance Deductible/Co-insurance
Professional Services	Deductible/Co-insurance	Deductible/Co-insurance
Emergency Services Hospital ER (Facility Charge Only)	$150 Copay	$150 Copay, then 100% to $1,000 per visit, then Deductible/Co-insurance
Urgent Care/ER Professional Services	$50 Copay, then 100% to $300 per visit, then Deductible/Co-insurance	Deductible/Co-insurance
Ambulance	Deductible/Co-insurance	Deductible/Co-insurance
Outpatient Surgical & Therapeutic Procedures Medical Faciltiy Services Physician and Surgeon Fees	 Deductible/Co-insurance Deductible/Co-insurance	 Deductible/Co-insurance Deductible/Co-insurance
Inpatient Hospitalization Medical Facility Services Anesthesiologists	 Deductible/Co-insurance Deductible/Co-insurance	 Deductible/Co-insurance Deductible/Co-insurance
Home Health, Skilled Nursing & Hospice Care	Deductible/Co-insurance	Deductible/Co-insurance
Mental Health & Substance Abuse	Deductible/Co-insurance	Deductible/Co-insurance
Durable Medical Equipment	Deductible/Co-insurance	Deductible/Co-insurance
Prescription Drug Benefits	$10 / $35 / 25%	Not Covered

Flex Series 2500		
	In-Network	**Out of Network**
Deductible	$2,500 Single/$5,000 Family	$5,000 Single/$10,000 Family
Co-Insurance	0%	50%
Co-Insurance Maximum	$6,350 Single/$12,700 Family	$9,000 Single/$18,000 Family
Preventive Services	100%	100%
Professional Office Visits	$30 Copay Primary Care $50 Copay Specialist	Deductible/Co-insurance
Outpatient Lab	$35 Copay	Deductible/Co-insurance
Outpatient Radiology	Deductible/Co-insurance	Deductible/Co-insurance
Diabetic Supplies	Deductible/Co-insurance	Deductible/Co-insurance
Allergy Treatment	$25 Copay, then 100% to $100 per visit	Deductible/Co-insurance
Outpatient Rehab & Therapy **Chiropractic Services**	Deductible/Co-insurance Deductible/Co-insurance	Deductible/Co-insurance Deductible/Co-insurance
Professional Services	Deductible/Co-insurance	Deductible/Co-insurance
Emergency Services Hospital ER (Facility Charge Only)	$150 Copay	$150 Copay, then 100% to $1,000 per visit, then Deductible/Co-insurance
Urgent Care/ER Professional Services	$50 Copay, then 100% to $300 per visit, then Deductible/Co-insurance	Deductible/Co-insurance
Ambulance	Deductible/Co-insurance	Deductible/Co-insurance
Outpatient Surgical & Therapeutic Procedures Medical Faciltiy Services Physician and Surgeon Fees	 Deductible/Co-insurance Deductible/Co-insurance	 Deductible/Co-insurance Deductible/Co-insurance
Inpatient Hospitalization Medical Facility Services Anesthesiologists	 Deductible/Co-insurance Deductible/Co-insurance	 Deductible/Co-insurance Deductible/Co-insurance
Home Health, Skilled Nursing & Hospice Care	Deductible/Co-insurance	Deductible/Co-insurance
Mental Health & Substance Abuse	Deductible/Co-insurance	Deductible/Co-insurance
Durable Medical Equipment	Deductible/Co-insurance	Deductible/Co-insurance
Prescription Drug Benefits	$10 / $35/ 25%	Not Covered

Flex Series 5000		
	In-Network	**Out of Network**
Deductible	$5,000 Single/$10,000 Family	$10,000 Single/$20,000 Family
Co-Insurance	0%	50%
Co-Insurance Maximum	$6,350 Single/$12,700 Family	$12,500 Single/$25,000 Family
Preventive Services	100%	100%
Professional Office Visits	$30 Copay Primary Care $50 Copay Specialist	Deductible/Co-insurance
Outpatient Lab	$35 Copay	Deductible/Co-insurance
Outpatient Radiology	Deductible/Co-insurance	Deductible/Co-insurance
Diabetic Supplies	Deductible/Co-insurance	Deductible/Co-insurance
Allergy Treatment	$25 Copay, then 100% to $100 per visit	Deductible/Co-insurance
Outpatient Rehab & Therapy **Chiropractic Services**	Deductible/Co-insurance Deductible/Co-insurance	Deductible/Co-insurance Deductible/Co-insurance
Professional Services	Deductible/Co-insurance	Deductible/Co-insurance
Emergency Services Hospital ER (Facility Charge Only)	$150 Copay	$150 Copay, then 100% to $1,000 per visit, then Deductible/Co-insurance
Urgent Care/ER Professional Services	$50 Copay, then 100% to $300 per visit, then Deductible/Co-insurance	Deductible/Co-insurance
Ambulance	Deductible/Co-insurance	Deductible/Co-insurance
Outpatient Surgical & Therapeutic Procedures Medical Faciltiy Services Physician and Surgeon Fees	 Deductible/Co-insurance Deductible/Co-insurance	 Deductible/Co-insurance Deductible/Co-insurance
Inpatient Hospitalization Medical Facility Services Anesthesiologists	 Deductible/Co-insurance Deductible/Co-insurance	 Deductible/Co-insurance Deductible/Co-insurance
Home Health, Skilled Nursing & Hospice Care	Deductible/Co-insurance	Deductible/Co-insurance
Mental Health & Substance Abuse	Deductible/Co-insurance	Deductible/Co-insurance
Durable Medical Equipment	Deductible/Co-insurance	Deductible/Co-insurance
Prescription Drug Benefits	$10 / $35 / 25%	Not Covered

Program Highlights

Who is Idilus?

Idilus is a national PEO with administrative offices in Chicago and the NY Metropolitan Area. They specialize in serving smaller high end service businesses that expect white glove service. They are most often characterized in the industry as a "Boutique PEO". Idilus is a PEO that is a co- employer organization that has the capability of ***AGGREGATING*** *hundreds of small employers including sole proprietors allowing each small businessperson to purchase better, more cost effective employee benefits while receiving services that are reserved for Fortune 100 companies.*

Who is this program available to?

This program is being rolled out to the New York Metropolitan area with enhanced benefit options. It will cover all businesses from one employee (sole proprietor) to one hundred.

How does it work?

Idilus' responsibilities under their agreement with the employer include the setting up of a payroll relationship with each business and their employees even if there is only one employee, a sole proprietor. The small business employees (including sole props) are also W-2 employees of Idilus, a PEO. Each small business owner (sole props included) will determine the payroll frequency they wish to utilize. The payroll frequency could be weekly, bi-weekly, semi-monthly, monthly, quarterly, or semiannually. Idilus will at each pay date deduct from the 'business account' the gross payroll and all taxes associated with the payroll being paid. This is the same procedure that payroll companies such as ADP and Paychex utilize, they deduct the employee and employer taxes with each payroll. The taxes will then be forwarded on, lessening or eliminating the need for sole proprietors to have to file estimated quarterly taxes (they should check with their accountant). The "pay check" will be net of all taxes due for that pay period. The actual *EMPLOYEE "pay check"* will be direct deposited back into the account the now employee has chosen, seventy two (72) hours after the payroll encumbrance. Idilus as stated earlier will be deducting both the employer portion as well as the employee portion of the taxes due.

Idilus, once they receive the paperwork and applications fully completed, will contact each new employer group to set up their payroll & enroll them in the medical benefits plan.

Idilus' PEO Products & Services

Idilus does not have management responsibility for your employees; they merely provide benefits and payroll expertise along with HR support. Idilus is not interested in running their clients business only advising as needed.

***Workers Compensation Insurance;** is provided to most member firms as part of the basic package charge. This is a benefit for sole proprietors who currently can't carry workers comp. The AMTRUST is the workers comp carrier.

State Disability Insurance; is provided to all employers, down to one life, Deducted and remitted by Idilus to the carrier.

Unemployment Insurance; with Idilus is being extended to Sole Proprietors. Sole Props will be covered for unemployment insurance benefits. They will be eligible for them upon separation of service form Idilus.

***Tax & Payroll services;** is provided as part of the basic package. Payroll frequencies are:

Sole Props:

Monthly, Quarterly

Groups:

Weekly, Bi-weekly, Semi-monthly, monthly

Each employer will choose the frequency that best fits their situation.

***Employee Assistance Program (EAP);** Idilus sponsors an EAP and it is available to all employee groups down to one life.

***Employers Practice Liability Insurance;** Idilus provides to all member employers as part of the basic package an Employees Practice Liability policy, and Human Resource consulting as needed.

The minimum annual payroll for sole proprietors is $15,000 annually for a single and $15,000 annually for a family employee. Federal, State and local **Tax Services** are processed as part of the basic package.

Sole proprietors will now be able to budget their tax payments with their payroll frequency, not having to file estimated quarterly taxes. Sole proprietors will receive Unemployment Benefits & Workers Compensation. FUTA and SUTA payments will be deducted and remitted as the Federal, State, and local taxes are.

**Included in basic services. (There is no additional charge for these products and services)*

Idilus Optional Benefit Services and Products

- Life Insurance provided on a ***guaranteed issue*** basis.
  ($50,000 @ $14.00 per month)

- Dental Insurance provided on a ***guaranteed issue*** basis.
  (2 plans: PPO $1500 Max with Orthodontia or $1,000 Max, No waiting periods on any services)

- Group Long Term Disability Insurance on a ***guaranteed issue*** basis.
  (90 Day wait, 5 Year payout, up to $10,000 benefit, Own Occupation)
  The benefit is determined by the salary amount set by the employer or sole proprietor. The disability insurance benefit payable is coordinated with the social welfare programs.

- Accident Indemnity Insurance on a ***guaranteed issue*** basis.

- Lump Sum Critical Illness Insurance with simplified underwriting.
  ($10,000 $25,000 $35,000)

- Medical Plan: Idilus offers a Fully Funded health plan. Fully funded means no risk for the employer and a health plan that utilizes the nation's largest PPO Network, accepted by 90% of all physicians in the United States.

The Medical plan has 6 different options with low deductible and out of pocket maximums; the plan then pays covered charges at 80%. Plan has in and out of network benefits. The plan has a full drug card. ***The plan summary follows, for specific plan details. The Plan has been around for close to a decade and is reinsured by A rated international reinsurance companies and has over 40,000 plan members***

All applications need to be submitted by the 25th of the month for the following month start.

Idilus-HR is an outsourced Human Resources provider. In a global marketplace filled with companies trying to get your payroll business, Idilus-HR offers you a team of professionals who are more personal, more adaptable to custom solutions, more local, you're more complete choice. We really will make your entire Human Resources process easier for you to manage.

When you bring Idilus – HR on board, you will not be just outsourcing payroll, you will be hiring your own dedicated Human Resources and Payroll Departments.

We offer customized one-of-a-kind Human Resources solutions for your unique business needs. We believe, as you do, that if you invest in your human resources, the returns will be limitless.

We know you don't have time to do it all, you're running a business. Yet, you still want a professional team to turn to that will take your employees concerns as seriously as you do. You don't want to hire additional employees and train them in areas in which you are not an expert. Your evenings and weekends should be yours – not spent with complex employee issues.

Health Application Form

Section 1: Employer Information

Employer Name: _____ Hire Date: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Section 2: Employee Information

Employee Name: _____ Date of Birth: _____

Last First M.I.

Address: _____ _____

Job Title

_____

City State Zip

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Home Phone: (_____) _____ Cell Phone: (_____) _____

E-mail Address: _____ Hours Worked per Week: _____

Spouse's Employer: _____ Spouse's Business Phone: (_____) _____

Section 3: Other Insurance Coverage

Are you or any dependent(s) disabled ☐ YES ☐ NO If YES, please indicate name(s): _____

Do you or your spouse have other health insurance? ☐ YES ☐ NO If YES, name of Carrier: _____

Policy Holder's Name: _____ Policy #: _____ Effective Date: _____

Name of Covered Dependents: _____

Section 4: Prior Coverage Information

To eliminate or reduce pre-existing condition waiting periods; a copy of your Certificate of Creditable Coverage from your current carrier will be required when enrollment in the program is completed. Submission of your prior coverage information does not automatically waive any pre-existing condition limitations.

Section 5: Subscriber / Dependents

(Please complete for employee subscriber and all participating dependents.)

First Name MI Last Name	Social Security #	DOB	Age	M / F	Tobacco Use YES / NO

Section 6: Health Plan Enrollment

☐ I elect to participate
☐ I decline participation

Coverage Level

☐ Employee Only
☐ Employee / Spouse
☐ Employee / Child(ren)
☐ Family

Plan Selected

Options provided upon underwriting approval

Section 7: Health Information

Please furnish us with the height and weight or you and your spouse:

Self: Height ____ feet _____ inches; _____ Weight **Spouse:** Height ____ feet _____ inches; _____ Weight

Please answer the following questions regarding any medical treatment, conditions, or medical treatment for you and your family. If you answer "Yes" to any question please provide detail in space provided below.

1. Have you or any of your dependent(s) been diagnosed or treated for any of the following conditions in the past five (5) years?

A. Cardiac Disorder	☐ Yes	☐ No	H. Aids / Immune System Disorder	☐ Yes	☐ No
B. Cancer (any form)	☐ Yes	☐ No	I. Alcohol / Drug Abuse	☐ Yes	☐ No
C. Diabetes	☐ Yes	☐ No	J. Mental / Nervous Disorder	☐ Yes	☐ No
D. Kidney Disorder	☐ Yes	☐ No	K. Neuromuscular Disorder	☐ Yes	☐ No
E. Respiratory Disorder	☐ Yes	☐ No	L. Stomach / Gastrointestinal	☐ Yes	☐ No
F. Liver Disorder	☐ Yes	☐ No	M. Arthritis, Back, Bone, Joint Disorder	☐ Yes	☐ No
G. High Blood Pressure	☐ Yes	☐ No	N. Seizures, convulsions, epilepsy	☐ Yes	☐ No

2. Within the past 5 years, have you or any dependent ever had an application for insurance declined, postponed, rated, or otherwise modified? …….. ☐ Yes ☐ No

3. Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, prescription management, or hospitalization in the amount of $5,000 or more?..... ☐ Yes ☐ No

   If Yes, please provide information on who and for what conditions in space provided below

4. Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? If Yes please provide information below….. ☐ Yes ☐ No

5. Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant? If Yes, please provide due date and detail in space provided below. …… ☐ Yes ☐ No

Question Number	Family Member	Disease / Diagnosis / Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

6. Prescriptions / Medications – Please list any medications, prescriptions, or injections taken in the last 12 months.

Family Member	Medication / Rx / Injection	Dosage	Medical Condition

Agreements

The answers and statements on this Group Enrollment Form are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its Home Office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract

Medical Authorization

I authorize any of the following to disclose any data it has on me, my health or on the health of my family. (1) any physician or other medical practitioner; (2) any hospital, clinic or other medical or medically related facility; (3) any insurance company; (4) The Medical Information Bureau; (5) any other organization, institution, or person that has any data on me or my health or on the health of my family. A copy of this shall be as valid as the original.

Fraud Warning

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Section 8: Signature

Employee Signature: _____ **Date:** _____

Form W-4 (2015)

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 2015 expires February 16, 2016. 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 2015. 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 $65,000 ($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 $65,000 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

2015

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 2015, 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)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Idilus Billing Application

Requested effective date (mm/dd/year) ____/____/____

Billing Information – Invoices should be sent to:

_____
Contact Person **Title**

E Mail Address_____ **Employer Industry**_____

_____
Company Name

_____
Address

_____
City **State** **Zip Code**

_____
Telephone **Fax**

Referred By_____

Employer Tax ID:_____ **Number of Employees:**_____

EFT Authorization for "Medical & Optional Benefit Programs"

Please Note there is a $30 Insufficient Funds Fee

Bank Name_____ **Account Name**_____

Bank Route Code#_____**Bank Account#**_____

Please deduct payment of $_____ between the 20th & 22th of the month prior to the next months coverage.

I understand this authority is to remain in full force and effect until the company has received written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by sending written notification by fax to (914) 428-8080 three (3) business days or more before this payment is scheduled to be made.

*******Please be aware that your bank statement will reflect the debit as **"Nu Era Benefits"**

Bank Account holders Name: _____

Signature of Depositor: _____

Date: ____/____/_____

PLEASE ATTACH A CHECK MARKED

VOID

TO ENSURE ACCURACY

Optional Idilus *Guardian* Benefit Upgrades

www.idilustotalsolution.com

Available only at time of enrollment of Idilus PEO Program

Cannot be added at later date after enrollment

Must enroll in Basic $50,000 Life plan to enroll in any other Riders

Dental PPO 1500	
Single	$ 75.00
E+ Spouse	$ 131.00
E+ Children	$ 124.00
Family	$ 190.00

Dental PPO 1000	
Single	$ 40.00
E+ Spouse	$ 74.00
E+ Children	$ 86.00
Family	$ 114.00

Vision Program	
Single	$ 10.00
E+ 1	$ 14.00
Family	$ 23.00

Long Term Disability (Primary only, Based on income)

Yearly Income	Monthly Income	Monthly Benefit	Rate
$28,000.00	$2,333.33	$1,400.00	**$ 17.61**
$32,000.00	$2,666.67	$1,600.00	**$ 19.35**
$40,000.00	$3,333.33	$2,000.00	**$ 22.83**
$50,000.00	$4,166.67	$2,500.00	**$ 27.17**
$60,000.00	$5,000.00	$3,000.00	**$ 31.52**
$70,000.00	$5,833.33	$3,500.00	**$ 35.87**
$80,000.00	$6,666.67	$4,000.00	**$ 40.22**
$90,000.00	$7,500.00	$4,500.00	**$ 44.57**
$100,000.00	$8,333.33	$5,000.00	**$ 48.91**
$110,000.00	$9,166.67	$5,500.00	**$ 53.26**
$120,000.00	$10,000.00	$6,000.00	**$ 57.61**
$130,000.00	$10,833.33	$6,500.00	**$ 61.96**
$140,000.00	$11,666.67	$7,000.00	**$ 66.30**
$150,000.00	$12,500.00	$7,500.00	**$ 70.65**
$160,000.00	$13,333.33	$8,000.00	**$ 75.00**
$170,000.00	$14,166.67	$8,500.00	**$ 79.35**
$180,000.00	$15,000.00	$9,000.00	**$ 83.70**
$190,000.00	$15,833.33	$9,500.00	**$ 88.04**
$200,000.00	$16,666.67	$10,000.00	**$ 92.36**

Basic $50,000 Life
(Primary Only)

Employee $ 14.50

If any optional Guardian product elected this is mandatory

$100,000 Voluntary Life (Primary Only)

18-29	$ 12.00	**30-34**	$ 13.00
35-39	$ 18.00	**40-44**	$ 30.00
45-49	$ 44.00	**50-54**	$ 65.00
55-59	$ 100.00	**60-64**	$ 155.00

These rates are monthly and in addition to the medical rate for the Idilus Program

See Next Page for brief plan summaries