AbelHR™

800-400-1968 • Fax: 609-860-0400 • AbelHR.com
2 Corporate Drive, Cranbury, New Jersey 08512-3604

National Capabilities

ABEL HR
EMPLOYEE ONBOARDING

Register as a "New User"

Home Advantages Products & Services About Us Contact Us Login

Login

Home Login

AbelHR
Your HR Friends with Benefits

We are pleased to offer a web based communication system to help you reduce administrative paperwork.

New Users

Register

New users must complete initial registration to gain access to the system.

Login

Forgot Username or Password

Company Code
abelhr

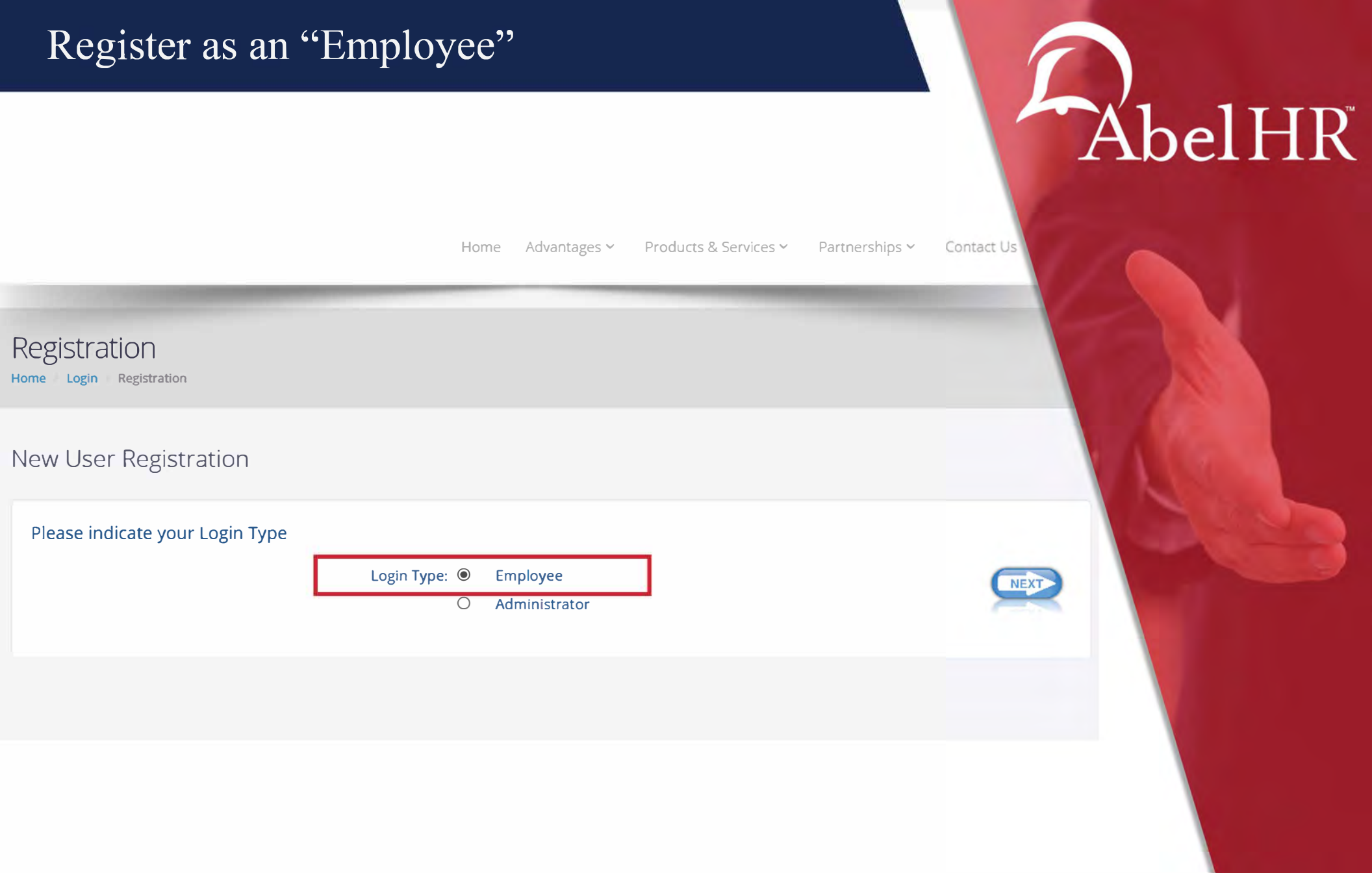
Username
Username

Password
Password

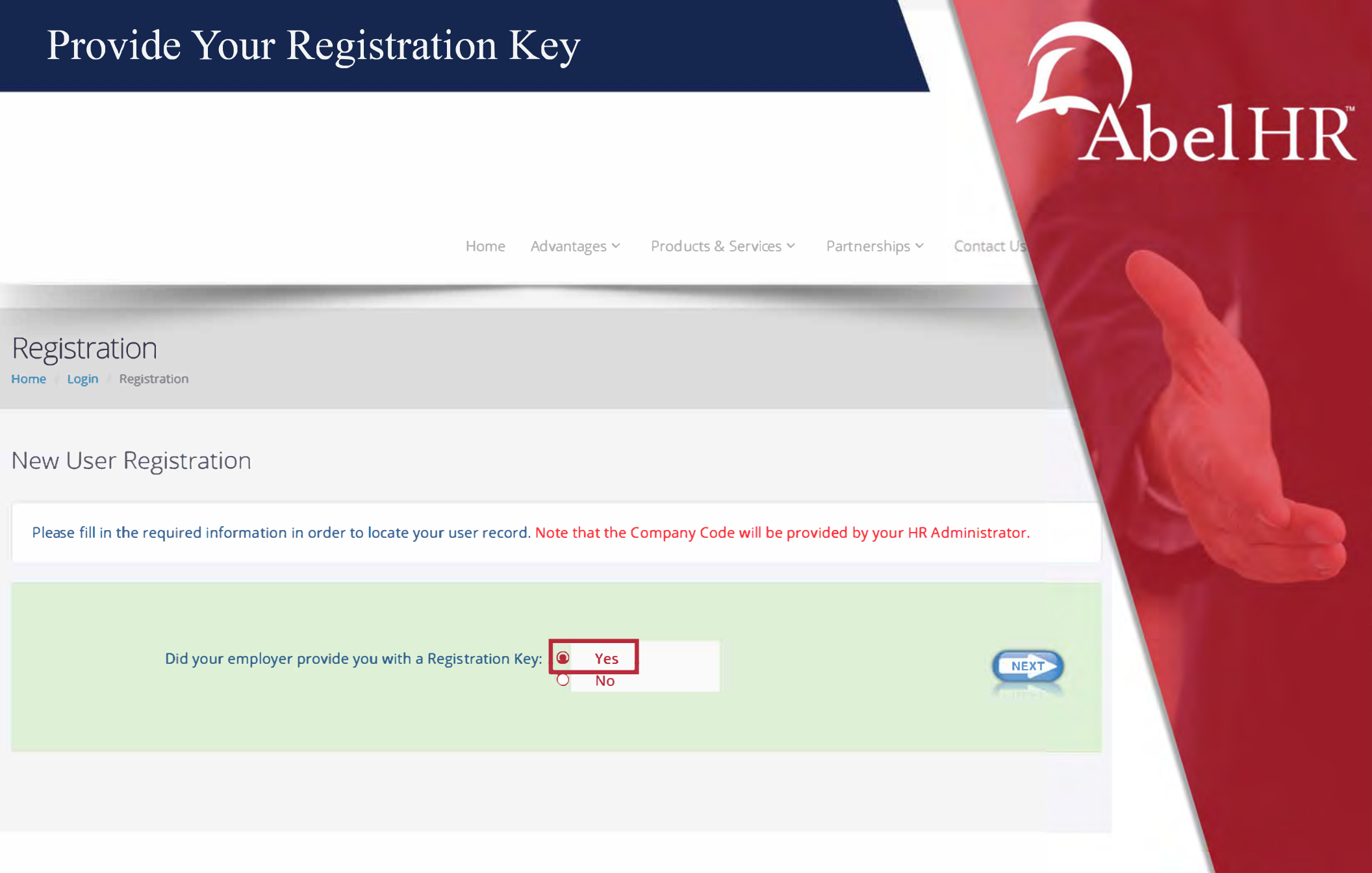
Login

AbelHR

Register as an “Employee”



Provide Your Registration Key



Create Your Account Information

Registration

Home Login Registration

Home Advantages Products & Services Partnerships Contact Us Login

New User Registration

Your record has been located. Please complete the New User Registration Process.

Username

Your Username must have at least 6 characters, cannot contain spaces, must begin with an alpha character, can contain mixed case alpha, digits, and the following special characters: (!@#$%&+?).

Password ••••••••••••

Your Password must have at least 8 characters including one capital, one lowercase, one numeric, and one special character from the following list: (!@#$%&+?).

Confirm Password ••••••••••••

Question << Please Select a Question >>

Answer Answer

Question << Please Select a Question >>

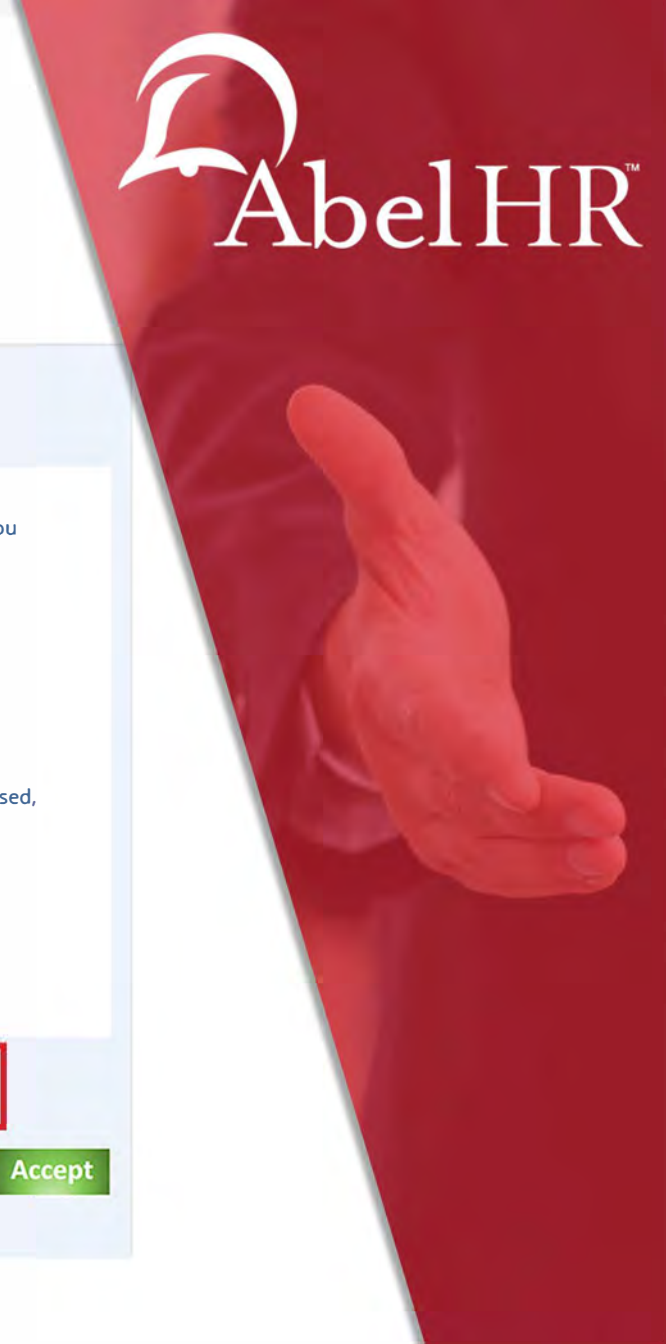
Answer Answer

Question << Please Select a Question >>

Answer Answer

Save

User Agreement



User Agreement

IMPORTANT NEW HIRE NOTICE:

The following pages are only to be completed by individuals who have received an offer of employment. If you are unclear as to whether or not you have received an offer of employment, please see your worksite supervisor immediately.

NOTE:

YOU ARE RESPONSIBLE FOR FULLY COMPLETING ALL PAGES IN THIS WEBSITE.

AGREEMENT:

By clicking on the **NEXT** button above, you acknowledge that you agree to provide all requested and required information to the best of your knowledge. You agree not to share your username and password to this site and to keep all data provided herein confidential. If a translator is used, then the translator acknowledges that they have explained and translated this agreement provision accordingly.

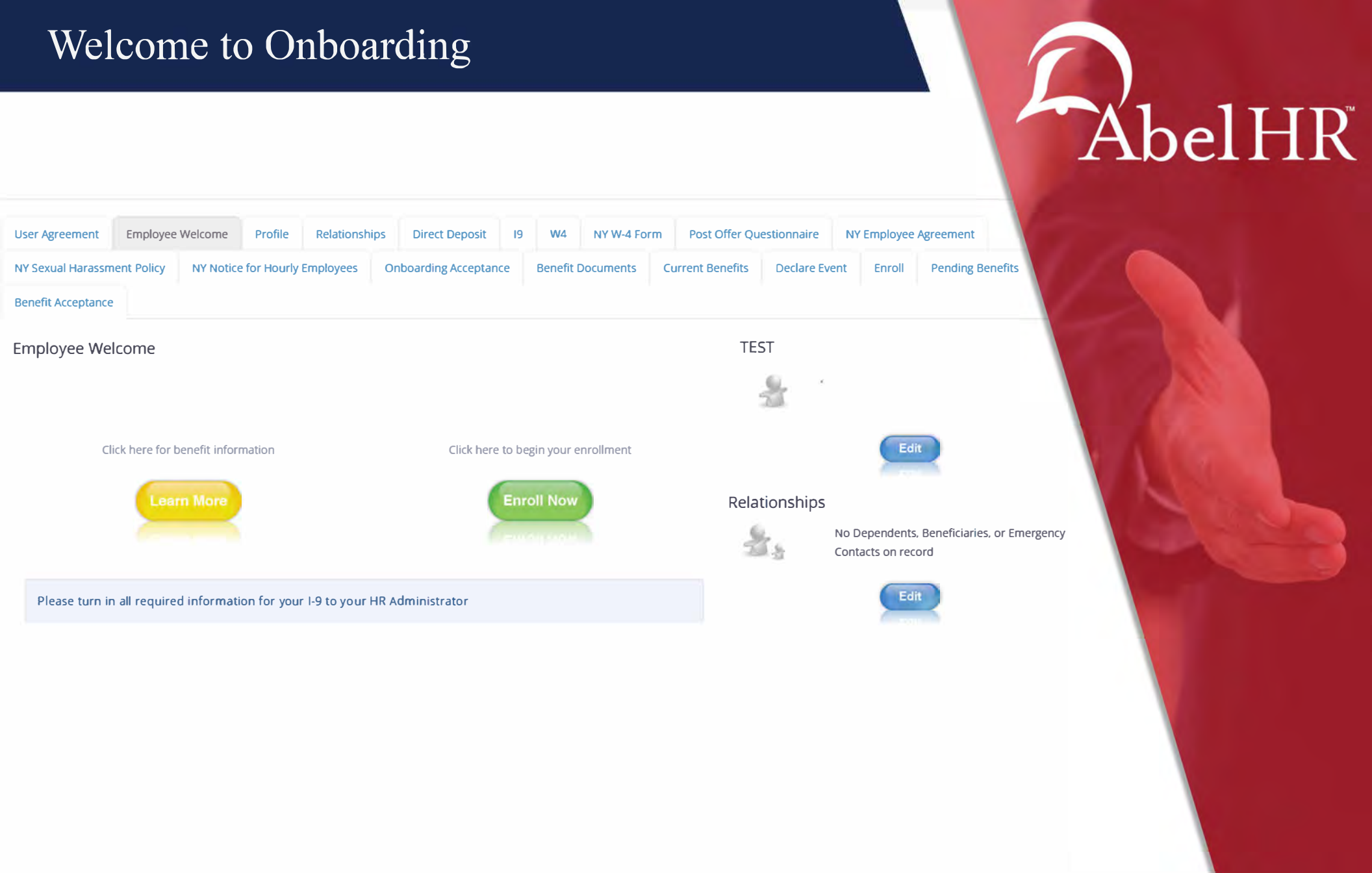
If you are not yet 18 years old, it may be ILLEGAL TO START WORK without obtaining completed working papers. **If this applies to you, DO NOT proceed until you get your Working Papers.** Working Papers MUST be obtained from the Public School District in which you live. If you have questions regarding Working Papers, please contact the HR Department at 609-860-0400 or HR@AbelHR.com

Employee Signature:

Date: 8/21/2019 4:38:31 PM

Accept

Welcome to Onboarding



User Agreement | Employee Welcome | Profile | Relationships | Direct Deposit | I9 | W4 | NY W-4 Form | Post Offer Questionnaire | NY Employee Agreement | NY Sexual Harassment Policy | NY Notice for Hourly Employees | Onboarding Acceptance | Benefit Documents | Current Benefits | Declare Event | Enroll | Pending Benefits | Benefit Acceptance

Employee Welcome

Click here for benefit information

Learn More

Click here to begin your enrollment

Enroll Now

Please turn in all required information for your I-9 to your HR Administrator

TEST

Edit

Relationships

No Dependents, Beneficiaries, or Emergency Contacts on record

Edit

Employee Profile

User Agreement | Employee Welcome | Profile | Relationships | Direct Deposit | I9 | W4 | NY W-4 Form | Post Offer Questionnaire | NY Employee Agreement | NY Sexual Harassment Policy | NY Notice for Hourly Employees | Onboarding Acceptance | Benefit Documents | Current Benefits | Declare Event | Enroll | Pending Benefits | Benefit Acceptance

Click here to update profile picture

* Required fields

Prefix: | TEST | Middl | TIFFANY

*Address: Line 1

Line 2

*City: City

*State:

*Country: USA

*Zip: Zip | Plus 4

Click radio button to choose Primary contact number

Phone: Mobile Phone | Home Phone | Work Phone

Click radio button to choose Primary Email

*Email: | Email2

Save | Cancel

*Required Fields

*SSN: | *Gender: Unknown | Language:

*Birth_Date: MM/DD/YYYY | Marital_Status: | Ethnicity:

*Employee_Number: TEST4 | Military: | Education: High School

☐ Tobacco User

Save | Cancel

Add Your Direct Deposit Information

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Direct Deposit

Employees are eligible, if they so desire, to enroll in the Direct Deposit Program. The Direct Deposit Program allows employees to have their net pay deposited into their personal savings or checking accounts. There is no charge by Abel for your participation in the Direct Deposit Program. If you have any questions, please contact Abel at 609-860-0400 or by email at payroll@ThinkAbel.com.

Please note that the completion of this form authorizes Abel to deposit funds into the named account(s). I/we understand that, in the event of a misapplication or error in the amount of funds deposited, Abel shall have the right to remove, reclaim or withdraw any incorrectly applied funds from this account(s).

I Elect to use Direct Deposit:

☐ Yes ☐ No

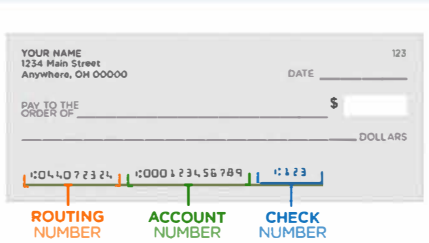
Direct Deposit Information #1

Bank Name:

Routing Number: Nine Digits / Re-enter

Account Number: / Re-enter

Account Type:



Amount Type: **$:** Used for a flat dollar amount, **%:** Used for a percentage of your pay into this account

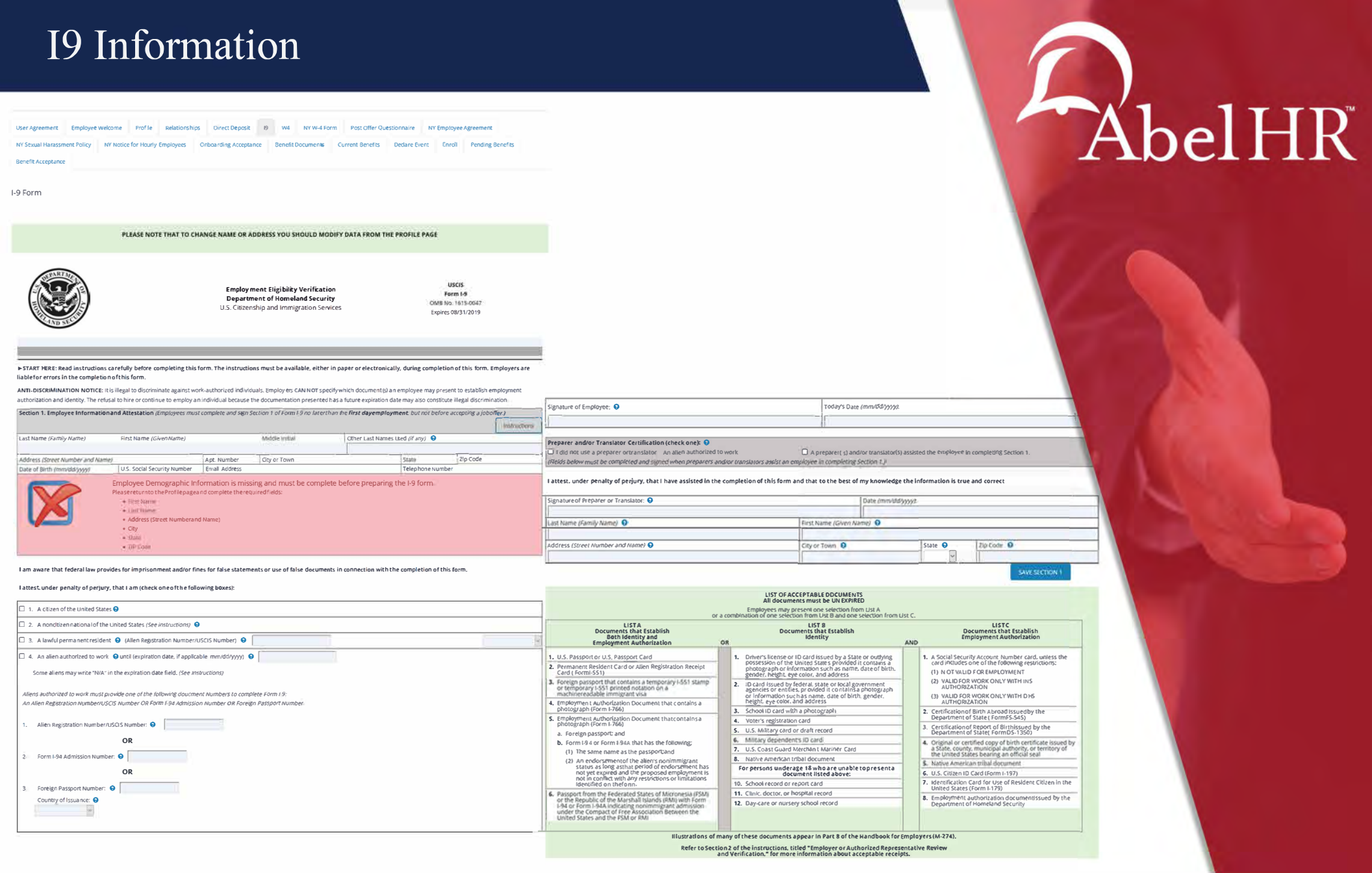
Amount:

Priority: **#:** Used to determine the order in which to allocate funds to each bank account.

Add Other Accounts

Save

I9 Information



W4 Form

Employee Welcome | Profile | Relationships | W4 | NJ W-4 Form | Benefit Documents | Current Benefits | Declare Event | Enroll | Pending Benefits | Benefit Acceptance

W-4 Form

INSTRUCTIONS

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information	**(a)** First name and middle initial	Last name	**(b) Social security number**
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.
	City or town, state and ZIP code		
	(c) ☐ **Single or Married filing separately** ☐ **Married filing jointly (or Qualifying widow(er))** ☐ **Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)**		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your income will be $200,000 or less ($400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by $2,000 ▶ $ Multiply the number of other dependents by $500 ▶ $ Add the amounts above and enter the total here		**3**	$
Step 4: (optional): Other Adjustments	**(a)** **Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income		**4(a)**	$
	(b) **Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here		**4(b)**	$
	(c) **Extra withholding.** Enter any additional tax you want withheld each pay period .		**4(c)**	$ 0

Step 5: Sign Here

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

Full Name

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

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
	Abel Administration Inc. **2 Corporate Drive** **Cranbury, NJ 08512**		

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat.No. 10220Q Form **W-4** (2020)

Save

Abel HR™

NJ W4 Form

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NY W-4 Form

INSTRUCTIONS

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

IT-2104

New York State · New York City · Yonkers

Firstname and middle initial	Last Name	Your social security number
TEST	TIFFANY	
Permanenthome address (number andstreetor ruralroute)	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 18) | 1 |

2 Total number of allowances for New York City (from line 29) | 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
	8/21/2019

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.): 08/21/2019

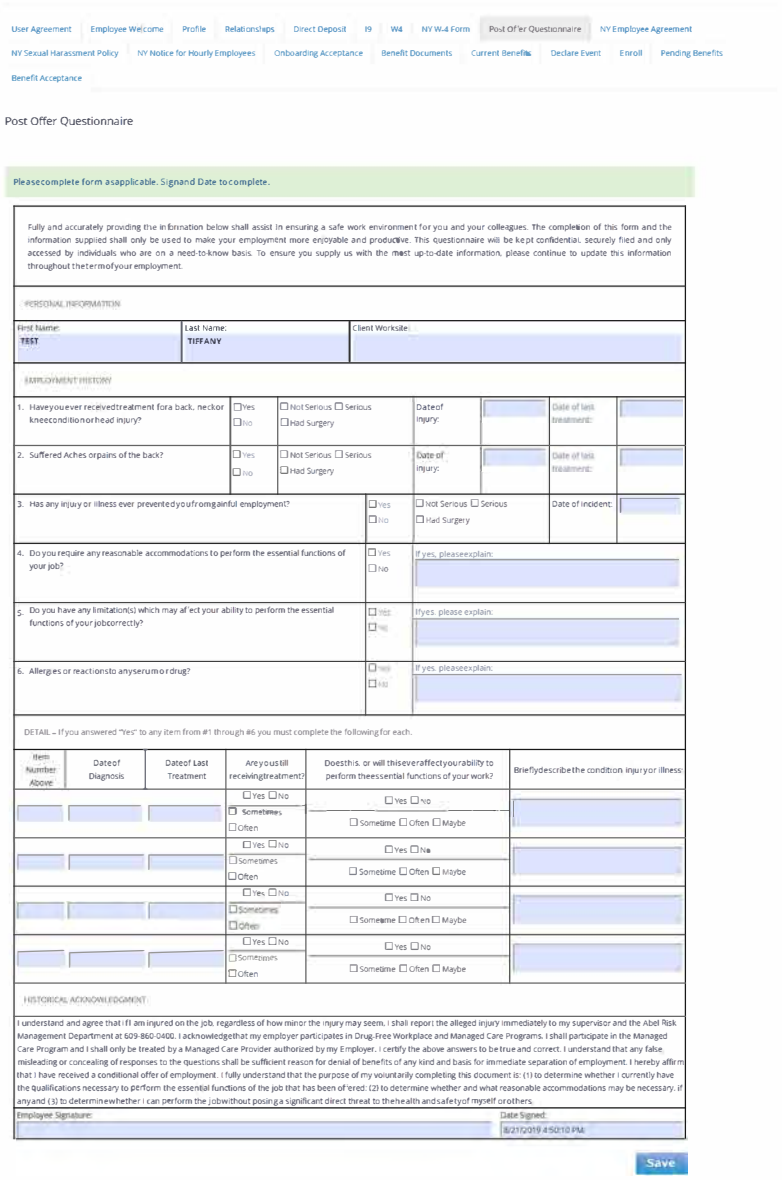
Are dependent health insurance benefits available for this employee? Yes ☐ No ☐

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
Abel HR III Inc **2 Corporate Drive** **Cranbury, NJ 08512**	27-1338271

Save

Post Offer Questionnaire



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Post Offer Questionnaire

Please complete form as applicable. Sign and Date to complete.

Fully and accurately providing the information below shall assist in ensuring a safe work environment for you and your colleagues. The completion of this form and the information supplied shall only be used to make your employment more enjoyable and productive. This questionnaire will be kept confidential, securely filed and only accessed by individuals who are on a need-to-know basis. To ensure you supply us with the most up-to-date information, please continue to update this information throughout the term of your employment.

PERSONAL INFORMATION

First Name:	Last Name:	Client Worksite:
TEST	TIFFANY	

EMPLOYMENT HISTORY

1. Have you ever received treatment for a back, neck or knee condition or head injury?	☐ Yes ☐ No	☐ Not Serious ☐ Serious ☐ Had Surgery	Date of injury:		Date of last treatment:	
2. Suffered Aches or pains of the back?	☐ Yes ☐ No	☐ Not Serious ☐ Serious ☐ Had Surgery	Date of injury:		Date of last treatment:	
3. Has any injury or illness ever prevented you from gainful employment?	☐ Yes ☐ No	☐ Not Serious ☐ Serious ☐ Had Surgery			Date of incident:	
4. Do you require any reasonable accommodations to perform the essential functions of your job?	☐ Yes ☐ No	If yes, please explain:				
5. Do you have any limitation(s) which may affect your ability to perform the essential functions of your job correctly?	☐ Yes ☐ No	If yes, please explain:				
6. Allergies or reactions to any serum or drug?	☐ Yes ☐ No	If yes, please explain:				

DETAIL – If you answered "Yes" to any item from #1 through #6 you must complete the following for each.

Item Number Above	Date of Diagnosis	Date of Last Treatment	Are you still receiving treatment?	Does this, or will this ever affect your ability to perform the essential functions of your work?	Briefly describe the condition, injury or illness:
			☐ Yes ☐ No ☐ Sometimes ☐ Often	☐ Yes ☐ No ☐ Sometime ☐ Often ☐ Maybe	
			☐ Yes ☐ No ☐ Sometimes ☐ Often	☐ Yes ☐ No ☐ Sometime ☐ Often ☐ Maybe	
			☐ Yes ☐ No ☐ Sometimes ☐ Often	☐ Yes ☐ No ☐ Sometime ☐ Often ☐ Maybe	
			☐ Yes ☐ No ☐ Sometimes ☐ Often	☐ Yes ☐ No ☐ Sometime ☐ Often ☐ Maybe	

HISTORICAL ACKNOWLEDGMENT

I understand and agree that if I am injured on the job, regardless of how minor the injury may seem, I shall report the alleged injury immediately to my supervisor and the Abel Risk Management Department at 609-860-0400. I acknowledge that my employer participates in Drug-Free Workplace and Managed Care Programs. I shall participate in the Managed Care Program and I shall only be treated by a Managed Care Provider authorized by my Employer. I certify the above answers to be true and correct. I understand that any false, misleading or concealing of responses to the questions shall be sufficient reason for denial of benefits of any kind and basis for immediate separation of employment. I hereby affirm that I have received a conditional offer of employment. I fully understand that the purpose of my voluntarily completing this document is: (1) to determine whether I currently have the qualifications necessary to perform the essential functions of the job that has been offered; (2) to determine whether and what reasonable accommodations may be necessary, if any and (3) to determine whether I can perform the job without posing a significant direct threat to the health and safety of myself or others.

Employee Signature:	Date Signed:
	8/27/2019 4:50:10 PM

Save

Abel HR™

NY Employee Agreement

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Employee Acknowledgement 1

NY Employee Agreement

I, the undersigned employee, in consideration of my at-will* employment, acknowledge and agree to the following:

- I have been retained by Abel HR ("Abel") which is a professional employer organization a/k/a employee leasing company. There is no guarantee or contract of employment which exists between me and my worksite control employer ("Client") to which I have been assigned, nor between Abel and me and Abel shall have no liability with regard to any employment agreement, if one is ever found to exist by a court or government agency of competent jurisdiction.
- I agree for the entire period of time I am actively paid by and through the Abel Program, that in the unlikely event Abel does not receive timely and full payment from Client, including but not limited to, payment for the services which I performed at or for Client, Abel shall only be responsible to compensate me at the applicable minimum wage, or for employees exempt from the overtime requirements, the legally required minimum salary, for any such pay period(s), and I consent to this method of compensation. I understand that Abel shall have no legal obligation and/or voluntarily waive any and all obligations to pay me any other compensation or benefits unless Abel has specifically, in a written agreement with me by Abel's President, adopted the Client's obligation to pay me such compensation and/or benefits. However, I do clearly understand and agree that Client, at all times, remains fully obligated to pay me any and all compensation and benefits, due and owing to me, and such obligation shall not be affected in any way by the relationship by and among the parties.
- I understand and agree that Abel shall not assume responsibility for any payment of bonuses, commissions, severance pay, deferred compensation, profit sharing, leave, vacation, sick, personal or pay for other paid time off, or for any other payment (collectively "Additional Benefits") where payment for such has not been timely and fully received by Abel from Client and agreed to, in writing, by the President of Abel. I do understand that Client, at all times, remains fully obligated for any and all Additional Benefits due and owing to me and such obligation shall not be affected in any way by the relationship among the parties.
- I agree that I shall be classified and deemed as a voluntary quit from my employment if I am a no-call or no-show for five days. Moreover, I have been informed and I agree that if my assignment at Client ends for any reason, I shall report to Abel within five calendar days for possible reassignment and that unemployment benefits shall be denied and/or delayed if I fail to strictly report.
- To the fullest extent permitted by law, in recognition of the fact that any work-related injuries which might be sustained by me are covered by state workers' compensation insurance statutes and to avoid the circumvention of such state statutes which may result from lawsuits or demands against Abel, its customers and Client based on the same injury or injuries, I hereby waive and forever release any rights, remedies and benefits I might have to make claims, bring suit, or brought by other third parties, against Abel, its customers and Client for damages, directly or indirectly, based upon injuries or the workplace accident which is/are covered under such workers' compensation statutes.
- I agree to promptly and fully comply with any drug testing policy currently in-place or which may be adopted, and I specifically agree to post-accident drug testing in any situation where it is not prohibited by applicable law.
- I understand that any and all managers, supervisors, team leaders and executives (collectively "Supervisors") at Client are not Supervisors for or on behalf of Abel, shall only be Supervisors for Client and have no supervisory or binding authority for or on behalf of Abel.
- I agree, understand and acknowledge receipt of the Anti-Bullying, Harassment and Discrimination policies and procedures including the reporting protocols and if at any time during my employment I believe I have been or am subject to any type of harassment and/or discrimination, including but not limited to harassment and/or discrimination based upon or because of race, sex, age, religion, color, retaliation, whistleblowing, national origin, handicap, pregnancy, disability, gender identity, marital status or any other legally protected classifications, I shall immediately contact Abel's President or Human Resources' Director at 1-800-400-1968 in order to obtain prompt assistance in the resolution of such matters.

*Your employment is a voluntary one and is subject to termination by any one of the parties with or without cause, and with or without notice, at any time. Nothing in any policies shall be interpreted to be in conflict with, eliminate or modify in any way the employemental will status of employees.

The policy of employment-at-will shall may not be modified by any officer or employee and shall not be modified in any publication or document. The only exception to this policy is a written employment agreement approved, at the sole discretion, of the President of Abel. The personnel policies shall not create and are not intended to be a contract or guarantee of employment.

Employee Signature: _____ Date: 8/21/2019 4:50:17 PM

Accept

Employee Acknowledgment 2

User Agreement | Employee Welcome | Profile | Relationships | Direct Deposit | I9 | W4 | NY W-4 Form | Post Offer Questionnaire | NY Employee Agreement | NY Sexual Harassment Policy | NY Notice for Hourly Employees | Onboarding Acceptance | Benefit Documents | Current Benefits | Declare Event | Enroll | Pending Benefits | Benefit Acceptance

Employee Acknowledgement 2

NY Sexual Harassment Policy

The Abel HR NY Sexual Harassment policy describes in detail important information about Abel HR's policy and procedure. I agree that if I do not fully understand anything discussed in this policy, I will contact the Abel HR Manager at 609-860-0400 or hr@AbelHR.com.

I further understand and acknowledge that the information contained within this NY Sexual Harassment policy can and does change and that these changes may supercede previously published policies. Only Abel HR corporate management can make changes to this policy.

Click Image Below to review policy.

Employee Signature: _____ Date: 8/21/2019 4:50:23 PM

Accept

NY Notice of Hourly Employees

NY Notice for Hourly Employees

Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name:
Atlantic State Advisors Inc.

Doing Business As (DBA) Name(s):

FEIN (optional):
83-2122278

Physical Address:
55 Westchester Ave, PO Box 189
Pound Ridge, NY 10576

Mailing Address:

Phone:

2. Notice given:
- [x] At hiring
- [ ] Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay:
15.00

Employers may not pay a non-hourly rate to a non-exempt employee in the Hospitality Industry, except for commissioned salespeople.

4. Allowances taken:
- [ ] None
- [ ] Tips ____ per hour
- [ ] Meals ____ per meal
- [ ] Lodging
- [ ] Other

5. Regular payday:

6. Pay is:
- [ ] Weekly
- [ ] Bi-Weekly
- [x] Other

7. Overtime Pay Rate:

$____ per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

8. Employee Acknowledgement:
On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:
- [ ] I have been given this pay notice in English because it is my primary language.
- [ ] My primary language is ____ I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

TEST TIFFANY
Print Name

Employee Signature

8/21/2019 4:50:40 PM
Date

Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.
Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibitemployees from discussing wages with their co-workers.

Save

LS 54 (01/17)

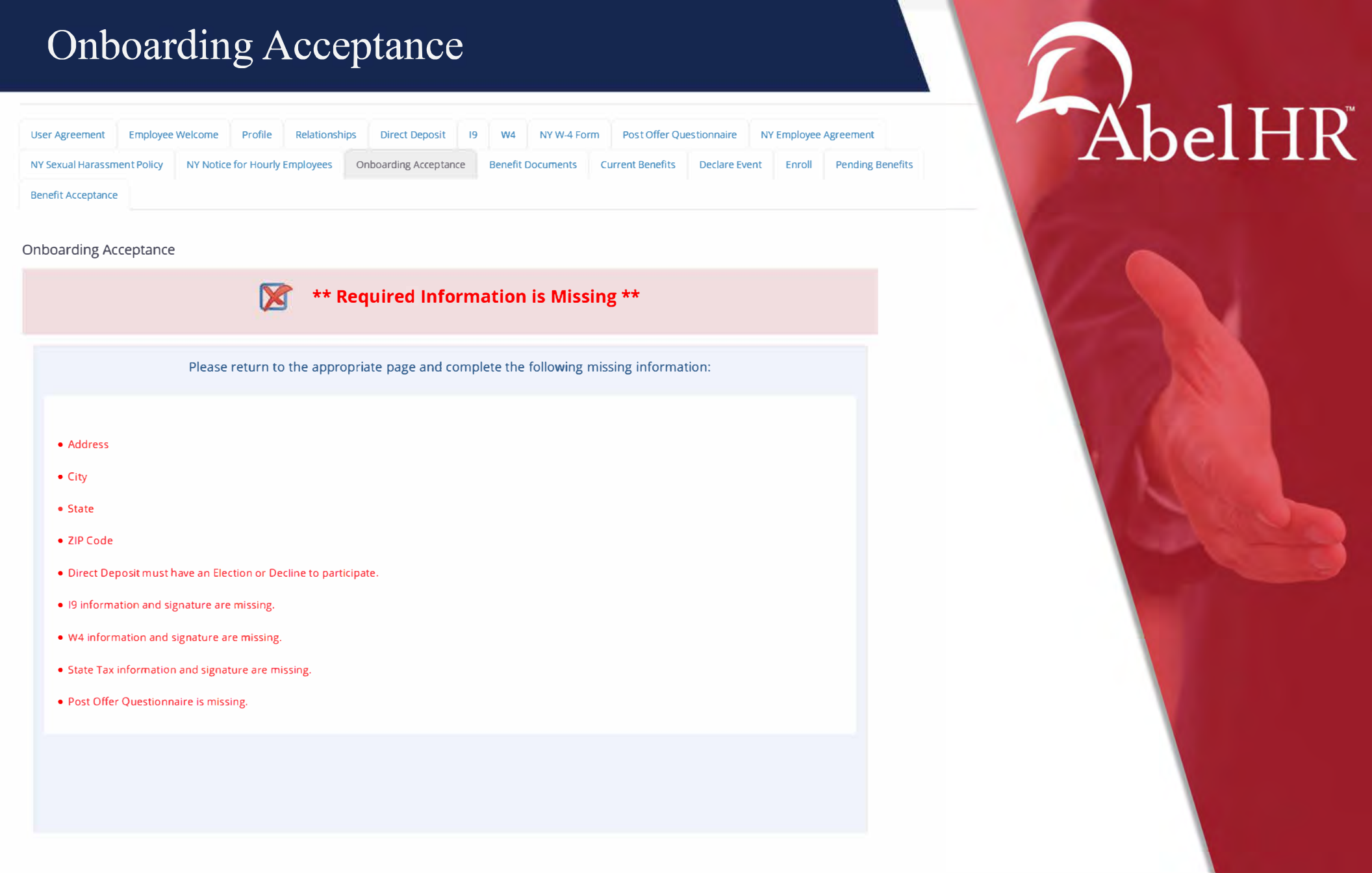
Onboarding Acceptance

Onboarding Acceptance

**** Required Information is Missing ****

Please return to the appropriate page and complete the following missing information:

- Address
- City
- State
- ZIP Code
- Direct Deposit must have an Election or Decline to participate.
- I9 information and signature are missing.
- W4 information and signature are missing.
- State Tax information and signature are missing.
- Post Offer Questionnaire is missing.



Benefit Documents

Benefit Documents

The information below represents key links and information about your Organization and their Employee Benefits. If you do not see what you are looking for, please contact your Administrator for additional assistance.

Benefit Information

Medical
Dental
Vision
Long Term Disability
Basic Life
Healthcare Flexible Spending
Dependent Care Flexible Spending
Transit
Parking

Benefit Documents

Employee Welcome | Profile | Relationships | W4 | NJ W-4 Form | Benefit Documents | Current Benefits | Declare Event | Enroll | Pending Benefits | Benefit Acceptance

Current Benefits

As of Date: mm/dd/yyyy Refresh

NEXT

*All costs are shown **Two Deductions Per Month***

Plan Description	Coverage	Effective Date	End Date	Employee	Employer	Total
Medical						
No Plan effective for the current date				$.00	$.00	$0.00
Healthcare Savings Account						
No Plan effective for the current date				$.00	$.00	$0.00
Dental						
No Plan effective for the current date				$.00	$.00	$0.00
Vision						
No Plan effective for the current date				$.00	$.00	$0.00
Long Term Disability						
Abel MetLife Employer Long Term Disability - $2,501 Monthly Benefit				$.00	$12.09	$12.09
Basic Life						
ABL MET 15K LIFE Basic Life and AD&D - $15,000 Employer Paid Benefit				$.00	$1.65	$1.65
Employee Supplemental Life						
No Plan effective for the current date				$.00	$.00	$0.00
Spouse Supplemental Life						
No Plan effective for the current date				$.00	$.00	$0.00
Child Supplemental Life						
No Plan effective for the current date				$.00	$.00	$0.00
Healthcare Flexible Spending						
No Plan effective for the current date				$.00	$.00	$0.00
Dependent Care Flexible Spending						
No Plan effective for the current date				$.00	$.00	$0.00
Transit						
No Plan effective for the current date				$.00	$.00	$0.00
Parking						
No Plan effective for the current date				$.00	$.00	$0.00
			Benefit Coverage Totals			

Abel HR™

Declare Event

Abel HR™

Welcome

Abel HR
Your HR Friends with Benefits

Powered by: HR ease

Employee Welcome | Profile | Relationships | W4 | NJ W-4 Form | Benefit Documents | Current Benefits | Declare Event | Enroll | Pending Benefits | Benefit Acceptance

Choose Your Event

Declare Event

PLEASE NOTE: Deductions are taken one month in advance of the effective date of the election. This may mean that retroactive deductions could be necessary.

Your options below will be limited to those that apply to you. If this is your Initial Enrollment period or if it is Open Enrollment, click on the **NEXT** arrow to proceed. If this is outside of your Initial Enrollment or an Open Enrollment timeframe and you have a life event, please choose the proper event below and the date of the event (not todays date - which is a default). If you do not see an option that you expect, please contact your HR Administrator for assistance.

Please note that most changes require documentation to be submitted before these will be fully enrolled. Please contact your administrator to determine what is necessary for your particular circumstances.

Event Type: << Select Event >>

Event Date: 03/16/2020

Notice

You may not change your benefit selections or any contributions made to the plan during the plan year unless there is a change in family or employment status which includes the following:

- Marriage, divorce or legal separation
- Birth, adoption or change in custody of a child
- Death of dependent
- Change in employment status of either you or your spouse which affect benefits

Any changes must be reported within 30 days of the actual event. If notification to Human Resources is not made within the required time period, you will not have the option to update your benefit coverage until the next annual enrollment period. Please take your time and make sure to understand your decision.

Enroll

User Agreement | Employee Welcome | Profile | Relationships | Direct Deposit | I9 | W4 | NY W-4 Form | Post Offer Questionnaire | NY Employee Agreement | NY Sexual Harassment Policy | NY Notice for Hourly Employees | Onboarding Acceptance | Benefit Documents | Current Benefits | Declare Event | Enroll | Pending Benefits | Benefit Acceptance

Election Pages

Medical | Dental | Vision | Long Term Dis | Basic Life | Supp Life EE | HC FSA | Dep Care FSA | Transit | Parking

NEXT

Medical

You have not made an election for Medical

Event Type: Review Info

Effective Date: 9/1/2019

% Complete 18%

Step 1: Learn about your Options

Medical Documents

- Medical - 2019 Oxford Plan 06 EPO
- Medical - 2019 Oxford Plan 08 EPO
- Medical - 2019 Summary of Benefits and Coverage Plan 06
- Medical - 2019 Summary of Benefits and Coverage Plan 08

Click here to see more information

Step 2: Elect or Decline Coverage

- (•) I choose to Elect Coverage
- ( ) I choose to Decline Coverage

Step 3: Choose Dependents to cover

Add or Edit

No Dependents found.

Step 4: Choose **Medical** Plan Option

All costs are shown Four Deductions Per Month

Plan	Plan Name	Coverage	EE Cost	ER Cost
○	Oxford PL 06 EPO T 80	Employee Only	$0.00	$169.01
○	Oxford PL 08 EPO T 80	Employee Only	$40.29	$169.01

Contribution Summary

Plan Type	EE Cost
Medical	$0.00
Dental	$0.00
Vision	$0.00
Long Term Dis	$0.00
Basic Life	$0.00
Supp Life EE	$0.00
Supp Life SP	$0.00
Supp Life CH	$0.00
HC FSA	$0.00
Dep Care FSA	$0.00
Transit	$0.00
Parking	$0.00

All costs are sh own Four Deductions Per Month

Total Employee Contribution

Pending Benefits

Pending Benefits

Existing | Pending | No Election

NEXT

*All costs are shown **Four Deductions Per Month***

Plan Description	Coverage	Effective Date	Employee	Employer	Total
Medical					
No Plan effective for the current date			$.00	$.00	$0.00
Dental					
No Plan effective for the current date			$.00	$.00	$0.00
Vision					
No Plan effective for the current date			$.00	$.00	$0.00
Long Term Disability					
No Plan effective for the current date			$.00	$.00	$0.00
Basic Life					
No Plan effective for the current date			$.00	$.00	$0.00
Employee Supplemental Life					
No Plan effective for the current date			$.00	$.00	$0.00
Spouse Supplemental Life					
No Plan effective for the current date			$.00	$.00	$0.00
Child Supplemental Life					
No Plan effective for the current date			$.00	$.00	$0.00
Healthcare Flexible Spending					
No Plan effective for the current date			$.00	$.00	$0.00
Dependent Care Flexible Spending					
No Plan effective for the current date			$.00	$.00	$0.00
Transit					
No Plan effective for the current date			$.00	$.00	$0.00
Parking					
No Plan effective for the current date			$.00	$.00	$0.00
		Benefit Coverage Totals	**$0.00**	**$0.00**	**$0.00**

Benefit Acceptance

Benefit Acceptance

Some required information is not complete. Please return to the *Employee Profile* tab and provide the following: SSN, Address Line 1, City, State, Zip, Birth Date, Gender

% Complete

18%

Contribution Summary

Total Employee Contribution

You must confirm your elections

NOTE: You must enter your initials and date and click on the **ACCEPT** button or your elections will not be fully processed. However, you may exit at any time and return later and the elections that you see on the "Review Pending" page will be available to continue. These pending elections will remain until the allowed timeframe to make elections has expired.

I agree that by clicking on the **ACCEPT** button that:

I hereby authorize my company to reduce my wages by the amount indicated on the **Review Pending** benefits page.

I understand that the enrollment elections I have made will remain in effect until the next annual enrollment period. Some benefits may not be changed unless I have a qualifying life change event such as marriage or divorce, birth or adoption of a child, change in employment status, death of a spouse or dependent, or change in spouse's employment status.

I declare that all of the information on this enrollment form is true and correct to the best of my knowledge.

I understand that information contained in this website is of a confidential nature. I will not disclose any of the data contained herein to any unauthorized persons or entities.

I agree that the username and password that I used to enter this Website represents my signature for any and all elections and changes made in this system.

Employee Signature: Date: 8/21/2019 4:52:24 PM

Accept

AbelHR™

To schedule a *LIVE DEMO*:

Please call 800.400.1968 or email us at info@AbelHR.com and a member of our staff will be glad to assist you.