

2012 Benefits Overview

Client Elective Benefits

Please check with your supervisor to see if other group benefits may be available for your worksite

- Simple HR Large Group Term Life Insurance
- Simple HR Flexible Spending Account
- Client-based Group Healthcare Plans
- Simple HR 401(k) Plan
- Simple HR Employee Assistance Program
- **SimplePay** Pay Card

Simple HR Voluntary Benefits

Available to every eligible employee!

- Guardian Dental
- Guardian Vision (VSP)
- Pre-Paid Legal Services
- Identity Theft Shield
- SYMETRA Defined Benefits
- Allstate Supplemental Insurance Benefits

(Please remember that the Client may offer their own worksite benefits)



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

Northeast Regional Office
PO Box 26040
Lehigh Valley PA 18002-6040

Bridgewater Office
PO Box 425
E. Bridgewater MA 02333-0425

Western Regional Office
PO Box 2454
Spokane WA 99210-2454

**Enrollment Form
For Non-Medical Coverages**

Planholder Name (Company Name) Simple HR				Group Plan No.		Division		Class		
Planholder Street Address					City			State	Zip	
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION CHANGE: <input type="checkbox"/> INCREASE <input type="checkbox"/> ADD DEPENDENT(S)/RIDER(S) <input type="checkbox"/> PREMIUM CLASS										
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED										
Name (Last, First, Middle Initial)				Sex	Birthdate		Employee Social Security #			
Employee:				<input type="checkbox"/> M <input type="checkbox"/> F						
Are you <input type="checkbox"/> Actively at work <input type="checkbox"/> Retired										
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed						Dependent Children: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of Marriage:										
Date of Full Time Employment	Hrs. Worked / Week	Annual Salary \$	Occupation / Job Title			Beneficiary(s)				
						Name (Last, First, Middle)		Relationship	%	
Employee's Street Address			City	State	Zip	Name (Last, First, Middle)		Relationship	%	
Business Phone #		Home Phone #		Email Address						
Name (Last, First, Middle Initial)				Sex	Birthdate		Dependent Social Security #			
Spouse:				<input type="checkbox"/> M <input type="checkbox"/> F						
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F						
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F						
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F						
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F						
(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): Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No										
(3) Do any dependents reside at a different address than indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name and address:										
(4) Do any dependent children have a mental or physical handicap or developmental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name(s):										

Please remember:

- The standard waiting time for these benefits is 90-days to first day of the following month.
- Please complete this application and forward to Simple HR (Fax: 850-650-9934).
- You must elect or decline participation in the benefits offered on the reverse side of this form.
- Your deductions will always begin 30-days prior to your effective date of coverage.
- Please sign and date your application.

VISION COVERAGE ELECTION: Issued by: The Guardian Life Insurance Company of America

- Employee
- Employee + ONE Dependent (One Child or Spouse)
- Employee + TWO OR MORE Dependents (Family or Children)
- I decline coverage for Employee Spouse Child(ren). I understand if I elect coverage at a later date, late entrant penalties will apply. If declining coverage, are you covered under another vision plan? Yes No
- If declining dependent coverage, are your dependents covered under another vision plan? Yes No

DENTAL COVERAGE ELECTION: Issued by: The Guardian Life Insurance Company of America

- Employee High Option
- Spouse Low Option
- Child(ren)
- I decline coverage for Employee Spouse Child(ren). 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? Yes No
- If declining dependent coverage, are your dependents covered under another dental plan? Yes No

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or my life coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- I understand that life 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 knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

X SIGNATURE OF EMPLOYEE	DATE
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PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN



Allstate PRODUCTS OFFERED THROUGH Simple HR

In our continuous efforts to make the best possible benefits options available to our employees, Simple HR offers a menu of additional supplemental insurance plans through Allstate Workplace Division.

Allstate programs fill in the gaps of major medical coverage and pay directly to you above and beyond your medical insurance.

Allstate plans:

- Are portable – they can be continued on a non-payroll basis at the same group rate upon termination
- Are pre-taxed – saving you tax dollars on the premiums

Allstate programs help with:

- Deductibles
- Co-Payments
- Out of pocket expenses
- Loss of earning power
- Expenses not covered by other insurance

We encourage you to ask about additional information to better understand how the Allstate plans can help protect you and your family when a medical event occurs.

ACCIDENT

... Helps cover the expenses associated with an accidental injury. Benefits are determined by state but may include:

- Emergency Treatment
- Initial Hospitalization and Confinement
- Accidental-Death and – Dismemberment
- Specific-Sum Injury
- Wellness

HOSPITAL CONFINEMENT INDEMNITY

... Helps cover the expenses associated with hospital stays. Benefits are determined by state and plan level selected, but may include:

- Daily Hospital Confinement
- Rehabilitation Unit

CANCER / SPECIFIED-DISEASE

... Pays a First-Occurrence Benefit when diagnosis of internal cancer is made. Benefits are determined by state but may include:

- Hospital Confinement

- Surgery
- Radiation and Chemotherapy
- National Cancer Institute (NCI) Evaluation / Consultation
- Cancer Screening Wellness

SHORT-TERM DISABILITY

... Helps provide income for an off-the-job sickness or injury. Choice of benefit periods (3,6,12, or 24 months), benefit amounts, and elimination periods available.

LIFE INSURANCE

... Helps provide Life Insurance to include Whole Life and Term Life with amounts up to \$200,000 depending on health conditions. May be used on top of Simple HR Term Life.

SPECIFIED HEALTH EVENT

... Pays benefits for such life-threatening conditions as:

- Stroke
- Heart attack and coronary artery bypass surgery
- Major human organ transplant
- Coma
- Third-degree burns
- Paralysis

Includes benefits for hospital confinement and continuing care.

HOSPITAL CONFINEMENT SICKNESS INDEMNITY

... Helps cover the expenses associated with hospital stays due to major illnesses. Benefits are determined by state and plan level selected, but may include:

- Physician Visits
- Initial Hospitalization
- Hospital Confinement
- Major Diagnostic Exams
- Surgical

Other valuable Allstate products may also be offered. Please contact Simple HR Benefits for additional information.



Allstate Workplace Division Supplemental Benefits

BENEFIT REQUEST FORM

Please complete the personal history information requested below:

NAME: _____

BIRTH DATE: _____ SMOKER? Yes No

Please select ***any*** of the Supplemental Benefit Plans that you may be interested in by checking the appropriate box and circle the coverage you desire for each benefit. An Allstate Representative, sponsored by Simple HR, will contact you for specific rate information. You will have the opportunity to accept or decline any of the plans you may have selected on this form. After enrolling, your deduction(s) will normally begin 30-days prior to your effective date. Typical rates average \$5-25 per weekly payroll deduction, per policy. Contact Shannon Coccia at 850-650-9935, ext 37 if you have any questions.

- | | | |
|--------------------------|----------------------|-------------|
| <input type="checkbox"/> | DISABILITY INSURANCE | EO ES EC EF |
| <input type="checkbox"/> | ACCIDENT INSURANCE | EO ES EC EF |
| <input type="checkbox"/> | SICKNESS INDEMNITY | EO ES EC EF |
| <input type="checkbox"/> | CANCER INSURANCE | EO ES EC EF |
| <input type="checkbox"/> | HOSPITAL CONFINEMENT | EO ES EC EF |
| <input type="checkbox"/> | LIFE INSURANCE | EO ES EC EF |
| <input type="checkbox"/> | SPECIFIED HEALTH | EO ES EC EF |

EO-employee only; ES-employee+spouse; EC-employee+child; EF-employee+family

NOTE: PLEASE RETURN THIS FORM DIRECTLY TO THE SIMPLE HR BENEFITS DEPARTMENT.



Symetra Select Benefits

Symetra Select Benefits provides valuable supplemental life and health insurance coverage for you and your eligible family members. Select Benefits can also be a valuable supplement to any major medical plan you or your dependents may already have. **Please note — Select Benefits is not a replacement for a major medical policy.**

Plan Features

- No deductibles or Co-Pays for medical benefits (some optional benefits may contain deductibles and co-pays)
- No limitations on pre-existing conditions
- No Network limitations (i.e., no PPOs or HMOs)
- No additional charge for dependents in most cases

Advantages to the Client

- No minimum number required to participate
- Attractive rates which cover the employee and any number of dependents
- A small contribution required by the Client versus the minimum of 50% requirement for major medical plans
- Most employees can afford this coverage with great coverage in all areas
- Can offer your employees peace of mind for important emergencies to the hospital and routine doctors visits (however, it does not cover major medical expenses)
- Enrollment is completely voluntary

Attached is a plan matrix to compare all three plans and the rate applicable to each plan. Applications must be completed in full and returned to the Simple HR Benefits Department at least 30 days prior to the date the coverage will be effective (always to the 1st day of the following month). More in-depth information is available **upon request.**

Should you have any questions concerning this benefit, please contact the Benefits Department at 850-650-9935, extension 37.

NOTE: The original benefit applications **MUST** be completed, signed, dated, and returned to Simple HR.

**ENROLLMENT
FORM**

Mail or Fax to:
Simple HR
P.O. Box 726
Destin, FL 32540-0726
Fax: (850) 650-9936

PART I – TO BE COMPLETED BY THE EMPLOYEE

Employee's Name (Last, First, Middle)		Social Security #	Date of Birth / /	Case Number 84750 <input type="checkbox"/> 84760 <input type="checkbox"/> 84770 <input type="checkbox"/>
Employee's Home Address		City	State	Zip Code
Employer's Name Pyramid Diversified Services				Sex <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Legally Separated				Date of Employment / /
Do you have an eligible spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of eligible Children:	Indicate eligible dependents you wish to insure: <input type="checkbox"/> None <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Spouse & Children		

DEPENDENT INFORMATION – Complete If You Are Requesting Family Coverage

No person can be insured under this policy as both an Employee and a dependent, or as a dependent of more than one Employee. Please complete the following information for each family member you wish to cover.

Dependents Name (Last, First, Middle)	Sex	Date of Birth	Relationship to Employee	Full-Time Student
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

BENEFICIARY DESIGNATION

PRIMARY (P) – The person(s) you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage (%) has not been designated, then each will receive an equal share of the benefit.

CONTINGENT (C) - The person(s) you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage (%) has not been designated, then each will receive an equal share of the benefit.

NOTE: The Group Policyholder may not be named as a Beneficiary.

BENEFICIARY DESIGNATION

Full Name & Address	Date of Birth	Relationship	Primary (P) Contingent (C)	% of Benefit

This Is Important – Please Read

A new Enrollment Form must be completed for any changes such as name change, beneficiary change, birth of a child, adoption of a child. The new form must be **dated, signed, and attached** to your original Enrollment Form.

This Election for Coverage Cannot Be Processed Unless All Questions Are Answered And The Form Is Signed And Dated.

DECLINATION OF INSURANCE

I have been given the opportunity to elect the Group Insurance Benefits as provided under a plan of Group Insurance established by my Employer. I have decided **NOT** to elect this coverage. I understand that if I decide to elect this insurance at a later date, satisfactory proof of insurability will be required at my expense.

Employee Signature

Date Signed

YES, I DO WANT THIS COVERAGE.

- I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company.
- I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance. **(Not applicable if the Employer pays 100% of the required contribution).**
- I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.
- All information submitted by me on this form at Symetra Life Insurance Company's request, to the best of my knowledge and belief, is true and complete.

Employee Signature

Date Signed

PART II – TO BE FILLED OUT BY THE EMPLOYER.

New Employee Late Entrant Enrollee Open Enrollment

Change Requests – Effective Date of Change ____/____/____ Effective Date of Coverage ____/____/____

Case Number 84750 84760 84770 Plan/Package Selected _____





LegalShieldSM
Total access. Total freedom.

Identity Theft Shield

It's no secret: Identity Theft is a major problem in America.

Think you're not at risk? Unfortunately, you are.

- Do you hand your credit card to servers at restaurants?
- Do you sign your credit cards?
- Do you supply personal information over the Internet?
- Do you keep your Social Security number in your wallet or purse?
- Do you leave mail at your home or business for the postal carrier to collect?
- Do you shred unwanted mail with personal information?

What does the Identity Theft ShieldSM Cover?

- ***Credit Reports***
- ***Continuous Credit Monitoring***
- ***Identity Restoration***

LegalShield Plan Benefits

Preventative Legal Services

- Legal Consultation & Advice
- Letters & Phone Calls
- Contract & Document Review
- Will Preparation

Motor Vehicle Legal Services

- Minor and Major Legal Expenses

Trial Defense Services

- Up to 60 Hours of Attorney Time

IRS Audit Legal Services

- Up to 50 Hours of Attorney Time

Preferred Member Rates

- Receive 25% off your Provider Law Firm's standard rate



EMPLOYEE
BENEFIT

membership application

Pre-Paid Legal Services®, Inc., and subsidiaries
Corporate Offices:
P.O. Box 145 • Ada, OK 74821-0145

Pre-Paid Legal Services, Inc., Associate Use Only

- CHECK ONE** Pre-Paid Legal Services®, Inc.
 Pre-Paid Legal Casualty™, Inc.
 Pre-Paid Legal Services of Tennessee, Inc.
 Pre-Paid Legal Services, Inc. of Florida
 National Pre-Paid Legal Services of Mississippi, Inc.
 Legal Service Plans of Virginia, Inc.
 Ohio Access to Justice, Inc.
administered by Pre-Paid Legal Services®, Inc.

- CHECK ALL THAT APPLY*** Standard Plan Expanded Plan
 Commercial Drivers Legal Plan (\$25 Enrollment Fee)
 Law Officers Legal Plan Exp. Law Officers Legal Plan
 Home-Based Business Plan (1st time enrollee)
 HBB Rider only (must be same payment method as Expanded Plan)
 Legal Shield Other* _____

Office Use Only

CWA	
FOB	
MODE	
PLAN	
FRAN	
GR#	

*Some plans may not be available in certain states.

IR

member information

Please print.

Today's Date / /

Month / Day / Year

Time of Day _____ A.M. (Circle One)
P.M.

SSN # - -

For internal use only by PPLSI. Our privacy policy is available upon request.

Name Last _____

First _____ MI _____

Mailing Address Apt. / Ste.# _____

Street Address _____

City _____

State _____ ZIP + 4 _____

Primary Member's Date of Birth / /

Month / Day / Year

Spouse Last _____

First _____ MI _____

Work Phone - - Ext.

Home Phone - -

Email Address _____

I do not wish to receive email updates from PPLSI about my membership.
(Your privacy is a priority with us! PPLSI will not sell your email address or personal information of any kind to third party vendors.)

Associate Use Only

Assigned Associate Number _____
 Associate Name _____
 Associate SSN Number (if Licensed) _____
 Associate License Number (In Florida) _____
 Business Phone _____
 Signature of Associate

Applicant: I understand that the written contract sets forth the terms of my membership, including any exclusions or limitations, and agree to be bound by the same. I further understand that the company will mail the written contract to me at the address noted herein within the next fourteen days. If I have not received my contract within that time frame, I understand that it is my responsibility to call the Pre-Paid Legal Home Office at 1-800-654-7757 to obtain a copy. The written contract, together with this application, constitutes the entire agreement between the company and the member with respect to the membership, and there are no agreements, understandings, warranties or representations other than as set forth herein and in the membership contract.

In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any materially false, incomplete, or misleading information concerning a material fact is guilty of a felony of the 3rd degree.

I hereby acknowledge that on this date, I purchased this plan in the city of _____ in the state of _____. By signing this application I certify I am legally residing in the United States of America.

Signature of Applicant

Dependents _____ / _____ / _____
Last / First / MI Date of Birth

_____ / _____ / _____
Last / First / MI Date of Birth

_____ / _____ / _____
Last / First / MI Date of Birth

Employer _____

Occupation _____

payroll deduction authorization

I hereby authorize my employer _____ City _____ State _____ to deduct \$ _____ per month from my earnings for my Pre-Paid Legal Services®, Inc., and subsidiaries membership and to remit such amount directly to Pre-Paid. I agree that my employer will not be responsible or liable for my decision to purchase the Pre-Paid membership or the services provided through my membership and that my employer's sole responsibility is to withhold and pay my membership fee to Pre-Paid.

Print name _____ SSN _____

Date _____ **Applicant signature:**

Return to:



P. O. Box 726
Destin, FL 32540



The **SimplePay** pay card is our newest offering to our employees and clients to improve our delivery of payroll services. The **SimplePay** pay card is an enhanced branded debit pay card that features a MasterCard® Logo personalized with the employee's name. This will allow you to conduct both PIN-based and signature-based transactions. The card will also provide the added flexibility of acceptance at more than 24 million MasterCard locations worldwide, including most retailers, grocers and restaurants.

Advantages to you would include:

- No further need for a hard check.
- No need to stand in line and pay high fees to cash a check.
- Convenience of a card with no bank account required.
- Safer than cash – if lost or stolen, the card can be replaced, funds intact, often within 24 hours.
- Flexible options to access your money.
- First transaction each pay period is FREE.
- Employees on direct deposit can also use the **SimplePay** pay card as an additional separate deposit each pay period.
- Instant load of funds from the Client for out-of-cycle pay adjustments.
- Signature transactions are FREE.
- No cost of the card to the employee except for normal transaction fees (see card disclaimer notice).