

## Full Time Employee Benefits Enrollment Instructions – ADP Vantage

### 1. Log In into your ADP Vantage Account www.adpvantage.adp.com

### 2. Select Myself & Enrollment

### 3. Select Enroll

Benefit	Plan Election	Coverage
MEDICAL	Waive Medical	
DENTAL	Waive Dental	
VISION	Waive Vision	
Medical Expense Reimbursement FSA	Waive	
Dependent Care FSA	Waive	
Parking	Waive Parking Coverage	
Transit	Waive Transit Coverage	

### 4. Add Dependents or Skip to Step 6

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### 5. Enter Dependent Information

Enrollments

**Add Dependents**

Click Add Another to add another dependent or to clear all field entries.

**Required Fields**

First Name\*  Middle Name:  
 Last Name\*  Suffix:  
 Birth Date\*  Social Security Number:  
 Gender\*  Relationship\*

Full Time Student  
 Disabled  
 Disability Date\*:

Choose dependent's communication address:

500 FIFTH AVE, SUITE 400, NEW YORK.  
 Enter a new address

Done  Cancel  Add Another


### 6. Plan Election Help Support

**Need help choosing a plan option?**

Health insurance is one of the most expensive purchases people make each year.

Take 5 minutes to evaluate your options.

Yes, tell me more.  No thanks.



### 7. Medical – Select Election or Waive Coverage

Dependents

**MEDICAL**

View my cost amounts:  Biweekly  Monthly  Annually

Enter or change your selections in the sections below.

**Options**

Need help choosing a plan option?  
Go to Help with Choosing your Options

Plan Options	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<input type="radio"/> HDHP Plan	\$9.90	\$94.63	\$94.43	\$137.77
<input type="radio"/> EPO Low Plan	\$14.07	\$134.64	\$120.12	\$196.02
<input type="radio"/> EPO Mid Plan	\$25.49	\$152.78	\$121.80	\$246.09
<input type="radio"/> POS	\$38.25	\$163.86	\$128.79	\$258.50
<input checked="" type="radio"/> Waive Medical				

**Coverage Information**

Name  Relationship  
 Self

Next  Cancel

### 8. Dental – Select Election or Waive Coverage

Dependents

**DENTAL**

View my cost amounts:  Biweekly  Monthly  Annually

Enter or change your selections in the sections below.

**Options**

Plan Options	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<input type="radio"/> Low POS	\$1.70	\$5.87	\$4.21	\$9.36
<input type="radio"/> High POS	\$5.61	\$14.87	\$15.82	\$19.52
<input checked="" type="radio"/> Waive Dental				

**Coverage Information**

Name  Relationship  
 Self

Next  Cancel

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### 9. Vision – Elect or Waive Coverage

**VISION**

View my cost amounts:  Biweekly  Monthly  Annually

Enter or change your selections in the sections below.

**Options**

Plan Options	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<input type="radio"/> Vision Plan	\$1.54	\$3.00	\$2.70	\$4.62
<input checked="" type="radio"/> Waive Vision				

**Coverage Information**

Name	Relationship
	Self

Legend

### 10. Medical FSA – Elect or Waive Coverage

**Medical Expense Reimbursement FSA**

Enter the total amount you want to contribute to your spending account for the

**Deductions**

Annual Contribution Amount:

Waive

(Note: Minimum contribution is \$1.00. Maximum contribution is \$2,550.00.)

### 11. Dependent Care FSA – Elect or Waive Coverage

**Dependent Care FSA**

Enter the total amount you want to contribute to your spending account for the ca

Dependent Care Spending Account (DCSA) contribution limits (\$5,000 if married and of contributions made to any DCSA plan during the tax year by both you and/or your Internal Revenue Service as noted above, you must include all contributions previous your spouse, if applicable, to any DCSA plan of any former or current employer in v

**Deductions**

Annual Contribution Amount:

Waive

(Note: Minimum contribution is \$1.00. Maximum contribution is \$5,050.00.)

### 12. Parking FSA – Elect or Waive Coverage

**Parking**

View my cost amounts:  Biweekly  Monthly  Annually

Enter or change your selections in the sections below. The 2015 maximum monthly contribution for Parking is \$250 (Annual \$3,000).

**Options**

Coverage Amount:

Waive Parking Coverage

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### 10. Transit FSA – Elect or Waive Coverage

**Transit**

View my cost amounts:  Biweekly  Monthly  Annually

Enter or change your selections in the sections below. The 2015 maximum monthly contribution for Transit is \$130 (Annual \$1,560).

**Options**

Coverage Amount

Waive Transit Coverage

### 11. Review & Confirm Elections

**Summary**

Review your selected benefits and dependent information carefully.

Click Save and Return Later to complete your enrollment at another time. Click Confirm Elections to complete your enrollment now.

**Personal Information**

Name: [Redacted]  
Address 1: [Redacted]  
Address 2: [Redacted]  
City: [Redacted]

**Dependents**

Manage Dependents - Reveal

Name: [Redacted] Relationship: [Redacted] Birth Date: [Redacted]

There are currently no entries.

**Benefit Elections**

Benefit	Plan Election	Coverage	Benefit Cost	Employee Contribution
MEDICAL	Waive Medical			\$0.00
DENTAL	Waive Dental			\$0.00
VISION	Waive Vision			\$0.00
Medical Expense Reimbursement FSA	Waive			\$0.00
Dependent Care FSA	Waive			\$0.00
Short Term Disability	Short Term Disability		\$0.00*	\$0.00
Parking	Waive Parking Coverage			\$0.00
Transit	Waive Transit Coverage			\$0.00
<b>Total Pre-tax Cost</b>			<b>\$0.00</b>	
<b>Total Post-tax Cost</b>			<b>\$0.00</b>	
<b>Total Cost</b>			<b>\$0.00</b>	
<b>Total Employer Contribution</b>				<b>\$0.00</b>

### 12. Select Agree to Confirmation Statement

**ZARA**

Home My Company Myself

**Enrollments**

**Certification Statement**

Certification Statement: By submitting the changes you have requested, you are certifying that the information you have provided in support of your requested change in election is true, accurate, and complete and you are providing the information intending that it will be relied upon by the Plan Administrator for purposes of effecting changes in your coverage elections under the Plan. Falsification of any of the information provided to the Plan Administrator may result in your termination from coverage under the Plan, or termination of the coverage of your spouse and/or dependents. In addition, the Plan reserves the right to demand reimbursement for benefits paid to you or anyone receiving benefits through you based on falsified claims.

Please note: In connection with documents that are part of the Plan records (such as this form), it is a criminal violation of federal law to make any false statement or representation of fact, knowing it to be false, or to knowingly conceal, cover up, or fail to disclose any fact the disclosure of which is necessary to administer the Plan in accordance with its terms. In addition to a requirement to restore benefits that are obtained falsely, federal law imposes fines (of not more than \$10,000) and/or imprisonment (not more than five years).

### 13. Wait & Print Your Enrollment Confirmation

**Confirmation**

You have successfully completed your enrollment. Your confirmation number is: 2015041020000

Click Print to print a copy of your elections and your confirmation number. Click Done to complete the enrollment process.

**Personal Information**

Name: [Redacted]  
Address 1: [Redacted]  
Address 2: [Redacted]  
City: [Redacted] State: NY Zip Code: [Redacted]

**Dependents**

Name: [Redacted] Relationship: [Redacted] Birth Date: [Redacted]

There are currently no entries.

**Benefit Elections**

Benefit	Plan Election	Coverage	Effective Date	Benefit Cost	Employee Contribution
MEDICAL	HDHP Plan	Employee Only Self	05/01/2015	\$8.90*	\$0.00
DENTAL	Low POS	Employee Only Self	05/01/2015	\$1.70*	\$0.00
VISION	Vision Plan	Employee Only Self	05/01/2015	\$1.54*	\$0.00
Short Term Disability	Short Term Disability		12/22/2014	\$0.00*	\$0.00
Parking	Waive Parking Coverage		12/22/2014		\$0.00
Transit	Waive Transit Coverage		12/22/2014		\$0.00
<b>Total Pre-tax Cost</b>				<b>\$0.00</b>	
<b>Total Post-tax Cost</b>				<b>\$13.14</b>	
<b>Total Cost</b>				<b>\$13.14</b>	
<b>Total Employer Contribution</b>					<b>\$0.00</b>