

CORPORATE MANAGEMENT GROUP

Employment Application

Office Hours: Monday-Friday 8am-4pm

Office Number: 507-923-7956

Office Address: 1825 7th St NW Rochester, Mn 55901



Applicant Information

(APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS AND A BACKGROUND CHECK WILL BE COMPLETED)

Please fully complete pages 1-3

Full Name: (Last Name, First Name) Haugen, Damian Date: 8-21-20

Address: (Street Address) 1590 8 1/2 st SE (Apt. /Unit #) 1

(City) Rochester (State) MN (ZIP Code) 55904

Phone: 507-606-2252 Email: _____

Social Security No. 477-27-8298 Date Available: _____

Position Applied for: Palletizer Desired Salary: _____

Shift Available to work: 1st 2nd 3rd Employment desired: Full-Time Part-Time

Are you authorized to work in the U.S.? Yes No

How did you hear about us? Indeed Referral Name: _____

If under 18, please list age: _____

Do you have responsibilities or commitments that will prevent you from meeting specified work schedules? No Yes

Education				
Type of School	Name of School	Location (Complete Mailing Address)	Number of Years Completed	Major & Degree
High School	Austin High	Austin, MN	1	diploma
College	Riverland Com. College	Albert Lea, MN	1	diploma
Bus. Or Trade School			1	
Professional School				

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PLEASE READ CAREFULLY APPLICATION FORM WAIVER

In exchange for the consideration of my job application by Corporate Management Group, Inc.,

I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements and the like as they may exist from time to time, or other company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of Corporate Management Group, Inc. (CMG), or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by an officer of CMG. Both the undersigned and CMG may end the employment relationship at any time, without specified notice or reason. If employed, I understand that CMG may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination. I hereby give CMG permission to contact schools, all previous employers (unless otherwise indicated), references and others and hereby release CMG from any liability as a result of such contact.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by CMG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by CMG policies.

I release CMG and other persons or entities from any claims that might be based on CMG's decision to conduct a background check.

I understand that, in connection with the routine processing of your employment application, CMG may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics and mode of living. Upon written request from me, CMG will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with CMG shall be probationary for a period of ninety (90) days and further that at any time during the probationary period or thereafter, my employment relationship with CMG is terminable at will for any reason by either party.

Signature of applicant Dan Hays Date: 8-21-20

m MINNESOTA IDENTIFICATION CARD

USA

NOT FOR FEDERAL IDENTIFICATION



1 HAUGEN
2 DAMIAN WADE
8 221 1/2 N 3RD AVE
ALBERT LEA, MN 56007-1618

4d ID# C603-084-413-409 4a ISS 04/23/2019
3e DOB 04/19/1994 4b EXP 04/19/2023

NOT A DRIVER'S LICENSE

Minnesota

15 SEX M 17 WGT 170 lb
16 HGT 5'-10" 18 EYES BRO

Damian

5e DD 00000001027441

04/19/94



SOCIAL SECURITY

477-27-8298

THIS NUMBER HAS BEEN ESTABLISHED FOR

DAMIAN WADE
HAUGEN

Damian

SIGNATURE

10/01/2018





New Employee Acknowledgement Form

Welcome to CMG

As a new employee, you will be provided with the website, username and password to view the new hire forms that you signed during your CMG interview. Please sign and date the bottom of the sheet stating that you received your login information.

CMG/ ESSG ,

Healthcare Notice of Exchange and Website for Enrollment

Safety Policy

Drug and Alcohol Testing Policy

View Paystubs

Website: <https://zenople.esgazure.com/login/cmog>

Login Name: 507-606-2252

Login Password: Dh@8298

I hereby acknowledge that I have been provided with the login information to view the items listed above. I understand that it is my responsibility to read and follow each document provided to me and that if I have any questions concerning the times or its content, that it is my responsibility to address my questions with my supervisor or CMG representative, and hereby waive any claim, now or in the future, that I did not receive, did not read or did not comprehend the items or their contents.

Signature: _____

Dan Hayes

Date: _____

8-21-20

Pay Information

Payday is every Friday

Name: Damian Haugen

Last 4 of SSN: 8298

Please mark what option you choose

Direct Deposit

Bank Name Money Network

Account Number 7277663801656055

Circle One

Checking -or- Savings

Routing Number 084003997

I Understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs included if the account number that I provide is incorrect.

Initial DH

Bank of America Money Network Card

↓ Office Use Only ↓

Account Number _____

Routing Number _____



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)
Address (Street Number and Name)			Apt. Number	City or Town	State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]	Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input checked="" type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee <u>Dai Haus</u>	Today's Date (mm/dd/yyyy) <u>08/21/2020</u>
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Preparer and/or Translator Certification (check one):

I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page



Authorization to Enter New Hire Information

By signing below, I authorize a member of Corporate Management Group – Rochester Office – to enter my new hire paperwork into the online Zenopole (NHO) site. I understand that I will be provided access via login name and password to view the forms that they have completed on my behalf.

Employee Signature: Dan Hays Date: 8-21-20

Insurance Information

I understand that the CMG Staff defaults to decline insurance when entering my new hire paperwork unless specified otherwise during my interview.

I understand that I have 30 days after my employment starts to apply for insurance through ESSG via the login information provided to me.

I agree: DA (initial)

CMG Preliminary Questions

Name: Damian Haugen

Date: 8-21-20

Please Mark Yes or No

1. If hired are you willing to take a drug test? Yes No
2. Do you have any known food allergies to soy, wheat, peanuts, or milk? Yes No
3. Are you able to work with pork? Yes No

To be completed during or after interview

Have you ever been convicted of a crime? Yes No

Explain Incident 2014 - got into verbal fights and the person felt
threaten

2017 - charged with supposely hit a child

Employee Signature: Damian Haugen

Interviewer Signature _____

Frequently Asked Questions

When can I enroll in a plan?

As a part-time or full-time employee, you are able to enroll within 30 days of your hire date, or during the annual open enrollment for the plan. If you do not enroll in one of those periods, you may only enroll if you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

What is a qualifying life event?

A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Death of an immediate family member
- Loss of dependent status
- Loss of prior coverage

When can I cancel off of the plan?

As our plans are pre-tax, you are only allowed to make changes/enroll/cancel during certain times of the year. The above listed times (your first 30 days of employment, during open enrollment, or within 30 days of a qualifying life event) are the only times you are able to change/enroll/cancel.

If I fill out a form, and do not get placed on assignment right away, do I need to fill out a new form?

Your form will stay valid for 6 months. If you are placed on assignment after 6 months of the signature date, you will need to fill out a new form to enroll in the plans. If you worked for a period of time and had deductions, and then stopped working for 6 consecutive weeks, you are considered a re-hire, and would need to fill out a new form to re-enroll. If you miss less than 6 consecutive weeks, the Fixed Indemnity insurance will continue without penalty or the need to re-enroll. After 3 missed weeks the Enhanced MEC coverage will be cancelled.

When will my deductions start and coverage begin?

Enhanced MEC Medical Plan 1 – Deductions will begin about 2 weeks after we at ESSG receive the form, coverage will begin on the first of the month following the start of deductions

Fixed Indemnity Benefits Plan 2 – Deductions will begin about 2 weeks after we at ESSG receive the form, coverage will begin the Monday following the first deduction

When will I receive my insurance card?

Enhanced MEC Medical Plan 1 – Health EZ mails your insurance card(s) the week your coverage takes effect.

Fixed Indemnity Benefits Plan 2 – Essential StaffCARE mails your insurance card(s) the week your coverage takes effect.

Additional Fixed Indemnity Benefit Plan 2 Information:

This plan does not qualify as minimum essential coverage as defined under the Affordable Care Act (ACA). This plan is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.

For Enrollees of California employer policies: In order to enroll in the Fixed Indemnity Medical Benefit, you must be enrolled in major medical coverage.

The Essential StaffCARE Fixed Indemnity Medical, Prescription Drug, and Dental Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1801, and 26.212. The Term Life, Accidental Death and Dismemberment and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

The Vision plan is underwritten by Companion Life Insurance Company, P.O. Box 100102, Columbia, S.C. and administered by Planned Administrators, Inc., 17 Technology Cr., Suite E2AG Columbia, S.C. For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

 **Essential StaffCARE**

ESG-1 ESC CU(UNAC*MN) P1 v19.0

ENROLLMENT FORM

VSI

219301-ESG-1

OFFICE USE ONLY

LOCATION _____

Rehire Date ___/___/_____

Fixed Indemnity Benefits Plan 2

ESC CU(UNAC*MN) P1 v20.1

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

First Name Damian	Last Name Haugen	Social Security # 477-27-8298	Home Phone 507-606-2252	Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Address 1950 8 1/2 St SE			Apt. # 1	
City Rochester	State MN	Zip 55904	Date of Birth 4/19/94	

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?

 Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN)	Medicare Effective Date
Name of Covered Person (s): 1.	2.
	3.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only <input checked="" type="checkbox"/>	\$19.96	\$6.17	\$2.42	\$0.60	\$4.20
Employee + 1 <input type="checkbox"/>	\$40.51	\$12.34	\$4.92	\$0.90	N/A
Employee + Family <input type="checkbox"/>	\$54.09	\$20.36	\$6.56	\$1.80	N/A
NO to ALL Benefits <input type="checkbox"/>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

¹This coverage is not available to residents of NH, HI, or PR. ²STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Full Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Full Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Full Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Full Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

DATE 08/21/2020

SIGNATURE

Dai Haas



Case Verification Number: 2020237204156LF

Report prepared: 08/24/2020

Company Information

Company ID: 1284996

Company Name: ESSG - Corporate Management Group

Client Company ID: 1284996

Client Company Name: ESSG - Corporate Management Group

Employee Information

Name: Damian Haugen

Date of Birth: 04/19/1994

U.S. Social Security Number: ***-**-8298

Employee's First Day of Employment: 08/24/2020

Citizenship Status: U.S. Citizen

Document Information

List B Document: Driver's license or ID card issued by a U.S. state or outlying possession

Document Subtype: State Issued ID Card

Document Number: *****3409

Expiration Date: 04/19/2023

State: Minnesota

List C Document: Social Security Card

Case Information

Case Status: Closed

Case Submitted By: Diana Elton

Current Case Result: Employment Authorized

Reason for Closure: Employment Authorized Auto Close