

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security

Report Prepared: 04/30/2015

E-Verify

Page: 1 of 1

Case Verification Number: 2015120111425ND

Case Information:

Employee Information:
 Last Name: Abel
 Middle Initial:
 Social Security Number: *** ** 8184
 Citizenship Status: A citizen of the United States
Document Information:
 List B Document: Driver's license or ID card issued by a U.S. state or outlying possession
 Document Name: Driver's license
 Driver's License or ID Card Number:
 Alien Number:
Additional Information:
 Hire Date: 04/30/2015
 Three-Day Rule Reason: MMS3269
 Submitted By:
Initial Case Result:
 Case Result: Employment Authorized

Employee Referred to SSA:

Referred By:
 Referred On:
 Case Result: Case Result from SSA (after SSA Tentative Nonconfirmation):
 Response Date:

Resubmitted to SSA (after Review and Update Employee Data):

Last Name:
 Middle Initial:
 Social Security Number:
 Resubmitted By:
 Resubmitted On:
 First Name:
 Other Names Used:
 Date of Birth:
 Resubmitted On:

Case Result from SSA (after Resubmission):

Case Result:
 Request Name Review:
 Comments:
 Submitted By:
 Submitted On:
 Case Result from DHS (after DHS Verification in Process):
 Response Date:

Employee Referred to DHS:

Referred By:
 Referred On:
 Case Result from DHS (after DHS Tentative Nonconfirmation):
 Response Date:
 Case Result:
 Photo Matching Results:
 Determination:

Employee Referred to DHS (Additional):

Referred By:

Referred On:

Case Result from DHS (after Additional DHS Tentative Nonconfirmation):

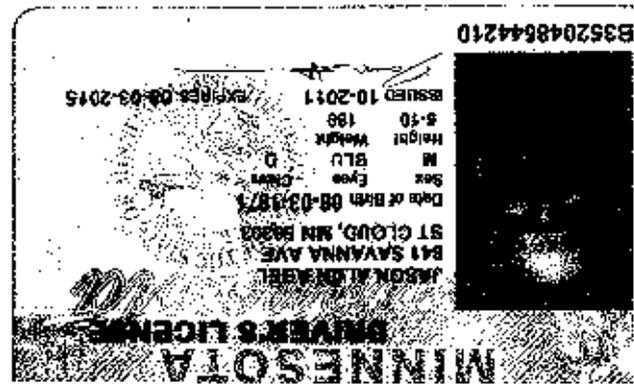
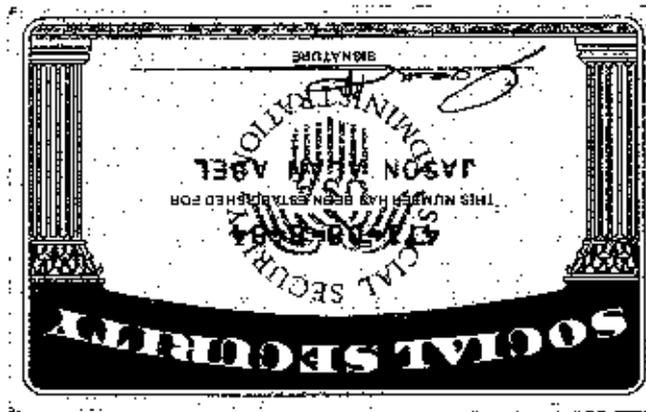
Case Result:

Response Date:

Case Closure:

Closure Statement: The employee continues to work for the employer after receiving an Employment Authorized result.
Closed By: JMS3269
Closed On: 04/30/2015

SENSITIVE BUT UNCLASSIFIED





7301 Ohms Lane Suite 405

Edina, MN 55439

Tel: 952.835.1288 • Fax: 952.835.1255

www.esgstaffingsolutions.com

New Hire Application

Personal Data - PLEASE PRINT LEGIBLY IN INK

Last Name: Abel
 First Name: Jason
 Middle Initial: A
 Street Address: 307 3rd Ave S.
 City/State/Zip: Sault Rapids MN 56379
 Phone Number: 320-266-8117
 Email Address: jabel19541@gmail.com
 Staffing Agency/Recruitment Partner: Kny Missel

All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

Are you legally authorized to work in the United States of America? YES NO

Applicant Certification and Authorization

I authorize Employer Solutions Staffing Group (ESSG) to use the information and statements contained in this application to determine my qualifications for employment. I authorize ESSG to make inquiries of my former employers, except as indicated in this application, regarding my previous duties, responsibilities, performance, compensation and eligibility for rehire.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. 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 ESSG policies.

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

I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

If hired, I agree to abide by the policies and procedures of ESSG.

Name (Print or type): Jason Abel
 Applicants Signature: *[Signature]*
 Date: 9/30/15

A copy or facsimile ("fax") will be considered the same as an original signature. Email will ONLY be used for employment correspondence

For ESSG Office Use Only		For ESSG Client Use	
DOH	NHW	1-9	8850
Emergency Contact Info	Background Release Form	Background Results	Unemployment Letter (if applicable)
ESG Application	W4	WFC Code	Work Site Loc.
ROP	Work Site Loc.	WFC Code	

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. **Exception** from withholding. If you are an exempt, complete only lines 1, 2, 3, 4 and 7 and sign the form on the last page. Your exemption for 2015 expires February 15, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her return, you cannot claim exemption from withholding if your income exceeds \$1,050 and includes more than \$500 of unearned income for example, interest and dividends.

Exemptions. An employer may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is blind, or
- Is age 65 or older,

• Will claim adjustments to income, tax credits, or itemized deductions, or his or her tax return.

• If you are a dependent, you may be able to claim exemption from withholding if you are a dependent, if the employee:

- Is blind, or
- Is age 65 or older,

• Will claim adjustments to income, tax credits, or itemized deductions, or his or her tax return.

• If you are a dependent, you may be able to claim exemption from withholding if you are a dependent, if the employee:

- Is blind, or
- Is age 65 or older,

• Will claim adjustments to income, tax credits, or itemized deductions, or his or her tax return.

• If you are a dependent, you may be able to claim exemption from withholding if you are a dependent, if the employee:

- Is blind, or
- Is age 65 or older,

• Will claim adjustments to income, tax credits, or itemized deductions, or his or her tax return.

• If you are a dependent, you may be able to claim exemption from withholding if you are a dependent, if the employee:

- Is blind, or
- Is age 65 or older,

• Will claim adjustments to income, tax credits, or itemized deductions, or his or her tax return.

• If you are a dependent, you may be able to claim exemption from withholding if you are a dependent, if the employee:

- Is blind, or
- Is age 65 or older,

Employee's Withholding Allowance Certificate

Form W-4 Department of the Treasury Internal Revenue Service

OMB No. 1545-0074 **2015**

Which 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.

1 Your first name and middle initial: **Jason A**
 Last name: **Holt**

2 Your social security number: **47108-6484**

3 Single Married Married, but withheld at higher single rate.
 Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

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 4 above or from the applicable worksheet on page 2): **4**

6 Additional amount, if any, you want withheld from each paycheck

7 I claim exemption from withholding for 2015, and 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.

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: *[Signature]*
 Date: **4/30/15**

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)

1 Home address (number and street or rural route): **307 329 Ave S**
 City or town, state, and ZIP code: **Bank Rapids MN 56379**

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 (2015)

Form W-4 (2015)

Form W-4 (2015)

Personal Allowances Worksheet (Keep for your records)

A Enter "1" for yourself if no one else can claim you as a dependent.

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.

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.)

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).

F Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit.

G Child Tax Credit (including additional child tax credit). See Pub. 503, Child and Dependent Care Expenses, for details. (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

H If your total income will be less than \$65,000 (\$100,000 if married), enter "2" for each eligible child; then pass "1" if you have two to four eligible children or less "2" if you have five or more eligible children.

I If your total income will be between \$65,000 and \$84,000 (\$100,000 and \$118,000 if married), enter "1" for each eligible child.

J Add lines A through I and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.)

• 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 your spouse has more than one job, and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earnings/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 5 of Form W-4 below.

1 A

2 B

3 C

4 D

5 E

6 F

7 G

8 H

9 I

10 J

11 K

12 L

13 M

14 N

15 O

16 P

17 Q

18 R

19 S

20 T

21 U

22 V

23 W

24 X

25 Y

26 Z

27 AA

28 AB

29 AC

30 AD

31 AE

32 AF

33 AG

34 AH

35 AI

36 AJ

37 AK

38 AL

39 AM

40 AN

41 AO

42 AP

43 AQ

44 AR

45 AS

46 AT

47 AU

48 AV

49 AW

50 AX



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

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

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

Signature of Employee	Date (mm/dd/yyyy)
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Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Country of Issuance: _____

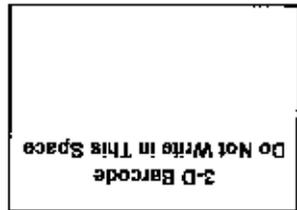
Foreign Passport Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

2. Form I-94 Admission Number: _____

OR

1. Alien Registration Number/USCIS Number: _____



For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number.

- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy). Some aliens may write "N/A" in this field. (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- A noncitizen national of the United States. (See instructions)
- A citizen of the United States

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

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.

Date of Birth (mm/dd/yyyy)		U.S. Social Security Number		E-mail Address		Telephone Number	
307 304 Ave S		301		Baird Rapids		MN 56379	
Last Name (Family Name)		First Name (Given Name)		Middle Initial		Other Names Used (if any)	
Abel		Jason		A			

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.)

▶ **START HERE.** Read instructions carefully before completing the form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.



Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
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C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial B. Date of Hire (if applicable) (mm/dd/yyyy):

Section 3: Reverification and Rehires (To be completed and signed by employer or authorized representative.)

Signature of Employer or Authorized Representative	Date (mm/dd/yyyy)	Title of Employer or Authorized Representative
Last Name (Family Name)	First Name (Given Name)	Employer's Business or Organization Name
7301 OHMS LANE SUITE 405	CITY or TOWN	State
Zip Code	Employer's Business or Organization Name	

The employee's first day of employment (mm/dd/yyyy) 04-30-2015 (See instructions for exemptions.)

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the employee is authorized to work in the United States.

Certification

Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
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Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):
Document Title:	Document Number:	Expiration Date (if any) (mm/dd/yyyy):

Employee Last Name, First Name and Middle Initial from Section 1: Abel, Jason A

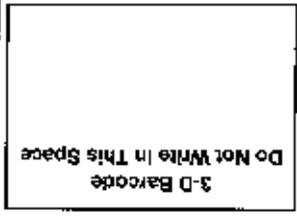
OR

AND

List C

Section 2: Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine the document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)



DISCLOSE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" that may include information about your character, general reputation, personal characteristics, and/or mode of living, and that can involve personal interviews with sources, such as your neighbors, friends, or associates. These reports may contain information regarding your education or employment history, social security number validation, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right upon written request made within a reasonable time, to request whether a consumer report has been requested and compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. Fax: 800-886-0774 or 952-941-9040. The scope of this notice and authorization is all-encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

<p>New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.</p>
<p>New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.</p>
<p>Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.</p>
<p>Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.</p>

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION AND A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING's website is at: www.orangetreescreening.com, another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by ESSG.

(Must include email address.)

Signature: [Signature]
 Date: 1/30/15

Last Name: Boel First: Jason Middle: A
 Other Names/Aliases: _____
 Social Security #: 471-08-8481
 Driver's License #: B352048544210
 State of Driver's License: MN
 Present Address: 307 389 Ave S #301
 Telephone # (Primary): 320-266-8117
 City/State/Zip: Sault Ste Marie MN 56379

*This information will be used for background screening purposes only and will not be used as hiring criteria.

Direct Deposit/Payroll Debit Card Authorization

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card. If you do not provide a written election, wages will be paid by Payroll Debit Card.

SECTION 1 BASIC INFORMATION

Employee Name: Jason Abel SSN# (last 4 digits): 471-08-8484 Effective Date: 4/30/15

SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below)

Payroll Debit Card (Please complete Sections 4 and 5 below)

SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: US Bank

Routing#: 05 Bank

Account#

Account Type: Checking Savings Other

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 incurred if the account number that I provide is incorrect.

Initial: JA Date: 4/30/15

SECTION 4 PAYROLL DEBIT CARD (OR GREAT CASH CARD)

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, RSSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.

Except for the routing and account number, RSSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)

First Name: _____ M.I.: _____ Last Name: _____
 Date of Birth: _____ Social Security#: _____
 Street Address (no box or apartment): _____
 City: _____ State: _____ Zip: _____
 (Cell) Phone (mobile): _____

GET TEXT ALERTS, when your paycheck is deposited on your card! Yes, sign me up, for text alerts
 All we need to know your cell phone service provider and mobile number above! My mobile service provider is: _____

RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)

Payroll Debit Card Routing #: _____ Payroll Debit Card Account #: _____
 I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize RSSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s).

SECTION 5 AUTHORIZATION

Employee's Signature: _____ Date: 4/30/15
 Employee's Signature: _____ Date: _____
 *E-mail is required for pay stub information. *E-mail is required for pay stub information.

This information will only be used to send your pay stubs electronically

E-mail: Jason Abel @ gmail.com

ENROLLMENT FORM

1:30 NAV+SAD P2M v15.0

OPTION 1 **FIXED INDEMNITY PLAN** Weekly Rates

You MUST enroll in the Indemnity Medical Insurance Plan before adding any additional Indemnity benefits, except Dental. Your coverage level for the Term Life will be identical to your medical plan selection.

FIXED INDEMNITY MEDICAL

\$20.91 Employee Only
 \$42.44 Employee + 1
 \$56.67 Employee + Family
 NO to all Indemnity benefits.

DENTAL

\$5.99 Employee Only
 \$11.98 Employee + 1
 \$19.77 Employee + Family
 NO

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

TERM LIFE

YES
 NO

\$0.60 Employee Only
 \$0.90 Employee + 1
 \$1.80 Employee + Family

SHORT-TERM DISABILITY

YES
 NO

\$4.20 Employee Only

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

OPTION 2 **AEC WELLNESS/PREVENTIVE PLAN** Monthly Rates

82193010-M-EMP

\$58.87 Employee Only
 \$87.73 Employee + 1
 \$186.99 Employee + Family
 NO to AEC Wellness/Preventive Plan

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 declaration of coverage.

Date 04/30/2015 Signature _____

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK

(Must Be Filled Out)

Social Security Number 411-8-8484
 Date of Birth 08/03/1971 Sex M F

Name Jason Abel
 Street Address 307 3rd Ave S
 City Sault Ste Marie State MI Zip 500379
 Home Phone 380-266-8117

Do you or any dependents have Medicare?
 Yes No If Yes:
 Medicare Health Insurance Claim Number (HICN) _____
 Medicare Effective Date _____
 Names of Covered Person(s)
 1. _____
 2. _____
 3. _____

REQUIRED DEPENDENT INFORMATION

Name _____
 Social Security Number _____
 Date of Birth _____ Sex M F
 Relationship: Spouse Child Domestic Partner

Name _____
 Social Security Number _____
 Date of Birth _____ Sex M F
 Relationship: Spouse Child Domestic Partner

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY _____
 RELATIONSHIP _____

Accidental Death & Dismemberment is part of the Term Life Benefit.