



New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Jackson First Name Adam Middle Initial D
 Street Address 8300 Sheridan Blvd Apt/Ste 9F
 City/State/Zip Arvada, Co, 80003
 Phone Number 812-606-1141 Email Address MrADJackson@hotmail.com
 Company/Employer Colorado Lights
720-932-5801

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.

Adam Jackson Name (Print or type) Adam Jackson Applicant's Signature 12/16/2014 Date

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

| | | | | |
|---------------------------------|----------------------------------|-----------------------------|---|--------------------------|
| DOH _____ | NHW _____ | I-9 _____ | 8850 _____ | W4 _____ |
| Emergency Contact Info _____ | Background Release Form _____ | Background Results _____ | Unemployment Letter (If applicable) _____ | ESC Application _____ |

For ESSG Client Use

| | | | |
|-----------|-----------|----------------------|---------------|
| DOH _____ | ROP _____ | Work Site Loc. _____ | WC Code _____ |
|-----------|-----------|----------------------|---------------|

Form W-4 (2013)

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.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

| | | | |
|----------|---|----------|----------|
| A | Enter "1" for yourself if no one else can claim you as a dependent | A | <u>1</u> |
| 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. } | B | <u>1</u> |
| 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.) | C | <u>0</u> |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return | D | <u>0</u> |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) | E | <u>0</u> |
| F | Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit | F | <u>0</u> |
| G | Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child | G | <u>0</u> |
| H | Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ | H | <u>2</u> |
| | For accuracy, complete all worksheets that apply. { • 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 you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/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 H on line 5 of Form W-4 below. | | |

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

| | | | | |
|---|------|--|---|---|
| Form W-4 Department of the Treasury Internal Revenue Service | | Employee's Withholding Allowance Certificate | | OMB No. 1545-0074 |
| ▶ Whether 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. | | 2013 | | |
| Your first name and middle initial Adam D | | Last name Jackson | | 2 Your social security number 312-92-8609 |
| Home address (number and street or rural route) 8300 Sheridan Blvd #9F | | 3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. | | |
| City or town, state, and ZIP code Arvada, Co 80003 | | 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. ▶ <input type="checkbox"/> | | |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) | 5 | 2 | | |
| 6 Additional amount, if any, you want withheld from each paycheck | 6 \$ | 5.00 | | |
| 7 I claim exemption from withholding for 2013, and I 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 ▶ | | 7 | exempt | |
| 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 (This form is not valid unless you sign it.) ▶ Adam Jackson | | Date ▶ 12/16/2014 | | |
| 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) Colorado Lighting | | 9 Office code (optional) | 10 Employer identification number (EIN) | |

Revision Date: 09/06/12
Expiration Date: 10/01/14



Affirmation of Legal Work Status
Pursuant to § 8-2-122, Colorado Revised Statutes

Employee Name: Jackson Adam Darnell 05/14/1984
Last First Middle Date of Birth

Social Security Number: 312 - 92 - 8609 Date of Hire: _____ (MM/DD/YYYY)

In accordance with § 8-2-122, C.R.S., within 20 days after hiring the new employee listed above,

I affirm all four of the following by signing this form:

1. I have examined the legal work status of the above named employee.
2. I have retained file copies of the documents required by 8 U.S.C. sec. 1324a.
3. I have not altered or falsified the employee's identification documents.
4. I have not knowingly hired an unauthorized alien.

Colorado Lighting
Print Name of Employer (or Designated Representative) Official Title

Signature of Employer (or Designated Representative) Date Signed by Employer (MM/DD/YYYY)

Business or Organization Name Employer Phone Number

The provision of false or fraudulent information on this form may subject the employer to a significant fine and/or additional penalties.

This form and the documents required by 8 U.S.C. sec. 1324 (copies or electronic copies) will be retained for the duration of the above named individual's employment.

§ 8-2-122(2), C.R.S.: On and after January 1, 2007, within twenty days after hiring a new employee, each employer in Colorado shall affirm that the employer has examined the legal work status of such newly-hired employee and has retained file copies of the documents required by 8 U.S.C. sec. 1324a; that the employer has not altered or falsified the employee's identification documents; and that the employer has not knowingly hired an unauthorized alien. The employer shall keep a written or electronic copy of the affirmation, and of the documents required by 8 U.S.C. sec. 1324a, for the term of employment of each employee.



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶ **START HERE.** Read instructions carefully before completing this 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.

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) Jackson | | First Name (Given Name) Adam | | Middle Initial D | Other Names Used (if any) | |
| Address (Street Number and Name) 8300 Sheridan Blvd | | | Apt. Number 9F | City or Town Arvada | | State Co |
| Date of Birth (mm/dd/yyyy) 05/14/1984 | | U.S. Social Security Number 312-92-8609 | | E-mail Address Mr ADJackson@hotmail.com | | Telephone Number 812-606-1141 |

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):

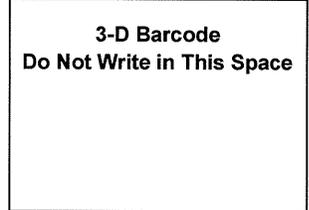
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field.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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____



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

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

| | |
|-------------------------------------|-------------------------------|
| Signature of Employee: Adam Jackson | Date (mm/dd/yyyy): 05/14/1984 |
|-------------------------------------|-------------------------------|

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

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.

| | | | | |
|--------------------------------------|--|-------------------------|--------------------|----------|
| Signature of Preparer or Translator: | | | 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





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 one 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.)

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

| List A Identity and Employment Authorization | OR | List B Identity | AND | List C Employment Authorization |
|---|----|---------------------------------------|-----|---------------------------------------|
| Document Title: | | Document Title: | | Document Title: |
| Issuing Authority: | | Issuing Authority: | | Issuing Authority: |
| Document Number: | | Document Number: | | Document Number: |
| Expiration Date (if any)(mm/dd/yyyy): | | Expiration Date (if any)(mm/dd/yyyy): | | Expiration Date (if any)(mm/dd/yyyy): |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | | |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | | |

**3-D Barcode
Do Not Write in This Space**

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions.)

| | | | | |
|--|--|-------------------------|--|-------------------|
| 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 EMPLOYER SOLUTIONS STAFFING GROUP LLC | |
| Employer's Business or Organization Address (Street Number and Name) 7301 OHMS LANE SUITE 405 | | City or Town EDINA | State MN | Zip Code 55439 |

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

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

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.

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

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.

| | | |
|---|--------------------|--|
| Signature of Employer or Authorized Representative: | Date (mm/dd/yyyy): | Print Name of Employer or Authorized Representative: |
|---|--------------------|--|

DISCLOSURE 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 credit history, criminal 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 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING's website is at www.orangetreescreening.com, or another outside organization. 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.

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.

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.

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.

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.

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: Adam Jackson MrADJackson@hotmail.com)

Signature: Adam Jackson Date: 12/16/2014

BACKGROUND INFORMATION

Last Name: Jackson First: Adam Middle: Darnell

Other Names/Alias: _____

Social Security #*: 312-92-8609 Date of Birth (mm/dd/yyyy)*: 05/14/1984

Driver's License #: 13-074-0789 State of Driver's License: Co

Present Address: 8300 Sheridan Blvd 9F Telephone # (Primary): _____

City/State/Zip: Arvada, Co, 80003

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

EMERGENCY CONTACT INFORMATION

EMPLOYER SOLUTIONS STAFFING GROUP
IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION

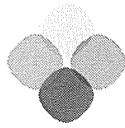
Employee Name: Adam Jackson
Address: 8300 Sheridan Blvd #9F Arvada, Co, 80003
Home Phone: 812-606-1141

EMERGENCY CONTACTS

Please list two people (in priority order) who could be contacted in case of an emergency

| | |
|--|--|
| Contact #1 Name: <u>Natasha Willis</u> Relationship: <u>fiancee</u> | Home Phone: Cell Phone: <u>812-606-1141</u> Work Phone: <u>303-996-8900</u> <u>Ext 1552</u> |
| Contact #2 Name: <u>Aaron Jackson</u> Relationship: <u>Brother</u> | Home Phone: Cell Phone: <u>317-513-9873</u> Work Phone: |

Additional information you want Employer Solutions Staffing Group and our clients to know in the event of an emergency:



employer solutions staffing group^{LLC}

Leveraging Resources in a Changing Market

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 <u>Adam D. Jackson</u> | SSN# (last 4 digits) <u>8609</u> | Effective Date |
|---|-------------------------------------|----------------|

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

| | |
|---------|--|
| ACCOUNT | <input type="checkbox"/> Update Bank Account |
| | Bank Name: <u>Key</u> |
| | Routing# <u>307070267</u> |
| | Account# <u>760062051338</u> |
| | Account Type: <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> 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 AD Date 12/16/2014

- To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work)
- If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

SECTION 4 PAYROLL DEBIT CARD (GLOBAL 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, ESSG 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, ESSG 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 |
| Street Address (PO BOX NOT ACCEPTABLE) | | | Social Security# |
| City | State | Zip | Cell Phone (mobile) |

GET TEXT ALERTS, when your paycheck is deposited on your card!
 All we need to know your cell phone service provider and mobile number above!

Yes, sign me up, for text alerts
 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 # <u>122242597</u> | 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 the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

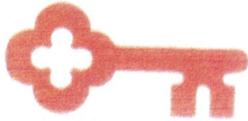
Employee's Signature: _____ Date: _____

SECTION 5 AUTHORIZATION

I authorize ESSG 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). *** E-mail is required for pay stub information.**

*E-mail: Mr AD Jackson @ hotmail.com
 this information will only be used to send your paystubs electronically

Employee's Signature: Adam Jackson Date: 12/16/2014



Direct Deposit Sign Up Form

Complete this form to request direct deposit into your KeyBank checking or savings account.

3 Easy Steps!

1 Fill-in this form online or print it off and fill it out.

2 Attach a voided check to this form to confirm your account and routing numbers.

3 Submit this completed form and a voided check to the appropriate department:

Payroll Deposits:
Forward this form to your employer's payroll department.

Retirement/Annuity, Dividend and Other Deposits:
Follow up with your current provider to determine where to forward this document.

Personal Information:

Adam D Jackson
First Name Middle Initial Last Name

312-92-8609
Social Security or Tax Payer ID Number

Address

City

State

Zip Code

Phone Number

Alternative Phone Number

Type of Deposit:

Payroll

Retirement/Annuity

Dividend

Other: _____ (non SSA/SSI*)

Account you would like your check automatically deposited into:

760062051338

KeyBank Account Number

Select one: Checking Savings

307070267

KeyBank Routing Number

Adam D Jackson

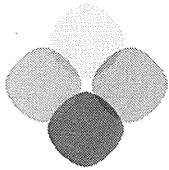
Name on the Account

I authorize (name of the company) _____ and KeyBank to automatically deposit my check into my account listed above. This authorization will remain in effect until I have filed a new authorization, or until this authorization is revoked by me in writing.

Customer Signature

Date

* If you would like to have your government checks deposited into your KeyBank account please go to www.key.com/directdeposit and fill-in online or print a copy of the Government Direct Deposit signup form.



employer solutions staffing group^{LLC}

Leveraging Resources in a Changing Market

STATEMENT OF CONFIDENTIALITY

This agreement made this 16 day of Dec, 2014, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Adam Jackson hereafter referred to as "employee".

WITNESSETH:

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of \$10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

Adam Jackson

Employee Signature

Employer Solutions Staffing Group LLC, Representative

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▶ See separate instructions.

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name Adam D Jackson Social security number ▶ 312-92-8609
Street address where you live 8300 Sheridan Blvd #9F
City or town, state, and ZIP code Arvada, Co, 80003
County Adams Telephone number 812-606-1141
If you are under age 40, enter your date of birth (month, day, year) 05/14/1984

- 1 Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

- 2 Check here if **any** of the following statements apply to you.
 - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a Received SNAP benefits (food stamps) for the past 6 months, **or**
 - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

- 3 Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

- 4 Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

- 5 Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

- 6 Check here if you are a member of a family that:
 - Received TANF payments for at least the past 18 months, **or**
 - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ Adam Jackson

Date 12/16/2014

EMPLOYER SECTION:

| | | |
|-----------------|--------------------------|-------------------|
| ESG FEIN#: | ESG Client Name & State: | |
| Hiring Manager: | Position: | Starting Wage: \$ |

EMPLOYEE SECTION:

| | | | |
|--|--|----------------------------------|---|
| Employee Name: <u>Adam D. Jackson</u> | Street Address: <u>8300 Sheridan Blvd #9F</u> | City/State: <u>Arvada, Co</u> | Zip: <u>80003</u> |
| SS#: <u>32 - 92 - 8609</u> | Date of Birth: <u>05 / 14 / 1984</u> | Age: <u>30</u> | Have you worked for this company before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | If yes, location: |

Please complete all questions, and sign and date the form.

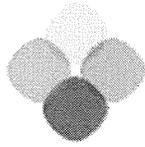
| | Yes | No |
|--|--------------------------|-------------------------------------|
| <p>1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.)</p> <p>Name of the person receiving benefits: _____ Relationship to you: _____</p> <p>City: _____ County: _____ State: _____</p> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <p>2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.)</p> <p>Name of the person receiving benefits: _____ Relationship to you: _____</p> <p>City: _____ County: _____ State: _____</p> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <p>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. <i>*If you checked yes please provide a copy of your SSI documentation.</i></p> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <p>4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below:</p> <p><input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program)</p> <p>Name of Agency: _____ Phone #: _____</p> <p>City: _____ County: _____ State: _____</p> <p><i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i></p> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <p>5. Are you a Veteran of the U.S. Military? <i>*If yes, please provide a copy of your DD-214 and letter of separation.</i> (If yes, please provide information below. If no, please continue to question #6.)</p> <p>Dates of Service - From: ____/____/____ To: ____/____/____</p> <p>Branch of Service: _____</p> <p>Are you entitled to or are you receiving compensation for a service-connected disability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Have you been unemployed at any time during the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, dates of unemployment - From: ____/____/____ To: ____/____/____</p> <p>Did you receive unemployment compensation at any point during your unemployment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <p>6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</p> <p>Conviction Date: ____/____/____ Release Date: ____/____/____</p> <p>Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____</p> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| Additional Tax Credits | |
|---|---|
| <p>IEC (Native American): Are you or your spouse a member of a Native American Tribe? <i>*If you checked yes please provide a copy of your CDIB card.</i></p> | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| <p>CA Residents: <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act?</p> <p><input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?</p> | |
| <p>SC Residents: <input type="checkbox"/> Do you receive Family Independence Benefits?</p> | |

PLEASE READ, SIGN, AND DATE:

Under penalties of perjury, I declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. dba Retrotax), or the Department of Labor.

New Employee Signature: Adam Jackson Date: 12/16/14



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INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

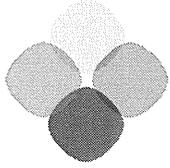
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

I have read my responsibilities and agree to abide by these guidelines.

Signed: Adam Jackson

Printed Name: Adam Jackson



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Important/Importante

LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between \$25-\$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the policy report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Adam Jackson

Signature/Firma: Adam Jackson



Employee Keeps This Form

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

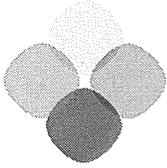
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Employer Solutions Staffing Group LLC - 952-767-9519**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.



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**Notification of Colorado Law Requirement –
Unemployment Acknowledgement**

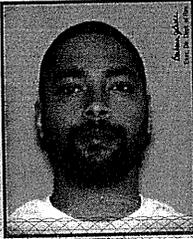
According to Colorado Statutes section 8-73-105.3. A temporary employee who is given a notice that the employee is required to contact or notify the employer upon completion of an assignment and to be available to work, as agreed upon at the time of hire, during a specified period of time, on specified dates, or upon call by the employer on an as-needed basis and who does not contact or notify the employer upon completion of an assignment in compliance with the notice and is not available to work at the agreed-upon times is deemed to have voluntarily terminated employment for the purpose of determining benefits pursuant to section 8-73-108 (5) (e). Also, a temporary employee who agrees to work on an as-needed basis and refuses all work within three separate pay periods when contacted by the employer is deemed to have voluntarily terminated employment for reasons that may or may not allow an award of benefits pursuant to section 8-73-108.

It is your responsibility to contact or notify ESSG (For example, by calling 303-920-1425, or using another means of contact) once your assignment ends. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact or notify ESSG once an assignment ends. I also acknowledge that I have received a separate copy of this form. AD (Initial)

Adam Jackson 12/16/2014
Employee Signature: Date:
Adam D. Jackson
Employee (please print your name here)

Colorado
Driver License



13-074-0789 Expires: 05-14-2018
Class: R Issued: 03-22-2013
End: DOB: 05-14-1984
Rest: V Previous Type: A
Ht: 5'10" Wt: 185 Eyes: BRO Sex: M
Voter: Y

Adam Jackson

ADAM DARNELL JACKSON
3803 W 69TH AVE #310
WESTMINSTER, CO 80030



CONFIDENTIALITY & NONSOLICITATION AGREEMENT

This agreement made this 9th day of October, 2013 (“the Agreement”), is between Corporate Management Group Inc. (“CMG”), Employer Solutions Staffing Group LLC (“ESSG”) **Colorado Lighting Inc.** (“the Company”) and Adam Jackson (“Employee”) (together “the Parties”).

The Company is engaged in the business of Lighting and Electrical Distribution. The Company has employed Employee to perform services for it and Employee has accepted said employment.

In consideration of the foregoing and Employee’s employment by the Company as good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Confidentiality

- a. Definition of “Confidential Information.” “Confidential Information” means all confidential business or financial information of the Company, including but not limited to any trade secrets, manufacturing plans, new product information, customer lists, or other information that is secret and of value.
- b. Employee’s Use of Confidential Information. The Company owns certain trade secrets and confidential information in connection with its business, which are valuable assets of the Company. During the duration, and after the termination of this Agreement, Employee shall not, without the Company’s prior written consent, directly or indirectly, use, disclose, or otherwise communicate any Confidential Information to any person or entity, except in performance of Employee’s legitimate duties for the Company.
- c. Acknowledgment of Confidential Information. Employee acknowledges that Employee will have access to Confidential Information, made accessible to Employee only in strict confidence by the Company. Employee acknowledges that unauthorized disclosure will damage the Company’s business and that Confidential Information could immediately be used by a competitor of the Company. The use and value of this Confidential Information depends on its continuing secrecy and the Company has taken appropriate steps to maintain this secrecy. Employee acknowledges that the restrictions contained in this section are reasonable and necessary for the protection of the Company’s business.
- d. Definition of Company Property. Company Property is defined as, but not limited to, all documents or other records containing or reflecting Confidential Information prepared by or provided to Employee and all copies, in any medium, of such materials. Employee shall not copy or use any Company Property for any purpose not relating directly to Employee’s work on the Company’s behalf, or use, disclose, or sell any Company Property, except with the Company’s prior written consent. Upon the termination of the employment relationship or upon the Company’s request, Employee shall immediately deliver to the Company all Company Property. Employee may comply with any subpoena or court order, if Employee submits a copy of the subpoena or court order to the Company’s President within three (3) working days of receipt.

- e. Third-Parties' Confidential Information. Employee acknowledges that the Company has and will receive from third parties confidential or proprietary information, and that the Company must maintain the confidentiality of such information. Employee shall not use or disclose any such information, except as permitted by the Company or the third party to whom the information belongs.
- f. Employee's Former Employer's Confidential Information. Employee shall not, during Employee's employment with the Company, improperly use or disclose to the Company any proprietary information or trade secrets belonging to any former employer or any third party to whom Employee owes a duty of confidentiality.

2. Nonsolicitation

- a. Covenants. During the term of Employee's employment and for a period of 24 months after termination of Employee's employment, Employee shall not directly or indirectly:
 - (1) Solicit, recruit or attempt to persuade any person then an employee, agent or contractor of the Company or any Company affiliate to terminate such person's employment or relationship with the Company or Company affiliate.
 - (2) Solicit business from any customer or client with whom Employee had contact during the employment relationship with the Company.
- b. Waiver. The above prohibition may be waived only by the Company's prior written consent.
- c. Acknowledgment of Restriction. Employee acknowledges that the restrictions contained in this section are reasonable and necessary for the protection of the Company's business.

3. General Provisions

- a. Disclosure of Obligations. Employee shall make the terms and conditions of this agreement known to any business or employer in competition with the Company, with which Employee becomes associated during the term of this agreement. The Company shall have the right to make the terms of this agreement known to third persons.
- b. Conflict of Obligations. Employee states that Employee is not now under any legal or contractual obligation conflicting with this agreement and that entering this agreement will not breach any agreement to which Employee is now a party. Employee agrees to reimburse and hold the Company harmless for any costs, damages, or fees sustained or expended by the Company as a result of Employee's breach of warranties under this section.
- c. Remedies. Employee acknowledges that breach of this agreement will cause the Company to suffer immediate and irreparable harm and damage for which money alone cannot fully compensate the Company. Employee agrees that upon breach or threat of imminent breach of any obligation under this agreement, the Company shall be entitled to a temporary restraining order, preliminary injunction, permanent injunction, or other injunctive relief, without posting any bond or other security, and that Employee shall not oppose entry of any of these measures. This section shall not be construed as an election of any remedy, or as a waiver of any right available to the Company under this agreement or the Colorado law governing this agreement, including the right to seek damages from Employee.
- d. Attorney's Fees. In the event of any controversy, claim, or dispute between the parties affecting or relating to the performance of this agreement, the prevailing party shall be entitled to recover all of its attorney's fees and costs.

- e. Entire Agreement. This agreement contains all of the terms agreed upon by the parties and supersedes all prior agreements, arrangements, and communications between the parties on this subject, whether oral or written.
- f. Survival. Employee's obligations under this agreement shall survive the termination of Employee's employment and shall be enforceable regardless of which party terminates the employment relationship and regardless of whether such termination is later claimed or found to be wrongful.
- g. Governing Law and Forum. All disputes or issues arising from this agreement or the Company's relationship with Employee shall be governed by the internal laws of the State of Colorado. Any action arising from or relating in any way to this agreement or Employee's employment with the Company shall be tried only in the state or federal courts situated in Colorado. The parties consent to jurisdiction and venue in those courts to the greatest extent possible under law.
- h. Severability. In the event any of the restrictions contained in this agreement are held to be unenforceable, the court so holding shall effect any change to the extent absolutely necessary to render the restrictions enforceable, while still maintaining the parties' expressed desire that the Company be protected to the greatest extent possible under the applicable law. Each of the terms and provisions of this agreement is severable in whole or in part, and any term or provision found to be invalid or illegal and unenforceable by the court shall be excised by the court, and the remaining terms and provisions shall not be affected and shall remain in full force and effect.
- i. Modification and Waiver. The parties agree that this agreement cannot be modified or waived without a written agreement signed by both parties. The Company's waiver of the breach of any provision of this agreement by Employee shall not constitute a waiver of any subsequent breach.
- j. Heirs and Assigns. This agreement shall be binding upon Employee's heirs, executors, administrators, or other legal representatives; shall inure to the benefit of the Company, its successors or assigns; and shall be freely assignable by the Company, but not by Employee.
- k. Headings. Numbers and titles to the sections of this agreement are for information purposes only and, where inconsistent with the text, are to be disregarded.
- l. Acknowledgment of Employee Opportunity to Seek Counsel. Employee has been afforded the opportunity to read, reflect upon, and consider the terms of the agreement; has been afforded the opportunity to discuss this agreement with an attorney or other adviser; and has read this entire agreement, fully understands its terms, and has voluntarily executed this agreement.
- m. **AT-WILL EMPLOYMENT. THE PARTIES ACKNOWLEDGE THAT THIS AGREEMENT SHALL NOT ALTER THE AT-WILL NATURE OF THEIR EMPLOYMENT RELATIONSHIP.**

DATED 12/16/2014 Adam Jackson
EMPLOYEE

DATED: _____
CMG/ESSG REPRESENTATIVE

BY _____

TITLE _____

ENROLLMENT FORM

ESC NAV*SAD P2M v15.0

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK

(Must Be Filled Out)

Social Security Number 312-92-8609
 Date of Birth 05/14/1984 Sex M F
 Name Adam Jackson
 Street Address 8300 Sheridan Blvd #9F
 City Arvada State CO Zip 80003
 Home Phone 812-606-1141

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 Adam
 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 your beneficiary information.

NAME OF BENEFICIARY
Natasha Wills
RELATIONSHIP
Fiancee

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

**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.**

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

DENTAL 

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

TERM LIFE 

- YES** \$0.60 Employee Only
- NO** \$0.90 Employee + 1
- NO** \$1.80 Employee + Family

SHORT-TERM DISABILITY 

- YES** \$4.20 Employee Only
- NO**

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

OPTION 2 82193010-M-EMP
MEC WELLNESS/PREVENTIVE PLAN Monthly Rates

- \$58.87 Employee Only
- \$87.73 Employee + 1
- \$186.99 Employee + Family
- NO to MEC 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 declination of coverage.

Signature Adam Jackson Date 12/16/2014

SOCIALLY SECURE

312-92-8609

THIS NUMBER HAS BEEN ESTABLISHED FOR

ADAM DARNELL

JACKSON

SIGNATURE

Adam Darnell Jackson

0912912008

FOR SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA

MANUFACTURED BY THE SECURITY PRINTING OFFICE