



SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2017353115229TF

Report Prepared: 12/19/2017

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Aguilar Carcamo

First Name: Jose

Date of Birth: 02/02/1989

Social Security Number: *** ** 2965

Hire Date: 12/19/2017

Citizenship Status: An alien authorized to work

Document Information

List A Document: Employment Authorization Document (Form I-766)

Allen Number: 208593207

Card Number: LIN1790929462

Document Expiration Date: 10/18/2018

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 12/19/2017

Case Submitted By: RPRI1528

Closed On: 12/19/2017

Closed By: RPRI1528

Closure Statement: The employee continues to work for the employer after receiving an Employment Authorized result.

SENSITIVE BUT UNCLASSIFIED



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

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

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

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

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

Last Name (Family Name) Aguila Carcamo		First Name (Given Name) Jose		Middle Initial E	Other Last Names Used (if any)	
Address (Street Number and Name) 7908 Dikson Ave			Apt. Number	City or Town 19H	State MN	ZIP Code 55076
Date of Birth (mm/dd/yyyy) 02/02/89	U.S. Social Security Number 470-87-2969	Employee's E-mail Address JA3234439@gmail			Employee's Telephone Number 612 462 5710	

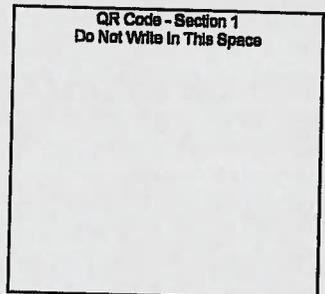
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

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

- 1. A citizen of the United States
- 2. A noncitizen national of the United States (See instructions)
- 3. A lawful permanent resident (Alien Registration Number/USCIS Number):

4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): **10/18/2019**
 Some aliens may write "N/A" in the expiration date field. (See instructions)
 Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
 An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

- 1. Alien Registration Number/USCIS Number: **208-593-207**
- OR
- 2. Form I-94 Admission Number: _____
- OR
- 3. Foreign Passport Number: _____
- Country of Issuance: _____

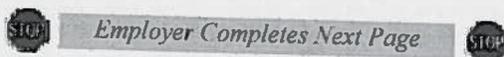


Signature of Employee 	Today's Date (mm/dd/yyyy) 12-19-17
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
 (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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





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

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

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name) <u>Aguilar Carcamo</u>	First Name (Given Name) <u>Jose</u>	M.I.	Citizenship/Immigration Status <u>4</u>
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List A OR List B AND List C
 Identity and Employment Authorization Identity Employment Authorization

Document Title <u>Employment Authorization</u> Issuing Authority <u>United States America</u> Document Number <u>208-593-007</u> Expiration Date (if any) (mm/dd/yyyy) <u>10-18-18</u>	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)
Document Title Issuing Authority Document Number Expiration Date (if any) (mm/dd/yyyy)	Additional Information	
	QR Code - Sections 2 & 3 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): 12-19-17. (See instructions for exemptions)

Signature of Employer or Authorized Representative <u>[Signature]</u>		Today's Date (mm/dd/yyyy) <u>12-19-2017.</u>	Title of Employer or Authorized Representative <u>On-Site Rep</u>	
Last Name of Employer or Authorized Representative <u>Ritter</u>		First Name of Employer or Authorized Representative <u>Kate</u>	Employer's Business or Organization Name <u>Employers Solutions</u>	
Employer's Business or Organization Address (Street Number and Name) <u>7480 Flying Cloud Dr. Suite 200</u>		City or Town <u>Eden Prairie</u>	State <u>MN</u>	ZIP Code <u>55344</u>

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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UNITED STATES OF AMERICA

EMPLOYMENT AUTHORIZATION CARD

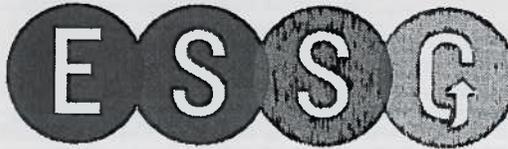


AGUILAR CARGAMO JOSE E



Surname
AGUILAR CARGAMO
Given Name
JOSE E
USCIS#
205-593-207 Category Card#
COG LIN1780929462
Country of Birth
El Salvador
Terms and Conditions
None
Date of Birth
02 FEB 1985 Sex
M
Valid From
10/19/17
Card Expires
10/18/18
NOT VALID FOR REENTRY TO U.S.

Signature *Waived*



employer solutions staffing group.

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Aguilar Carcamo First Name Jose Middle Initial E
 Street Address 7908 Dikson Avenue Apt/Ste _____
 City/State/Zip Inver Grove Heights, MN 55076 Social Security Last Four XXX-XX-
 Phone Number 6124625710 Email Address Ja3234439@gmail.com @
 Staffing Agency/Recruitment Partner CMG

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.

Jesus Aguilar Carcamo
 Name (Print or type)

Jesus Aguilar Carcamo
Jesus Aguilar Carcamo (Dec 19, 2017)
 Applicant's Signature

Dec 19, 2017
 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 _____	



employer solutions staffing group
Wage Payment Method Authorization (Minnesota)

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 paper Check.

SECTION 1 BASIC INFORMATION

Employee Name Jose E Aguilar SSN# (last 4 digits) 2965 Effective Date 12/19/2017

SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated*
 Payroll Debit Card (Please complete Sections 4 and 5 below) Paper Check (Please complete Section 5 below)

SECTION 3 DIRECT DEPOSIT

Update Bank Account
 Bank Name: Wells Fargo
 Routing#: _____
 Account# 7446332954
 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 12/19/17

- 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

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) _____

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 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: Ja3234439@smail.com
 this information will only be used to send your paystubs electronically

Employee's Signature: [Signature] Date: 12-19-17

Form W-4 (2017)

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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

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

- is age 65 or older,
- is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you aren't 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 2017. 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 _____
B	Enter "1" if: <ul style="list-style-type: none"> • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
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 _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child. 	G _____
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 _____

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 \$50,000 (\$20,000 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	<h3>Employee's Withholding Allowance Certificate</h3> <p>▶ 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.</p>	OMB No. 1545-0074 <h1 style="font-size: 2em;">2017</h1>
1 Your first name and middle initial Jose E		Last name Aguilar Carcamo
Home address (number and street or rural route) 7908 Dikson Avenue		2 Your social security number 470812965
City or town, state, and ZIP code Inver Grove Heights, MN 55076		3 <input checked="" type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
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 \$
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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
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.) ▶ <i>Jesus Aguilar Carcamo</i> Jesus Aguilar Carcamo (Dec. 19, 2017)		Date ▶ Dec 19, 2017
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)

**EMPLOYER SOLUTIONS STAFFING GROUP
BACKGROUND CHECK AUTHORIZATION**

Employee Name: Jesus Aguilar Carcamo
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: 7908 Dikson Avenue Inver Grove Heights, MN 55076
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: _____
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: _____
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: 470812965 DOB: 02/02/1989

Phone Number: 6124625710

Driver's License Number/State: _____

The information contained in this application is correct to the best of my knowledge.

I hereby authorize Employer Solutions Staffing Group, LLC and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Employer Solutions Staffing Group, LLC or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Employer Solutions Staffing Group, LLC and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: *Jesus Aguilar Carcamo* Date: Dec 19, 2017
Jesus Aguilar Carcamo (1/19/2017)

Notice to CA, MN, and OK Residents:

Please check the box below if you wish to receive a copy of a consumer report that is requested.

I wish to receive a copy of any Background Check Report on me that is requested.

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identity theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates.	a. Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above:	
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration

EMERGENCY CONTACT INFORMATION

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

Employee Name: Jesus Aguilar Carcamo

Address: 7908 Dikson Avenue Inver Grove Heights, MN 55076

Home Phone: 6124625710

EMERGENCY CONTACTS <i>Please list two people (in priority order) who could be contacted in case of an emergency</i>	
<p style="text-align: center;">Contact #1</p> <p>Name: <u>Juan Jose Chacon</u></p> <p>Relationship: _____</p>	<p>Home Phone: _____</p> <p>Cell Phone: <u>6512000769</u></p> <p>Work Phone: _____</p>
<p style="text-align: center;">Contact #2</p> <p>Name: _____</p> <p>Relationship: _____</p>	<p>Home Phone: _____</p> <p>Cell Phone: _____</p> <p>Work Phone: _____</p>

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

This information will remain confidential and will only be used in the case of an emergency.



employer solutions staffing group_{llc}

STATEMENT OF CONFIDENTIALITY

This agreement made this ____ day of _____, 201__, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and _____ 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.

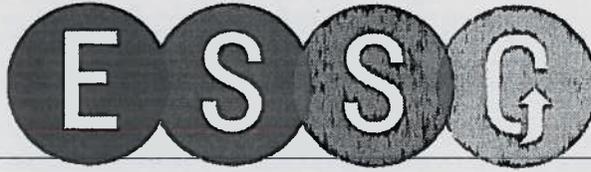
In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of \$10,000 as liquidated damages for every such violation; provided, however, that the payment of such 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.

Jesus Aguilar Carcamo

Jesus Aguilar Carcamo (Dec 19, 2017)

Employee Signature

Employer Solutions Staffing Group LLC, Representative



employer solutions staffing group_{llc}

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.

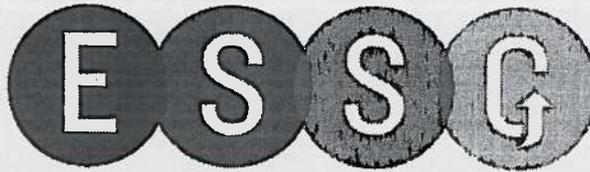
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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: Jesus Aguilar Carcamo
Jesus Aguilar Carcamo (Dec 19, 2017)

Printed Name: Jesus Aguilar Carcamo



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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 police 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): Jesus Aguilar Carcamo

Signature/Firma: *Jesus Aguilar Carcamo*
Jesus Aguilar Carcamo (Dec 19, 2017)



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ESSG WORKPLACE SAFETY POLICY

It is ESSG's policy that all employees should be able to enjoy a hazard free and safe work environment. It is ESSG's duty to:

- (1) Ensure that its clients provide you with a workplace free from serious recognized hazards and comply with standards, rules and regulations issued under the OSH Act.
- (2) Ensure that its clients perform a job hazard assessment in order to identify and eliminate potential safety and health hazards and to determine necessary training and protections for employees at the facility.
- (3) Make sure employees have and use safe tools and equipment.
- (4) Establish or update operating procedures and communicate them so that employees follow safety and health requirements.
- (5) Provide safety training in a language and vocabulary workers can understand.

ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

To help ensure a safe workplace, you have certain responsibilities too, which include the following:

- Responsibility to work in compliance with OSHA laws and regulations
- Responsibility to use personal protective equipment and clothing as directed by the host employer
- Responsibility to report workplace hazards and dangers
- Responsibility to work in a manner as required by the employer and use the prescribed safety equipment.

You have the following basic rights:

- Right to refuse unsafe work
- Right to know or be informed about actual and potential dangers in the workplace
- Right to review copies of appropriate standards, rules, regulations and requirements that the host employer is required to have available at the workplace.



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- **Right to request information about safety and health hazards in the workplace, appropriate precautions to take, and procedures to follow if involved in an accident or exposed to hazardous substances**
- **Right to gain access to relevant personal exposure and medical records.**

You can have your name withheld from the host employer and any other entity, by request, if you sign and file a written complaint. You can request to be advised of OSHA actions regarding a complaint, and request an informal review of any decision not to inspect the site or issue a citation. And, you can file a complaint if you are punished or discriminated against for acting as a "whistleblower" under the OSH Act or 13 other federal statutes for which OSHA has jurisdiction, or for refusing to work when faced with imminent danger of death or serious injury and there is insufficient time for OSHA to inspect. Retaliation or reprisal taken against anyone who has expressed concern about workplace safety is illegal.

If you believe that your right to a safe workplace has been violated, you can make a report to a manager of the host worksite employer and/or ESSG (by telephoning **952.835.1288/1.866.496.7573**) and asking for the ESSG Safety Director. You can also contact OSHA directly with any concern. ESSG recognizes the serious nature of ensuring workplace safety will endeavor to protect any employee who may have been subjected to unsafe or hazardous worksite conditions.



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Acknowledgement of Receipt of Workplace Safety Policy

I certify that I have received a copy of Employer Solutions Staffing Group's ESSG WORKPLACE SAFETY POLICY. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at 952.835.1288/1.866.496.7573 with any questions I may have about this policy. I agree to comply with ESSG's policy on ESSG WORKPLACE SAFETY POLICY and I understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am believe that I am working in an unsafe or dangerous work environment, I will immediately contact my supervisor, manager, director or ESSG's Safety Director at 952.835.1288/1.866.496.7573 in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Jesus Aguilar Carcamo

Employee's Signature:

Jesus Aguilar Carcamo
Jesus Aguilar Carcamo (Dec 19, 2017)

Date: Dec 19, 2017

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

OMB No. 1545-1500

► Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

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

Your name Jesus Aguilar Carcamo Social security number ► 470812965

Street address where you live 7908 Dikson Avenue

City or town, state, and ZIP code Inver Grove Heights, MN 55076

County _____ Telephone number 6124625710

If you are under age 40, enter your date of birth (month, day, year) 02/02/1989

- 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.
- 7 Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

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 ► Jesus Aguilar Carcamo
Jesus Aguilar Carcamo (Dec 19, 2017)

Date Dec 19, 2017

EMPLOYER SECTION:

Client:		Company:	
Location:		Position:	Starting Wage: \$

EMPLOYEE SECTION:

First Name: Last Name: Jesus Aguilar Carcamo		Suffix:	Street Address: 7908 Dikson Avenue		City/State: Inver Grove Heights, MN	Zip: 55076
SS#: 470812965	Date of Birth: 02/02/1989	Age:	Have you worked for this company before? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, location:	

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

Yes No

- 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.)
Name of the person receiving benefits: _____ Relationship to you: _____
City: _____ County: _____ State: _____ Yes No
- 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.)
Name of the person receiving benefits: _____ Relationship to you: _____
City: _____ County: _____ State: _____ Yes No
- 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. *If you checked yes please provide a copy of your SSI documentation. Yes No
- 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:
 Vocational Rehabilitation Agency Dept. of Veterans Affairs Employment Network (Ticket to Work Program)
Name of Agency: _____ Phone #: _____
City: _____ County: _____ State: _____
*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation. Yes No
- Are you a Veteran of the U.S. Military? *If yes, please provide a copy of your DD-214 and letter of separation. (If yes, please provide information below. If no, please continue to question #6.)
Dates of Service - From: _____ To: _____
Branch of Service: _____
Are you entitled to or are you receiving compensation for a service-connected disability? Yes No
- Have you been unemployed at any time during the last 12 months?
If yes, dates of unemployment - From: _____ To: _____
Did you receive unemployment compensation at any point during your unemployment?
If yes, in which state did you receive unemployment compensation? _____ Yes No
- Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Yes No
Conviction Date: _____ Release Date: _____
Was this a Federal or State conviction? If State - County: _____ State: _____

Additional Tax Credits

- IEC (Native American): Are you or your spouse a member of a Native American Tribe? (If you checked yes please provide a copy of your CDIB card.) Yes No
- CA Residents: Are you the child of foster parents? Do you receive CalWorks? Workforce Investment Act?
 Are you a migrant or seasonal farm worker? Have you ever been convicted of a misdemeanor?
- SC Residents: Do you receive Family Independence Benefits?

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: Jesus Aguilar Carcamo
Jesus Aguilar Carcamo (Dec 19, 2017)

Date: Dec 19, 2017



U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: January 31, 2020

LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM Work Opportunity Tax Credit (WOTC) Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

New Hire's Signature: Jesus Aguilar Carcamo
Jesus Aguilar Carcamo (Dec 19, 2017) Date Dec 19, 2017

New Hire Name: Jesus Aguilar Carcamo

Social Security Number: 470812965

Employer Name: _____

Please check the statements below if they apply to you.

I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

I declare that I have been in a period of unemployment since _____
(Enter start date)

Privacy Act Notice:
The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

**DRUG AND ALCOHOL
TESTING CONSENT FORM**

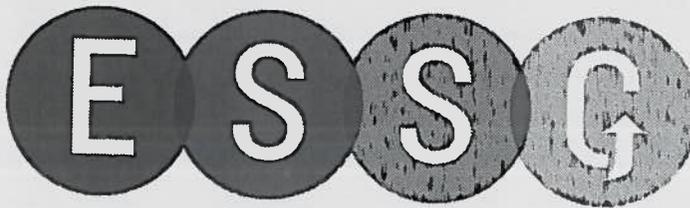
1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

Jose Enrique Aguilar Carcamo
Individual's Name
19-19-17
Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6



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

According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment.

It is your responsibility to contact ESSG (for instance, by calling 952.277.5227 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. JA (Initial)

 12-19-17
Employee Signature: Date:
Jose Enrique Aguilan Carcamo
Employee (please print your name here)

EL RECIBO DE GUIA de EMPLEADO Y EMPLEO EN HACE la DECLARACION

Esto es de reconocer que he leído el Guía del Empleado el Employer Solutions Staffing Group LLC y entiendo que expone los términos y las condiciones de mi empleo así como los deberes, responsabilidades y obligaciones de mi empleo con la compañía. Entiendo y concuerdo que es mi responsabilidad de respetar las reglas, políticas y estándares adelante en la Guía.

Reconozco también que mi empleo con el ESSG no es por un espacio de tiempo especificado y puede ser terminado en tiempo para ninguna razón, con ni sin la causa ni la nota, por mí ni por la compañía. Reconozco que ningunas declaraciones ni representaciones orales ni escrita con respecto a mi empleo pueden alterar el renunciar. Reconozco también que ningún encargado ni el empleado tiene la autoridad para entrar en un acuerdo del empleo, expresar o implicó, previendo el empleo de otra manera que a voluntad.

Reconozco también eso, menos la política del empleo a voluntad, el ESSG reserva el derecho de revisar, borrar y añadir a las provisiones de esta Guía de Empleado. Todo tales revisiones, las supresiones o las adiciones deben estar en la escritura y deben ser firmadas por el director general de la compañía. Ningunas declaraciones ni las representaciones orales pueden cambiar las provisiones de esta Guía. Reconozco también eso, menos la política del empleo a voluntad, los términos y las condiciones del empleo con la compañía pueden ser modificados en la única discreción de la compañía, con o sin la causa o la nota, en alguno tiempo. Ningún contrato tácito con respecto a cualquier decisión con respecto a mi empleo, el término del empleo ni la condición del empleo puede ser establecido por cualquier otra declaración, el conducto, la política ni la práctica.

Entiendo que el acuerdo que renuncia con respecto a mi posición del empleo de a voluntad y el derecho de compañía para determinar y modificar los términos y las condiciones del empleo constituyen el acuerdo entero entre mí y el ESSG con respecto a la duración de mi empleo, las circunstancias bajo que mi empleo puede ser terminado y las circunstancias bajo que los términos y las condiciones de mi empleo pueden cambiar. Entiendo aún más que este acuerdo desbanca todo acuerdos previos, las comprensiones y las representaciones con respecto a mi empleo con la compañía.

Si tengo las preguntas con respecto al contenido o interpretación de esta Guía, yo los traeré a la atención del ESSG.

FECHE 12-19-2017

EL EMPLEADO

NAME JOSE Enrique Aguilan CARLAMO

POR FAVOR IMPRIME a EMPLEADO

ESSG

REPRESENTATIVE _____

El reconocimiento de la Política de Recibo Contra Hostigamiento/Acoso

Certifico que he recibido una copia de la Política del Contra Hostigamiento/Acoso del Employer Solutions Staffing Group LLC. Entiendo que soy mi responsabilidad de leer esta política y preguntar a mi supervisor, un miembro de la administración o para telefonar las Employer Solutions Staffing Group (ESSG) en **1.866.496.7573/952.835.1288** con cualquiera pregunta puedo tener acerca de esta política. Conuerdo en conformarse con la política de la Compañía en Contra Hostigamiento/Acoso y entender que el fracaso para obedecer es el motivo para la acción disciplinaria, hasta e inclusive la terminación.

Conuerdo también que si en tiempo durante mi empleo que soy implicado en cualquier disputa del empleo o soy sujeto a cualquier tipo de la discriminación, inclusive la discriminación a causa de la carrera, el sexo, la edad, la religión, el color, el origen nacional, la incapacidad, la posición marital y sexual de la orientación o el veterano, o si soy sujeto a cualquier tipo del acoso inclusive el acoso sexual, yo contactaré inmediatamente a mi supervisor, el encargado, el encargado o el Departamento Humano de Recurso de ESSG en **1.866.496.7573/952.835.1288** para obtener ayuda en la resolución de tales asuntos.

El Nombre del empleado (por favor Impresión) :

Jose Enrique Aguilan Carcamo

La Firma del empleado:



Fecha: 12-19-2017

EL RECONOCIMIENTO

La guía fue revisada conmigo, y he recibido mi copia personal. Reconozco también que he sido dado la oportunidad de hacer preguntas y expresar concierne durante mi orientación. Adicionalmente, entiendo y sostengo lo siguiente:

1. Esta guía es pensada como una guía y no un acuerdo de empleo que crea una relación contractual, y que la relación del empleo puede ser terminada a voluntad por cualquier partido en tiempo.
2. Las necesidades cambiantes del negocio requerirán la modificación en el método, en las prácticas y las políticas, y la compañía revisará unilateralmente, como sea necesario, para encontrar estas necesidades cambiantes.
3. Concuero **en notificar** mi Consultor del ESSG **inmediatamente** de cualquier cambio en mis datos personales tales como el número de teléfono, la dirección, la notificación de la emergencia, etc.
4. Soy responsable de la información proporcionada en esto y, sobre mi separación, volveré esta guía a mi Consultor del ESSG.

La fecha: 12-19-2007

La Firma del Socio 

El Nombre Impreso del socio: _____

La orientación proporcionada por: _____

ENROLLMENT FORM

ESC CU(UNAC-MN) P1

A. REQUIRED EMPLOYEE INFORMATION

Name JOSE ENRIQUE AGUILAR CARCAMO

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

Address 7908 DIXSON AVE

Social Security # 470812965

Home Phone 612 462 5910

City IGH

State MN

Zip 55076

Sex M F

Apt. # _____

Date of Birth ___/___/___

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

Medicare Health Insurance Claim Number (HICN)

Yes No. If Yes, please continue.
Medicare Effective Date

Name of Covered Person (s):

1. _____

2. _____

3. _____

C. LIMITED BENEFITS PLAN SELECTION

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

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only <input type="checkbox"/>	\$20.25 <input checked="" type="checkbox"/>	\$6.17 <input checked="" type="checkbox"/>	\$2.42 <input checked="" type="checkbox"/>	\$0.60 <input checked="" type="checkbox"/>	\$4.20 <input checked="" type="checkbox"/>
Employee + 1 <input checked="" type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
NO to ALL Benefits <input type="checkbox"/>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

¹This coverage is not available to residents of NH, HI, or PR. ²STD is not available to persons who work in CA, HI, NJ, NY, or RI. For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
Emmanuel Adonay		01/04/14	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Aguilar Espinoza		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE

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. **YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE**

DATE 12/19/2017

SIGNATURE [Signature]



Enhanced MEC Plan Plan 1

Benefit Plan Administration

Benefits Enrollment Form

Employee Information New Employee Rehire Rehire Date

Name (First and Last) Jose E. Aguilar Carcamo

Address 7908 Dixon Ave. City Inver Grove Heights State MN Zip Code 55076

Gender Male Female Marital Status Single Married Divorced Date of Birth 02-02-1989

Phone Number: 612 462-5710 Email Address: _____ Social Security Number 470-81-2965 Date of Hire 12/20/17

Please Select Desired Coverage:

Employee Only - \$24.00/Week Employee+Spouse - \$38.00/Week Employee+Child(ren) - \$36.00/Week Family - \$63.00/Week

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
Dependent					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Dependent					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Dependent					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature _____ Date _____

EMPLOYEES DECLINING **I am DECLINING coverage**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption or parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature [Signature] Date 12-19-2017