CMG
CORPORATE MANAGEMENT GROUP

CMG APPLICATION FOR EMPLOYMENT

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

PLEASE COMPLETE PAGES 1-5 DATE 1-30-17

Name Burtard Alicia Marie
Last First Middle Maiden

Present address 1913W 101st Ave
Number Street

Thornton CO 80260
City State Zip

Social Security No. 524 - 77 - 7724

Telephone (303) 803 7353 E-Mail wittyinpink@icloud.com

If under 18, please list age _____ Referred by Jamie Thompson

Position applied for (1) Short Term Receptionist
and salary desired (2) $12/hr
(Be specific)

Shift available to work
1st ✓
2nd ✓
3rd ✓

How many hours can you work weekly? 40 hrs Can you work nights? yes

Employment desired ___ FULL-TIME ONLY ___ PART-TIME ONLY ✗ FULL- OR PART-TIME

When available for work? Immediately

Do you have responsibilities or commitments that will prevent you from meeting specified work schedules?
✗ No ___ Yes If so, please explain _____

Do you anticipate any absences from work on a regular basis?
✗ No ___ Yes If so, please explain _____

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete mailing address)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Bus. or Trade School				
Professional School				

HAVE YOU EVER BEEN CONVICTED OF A CRIME? ☒ No ___ Yes

If yes, explain number of conviction(s), nature of offense(s), dates of conviction(s), sentence(s) imposed, and type(s) of rehabilitation. _____

APPLICATION FOR EMPLOYMENT

DO YOU HAVE A DRIVER'S LICENSE? ☒ Yes ___ No

What is your means of transportation to work? Personal Vehicle

Driver's license number 07-072-0987 State of issue CO

Operator ___ Commercial (CDL) ___ Chauffeur ___

Expiration date 8-17-2021

Have you had any accidents during the past three years? ___ Yes ☒ No

If so, how many? _____

Have you had any moving violations during the past three years? ___ Yes ☒ No

If so, how many? _____

Please list two references other than relatives or previous employers.

Name Pat Booth	Name Melissa Weisser
Position Customer Service Supervisor	Position Hearing Aid Lab Technician
Company Department of Veterans Affairs	Company "
Address 555 Carporate Cir	Address "
Golden, CO 80401	"
Telephone (303) 515 1969	Telephone (720) 971 9737

APPLICATION FOR EMPLOYMENT

MILITARY

HAVE YOU EVER BEEN IN THE ARMED FORCES? __ Yes ☒ No

ARE YOU NOW A MEMBER OF THE RESERVE OR NATIONAL GUARD? __ Yes ☒ No

Branch _____ Specialty _____

Date Entered _____ Discharge Date _____

WORK EXPERIENCE

Please list your work experience for the **past five years** beginning with your most recent job held.
If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name _____ Position _____ Company _____ Address _____ _____ Telephone (_____)_____	Supervisor name _____	
	Employment dates	Pay or salary
	From To	Start Final
	Your last job title _____	
Reason for leaving (be specific) _____		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.		

Name _____ Position _____ Company _____ Address _____ _____ Telephone (_____)_____	Supervisor name _____	
	Employment dates	Pay or salary
	From To	Start Final
	Your last job title _____	
Reason for leaving (be specific) _____		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.		

APPLICATION FOR EMPLOYMENT

WORK EXPERIENCE

Please list your work experience for the **past five years** beginning with your most recent job held.
If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name _____	Supervisor name _____	
Position _____	Employment dates	Pay or salary
Company _____	From	Start
Address _____	To	Final
_____		
Telephone (_____)_____	Your last job title _____	
Reason for leaving (be specific) _____		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.		

Name _____	Supervisor name _____	
Position _____	Employment dates	Pay or salary
Company _____	From	Start
Address _____	To	Final
_____		
Telephone (_____)_____	Your last job title _____	
Reason for leaving (be specific) _____		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.		

May we contact your present employer? __ Yes __ No

Did you complete this application yourself __ Yes __ No

If not, who did? _____

PLEASE READ CAREFULLY
APPLICATION FORM WAIVER

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

I agree that:

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

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

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

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

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

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

Signature of applicant Micia Bustard Date: 1-30-17

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	1
B	Enter "1" if: • 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	0
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	0
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	0
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	0
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	0
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 $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	0
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	1

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

Employee's Withholding Allowance Certificate

▶ **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.**

OMB No. 1545-0074
2017

1 Your first name and middle initial: Alicia M
Last name: Burtard
2 Your social security number: 524-77-7724

Home address (number and street or rural route): 1913 W 101st Ave
3 ☐ Single ☒ Married ☐ 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: Thornton, CO, 80260
4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	1
6	Additional amount, if any, you want withheld from each paycheck	6	$ 0
7	I claim exemption from withholding for 2017, 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	

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.) ▶ Alicia Burtard
Date ▶ 1-30-17

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)

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q Form **W-4** (2017)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $

2 Enter: { $12,700 if married filing jointly or qualifying widow(er) / $9,350 if head of household / $6,350 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2017 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

_____, or any of its subsidiaries may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history (State and Federal records), social security verification, address trace, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised NationSearch LLC. 11160 Huron St. Suite 100 Northglenn, Co 80234, (800)-827-9550 will be conducting the ICR or another outside organization. The scope of this notice and authorization is all encompassing, however, allowing the Company 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.

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 those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, credit reporting agency, employer, to provide any and all background information requested by NationSearch LLC. 11160 Huron St. Suite 100 Northglenn, CO 80234 (800)-827-9550, 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.

Notice to California Applicants: Notice to California Applicants: Under section 1786.22 of California Civil Code, you have the right to request from NationSearch, upon proper identification, the nature and substance of all information in files pertaining to you, including the sources of information, and recipients of any reports on you, which NationSearch has previously furnished within the two-year period preceding your request. You may view the file maintained on you by contacting NationSearch during normal business hours. You may also obtain a copy of this report(s) upon submitting proper identification. Upon making a written request, you may receive a summary of your report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly.

Notice to Maine Applicants: Under Chapter 210 Section 1314 of Maine revised Statutes, you have the right, upon request, to be informed within 5 business days of such a request to whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency, NationSearch and request a copy of the report(s) compiled.

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 the Company. ☐

Last Name:	First:	SS#
Other Names used:	Date of Birth: For employment Purposes Only	
Motor Vehicle Number and State of Issue: (Driver's License #, NOT License Plate #)		
Address:		

Signature:_____ Date:_____

Please initial this box in affirmation that you have been advised of your rights as it pertains to this consumer investigative report, and are aware of the agency conducting the investigation: ☐

IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION

Name: _____

Address: _____

Home Phone: _____

Person(s) to contact in case of an emergency on the job (in order of preference):

1. **Name:** Timothy Happs

   Phone (work): _____

   Phone (home): 303 725 8492

2. **Name:** Melissa Weisser

   Phone (work): _____

   Phone (home): 720 971 9737

Additional information you want CMG and our clients to know in the event of an emergency:

Drug Allergy- Sulfa

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

Employee Name: Burtard (Last) Alicia (First) Marie (Middle) 8/17/1990 (Date of Birth)

Social Security Number: 524-77-7724 Date of Hire: 1-30-17

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

I affirm all four of the following:

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.

AJ Findley
Print Name of Employer (or Designated Representative)

Executive Assistant
Official Title

AJ Findley
Signature of Employer (or Designated Representative)

2/1/17
Date Signed

Corporate Management Group 12000 N. Washington Street #290
Thornton, CO 80241
Business or Organization Name

303-920-1425
Employer Phone Number

§ 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.

This affirmation 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.

This affirmation is provided as a courtesy by the Colorado Division of Labor.

Authorization of Direct Deposit

The undersigned (hereafter referred to as the "employee") hereby authorizes and requests PAYCOM to make deposits from time to time in the account(s) identified below and authorizes the bank to accept such deposits. It is agreed that these deposits may be made electronically and under the Rules of the National Automated Clearing House Association. It is agreed that PAYCOM is only responsible for direct deposit of funds that have previously been received from _____ hereafter referred to as the "employer".

Attach a voided check, copy of a check, or spec sheet for each account. Indicate whether it is a checking or saving account. (No deposit slips)

1. Call your bank and confirm the **ACH Routing Number(s)** and Account numbers for **Checking and/or Savings**
2. Complete and Sign the form

Main Account (Net Pay) - Checking or Savings Account (circle one)

Acct # _____

ACH Routing # /_/_/_/_/_/_/_/_/_/

Bank Name _____

Additional Account - Checking or Savings Account (circle one)

Acct # _____ Dollar Amount _____

ACH Routing # /_/_/_/_/_/_/_/_/_/

Bank Name _____

Additional Account - Checking or Savings Account (circle one)

Acct # _____ Dollar Amount _____

ACH Routing # /_/_/_/_/_/_/_/_/_/

Bank Name _____

Additional Account - Checking or Savings Account (circle one)

Acct # _____ Dollar Amount _____

ACH Routing # /_/_/_/_/_/_/_/_/_/

Bank Name _____

Additional Account - Checking or Savings Account (circle one)

Acct # _____ Dollar Amount _____

ACH Routing # /_/_/_/_/_/_/_/_/_/

Bank Name _____

Pay Card →

Routing#:

073 972 181

Card#:

4853 4001 1629 8102

Set up thru GCC ☑

Employee Name _____ **SS#** ____/____/____

Address _____ **City** _____ **State** ___ **Zip** _____

Employee Signature Alicia Bustard

PAYROLL CARD DIRECT DEPOSIT AGREEMENT

ABA ROUTING NUMBER	073972181
PAYCARD ACCOUNT NUMBER	_____
CARDHOLDER NAME	
SOCIAL SECURITY NUMBER	_____ - _____ - _____

I AUTHORIZE _____ TO INITIATE CREDIT ENTRIES AND, IF NECESSARY, TO INITIATE ANY ACTIONS TO REVERSE OR CORRECT AN ERRONEOUS CREDIT ENTRY TO MY PAY CARD ACCOUNT AT META BANK, FOR THE PURPOSE OF AUTOMATICALLY DEPOSITING FUNDS INTO MY ACCOUNT.

I UNDERSTAND THAT THIS AUTHORIZATION REPLACES ANY PREVIOUS AND WILL REMAIN IN FULL FORCE AND EFFECT UNTIL THE AFOREMENTIONED COMPANY HAS RECEIVED WRITTEN NOTIFICATION FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD THE AFOREMENTIONED COMPANY AND US BANK A REASONABLE OPPORTUNITY TO ACT ON IT.

SIGNATURE _____ Alicia Burtard

DATE ____/____/____

PLEASE COMPLETE THIS FORM AND RETURN IT TO YOUR EMPLOYER.

To Activate Your New
Global Cash Card
visit us on the web
www.globalcashcard.com/activate
or Call
toll-free 1-(866) 929-8096

Outside of the U.S.
Call (949) 751-0360

Please have your card handy for activation.
Thank you.

4853 4001 1629 8102

...PÓSITO DIRECTO

_____

_____

_____

95-9200

SARIO, TAMBIÉN QUE SE INICIE CUALQUIER ACCIÓN PARA INVERTIR O

DARA EN EFECTO HASTA QUE LA COMPAÑÍA REFERIDA RECIBIDO LA
PROPORCIONAR LA COMPAÑÍA REFERIDA Y META BANK PARA DARLE

Y DEVUELVA A SU COMPAÑÍA

To: All Employees
Quien: *Todos Empleados*

From: Corporate Management Group & Employer Solutions Group
De: *Corporate Management Group y Employer Solutions Group*

Re: Stop Payment Check Fee
Re: *Tarifa de cheque parado*

Effective immediately, to replace a lost or stolen check, $50.00 will be deducted from the replacement check for a stop payment fee and for a reprocessing fee. *Efectivo inmediatamente, para reemplazar un cheque de sueldo perdido o robado, $50.00 de tarifa sera deducido de el cheque reemplazado para parar el cheque original y para procesarlo denuevo.*

If you lose your check, we will first have to verify that it has not been processed through the bank. If it has not, a new check will be issued, minus the $50.00 fee. *Si usted pierde su cheque, tendremos que verificar que no ha sido procesado en el banco. Si no, un cheque nuevo sera processado, menos las tarifa de $50.00.*

If your check is stolen, we will first need a copy of the police report before a new check can be reissued. After we receive a copy of the police report, a new check will be issued following the same procedures as listed above. *Si su cheque es robado, necesitaremos una copia de el reporte de policia antes de que un cheque nuevo sera procesado. Despues de obtener una copia del reporte de policia, un cheque nuevo sera procesado usando los mismos procedimientos mencionados arriba.*

If you have any questions regarding this new policy, please contact your On-Site Representative or the Corporate Office (303-920-1425). *Si usted tiene preguntas sobre esta poliza, por favor contacte a su representante de CMG o la oficina corporal al (303-920-1425)*

Thank you for your continued dedication and hard work!

Gracias por su dedicacion continua!

By signing below you are confirming that you understand the above policy.
Con su firma abajo usted esta confirmando que entiende la poliza descrita.

Signature/*Firma*: Alicia Bustard
Date/*Fecha*: 1-30-17

CMG
CORPORATE MANAGEMENT GROUP

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 you responsibility to contact or notify CMG 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 CMG once an assignment ends. I also acknowledge that I have received a separate copy of this form.

AB (Initial)

Alicia Burtard
Employee Signature:

1-30-17
Date:

Alicia Burtard
Employee (please print your name here)

ANTI-HARASSMENT POLICY

It is Corporate Management Group's (CMG) policy that all employees should be able to enjoy a work environment free from all forms of discrimination, including harassment. As such, CMG is committed to vigorously enforcing their Anti-harassment Policy. This policy applies to all employees of the organization (without regard to position) and individuals not directly connected to CMG (e.g., an outside vendor, consultant, customer or guest). Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, creed, religion, national origin, sex, marital status, status with regard to public assistance, membership or activity in a local commission, disability, sexual orientation or veteran status. Harassment is considered a form of discrimination and is specifically included among the prohibitions under Title VII of the Civil Rights Act of 1964. In addition, retaliation or reprisal taken against anyone who has expressed concern about harassment or discrimination against the individual raising the concern is illegal.

The Equal Employment Opportunity Commission (EEOC) defines sexual harassment as "unwelcome sexual advances, requests for sexual favors, sexual comments, or other verbal or physical acts of a sexual or sex-based nature including, but not limited to drawings, pictures, jokes, and/or teasing where (1) submission to such conduct is made either explicitly or implicitly a term or a condition of an individual's employment; (2) an employment decision is based on an individual's acceptance or rejection of such conduct; or (3) such conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment."

The Anti-harassment Policy prohibits harassment and/or retaliation by any individual employed by, doing business with or for, or visiting CMG. Employees who believe they have been the subject of harassment and/or retaliation or an employee who may have been witness to harassment and/or retaliation must report the incident immediately. Information and/or allegations must be reported to a manager of CMG **(by telephoning 866.920.1425 or 303.920.1425)**. Only those who have an immediate need to know, including the alleged target of harassment or retaliation, the alleged harassers or retaliators, and any witnesses may find out the identity of the complainant. All individuals contacted in the course of an investigation will be advised that all persons involved in a charge are entitled to respect and that any retaliation or reprisal against an individual who is an alleged target of harassment or retaliation, who has made a complaint, or who has provided information in connection with a complaint, is a separate violation of CMG's policy. All information will be disclosed only on a need-to-know basis to allow CMG to

investigate and resolve the incident. CMG recognizes the serious nature of harassment and therefore will endeavor to protect the employee who may have been subjected to harassment, any witnesses and the party against whom allegations have been filed to every possible extent.

Harassment is unlawful and has a negative impact on employees. Violation of the Anti-harassment Policy will not be tolerated by CMG and may result in discipline up to and including termination. Offensive acts or conduct have no legitimate business purpose; accordingly, any employee, regardless of his/her position within CMG, who it is determined has engaged in such conduct will be made to bear the full responsibility for such unlawful conduct.

With respect to sexual harassment, the following is prohibited:

1. Unwelcome sexual advances, request for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, especially where:

   - ☐ Submission to such conduct is made either explicitly or implicitly a term or condition of employment;
   - ☐ Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or
   - ☐ Such conduct has the purpose or effect of creating an intimidating, hostile or offensive working environment.

2. Offensive comments, jokes, innuendoes and other sexually-oriented statements.

If Harassment Occurs:

1. When possible, confront the harasser and tell him/her to stop. Sometimes a simple confrontation will end the situation.
2. If confrontation is unsuccessful, immediately contact your CMG supervisor to report the harassment.
3. An investigation will be conducted and appropriate action taken, including disciplinary measures. We will investigate, in confidence; all reported incidents of harassment and retaliation.

Employee Signature: Alicia Bustard

Date: 1-30-17

CORPORATE MANAGEMENT GROUP

Employees:

Implementation of the Affordable Care Act (ACA) of 2010 (the health care reform law) requires that we send you this notice. The notice describes the new online Health Insurance Marketplace (also called an Exchange), which is available at www.healthcare.gov beginning October 1, 2013. The Marketplace describes options you may have available for health insurance (other than employer-based plans) and is designed so you can make easy cost and coverage comparisons. The enclosed notice also includes information about coverage you may be eligible for through Corporate Management Group (CMG).

If you have coverage through Essential StaffCare, please be advised that the Essential StaffCare plan does not meet the criteria to avoid a penalty under the ACA plan requirements for 2014 and beyond.

Starting in 2014, if you do not have medical coverage, you will have to pay a penalty (in the form of a tax). If you do not qualify for coverage through CMG or you do not enroll yourself or a dependent, it is your responsibility to obtain coverage or pay the penalty. This penalty is known as the "individual mandate penalty."

The individual mandate penalty increases each year. In 2014 the penalty is 1% of your household yearly income or $95 per adult and $47.50 per child (up to $285 for a family), whichever is higher. In 2015 the penalty is 2% of your household yearly income or $325 per adult and $162.50 per child (up to $975 for a family), whichever is higher. The penalty for 2016 is 2.5% of your household yearly income or $695 per adult and $347.50 per child (up to $2,085 for a family), whichever is higher. **If you chose to pay the penalty you will not get any health insurance coverage and will be 100% responsible for the cost of your medical care.**

If you are considered to be low income, Medicaid could be a viable option. Some states will also be expanding the eligibility rule and income requirements to qualify for Medicaid. To determine if the state where you live is expanding Medicaid coverage and to learn about Medicaid, please visit https://www.healthcare.gov/do-i-qualify-for-medicaid.

Please remember that open enrollment in the Marketplace begins on **October 1, 2013** and ends on March 31, 2014. After open enrollment ends you will not be able to get health coverage through Marketplace until the **next annual enrollment period**, unless you have a qualifying life event.

Thank you,

Corporate Management Group
303-920-1425
Pay@corpmgmtgroup.com

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.

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?

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.

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[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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Corporate Management Group, Inc.		4. Employer Identification Number (EIN) 20-1535646
5. Employer address 12000 N. Washington Street, Suite #290		6. Employer phone number 303-920-1425
7. City Thornton	8. State CO	9. ZIP code 80241
10. Who can we contact at this job? Corporate office		
11. Phone number (if different from above)	12. Email address Pay@corpmgmtgroup.com	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Form **8850**
(Rev. January 2013)
Department of the Treasury
Internal Revenue Service

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

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

OMB No. 1545-1500

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

Your name Alicia Marie Burtard Social security number ▶ 524-77-7724

Street address where you live 1913 W 101st Ave

City or town, state, and ZIP code Thornton, CO 80260

County Adams Telephone number 303 803 7353

If you are under age 40, enter your date of birth (month, day, year) 08-17-1990

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 ▶ Alicia Burtard **Date** 1-30-17

For Employer's Use Only

Employer's name Corporate Management Group Telephone no. 303-920-1425 EIN ▶ 201535646

Street address 12000 N Washington St #290

City or town, state, and ZIP code Thornton, CO 80241

Person to contact, if different from above _____ Telephone no. _____

Street address _____

City or town, state, and ZIP code _____

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under Members of Targeted Groups in the separate instructions), enter that group number (4 or 6) . . . . . ▶ _____

Date applicant:

Gave information 1-30-17 Was offered job _____ Was hired _____ Started job _____

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶ **Title** **Date**

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . 6 hr., 27 min.

Learning about the law or the form . . . . . 30 min.

Preparing and sending this form to the SWA . . . . . 37 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:M:S, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224.

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.

DISCLOSURE AND AUTHORIZATION REGARDING PROCUREMENT OF BACKGROUND REPORTS

It is recognized and understood that the Fair Credit Reporting Act provides that anyone "who knowingly and willfully obtains information on a consumer from a consumer reporting agency under false pretenses" shall be fined not more than $2,500 or imprisoned not more than a year, or both.

In connection with my application for EMPLOYMENT (including contract for services), I understand that investigative background inquiries are to be made on me which may include criminal convictions, motor vehicle, and other reports. These reports may include information as to my character, work habits, performance, education and experience along with reasons for termination of employment from previous employers. Further, I understand that you will be requesting information from various Federal, State, and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil and other experiences. *If I include a current employer for verification, I may jeopardize my position within that company.* I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from any liability and responsibility for doing so. I hereby consent to obtaining the above information from BACKGROUND SOURCE INT'L and/or any of their licensed agents. This authorization and consent shall be valid in original, fax or copy form. I further authorize ongoing procurement of the above mentioned reports at any time during my employment (or contract).

***Applicant Signature:** Alicia Burtard **Date:** 1-30-17

Please PRINT clearly: Position applied for: Short-Term Receptionist

Name: Alicia (First) Marie (Middle) Burtard (Last) Maiden / AKA: _____

Soc. Sec. #: 524-77-7724 *Sex: F *Race: Cau. *Date of Birth: August 17, 1990

Current Address: 1913 W 101st Ave County: Adams

*City: Thornton State: CO Zip: 80260 How long: 11/17 to present

Previous Address: _____ County: _____

City: _____ State: _____ Zip: _____ How long: _____ to _____

Motor Vehicle Report **Fax to:** (208)769-7282

Name as it appears: _____ License #: _____ State held: _____

*Responses to these are completely voluntary. You need not respond to have your application considered. However, without this information, we may be unable to distinguish you from another in the event we discover adverse information during our background investigation. 03/06/01

B1 **221900-CMG** OFFICE USE ONLY LOCATION _____ New Hire ☐ Rehire ☐ Date __/__/____

ENROLLMENT FORM

ESC/MEC ES P2DM v18.2

A. REQUIRED EMPLOYEE INFORMATION

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

Name	Home Phone	
Social Security #	Date of Birth / /	Sex M F
Address		Apt. #
City	Zip	State

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare benefits?
☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. This plan is underwritten by BCS Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only	☐ **$23.69**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + 1	☐ **$48.08**	**$10.80**	**$4.92**	**$0.90**	
Employee + Family	☐ **$64.20**	**$17.82**	**$6.56**	**$1.80**	
	☐ **NO** to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82219000-M-CMG **Direct Payment Monthly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. This plan satisfies the federal healthcare reform Individual Mandate. This is an offer of ACA compliant coverage and by purchasing this plan, you will not be taxed for failing to purchase insurance required by the Affordable Care Act. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ **$62.00** Employee Only ☐ **$69.02** Employee + 1 ☐ **$73.67** Employee + Family ☒ **NO** to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage.

DATE 01/30/2017 ▶ **SIGNATURE** Alicia Bertard

This is an Essential StaffCARE Enrollment For

CMG
CORPORATE MANAGEMENT GROUP

Limited Benefit & Self-Funded Minimum Essential Coverage (MEC) Enrollment Guide

Complete the Enrollment Form to Elect or Decline Coverage

IMPORTANT PLAN INFORMATION: You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

Advantages of the Fixed Indemnity Medical Plan

- ☑ Covers Day to Day Medical Expenses
- ○ Satisfies the Individual Mandate
- ☑ You may still be eligible to receive a subsidy from the health insurance exchange
- ☑ Offers Dental, Vision, Term Life and STD

Advantages of the MEC Wellness/Preventive Plan

- ○ Covers Day to Day Medical Expenses
- ☑ Satisfies the Individual Mandate
- ○ You may still be eligible to receive a subsidy from the health insurance exchange
- ○ Offers Dental, Vision, Term Life and STD

1. You **MUST** complete the Enrollment Form as part of your New Hire Process.
2. Elect or decline all benefits on the Enrollment Form.
3. You **MUST** Sign and Date the bottom of the form, even if you decline coverage.
4. Return the Enrollment Form to your Branch Manager.
5. Keep the Benefits at a Glance page for your records.

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

THE FIXED INDEMNITY MEDICAL PLAN IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED UNDER THE AFFORDABLE CARE ACT (ACA).

The Essential StaffCARE Fixed Indemnity Medical, Prescription Drug, Accidental Loss of Life, Limb & Sight, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1214, 26.212, and 26.213. The Term Life and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

The MEC Wellness/Preventive Plan is an employer-sponsored, self-funded plan that has been deemed to be in compliance with ACA rules and regulations. More information about Preventive Services may be found on the government website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

Availability of Summary Health Information for MEC/Wellness Preventive Plan

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: *essentialstaffcare.com/sbcmec*. A paper copy is also available, free of charge, by calling Essential StaffCARE Customer Service 1-866-798-0803.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

Essential StaffCARE

Employment Eligibility Verification

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

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

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*
Burtard	Alicia	M	N/A

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code
1913 W 101st Ave	N/A	Thornton	CO	80260

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
08/17/1990	524-77-7724	wittyinpink@icloud.com	(303) 803-7353

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):

- [x] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States *(See instructions)* N/A
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number): N/A
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): N/A
  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: N/A
   OR
2. Form I-94 Admission Number: N/A
   OR
3. Foreign Passport Number: N/A
   Country of Issuance: N/A

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*
Alicia Burtard	1/30/2017

Preparer and/or Translator Certification (check one):

- [x] 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

STOP *Employer Completes Next Page* STOP

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)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status
	Burtard	Alicia	M	

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title: CO Driver License		Document Title: Birth Certificate
Issuing Authority		Issuing Authority: CO DMV		Issuing Authority: State of MD
Document Number		Document Number: 07-072-0987		Document Number: 119-9047519
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*: 08/17/2021		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

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)*: 01/30/2017 ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Andrea Findley	02/01/2017	Executive Assistant

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Findley	Andrea	Corporate Management Group

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
12000 N. Washington St. #350	Thornton	CO	80241

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)*

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

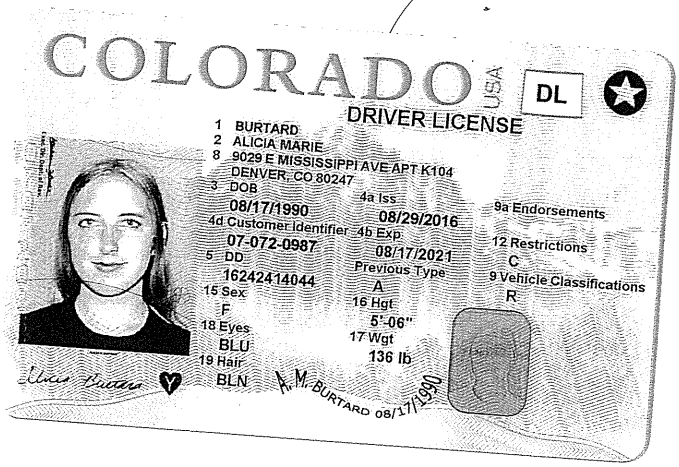
LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



COLORADO USA

DL

DRIVER LICENSE

1 BURTARD
2 ALICIA MARIE
8 9029 E MISSISSIPPI AVE APT K104
DENVER, CO 80247
3 DOB
08/17/1990
4a Iss
08/29/2016
4b Exp
08/17/2021
4d Customer Identifier
07-072-0987
5 DD
16242414044
Previous Type
A
9a Endorsements
12 Restrictions
C
9 Vehicle Classifications
R
15 Sex
F
16 Hgt
5'-06"
17 Wgt
136 lb
18 Eyes
BLU
19 Hair
BLN

A. M. BURTARD 08/17/1990

VALID ONLY WITH IMPRESSED SEAL

I HEREBY CERTIFY THAT THE ATTACHED IS A TRUE COPY OF A RECORD ON FILE IN THE DIVISION OF VITAL RECORDS.

DATE ISSUED: MAY 02 1996

Julia E. Davidson-Randall
STATE REGISTRAR OF VITAL RECORDS

1-STATE REGISTRAR

State of Maryland
CERTIFICATE OF LIVE BIRTH

BIRTH NUMBER 119-90 47519

1. CHILD'S NAME (First, Middle, Last): ALICIA MARIE BURTARD
2. DATE OF BIRTH (Month, Day, Year): 08-17-90
3. TIME OF BIRTH: 1924 M
4. SEX: (1) ☐ M (2) ☒ F
5. CITY, TOWN, OR LOCATION OF BIRTH: BETHESDA
6. COUNTY OF BIRTH: MONTGOMERY
7. PLACE OF BIRTH: (1) ☒ Hospital (2) ☐ Freestanding Birthing Center (3) ☐ Clinic/Doctor's Office (4) ☐ Residence (5) ☐ Born enroute to hospital (6) ☐ Other (Specify)
8. FACILITY NAME (If not institution, give street and number): National Naval Medical Center 8901 WISCONSIN AVE
9. I certify that this child was born alive at the place and time and on the date stated. Signature ► MMSMD
10. DATE SIGNED (Month, Day, Year): 8/29/90
11. ATTENDANT'S NAME AND TITLE (If other than certifier) (Type/Print) Name (1) ☐ M.D. (2) ☐ D.O. (3) ☐ C.N.M. (4) ☐ Other midwife (5) ☐ Other (Specify)
12. CERTIFIER'S NAME AND TITLE (Type/Print) Name D. L. ARMSTRONG, LT, MC, USNR (1) ☒ M.D. (2) ☐ D.O. (3) ☐ Hospital Admin. (4) ☐ C.N.M. (5) ☐ Other midwife (6) Other (Specify)
13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14. MOTHER'S FULL MAIDEN NAME (First, Middle, Last): JOAN MARIE JOHNSON
15a. MOTHER'S AGE (At time of this birth): 27 YEARS
15b. DATE OF BIRTH (Month, Day, Year): 03-15-63
16. BIRTHPLACE (State or Foreign Country): COLORADO
17a. RESIDENCE—STATE: MARYLAND
17b. COUNTY: CHARLES
17c. CITY, TOWN, OR LOCATION: INDIAN HEAD
17d. STREET AND NUMBER: 24 CHINABERRY LN
17e. ZIP CODE: 20640
17f. INSIDE CITY LIMITS? (Yes or no): Yes
18. FATHER'S NAME (First, Middle, Last): JAMES ROBERT BURTARD
19. AGE (At time of this birth): 33 YEARS
20. DATE OF BIRTH (Month, Day, Year): 10-04-57
21. BIRTHPLACE (State or Foreign Country): COLORADO
22. PARENT(S) REQUEST SOCIAL SECURITY NUMBER ISSUANCE FOR THIS CHILD: (1) ☒ YES (0) ☐ NO
23. FATHER'S SOCIAL SECURITY NO: 396-68-9909
24. MOTHER'S SOCIAL SECURITY NO: 524-78-6431
25. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. Signature of Parent or Other Informant ►
26. CORRECTIONS OR AMENDMENTS
27. DATE FILED BY REGISTRAR: SEP 13 '90
28. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

E-Verify

SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2017033104205AB

Report Prepared: 02/02/2017

Company Information

Company ID: 31504

Company Name: Corporate Management Group, INC.

Employee Information

Last Name: Burtard

First Name: Alicia

Date of Birth: 08/17/1990

Social Security Number: *** ** 7724

Hire Date: 01/30/2017

Citizenship Status: A citizen of the United States

Document Information

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

List C Document: U.S. birth certificate (original or certified copy)

Document Name: Driver's license

Document State: Colorado

Driver's License or ID Card Number:

Document Expiration Date: 08/17/2021

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 02/02/2017

Case Submitted By: AFIN1933

Closed On: 02/02/2017

Closed By: AFIN1933

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

SENSITIVE BUT UNCLASSIFIED