



employer solutions staffing group.

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Moua First Name Alie Middle Initial C
 Street Address 3417 77th ave n Apt/Ste C
 City/State/Zip Brooklyn Park 55443 Social Security Last Four XXX-XX- 4811
 Phone Number 503-290-4508 Email Address alitha_chuah@hotmail.com@
 Staffing Agency/Recruitment Partner Rachel

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.

Alie Moua
 Name (Print or type)

Alie Moua
Alie Moua (Mar 7, 2018)
 Applicant's Signature

Mar 7, 2018
 Date

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

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

Form W-4 (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 this form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Notes: 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 credit 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 \$150,000 (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** _____

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 (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) **F** _____

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** _____

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
 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2017	
▶ 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.					
1 Your first name and middle initial Alië		Last name Moua		2 Your social security number 242-39-4811	
Home address (number and street or rural route) 3417 77th ave n			C		
City or town, state, and ZIP code Brooklyn Park 55443			3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>					
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5 <u>1</u>	
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. • 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>Alië Moua</i> ▶ Alië Moua (Mar 7, 2017)			Date ▶ Mar 7, 2018		
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)

2017 Minnesota Employee Withholding Allowance/Exemption Certificate

Employees

You must complete and give this form to your employer if you do any of the following:

- Claim fewer Minnesota withholding allowances than your federal allowances
- Claim more than 10 Minnesota withholding allowances
- Want additional Minnesota tax withheld from your pay each pay period
- Claim to be exempt from federal withholding or claim to be exempt from Minnesota withholding

Do not complete this form if you are claiming the same number of Minnesota allowances as federal and the number claimed is 10 or less.

Employee's first name and Initial Alie Moua		Last name	Employee's Social Security number 242-39-4811
Permanent address 3417 77th ave n			Marital status (check one box) <input checked="" type="radio"/> Single; Married, but legally separated; or Spouse is a nonresident alien <input type="radio"/> Married <input type="radio"/> Married, but withhold at higher Single rate
City Brooklyn Park	State	ZIP code 55443	

Employee Information

Employees: Read instructions on back, complete Section 1 OR Section 2, sign and give the completed form to your employer. (Do not complete both Section 1 and Section 2. Completing both sections will make the form invalid.)

Section 1 – Determining Minnesota allowances

Complete Section 1 if you claim fewer Minnesota allowances than your federal allowances, AND/OR if you want additional Minnesota withholding deducted each pay period.

- Total number of federal allowances claimed on federal Form W-4 **1** _____
- Total number of Minnesota allowances (line 2 cannot be more than line 1) **1** _____
- Additional Minnesota withholding you want deducted each pay period **3** \$ _____

Section 2 – Exemption from Minnesota withholding

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding (see Section 2 instructions for qualifications). If applicable, check one box below to indicate the reason why you believe you are exempt:

- I meet the requirements and claim exempt from both federal and Minnesota income tax withholding.
- Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding because I had no Minnesota income tax liability last year, I received a refund of all Minnesota income tax withheld, AND I expect to have no Minnesota income tax liability this year.
- My spouse is a military service member assigned to a military location in Minnesota, my domicile (legal residence) is in another state, AND I am in Minnesota solely to be with my spouse. My state of domicile is _____
- I am an American Indian living and working on a reservation.
- I am a member of the Minnesota National Guard or an active duty U.S. military member and claim exempt from Minnesota withholding on my military pay.
- I receive a military pension or other military retirement pay as calculated under Title 10, 1401 through 1414, 1447 through 1455, and 12733 and claim exempt from Minnesota withholding on this retirement pay.

I certify that all information provided in Section 1 OR Section 2 is correct. I understand there is a \$500 penalty for filing a false withholding allowance/exemption certificate.

Employee's signature Alie Moua	Date Mar 7, 2018	Daytime phone 503-290-4808
--	----------------------------	--------------------------------------

Employees: Give the completed form to your employer.

Exempt from Minnesota Withholding

Sign Here

Employers

If you are required to send a copy of this form to the Department of Revenue (see instructions), you must enter the employer information below and mail this form to: Minnesota Revenue, Mail Station 8501, St. Paul, MN 55146-6501. (Incomplete forms are considered invalid.) A \$50 penalty may be assessed for each required Form W-4MN not filed with the department.

Keep a copy for your records.

Name of employer		Federal employer ID number (FEIN)	Minnesota tax ID number
Address		City	State ZIP code

Employer Information



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) Moua		First Name (Given Name) Alie		Middle Initial C	Other Last Names Used (if any) N/A	
Address (Street Number and Name) 3417 77th ave n			Apt. Number N/A	City or Town Brooklyn Park		State Mn
Date of Birth (mm/dd/yyyy) 12/03/1980		U.S. Social Security Number 242-39-4811		Employee's E-mail Address alitha_chuah@hotmail.com		Employee's Telephone Number 503-290-4508

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): 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 Alie Moua Today's Date (mm/dd/yyyy) Mar 7, 2018
Alie Moua (Mar 7, 2018)

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

SECT Employer Completes Next Page SECT



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>Mora</u>	First Name (Given Name) <u>Stie</u>	M.I. <u>E</u>	Citizenship/Immigration Status <u>IT</u>
------------------------------	--	--	------------------	---

List A Identify and Employment Authorization		OR	List B Identity	AND	List C Employment Authorization
Document Title			Document Title <u>Drivers License</u>		Document Title <u>Social Security Card</u>
Issuing Authority			Issuing Authority <u>State of N.H.</u>		Issuing Authority
Document Number			Document Number <u>K1031144588415</u>		Document Number <u>747-21-4811</u>
Expiration Date (if any)(mm/dd/yyyy)			Expiration Date (if any)(mm/dd/yyyy) <u>11/03/2021</u>		Expiration Date (if any)(mm/dd/yyyy) <u>N/A</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)					

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): 03/07/2018 (See instructions for exemptions)

Signature of Employer or Authorized Representative <u>R. S. Smith</u>	Today's Date (mm/dd/yyyy) <u>03/07/2018</u>	Title of Employer or Authorized Representative <u>Recruiter</u>
Last Name of Employer or Authorized Representative <u>Smith</u>	First Name of Employer or Authorized Representative <u>Rachel</u>	Employer's Business or Organization Name
Employer's Business or Organization Address (Street Number and Name)		City or Town
		State
		ZIP Code

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

MINNESOTA
DRIVER'S LICENSE



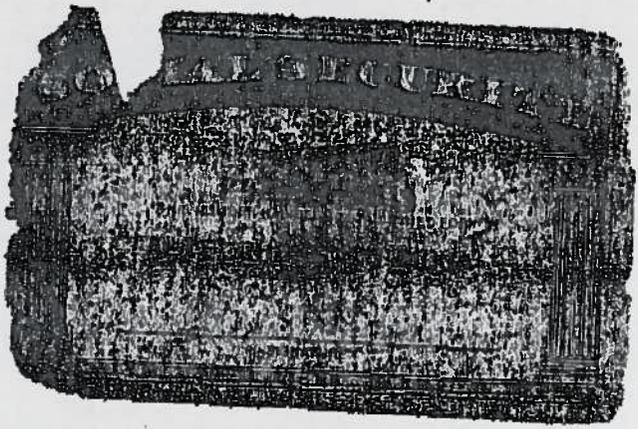
ALE CHONGSO
2417 77TH AVE N
BROOKLYN PARK, MN 55429

Date of Birth 12-12-1980
Sex Male
Eye BRN
Hair BRN
Height 5-3 Weight 160

ISSUED 12-2017 EXPIRES 12-03-2021

Ale Chongso

K681-174588-15



Authorization

Authorization: By signing below, you authorize: (a) backgroundchecks.com ("BGC") and/or Orange Tree Employment Screening to request information about you from any public or private information source; (b) anyone to provide information about you to BGC and/or Orange Tree Employment Screening; (c) BGC and/or Orange Tree Employment Screening to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) Employer Solutions Staffing Group, LLC ("ESSG") to share those reports with others for legitimate business purposes related to your employment. BGC and/or Orange Tree Employment Screening may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an employee of ESSG.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

Personal Information: Please print the information requested below to identify yourself for BGC.

Printed name: Alie C Moua
First Middle (none) Last

Other names used: _____
Current county of residence: _____

Current and former addresses:

<u>12/2014</u> from Mo/Yr	<u>current</u> to Mo/Yr	<u>3417 77th ave n</u> Street	<u>Brooklyn Park</u> City, State & Zip	<u>55443</u> City, State & Zip
<u>01/2007</u> from Mo/Yr	<u>12/2014</u> to Mo/Yr	<u>7925 Kyle ave n</u> Street	<u>Brooklyn Park, MN</u> City, State & Zip	<u>55443</u> City, State & Zip
_____	_____	_____	_____	_____

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

<u>12/03/1980</u> Date of birth	<u>242-39-4811</u> Social security number
<u>k681174588415</u> Driver's license number & state	<u>Alie Chongnou Moua</u> Name as it appears on license

Report Copy: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box:

Alie Moua
Alie Moua (Mar 7, 2018)

Signature

Mar 7, 2018

Date

EMERGENCY CONTACT INFORMATION

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

Employee Name: Alle Moua

Address: 3417 77th ave n

Brooklyn Park

55443

Home Phone: 503-290-4508

EMERGENCY CONTACTS

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

Contact #1 Name: Victoria Moua Relationship: sister	Home Phone: 6122025011 Cell Phone: Work Phone:
Contact #2 Name: Houston Moua Relationship: brother	Home Phone: 6122745352 Cell Phone: Work Phone:

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

N/A

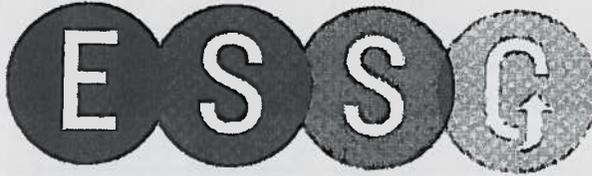
This information will remain confidential and will only be used in the case of an emergency.



employer solutions staffing group.
Direct Deposit/Payroll Debit Card Authorization

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

SECTION 1 BASIC INFORMATION		
Employee Name Alle Moua	SSN# (last 4 digits) 4811	Effective Date 03/12/2018
SECTION 2 PAYROLL ELECTION		
<input type="radio"/> Direct Deposit (Please complete Sections 3 and 5 below) <i>Note: Direct Deposit accounts may take up to 7 days to be activated.</i> <input checked="" type="radio"/> Payroll Debit Card (Please complete Sections 4 and 5 below)		
SECTION 3 DIRECT DEPOSIT		
ACCOUNT	<input type="checkbox"/> Update Bank Account	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 _____ Date _____
	Bank Name:	
	Routing#	
	Account#	
	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other	
<ul style="list-style-type: none"> To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work) If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods. 		
SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)		
Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.		
Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.		
CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)		
First Name Alle	MI. C	Last Name Moua
Date of Birth 12/03/1980		Social Security# 242394811
Street Address (PO BOX NOT ACCEPTABLE) 3417 77th Ave N		
City Brooklyn Park	State MN	Zip 55443
Cell Phone (mobile) 5032904508		
RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)		
Payroll Debit Card Routing # 073972181	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: <u><i>Alle Moua</i></u> Alle Moua (Mar 7, 2018)		Date: <u>03/07/2018</u>
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: <u>alitha_chuah@hotmail.com</u> @ _____ this information will only be used to send your paystubs electronically		
Employee's Signature: <u><i>Alle Moua</i></u> Alle Moua (Mar 7, 2018)		Date: <u>Mar 7, 2018</u>



employer solutions staffing group_{llc}

STATEMENT OF CONFIDENTIALITY

This agreement made this 7 day of March, 2018, 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.

Alie Mousa
Alie Mousa (Mar 7, 2018)

Employee Signature

[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.

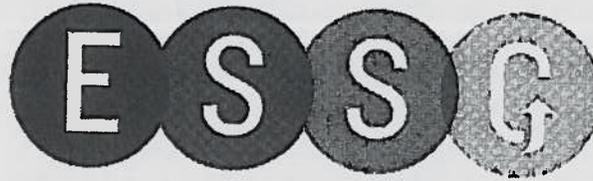
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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: Alie Moua
Alie Moua (Mar 7, 2018)

Printed Name: Alie Moua



employer solutions staffing group_{LLC}

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): Alie Moua

Signature/Firma: Alie Moua
Alie Moua (Mar 7, 2018)



employer solutions staffing group, inc

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.



employer solutions staffing group..

- 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.



employer solutions staffing group, inc

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 952.835.1288/1.866.496.7578 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 952.835.1288/1.866.496.7578 in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Alie Moua

Employee's Signature:

Alie Moua

Alie Moua (Mar 7, 2018)

Date: Mar 7, 2018

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 Alle Moua Social security number ► 242-39-4811
Street address where you live 3417 77th ave n
City or town, state, and ZIP code Brooklyn Park 55443
County Hennepin Telephone number 503-290-4508
If you are under age 40, enter your date of birth (month, day, year) 12/03/1980

- 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 6 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 ► Alle Moua
Alle Moua (Mar 7, 2018)

Date Mar 7, 2018

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

First Name: Last Name:		Suffix:	Street Address:		City/State:	Zip:
Alle Moua			3417 77th ave n		Brooklyn Park, Mn	55443
SS#:	Date of Birth:	Age:	Have you worked for this company before?	If yes, location:		
242-39-4811	12-03-1980	38	Yes <input type="radio"/> No <input checked="" type="radio"/>			

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

	Yes	No
<p>1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____</p>	<input type="radio"/>	<input checked="" type="radio"/>
<p>2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____</p>	<input type="radio"/>	<input checked="" type="radio"/>
<p>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. *If you checked yes please provide a copy of your SSI documentation.</p>	<input type="radio"/>	<input checked="" type="radio"/>
<p>4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below: <input type="checkbox"/> Vocational Rehabilitation Agency <input checked="" type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> 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.</p>	<input type="radio"/>	<input checked="" type="radio"/>
<p>5. 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?</p>	<input type="radio"/>	<input checked="" type="radio"/>
<p>6. 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? _____</p>	<input type="radio"/>	<input checked="" type="radio"/>
<p>7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Conviction Date: _____ Release Date: _____ Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____</p>	<input type="radio"/>	<input checked="" type="radio"/>
Additional Tax Credits		
<p>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.</p>	<input type="radio"/>	<input checked="" type="radio"/>
<p>CA Residents: <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act? <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?</p>		
<p>SC Residents: <input type="checkbox"/> Do you receive Family Independence Benefits?</p>		

PLEASE READ, SIGN, AND DATE:

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

New Employee Signature: Alle Moua
ALLE MOUA (MAR 7, 2018)

Date: Mar 7, 2018



U.S. Department of 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: Alie Moua Date Mar 7, 2018
Alie Moua (Mar 7, 2018)

New Hire Name: Alie Moua

Social Security Number: 242-39-4811

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-4610, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.



employer solutions staffing group.
Leveraging Resources in a Changing Market

**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) falls 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. This paragraph applies only if, at the time of beginning of employment with the staffing service, the applicant signed and was provided a copy of a separate document written in clear and concise language that informed the applicant of this paragraph and that unemployment benefits may be affected.

It is your responsibility to contact ESSG through Corporate Management Group (for instance, by calling 303-920-1425 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. AM (Initial)

Alie Moua

Alie Moua (Mar 7, 2018)

Mar 7, 2018

Employee Signature: _____

Date: _____

Alie Moua

Employee (please print your name here) _____

**Telephone: 303-920-1425
12000 N. Washington Street Suite 350
Thornton, CO 80241**

**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.

Alie Moua
Alie Moua (Mar 7, 2018)

Individual's Name

Mar 7, 2018

Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6



Enhanced MEC_Plan 1



Benefits Enrollment Form New Employee Rehire Rehire Date 242-39-4811

Employee Information

Name (First and Last) Alie		Social Security Number 242-39-4811	
Address 3417 77th ave n		City Brooklyn Park	State Mn
Zip Code 55443			
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Birth 12/03/1980	Date of Hire 3/12/2018
Phone Number: 3417 77th ave n		Email Address: alitha_chuah@hotmail.com	

Please Select Desired Coverage:

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

Dependent

Brooklyn Park	Social Security # 503-290-4508	Birth Date	Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
First Name M.I. Last Name				

Dependent

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

Dependent

55443	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
First Name M.I. Last Name				

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

alitha_chuah@hotmail.com

EFF. DATE

EFF. DATE

EFF. DATE

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 Alie
Alie (Mar 7, 2018)

Date 3/7/2018

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 of 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 Alie
Alie (Mar 7, 2018)

Date

Employer Solutions Staffing Group Health Benefits Team
PO Box 46270
Minneapolis, MN 55344
Phone: 952-787-9519 Fax: 952-787-9515
Email: Health@employersolutionsgroup.com

Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION _____ Rehire Date ___/___/___

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name Alie	Social Security # 242-39-4811	Home Phone	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Address 3417 77th ave			Apt. #
City Brooklyn Park	State Mn	Zip 55443	Date of Birth 12/08/1980

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

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

Medicare Health Insurance Claim Number (HICN) _____

Name of Covered Person (s):
 1. _____ 2. _____ 3. _____

C. LIMITED BENEFITS PLAN SELECTION Payroll Deducted Weekly Rates

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

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

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

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.
 Name **Victoria Moua** Relationship **sis**

D. REQUIRED DEPENDENT INFORMATION

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

E. REQUIRED SIGNATURE YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

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

DATE **3/07/2018** SIGNATURE **Alie**

This Plan DOES NOT Alleviate the Individual Mandate Penalty

This is an Essential StaffCARE Enrollment Form.

Benefit Enrollment/Change Form

A. Employee Information (All information is required)

First Name: 242-39-4811 MI: C Last Name: Moua
 SSN#: 242-39-4811 Date of Hire: 3417 77th ave n
 Date of Birth: 12/03/1980 Gender: M or F Marital Status: 3/12/2018
 Address: 3417 77th ave n City: Brooklyn Park State: Mn Zip: 55443
 Daytime Phone: (503-290-4508 Home phone: () Email: alitha_chuah@hotmail.com

B. Change of Status/Coverage

Date of Qualifying Event:

<input checked="" type="checkbox"/> Open Enrollment	<input type="checkbox"/> COBRA / Term. of Employment	<input checked="" type="checkbox"/> Add Dependent	<input type="checkbox"/> Change Name
<input type="checkbox"/> New Enrollment	<input checked="" type="checkbox"/> Medicare	<input type="checkbox"/> Drop Dependent	<input type="checkbox"/> Change Address
<input type="checkbox"/> Reduction in Hours	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Birth / Death	<input checked="" type="checkbox"/> Other 3/7/2018
		<input type="checkbox"/> Marriage / Divorce	

C. Medical Plan Options (If electing coverage please make a selection in both 1 & 2)

1. Plan Election	<input checked="" type="checkbox"/> \$2,500 Copay Plan	<input type="checkbox"/> \$6,000 Copay Plan	<input type="checkbox"/> \$3,000 HSA Plan	<input type="checkbox"/> \$6,000 HSA Plan	<input type="checkbox"/> Decline Coverage (please complete sections E. & G.)
2. Coverage Election	<input type="checkbox"/> Employee only		<input type="checkbox"/> Employee + Spouse		<input type="checkbox"/> Employee + Children
					<input type="checkbox"/> Family

D. Dependent/Spouse Information (Must be completed for coverage of dependents)

Name (Last, First, MI)	Relationship	Birth date	SSN	M/F	Disabled (Y/N)	Please check below to include on medical plan
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical

E. Other Insurance Coverage Information Please check one:

I have enrolled thru the state or federal Marketplace
 I have other insurance coverage
 I do not have other insurance coverage
 I have other insurance coverage, but intend to cancel that coverage

Policyholder's Name: _____ Policyholder's Date of Birth: _____
 Insurance Co. Name: _____ Policy Number: _____ Group Number: _____
 Insurance Co. Address: _____ Names of covered individuals: _____

F. Health Savings Account

Yes, I would like to set up a Health Savings Account (This option is available if you enroll in the HSA plan). Your annual deduction will be divided into equal amounts and deducted from each pay period throughout the year.

I elect to have an ANNUAL deduction of \$ alitha_chuah@hotmail.com (maximum of \$3,450 for employee-only coverage, or \$6,900 for all other levels of coverage) reduced from my salary before taxes to reimburse me for qualified expenses which I incur during the plan year. Maximum contribution to the HSA Plan will be reduced by company contribution. Employees who are age 55 or older can make a catch-up contribution of \$1,000 in addition to IRS maximums.

G. Enrollment Waiver (check box only if declining coverage)

I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions.

I understand by not enrolling in this plan or a Marketplace health plan as mandated by PPACA, that I may be subject to a tax penalty.

H. Employee Authorization

I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease. I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.

To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.

Alie
 Alie (Mar 7, 2018)
 Employee Signature _____ Date Mar 7, 2018

Benefit Enrollment/Change Form

A. Employee Information (All information is required)

First Name: 242-39-4811 MI: C Last Name: Moua
 SSN#: 242-39-4811 Date of Hire: 3417 77th ave n
 Date of Birth: 12/03/1980 Gender: M or F Marital Status: 3/12/2018
 Address: 3417 77th ave n City: Brooklyn Park State: Mn Zip: 55443
 Daytime Phone: (503-290-4508 Home phone: () Email: alitha_chuah@hotmail.com

B. Change of Status/Coverage

Date of Qualifying Event:

<input checked="" type="checkbox"/> Open Enrollment	<input type="checkbox"/> COBRA / Term. of Employment	<input checked="" type="checkbox"/> Add Dependent	<input type="checkbox"/> Change Name
<input type="checkbox"/> New Enrollment	<input checked="" type="checkbox"/> Medicare	<input type="checkbox"/> Drop Dependent	<input type="checkbox"/> Change Address
<input type="checkbox"/> Reduction in Hours	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Birth / Death	<input checked="" type="checkbox"/> Other 3/7/2018
		<input type="checkbox"/> Marriage / Divorce	

C. Medical Plan Options (If electing coverage please make a selection in both 1 & 2)

1. Plan Election \$2,500 Copay Plan \$5,000 Copay Plan \$3,000 HSA Plan \$8,000 HSA Plan Decline Coverage (please complete sections E. & G.)

2. Coverage Election Employee only Employee + Spouse Employee + Children Family

D. Dependent/Spouse Information (Must be completed for coverage of dependents)

Name (Last, First, MI)	Relationship	Birth date	SSN	M/F	Disabled (Y/N)	Please check below to include on medical plan
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical

E. Other Insurance Coverage Information Please check one:

I have enrolled thru the state or federal Marketplace I have other insurance coverage I do not have other insurance coverage I have other insurance coverage, but intend to cancel that coverage

Policyholder's Name: _____ Policyholder's Date of Birth: _____
 Insurance Co. Name: _____ Policy Number: _____ Group Number: _____
 Insurance Co. Address: _____ Names of covered individuals: _____

F. Health Savings Account

Yes, I would like to set up a Health Savings Account (This option is available if you enroll in the HSA plan). Your annual deduction will be divided into equal amounts and deducted from each pay period throughout the year.

I elect to have an ANNUAL deduction of \$ alitha_chuah@hotmail.com (maximum of \$3,450 for employee-only coverage, or \$6,900 for all other levels of coverage) reduced from my salary before taxes to reimburse me for qualified expenses which I incur during the plan year. Maximum contribution to the HSA Plan will be reduced by company contribution. Employees who are age 55 or older can make a catch-up contribution of \$1,000 in addition to IRS maximums.

G. Enrollment Waiver (check box only if declining coverage)

I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions.

I understand by not enrolling in this plan or a Marketplace health plan as mandated by PPACA, that I may be subject to a tax penalty.

H. Employee Authorization

I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease. I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.

To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.

Alie
 Alie (Mar 7, 2018)
 Employee Signature _____ Date Mar 7, 2018

Signature: Alie
Alie (Mar 7, 2016)

Email: alitha_chuah@hotmail.com