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)*
Lambert-Bey	Allen	C	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code
518 16th Ave N	518	South St Paul	MN	55075

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
09/15/1989	230-59-0950	LBey89@aol.com	651-737-5215

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)*
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
  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: _____
   OR
2. Form I-94 Admission Number: _____
   OR
3. Foreign Passport Number: _____
   Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*
Allen Bey	11/14/17

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.)

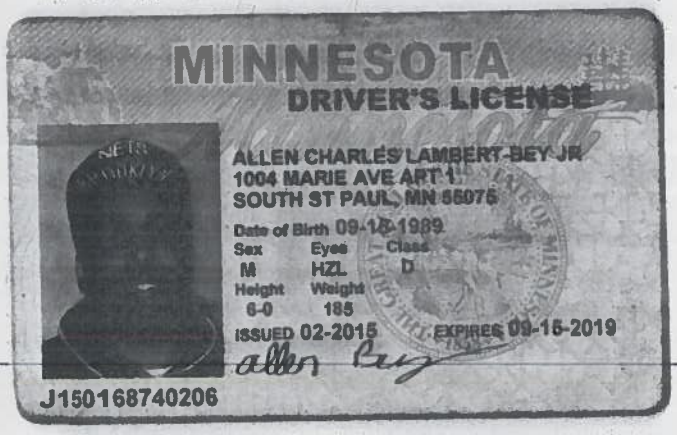
I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

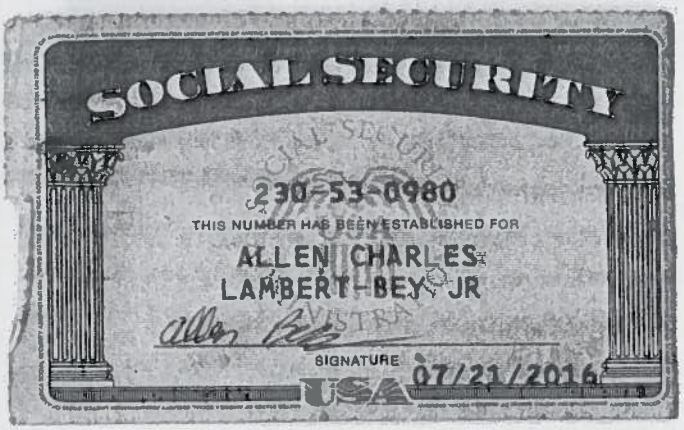
Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*
Allen Bey	11/14/17

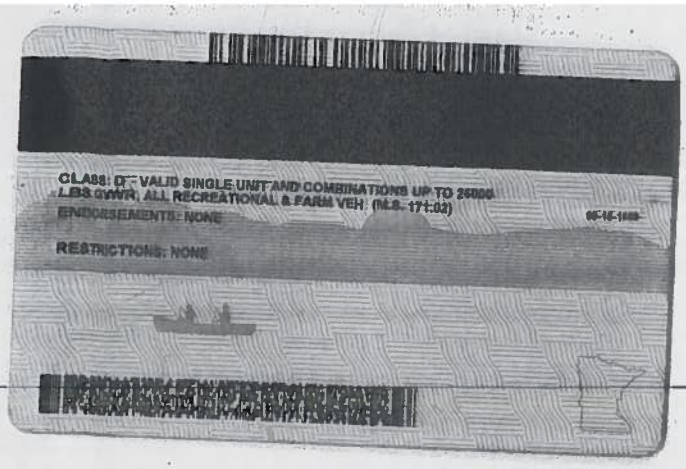
Last Name *(Family Name)*	First Name *(Given Name)*
Lambert-Bey	Allen

Address *(Street Number and Name)*	City or Town	State	ZIP Code
518 16th Ave N	South St Paul	MN	55075

STOP *Employer Completes Next Page* STOP


MINNESOTA
DRIVER'S LICENSE
ALLEN CHARLES LAMBERT-BEY JR
1004 MARIE AVE ART 1
SOUTH ST PAUL, MN 55075
Date of Birth 09-15-1989
Sex Eyes Class
M HZL D
Height Weight
6-0 185
ISSUED 02-2015
EXPIRES 09-15-2019
J150168740206


SOCIAL SECURITY
230-53-0980
THIS NUMBER HAS BEEN ESTABLISHED FOR
ALLEN CHARLES
LAMBERT-BEY JR
SIGNATURE
07/21/2016
USA



This card belongs to the Social Security Administration and you must return it if we ask for it.

If you find a card that isn't yours, please return it to:
Social Security Administration
P.O. Box 33008, Baltimore, MD 21290-3008

For any other Social Security business/information, contact your local Social Security office. If you write to the above address for any business other than returning a found card you will not receive a response.

Social Security Administration
Form SSA-3000 (08-2011)

G70498272

employer solutions staffing group

Wage Payment Method Authorization (Minnesota)

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

SECTION 1 BASIC INFORMATION

Employee Name	SSN# (last 4 digits)	Effective Date
Allen Lambert-Bey	230-53-0980	

SECTION 2 PAYROLL ELECTION

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

SECTION 3 DIRECT DEPOSIT

Attach Voided Check

☐ Update Bank Account

Bank Name:

Routing#

Account#

Account Type: ☑ Checking ☐ Savings ☐ Other _____

I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.

Initial AB Date 11/14/17

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

SECTION 4 PAYROLL DEBIT CARD

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

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

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

First Name	M.I.	Last Name	Date of Birth
Allen	C	Lambert-Bey	09/15/1989

Street Address (PO BOX NOT ACCEPTABLE)			Social Security#
518 16th Ave N			230-53-0980

City	State	Zip	Cell Phone (mobile)
South St Paul	MN	55075	651-707-3215

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

Payroll Debit Card Routing #	Payroll Debit Card Account #
	4053-4002-7248-1567

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: Allen Bey Date: 11/14/17

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:** LBey89@aol.com
this information will only be used to send your paystubs electronically

Employee's Signature: Allen Bey Date: 11/14/17

employer solutions staffing group llc

Notification of Minnesota Law Requirement – Unemployment Acknowledgement

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

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

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

Allen Bey
Employee Signature:

11/14/17
Date:

Allen Bey
Employee (please print your name here)

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.

allen Bay
Individual's Name

11/14/17
Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6

[redacted]

Acknowledgement of Receipt Antiharassment Policy

I certify that I have received a copy of Employer Solutions Staffing Group's Antiharassment Policy. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at **952.835.1288/1.866.496.7573** with any questions I may have about this policy. I agree to comply with ESSG's policy on Antiharassment and 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 involved in any employment dispute or I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, marital, sexual orientation or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact my supervisor, manager, director or ESSG's Human Resource Department at **952.835.1288/1.866.496.7573** in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Allen Lambert-Bey

Employee's Signature:

allen Bey Date: 11/14/17

RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT

This is to acknowledge that I have read the Employer Solutions Staffing Group LLC Temporary Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities and obligations of my employment with the company. I understand and agree that it is my responsibility to abide by the rules, policies and standards set forth in the Handbook.

I also acknowledge that my employment with ESSG is not for a specified period of time and can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no manager or employee has the authority to enter into an employment agreement, express or implied, providing for employment other than at-will.

I also acknowledge that, except for the policy of at-will employment, ESSG reserves the right to revise, delete and add to the provisions of this Employee Handbook. All such revisions, deletions or additions must be in writing and must be signed by the CEO of the company. No oral statements or representations can change the provisions of this Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company, with or without cause or notice, at any time. No implied contract concerning any employment-related decision, term of employment or condition of employment can be established by any other statement, conduct, policy or practice.

I understand the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and ESSG concerning the duration of my employment, the circumstances under which my employment may be terminated and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings and representations concerning my employment with the company.

If I have questions regarding the content or interpretation of this Handbook, I will bring them to the attention of ESSG.

DATE 11/14/17

EMPLOYEE NAME Allen Lambert-Bey
PLEASE PRINT

EMPLOYEE SIGNATURE Allen Bey

ESSG REPRESENTATIVE KRO

ACKNOWLEDGMENT

The associate handbook was reviewed with me, and I have received my personal copy. I also acknowledge that I have been given the opportunity to ask questions and express concerns during my orientation. Additionally, I understand and support the following:

1. This handbook is intended as a guide and **not** an employment agreement that creates a contractual relationship, and that the employment relationship may be terminated at the will of either party at any time.

2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.

3. I agree to **notify** my ESSG Consultant **immediately** of any change in my personal data such as phone number, address, emergency notification, etc.

4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my ESSG Consultant.

Date: 11/14/17

Associate's Signature: Allen B

Associate's Printed Name: _____

Orientation provided by: KD

employer solutions staffing group
Leveraging Resources in a Changing Market

ESG employer solutions group

ESNG employer solutions nationwide group

bpa Benefit Plan Administrator

Enhanced MEC Plan_Plan 1

Benefits Enrollment Form ☐ New Employee ☐ Rehire Rehire Date______________

Employee Information

Name (First and Last): Allen Lombart-Bey		Social Security Number: 230-530900	
Address: 518 16th Ave N	City: South St Paul	State: MN	Zip Code: 55075
Gender: ☑ Male ☐ Female	Marital Status: ☑ Single ☐ Married ☐ Divorced	Date of Birth: 09/15/1989	Date of Hire
Phone Number: 651-707-5215	Email Address: LBey89@aol.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

First Name M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Dependent

First Name M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Dependent

First Name M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

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

EMPLOYEES DECLINING ☑ **I am DECLINING coverage** Date

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 *Allen Bey*

Date 11/14/17

Employer Solutions Staffing Group Health Benefits Team
PO Box 46270 Minneapolis, MN 55344-9956
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com

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

ENROLLMENT FORM

ESC CU(UNAC-MN) P1

A. REQUIRED EMPLOYEE INFORMATION

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

Name Allen Lambert-Bey

Social Security # 230-57-0980

Home Phone 651-707-5215

Sex [M] [F]

Address 518 16th Ave N

Apt. # 518

City South St Paul

State MN

Zip 55075

Date of Birth 09/15/19

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

Medicare Health Insurance Claim Number (HICN)

☐ Yes ☑ No. If Yes, please continue.

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

Medicare Effective Date

C. LIMITED BENEFITS PLAN SELECTION

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

Payroll Deducted Weekly Rat

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only ☐	$20.25	$6.17	$2.42	$0.60	$4.20
Employee + 1 ☐	$41.10	$12.34	$4.92	$0.90	
Employee + Family ☐	$54.88	$20.36	$6.56	$1.80	
NO to ALL Benefits ☑	☐ Yes ☑ No	☐ 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 Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
Name	Social Security #	Date of Birth / /	Sex [M] [F]	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex [M] [F]	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex [M] [F]	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
	Social Security #	Date of Birth / /	Sex [M] [F]	Relationship ☐ Spouse ☐ Child ☐ 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 11/14/2017 ▶ **SIGNATURE** Allen Bey

This is an Essential StaffCARE Enrollment Form.

CORPORATE MANAGEMENT GROUP

Employment Application

Office Hours: 9am-4pm Mon-Fri
Office Number: 651-666-3883
Office Address: 404 Broadway Ave St. Paul Park, MN 55071

Applicant Information

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

Please fully complete pages 1-3

Full Name: *(Last Name, First Name)* Castillo Daniel **Date:** 11/14/2017

Address: *(Street Address)* 2123 2nd ave Newp **(Apt. /Unit #)** _____

(City) Newport *(State)* MN *(ZIP Code)* 55055

Phone: 651-335-2302 **Email:** Daniel Castillo8911@gmail.com

Social Security No. [redacted]477-17-4947 **Date Available:** _____

Position Applied for: warehouse **Desired Salary:** 13--15

Shift Available to work: __ 1st __ 2nd X 3rd **Employment desired:** X Full-Time __ Part-Time

What is your means of transportation to work? Car or ride

Are you authorized to work in the U.S? X Yes __ No

How did you hear about us? employee **Referral Name:** Chang Charles

If under 18, please list age: _____

Education

Type of School	Name of School	Location (Complete Mailing Address)	Number of Years Completed	Major & Degree
High School	Park High		3	none
College				
Bus. Or Trade School				
Professional School				

CORPORATE MANAGEMENT GROUP

Employment Application

Office Hours: 9am-4pm Mon-Fri
Office Number: 651-666-3883
Office Address: 404 Broadway Ave St. Paul Park, MN 55071

Previous Employment

Company: Republic Services Phone: 651-335-8532

Address: _____ Supervisor: Jeremy

Job Title: line lead Starting Salary: $ 12.00 Ending Salary: $ 14.00

Responsibilities: make sure my mechains running good

From: 5/10 To: 3/17 Reason for Leaving: no transportation transportation

May we contact your previous supervisor for reference? X Yes __ No

Company: Village Lawn Services Phone: 651-357-8571

Address: _____ Supervisor: Kieth Albrecht

Job Title: Landscaping Starting Salary: $ 10.00 Ending Salary: $ 15.60

Responsibilities: cut grass make yards look nice

From: 8/14 To: 4/16 Reason for Leaving: moved

May we contact your previous supervisor for reference? X Yes __ No

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: $_____ Ending Salary: $_____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for reference? __ Yes __ No

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: $_____ Ending Salary: $_____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for reference? __ Yes __ No

I certify that my answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

CORPORATE MANAGEMENT GROUP
Employment Application
Office Hours: 9am-4pm Mon-Fri
Office Number: 651-666-3883
Office Address: 404 Broadway Ave St. Paul Park, MN 55071

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 Daniel Castillo Date: 11/14/2017