E-Verify

SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2016284121934HW

Report Prepared: 10/10/2016

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Keihn

First Name: Andrew

Date of Birth: 04/08/1979

Social Security Number: *** ** 0240

Hire Date: 10/10/2016

Citizenship Status: A citizen of the United States

Document Information

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

List C Document: Social Security Card

Document Name: Driver's license

Document State: Minnesota

Driver's License or ID Card Number:

Document Expiration Date: 04/08/2020

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 10/10/2016

Case Submitted By: VMOR1873

Closed On: 10/10/2016

Closed By: VMOR1873

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

SENSITIVE BUT UNCLASSIFIED

For more information contact us at 888-464-4218 or E-Verify@dhs.gov.

U.S. Department of Homeland Security

U.S. Citizenship and Immigration Services

Enable Permanent Tooltips

Accessibility

Download Viewers

Employer Solutions Staffing Group, LLC
7301 Ohms Lane, Suite 405
Edina, MN 55439
(952) 835-1288

COMMERCIAL DRIVER APPLICATION

FILL IN ALL BLANKS & PROVIDE ALL INFORMATION REQUESTED--PRINT OR TYPE

Date: 10/10/16

Name: First Andrew Middle Joseph Last Keiser

Address 8939 Hadley Ave S. Home telephone: 651-528-7252

City Cottage Grove State MN Zip 55016 Cellular telephone: _____

Date of Birth: 04/08/1979 Social Security Number: 475-96-0740

X If your above address is less than 3 years continue listing them below to cover the previous 3 year period:

1 Street 2200 Southview Blvd Dates: From _____ To 10/2014

City So. St. Paul State MN Zip 55075

2 Street _____ Dates: From _____ To _____

City _____ State _____ Zip _____

3 Street _____ Dates: From _____ To _____

City _____ State _____ Zip _____

Use backside of sheet for additional addresses

X Driver's License Information: all licenses held, last 3 years:

State Minnesota Number X944 220 093 017 Expiration Date 4/8/2020

State _____ Number _____ Expiration Date _____

State _____ Number _____ Expiration Date _____

Experience:

Single Axle Dump (Type of vehicle driven)	09/2009 to 06/2015 (Dates)		(Approximate mileage driven)
Tandem Axle Dump (Type of vehicle driven)	05/2006 to 04/2009 (Dates)		(Approximate mileage driven)
(Type of vehicle driven)	to (Dates)		(Approximate mileage driven)

All Accidents, last 3 years: (If none, write NONE)

Date _____ Describe NONE Fatalities _____ Injuries _____

Date _____ Describe _____ Fatalities _____ Injuries _____

Date _____ Describe _____ Fatalities _____ Injuries _____

revised 08/04

List all Traffic Violations Convictions, last 3 years: (If none, write NONE)

Date None Violation _____ State _____ Commercial Vehicle: Yes / No

Date _____ Violation _____ State _____ Commercial Vehicle: Yes / No

Date _____ Violation _____ State _____ Commercial Vehicle: Yes / No

Date _____ Violation _____ State _____ Commercial Vehicle: Yes / No

Date _____ Violation _____ State _____ Commercial Vehicle: Yes / No

Date _____ Violation _____ State _____ Commercial Vehicle: Yes / No

Date _____ Violation _____ State _____ Commercial Vehicle: Yes / No

Date _____ Violation _____ State _____ Commercial Vehicle: Yes / No

Have you ever had any driver license denied, suspended, revoked or canceled by any issuing state agency?

☒ Yes ☐ No If yes; state of issuance; explanation: Minnesota, Misdemeanor DWI in 2004

Employment History, last 10 years (383.35)—account for gaps between employers: (If owner/operator, list carriers leased to)

1) Employer: Kraemer NA Dates: 06/2015 to Present

Address: 1020 Cliff Rd W Supervisor: Jeff Ott

City, State, Zip code: Burnsville, MN, 55337 Telephone: 952-890-3611

Were you subject to the Federal Motor Carrier Safety Regulations during this period? ☐ Yes ☒ No

Were you subject to 49 CFR part 40 controlled substance and alcohol testing during this period? ☒ Yes ☐ No

Reason for Leaving: Still Employed

2) Employer: Q3 Contracting Dates: 09/2006 to 06/2015

Address: 30666 Spruce St Supervisor: Bruce Setzer

City, State, Zip code: Little Canada, MN, 55117 Telephone: 612-282-5731

Were you subject to the Federal Motor Carrier Safety Regulations during this period? ☒ Yes ☐ No

Were you subject to 49 CFR part 40 controlled substance and alcohol testing during this period? ☒ Yes ☐ No

Reason for Leaving: Lack of advancement

3) Employer: Asphalt Driveway Co. Dates: 05/2006 to 09/2009

Address: 1211 Hwy 36a Service Rd Supervisor: Steve Hannon

City, State, Zip code: Maplewood, MN, 55109 Telephone: 651-494-9416

Were you subject to the Federal Motor Carrier Safety Regulations during this period? ☒ Yes ☐ No

Were you subject to 49 CFR part 40 controlled substance and alcohol testing during this period? ☒ Yes ☐ No

Reason for Leaving: Seasonal

4) Employer: _____ Dates: _____ to _____

Address: _____ Supervisor: _____

City, State, Zip code _____ Telephone: _____

Were you subject to the Federal Motor Carrier Safety Regulations during this period? ☐ Yes ☐ No

Were you subject to 49 CFR part 40 controlled substance and alcohol testing during this period? ☐ Yes ☐ No

Reason for Leaving: _____

5) Employer: _____ Dates: _____ to _____

Address: _____ Supervisor: _____

City, State, Zip code: _____ Telephone: _____

Were you subject to the Federal Motor Carrier Safety Regulations during this period? ☐ Yes ☐ No

Were you subject to 49 CFR part 40 controlled substance and alcohol testing during this period? ☐ Yes ☐ No

Reason for Leaving: _____

6) Employer: _____ Dates: _____ to _____

Address: _____ Supervisor: _____

City, State, Zip Code: _____ Telephone: _____

Were you subject to the Federal Motor Carrier Safety Regulations during this period? ☐ Yes ☐ No

Were you subject to 49 CFR part 40 controlled substance and alcohol testing during this period? ☐ Yes ☐ No

Reason for Leaving: _____

7) **Employer:** _____ **Dates:** _____ **to** _____

Address: _____ **Supervisor:** _____

City, State, Zip code: _____ **Telephone:** _____

Were you subject to the Federal Motor Carrier Safety Regulations during this period? ☐ **Yes** ☐ **No**

Were you subject to 49 CFR part 40 controlled substance and alcohol testing during this period? ☐ **Yes** ☐ **No**

Reason for Leaving: _____

_____

Use backside of sheet for additional employers

For driver applicants of commercial motor vehicles that require a Commercial Driver License (CDL) the applicant must disclose their controlled substance and alcohol status per the requirements of 49 CFR part 40.25(j).

As a prospective driver employee, you have the right to review information provided by previous employers. You have the right to have errors in the information corrected by the previous employer(s) and for that previous employer(s) to re-send the corrected information to the prospective employer; the right to have a rebuttal statement attached to the alleged erroneous information, if the previous employer and the driver cannot agree on the accuracy of the information.

Driver employees who have previous Department of Transportation regulated employment history in the preceding three years, and wish to review previous employer provided investigative information, must submit a written request to the prospective employer, which may be done at anytime, including when applying or as late as thirty (30) days after being employed or being notified of denial of employment. The prospective employer must provide this information to the applicant within five (5) business days of receiving the written request. If the prospective employer has not yet received the requested information from the previous employer(s), then the five (5) business day deadlines will begin when the prospective employer receives the requested safety performance history information. If the driver has not arranged to pick up or receive the requested records within thirty (30) days of the prospective employer making them available, the prospective motor carrier may consider the driver to have waived their request to review the records.

Certification

"I certify that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge."

X _____ X 10/10/16

Applicant's Signature **Date Signed**

TO BE COMPLETED BY THE EMPLOYER:

Application received by:

Name _____

Title _____ **Date** _____

Application reviewed for completeness by:

Name _____

Title _____ **Date** _____

SIGNIFICANT DATES:

Date of Hire: _____

Time & Date of Pre-Employment CST: _____

Time & Date of Pre-Employment CST Results Received: _____

Date First Used in Safety Sensitive Position: _____

Date of Termination: _____

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 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 do not apply to supplemental wages greater than $1,000,000.

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

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

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	1
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	B	
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 $65,000 ($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 $65,000 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 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2015

1 Your first name and middle initial	Last name	2 Your social security number
Andrew J	Keihn	475-96-0240

Home address (number and street or rural route): 8939 Hadley Ave S.

City or town, state, and ZIP code: Cottage Grove MN 55016

3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5 1
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2015, 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.) ▶ [signature] **Date** ▶ 10/10/2016

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)

Employment Eligibility Verification

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

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

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (*Family Name*)	First Name (*Given Name*)	Middle Initial	Other Names Used (*if any*)
Kahn	Andrew	J	

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code
8939 Hadley Ave S.		Cottage Grove	MN	55016

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
04/08/1979	475-76-024C		651-528-7252

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

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

☒ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (*mm/dd/yyyy*):
A. J. Kahn	10/10/2016

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

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

Signature of Preparer or Translator:			Date (*mm/dd/yyyy*):
Last Name (*Family Name*)	First Name (*Given Name*)		
Address (*Street Number and Name*)	City or Town	State	Zip Code

STOP *Employer Completes Next Page* STOP

STOP **Employer Completes This Page** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: MN Drivers License Commercial		Document Title: Social Security Card
Issuing Authority:		Issuing Authority: State of Minnesota		Issuing Authority: Social Security Admin
Document Number:		Document Number: X944220 093017		Document Number: 475-96-0240
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: 04-08-2020		Expiration Date *(if any)(mm/dd/yyyy)*: N/A
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode Do Not Write in This Space

Certification

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

The employee's first day of employment *(mm/dd/yyyy)*: 10-10-2016 ***(See instructions for exemptions.)***

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Vanessa Morales	10-10-2016	Staffing Specialist

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Morales	Vanessa	EMPLOYER SOLUTIONS STAFFING GROUP LLC

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
7301 OHMS LANE SUITE 405	EDINA	MN	55439

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

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MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined Andrew Joseph Keihn. In accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified, and I applicable only when:

- ☐ wearing corrective lenses
- ☐ wearing hearing aid
- ☑ accompanied by a ——— waiver/exemption
- ☐ driving within an exempt intracity zone (49 CFR 391.62)
- ☐ accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER: [signature] | TELEPHONE: 651-455-5463 | DATE: 06-15-15

MEDICAL EXAMINER'S NAME (PRINT): Dr. Virginia Rivas-Castro

☐ MD ☒ Chiropractor ☐ DO ☐ Advanced Practice Nurse ☐ Physician Assistant ☐ Other Practitioner

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO.: 5070 | ISSUING STATE: MN

NATIONAL REGISTRY NO.: 3207652900

SIGNATURE OF DRIVER: [signature] | INTRASTATE ONLY ☐ YES ☑ NO | CDL ☑ YES ☐ NO

DRIVER'S LICENSE NO.: X944220093017 | STATE: MN

ADDRESS OF DRIVER: 8939 Hadley Ave S. Cottage Grove, MN 55016

MEDICAL CERTIFICATION EXPIRATION DATE: 06 | 15 | 2017

COPY – MOTOR CARRIER

26520 (7/13)

MINNESOTA

DRIVER'S LICENSE
COMMERCIAL

ANDREW JOSEPH KEIHN
8939 HADLEY AVE S
COTTAGE GROVE, MN 55016

Date of Birth 04-08-1979

Sex	Eyes	Class
M	GRN	B
Height	Weight	
6-0	215	

ISSUED 04-2016 EXPIRES 04-08-2020

[signature]

X944220093017

SOCIAL SECURITY

475-96-0240
THIS NUMBER HAS BEEN ESTABLISHED FOR

ANDREW J KEIHN

[signature]
SIGNATURE

employer solutions staffing group
Leveraging Resources in a Changing Market

Direct Deposit/Payroll Debit Card Authorization

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

SECTION 1 BASIC INFORMATION

Employee Name	SSN# (last 4 digits)	Effective Date
Andrew Reihm	0240	10/10/16

SECTION 2 PAYROLL ELECTION

☐ **Direct Deposit** (Please complete Sections 3 and 5 below)
☐ **Payroll Debit Card** (Please complete Sections 4 and 5 below)

SECTION 3 DIRECT DEPOSIT

ACCOUNT 1

☐ 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 _____ Date _____

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

SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

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

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

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

First Name	M.I.	Last Name	Date of Birth

Street Address (PO BOX NOT ACCEPTABLE)	Social Security#

City	State	Zip	Cell Phone (mobile)

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

Payroll Debit Card Routing #	Payroll Debit Card Account #
073972181	

I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature:_____ Date:_____

SECTION 5 AUTHORIZATION

I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustmentsfor any credit entries made in error to my account(s). *** E-mail is required for pay stub information.**

***E-mail:** _____ @ _____
this information will only be used to send your paystubs electronically

Employee's Signature: _____ Date: 10/10/16

EMERGENCY CONTACT INFORMATION

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

Employee Name: Andrew Kohn

Address: 8939 Hadley Ave S. Cottage Grove MN 55016

Home Phone: 651-528-7252

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1	Home Phone: 651-528-7252
Name: Tiffany Santori	Cell Phone: 612-237-0211
Relationship: Wife	Work Phone:
Contact #2	Home Phone:
Name: Kathy Schaefer	Cell Phone: 651-675-8802
Relationship: Mother	Work Phone:

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

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

employer solutions staffing group.
Leveraging Resources in a Changing Market

ESG employer solutions group.

ESNG employer solutions nationwide group.

bpa Benefit Plan Administrators, Inc.

Enhanced MEC Plan_Plan 1

Benefits Enrollment Form New Employee_ Rehire Rehire Date_____

Employee Information

Name (First and Last)		Social Security Number	
Andrew Keihn		475-96-0240	
Address	**City**	**State**	**Zip Code**
8939 Hadley Ave S.	Cottage Grove	MN	55016
Gender (Male) Female	**Marital Status** Married (Single) Divorced	**Date of Birth** 04/08/1979	**Date of Hire**
Phone Number: 651-528-7252	**Email Address:**		

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 Date

EMPLOYEES DECLINING **I am DECLINING coverage**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption 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 Andrew Keihn Date 10/10/16

Employer Solutions Staffing Group Health Benefits Team
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
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	Social Security #	Home Phone	Sex
Andrew Kahn	475-96-0240	(651-528-7252	[X] M [ ] F

Address	Apt. #
8939 Hadley Ave S.	

City	State	Zip	Date of Birth
Cottage Grove	MN	55016	04/08/1979

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

[ ] Yes [ ] No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) | Medicare Effective Date

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 [ ]	$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 [X]	[ ] Yes [X] No	[ ] Yes [X] No	[ ] Yes [X] No	[ ] Yes [X] No	[ ] Yes [X] 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
		/ /	[ ] M [ ] F	[ ] Spouse [ ] Child [ ] Domestic Partner
		/ /	[ ] M [ ] F	[ ] Spouse [ ] Child [ ] Domestic Partner
		/ /	[ ] M [ ] F	[ ] Spouse [ ] Child [ ] Domestic Partner
		/ /	[ ] M [ ] F	[ ] 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 10/10/2016 ▶ **SIGNATURE** A. Kahn

This is an Essential StaffCARE Enrollment Form.