

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

OMB No. 1545-1500

▶ See separate instructions.

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

Your name Angela Ch Ruiz Rivera Social security number ▶ 598-36-10911
Street address where you live Carr 1082 Km 5.5 sector El Alto Garrochales Arecibo
City or town, state, and ZIP code P.O. Box El Garrochales P.R 00652
County Arecibo, Puerto Rico Telephone number (787) 996-8913
If you are under age 40, enter your date of birth (month, day, year) dic-09-1992

- 1 Check here if you are completing this form **before** August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.
- 2 Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 3 Check here if **any** of the following statements apply to you.
 - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a Received SNAP benefits (food stamps) for the past 6 months, or
 - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and**, for at least 4 weeks during the past year, I received unemployment compensation.
 - I am at least age 16 but **not** age 25 or older, **and**:
 - a During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
 - b During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
 - c I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate or I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.
- 4 Check here if you are a veteran entitled to compensation for a service-connected disability **and**, during the past year, you were:
 - Discharged or released from active duty in the U.S. Armed Forces, or
 - Unemployed for a period or periods totaling at least 6 months.
- 5 Check here if you are a member of a family that:
 - Received TANF payments for at least the past 18 months, or
 - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, or
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ Angela Ch Ruiz Rivera

Date Feb / 13 / 2015

COMISIÓN ESTATAL DE ELECCIONES
ESTADO LIBRE ASOCIADO DE PUERTO RICO
TARJETA DE IDENTIFICACION ELECTORAL

Nombre Estatal: **6114559** Estado: **PR**

RUIZ RIVERA
Carnet No: **169**
MAYORIA
Calle de Hacienda

ANGELA CHALYMAR
Carnet No: **19-CIG-4932**
Fecha de Emisión: **15-SEP-2004**

Fecha del Estado: **15-SEP-2004**





Estado Libre Asociado de Puerto Rico
Comisión Estatal de Elecciones

6206759

ANGELA CHALYMAR RUIZ RIVERA
BOGARROCHALE
CARRETERA KM 5.9
BARCELONETA, PR 00617

Operator / Conductor

ANGELA CHALYMAR RUIZ RIVERA
Carnet No: **19-CIG-4932**
Fecha de Emisión: **15-SEP-2004**

Fecha del Estado: **15-SEP-2004**







YOUTH SELF-ATTESTATION FORM
Work Opportunity Tax Credit 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 Form ETA 9061 for each certification request filed.

New Hire Name: Angela Ch Ruiz Rivera

Social Security Number: 598-36-6911 / Date of Birth: dic-09-1992

Employer Name: Employer Solutions Staffing Group

Employer Federal ID (EIN) Number: -

Please check all the statements that apply to you. Sign and date this form where indicated below.

- In the past 6 months, I have not attended a secondary, technical or postsecondary school for more than an average of 10 hours per week, not counting periods during which the school is closed for scheduled vacations.
- I do not have a High School Diploma or GED certificate.
- I have a High-School diploma or GED certificate awarded more than 6 months ago and I have not attended or been admitted to a technical or post-secondary school. I also have not held a job (other than occasionally) since receiving my High-School diploma or GED certificate.

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

New Hire's Signature: Angela Ch Ruiz Rivera Date 02-13-2015

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, including the Social Security Number, 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 5 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 Adult Services, Room S-4209, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

**HIRE Act FICA Payroll Holiday and
Employee Retention Tax Credit
Employee Affidavit**

Employer Name: CMG FEIN: _____

Hire Location: Abbuie - Barceloneta

Employee Name: Angela Ch. Ruiz Rivera

Social Security Number: _____ 1st Day of Work: _____

EMPLOYEE: Please check **one statement that applies to you and sign and date where indicated below.**

- I was unemployed during the entire 60 day-period prior to my first day of employment at this company.
- I worked less than a total of 40 hours during the 60-day period prior to my first day of employment at this company.

OR

- I worked MORE than a total of 40 hours during the 60-day period prior to my first day of employment at this company.

Under penalties of perjury, I hereby declare that the information above is true and correct to the best of my knowledge. By signing this form, I hereby authorize the release to my new employer or its agents information held by any parties needed to determine my eligibility for federal and/or state Incentive programs.

Employee Signature: Angela Ch. Ruiz Rivera Today's Date: 02-13-2015

For employer's use only:

- Employee is being hired for a new position within the company.
- Employee is replacing an employee who either quit or was terminated with just cause.
- Employee is replacing an employee who was laid off.

Hiring Manager's Signature: _____ Date: _____

Form A (revised 07/09) WORK OPPORTUNITY TAX CREDIT

PLEASE CHECK "YES" OR "NO" AND ANSWER ALL QUESTIONS

Name Angela Ch. River Rivera
 Address Car 1082 Km 5.5 sector 511th Comarcas Arecibo
 City Arecibo State P.R. Zip 00652 Social Security # 598-36-6911
 Date of Birth 01-09-1992 Age _____

Please CHECK ONE ANSWER for each of the following questions, and complete question #5:

1. Have you or any family member living with you received Temporary Assistance to Needy Families (TANF) or Aid to Families with Dependent Children (AFDC) during the past 24 months? Yes No
2. Have you or any family member living with you received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) at any time during the past fifteen (15) months? Yes No
3. Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days? Yes No
4. Are you part of the Ticket to Work program? Yes No

5. Name of person who received benefits N/A
 Relationship N/A City & State where benefits received N/A

6. Are you a veteran? Yes No and Disabled due to service? Yes No
 Service Dates: From: N/A To: N/A Branch: _____

7. Have you been unemployed at any time during the last 12 months? Yes No
 If yes, dates of unemployment: From: N/A To: N/A
 Did you receive unemployment compensation at any point during your unemployment?
 If yes, dates received compensation: From: N/A To: N/A Yes No

8. Have you been convicted of a felony or released from prison in the last 12 months?
 Date of Conviction: N/A Date of Release: N/A Yes No
 Parole Officer's Name: N/A Parole Officer's Phone # _____

9. Have you received rehabilitation services from a State approved or Department of Veterans Affairs approved Vocational rehabilitation agency? Yes No
 Name of Agency N/A Phone # N/A
 Address of Agency N/A Counselor's Name N/A

10. Have you attended High School, College or Technical School for more than an average of 10 hours per week at any time during the last 6 months? Yes No

11. Did you receive a high school diploma or GED? If yes, date received: N/A Yes No
 Have you been employed or been admitted to technical school or college since then? Yes No

12. How much in gross wages have you earned TOTAL in the past six months? \$ N/A

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, or the Department of Labor.

→ NEW HIRE SIGNATURE Angela Ch River Rivera DATE 02-13-2014

Questions below to be completed by manager
 Starting Wage _____ Position _____
 Has employee worked for this company before? _____ If yes, date and location _____



ANTI-HARASSMENT POLICY

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

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

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

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

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

With respect to sexual harassment, the following is prohibited:

1. Unwelcome sexual advances, request for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, especially where:
 - Submission to such conduct is made either explicitly or implicitly a term or condition of employment;
 - Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or
 - Such conduct has the purpose or effect of creating an intimidating, hostile or offensive working environment.
2. Offensive comments, jokes, innuendoes and other sexually-oriented statements.

If Harassment Occurs:

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

Employee Signature: Angela Ch. Ruiz Rivera

Date: 07-09-2015



To: All Employees

Quien: Todos Empleados

From: Corporate Management Group & Employer Solutions Group

De: Corporate Management Group y Employer Solutions Group

Re: Stop Payment Check Fee

Re: Tarifa de cheque parado

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

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

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

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

Thank you for your continued dedication and hard work!

Gracias por su dedicacion continua!

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

Signature/Firma: _____

Date/Fecha: _____

February 2011

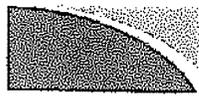
**EMPLOYER SOLUTIONS STAFFING GROUP
IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION**

Name: Angela Ch. Ruiz Rivera
Address: _____
Home Phone: 787-996-8913

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

1. Name: Brunilda Rivera Ayala
Phone (work): 787-925-9553
Phone (home): _____
2. Name: Carlos Beillo
Phone (work): _____
Phone (home): 939-292-4576

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



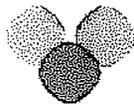
Essential StaffCARE

Health Insurance Enrollment Form

Complete the Enrollment Form to Elect or Decline Coverage

- You **MUST** Complete the Enrollment Form for the New Hire Process
 - You **MUST** Elect or Decline Medical Coverage on the Enrollment Form
 - You **MUST** Sign the Bottom of the Form, even if you Decline Coverage
 - Return the Enrollment Form to your Branch Manager
 - Keep the Plan Information Packet for Your Records
-

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.



employer solutions staffing group.

Leveraging Resources in a Changing Market

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

The Essential StaffCARE Medical/Rx and Dental Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.204 and 26.212. The Term Life, Accidental Death and Dismemberment, and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

Form: ESC CU(NAV*SAD) P2 v13.0

FREQUENTLY ASKED QUESTIONS

How do I enroll?

Enrolling in the Essential StaffCARE plan is easy. You can enroll by completing an Essential StaffCARE enrollment application and returning it to your manager.

When can I enroll in the plan?

As a full-time and/or part-time employee, you are able to enroll in the Essential StaffCARE program within 30 days of your hire date, 1st paycheck date, or your employer's annual 30 day open enrollment period. If you do not enroll during one of these time periods, you will have to wait until the next annual open enrollment, unless you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

What is a qualifying life event?

A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Death of an immediate family member
- Medicare entitlement
- Employer bankruptcy
- Loss of dependent status
- Loss of prior coverage

In addition, you may request a special enrollment (for yourself, your spouse, and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit.

Are dependents covered?

Yes. Eligible dependents include your spouse and your children up to age 26.

When does coverage begin?

Coverage will begin the Monday following a payroll deduction and continues as long as you have a deduction from your paycheck. Please review your check stub for deductions. If you miss a payroll deduction, to avoid a break in coverage, you may make direct payments to PAI. After six consecutive weeks without a payroll deduction or direct premium payment, coverage will be terminated and COBRA information will be sent at that time.

If I complete an enrollment form, but do not get placed on assignment right away, will I have to complete a new form?

After six months if there has not been a deduction from your paycheck, please fill out a new enrollment form. Missing information will delay the process.

Can I make changes or cancel coverage?

You may cancel or reduce coverage at any time unless your premiums are deducted pre-tax. You will only have 30 days from your hire date or first paycheck date to enroll, add additional benefits or add additional insured members. After this time frame, you will only be allowed to enroll, add benefits or add additional insured members during your annual open enrollment period or within 30 days of a qualifying life event.

(Please refer to the "PLEASE NOTE" section on the previous page to see if deductions are Post-Tax or Pre-Tax)

How can I make changes?

To make changes or cancel coverage by telephone call (800) 269-7783. Enter your PIN CODE plus the last four digits of your Social Security number (SSN).

PIN CODE: 142 + _____
(last four digits of your SSN)

Remember, it may take up to two or three weeks for the changes or cancellation to be reflected on your paycheck. Coverage will continue as long as you have a paycheck deduction.

Is there a pre-existing clause for the Medical Benefit?

There are no restrictions for pre-existing conditions in this medical plan. Even if you were previously diagnosed with a condition, you can receive coverage for related services as soon as your coverage goes into effect.

Is there coverage for contraceptives on this plan?

Oral contraceptives are covered under the prescription benefit. Non-oral contraceptives are not covered.

Are maternity benefits covered?

Yes, maternity benefits are covered the same as any other condition under this plan.

NETWORK INFORMATION

Prescription Drug Network

If enrolled in the medical plan, you are automatically covered by the prescription drug program through the Caremark Pharmacy Network. Caremark has a national network with over 58,000 participating pharmacies. To find a local participating Caremark pharmacy, you can visit www.caremark.com. Prescription drug benefit information can be found on the Benefits at a Glance page.

Stretch Your Benefit Dollars

This benefit plan offers you and your family savings for medical care through discounts negotiated with providers and facilities in the First Health Network. Choosing an in-network provider helps maximize benefits. When you use an in-network provider, you will automatically receive the network discount and the doctor's office will file the claim for you. If you use a doctor who is not part of the network, you will not receive the discount and you may need to file the claim yourself.

How Do I Locate a Doctor?

Enrolled members are encouraged to visit providers in the networks listed in order to maximize their benefit dollars. To find a participating provider or verify your current medical provider is in-network, please call or visit the network websites referenced on this page.

What if I need to have a prescription filled?

For generic and brand prescriptions, the plan pays you \$20 per day up to the annual maximum, for drugs dispensed by a pharmacist. Prescription drug coverage is not provided for drugs administered during a physician office visit or hospital stay. If you choose a participating pharmacy and present your ID card, you will receive a discount off the retail price of the prescription at the time of purchase. Save your receipt to file a claim for reimbursement of the fixed dollar amount.

Do I have to go to an in-network provider?

It is not required that you go to an in-network provider. If you choose a provider who participates in the PPO network, you receive two key advantages:

- PPO discount for all services.
- The provider will file the claim to the plan.

Medical

- First Health Network
1-800-226-5116
www.firsthealth.com

Prescription

- Caremark
1-888-963-7290
www.caremark.com

Vision - (discount only)

- EyeMed Vision Care
1-866-559-5252
www.eyemedvisioncare.com

Dental

- DenteMax
1-800-752-1547
www.dentemax.com

Do not contact the above Networks for questions regarding your medical benefits. All medical benefit questions should be directed to the Essential StaffCARE Member Services line at 1-866-798-0803.

When should I expect an ID card?

ID cards will be mailed as soon as your enrollment form is received and processed. You should receive your ID card within 10 business days of your effective date.

Member ID Cards

An ID card and confirmation of coverage letter will be mailed to your home address. If you do not receive these documents within 10 business days of your effective date, or have a change of address, please contact the Essential StaffCARE Customer Service at 1-866-798-0803. Present your ID card to the provider at the time of service. These ID cards are used for identification purposes and providers use them to verify eligibility status.

BENEFITS AT A GLANCE

Policy Number 219301-EMP

Medical Benefits - Plan 2

Inpatient Benefits		Outpatient Benefits ¹		Weekly Rates
Annual Inpatient Maximum	No Maximum	Annual Outpatient Maximum		\$2,000
Daily Standard Care Maximum	\$500 per day	Physician Office Visit		\$100 per day
Daily Intensive Care Unit Maximum ²	\$600 per day	Diagnostic Lab		\$75 per day
Surgery	\$3,000 per day	Diagnostic X-ray		\$200 per day
Anesthesiology	\$600 per day	Ambulance Services		\$300 per day
First Hospital Admission one per year	\$250	Physical, Occupational, and Speech Therapy		\$50 per day
Skilled Nursing payable for stays in a skilled nursing facility after a hospital stay	\$100 per day	Emergency Room - Sickness		\$200 per day
Prescription Drug ³		Emergency Room - Accident		\$500 per day
Prescription Drug Annual Maximum	\$600	Outpatient Surgery		\$500 per day
Prescription Drug Benefits	\$20 per day	Anesthesiology		\$200 per day

Wellness Care

Wellness Care one per year \$100

Employee Only	\$20.91	Employee + One	\$42.44	Employee + Family	\$56.67
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¹ all outpatient benefits are subject to the outpatient maximum ² pays in addition to standard care benefit ³ not subject to outpatient maximum

Dental Benefits

	Waiting Period	Co-insurance	Annual Maximum Benefit	Deductible	Weekly Rates
Coverage A	None	100%	\$750	\$50	
Coverage B	3 months	60%	Exams, Cleanings, Intraoral Films and Bitewings		
Coverage C	12 months	50%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures		
			Periodontics, Crowns, Bridges, Endodontics and Dentures		
Employee Only	\$5.99	Employee + One	\$11.98	Employee + Family	\$19.77

Short-Term Disability

Benefit	60% of Salary up to \$150 per week	Waiting Period / Maximum Benefit Period	7 days / 26 weeks	Weekly Rates
Employee Only	\$4.20			

Term Life Benefits

			Weekly Rates
Employee Amount	\$10,000 (reduces to \$7,500 at 65; \$5,000 at age 70)	Child Amount (6 months to 26 years old)	\$5,000
Spouse Amount	\$5,000 (terminates at age 70)	Infant Amount (15 days to 6 months)	\$1,000

Accidental Death and Dismemberment Benefit

Employee Amount	\$20,000	Child Amount (6 months to 26 years old)	\$5,000
Spouse Amount	\$20,000	Infant Amount (15 days to 6 months)	\$2,500
Employee Only	\$0.60	Employee + One	\$0.90
		Employee + Family	\$1.80

EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

MEDICAL

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane;
- Declared or undeclared war;
- Serving on full-time active duty in the armed forces;
- The covered person's commission of a felony;
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law;

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions;
- Hearing examinations or hearing aids;
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident;
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force;
- Services provided by a member of the covered person's immediate family.

PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on Covered Procedures or limitations, please see your summary plan description.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury;
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent; or a person who resides in your home;
- Declared or undeclared war or act of war;
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony;
- Your participation in a riot;
- If you engage in an illegal occupation;
- Release of nuclear energy;
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

Short-Term Disability benefits are not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

TERM LIFE WITH ACCIDENTAL DEATH & DISMEMBERMENT

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

For Accidental Death and Dismemberment benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

Attempted suicide or intentionally self-inflicted injury; bodily or mental infirmity; disease of any kind; or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound or accidental ingestion of poisonous food substance; voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you, your spouse or domestic partner; you, your spouse's or domestic partner's child; sibling or parent; or a person who resides in your home; declared or undeclared war or act of war; your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony; your participation in a riot; if you engage in an illegal occupation; release of nuclear energy; operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; work-related injury or sickness.

Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen. If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck. The time that the money goes into your account on pay day varies by bank. Please allow until at least 10 am on your payday for the deposit to show.

Please print

Check one of the following	Effective Date
<input checked="" type="checkbox"/> Start	<input type="checkbox"/> As Soon As Possible
<input type="checkbox"/> Stop	<input type="checkbox"/> Future Paydate
<input type="checkbox"/> Change	____/____/____

Social Security Number
598-36-6911

Name (Last, First Middle Initial) Ruiz Rivera Arecibo Ch.			
Home Address	Street	City	State Zipcode
Carr 682 km 5-5 sector El Alto Garrochales Arecibo			
Date (Mo/Day/Yr) dic-12-2015	Employee Signature Lugelo Ch Ruiz Rivera	Daytime Phone Number -87-996-8913	

SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION

Financial Institution Name (Bank, Savings Institution, Credit Union, etc.)
Banco Popular Puerto Rico # cuenta 287261085

Type of Account
 Checking Savings Money Market Checking Money Market Investment Requires Submission of ACH form from your broker

I authorize Employer Solutions Staffing Group to direct deposit funds to my account in the financial institution listed above. If funds to which I am not entitled are deposited in my account, I authorize Employer Solutions Staffing Group to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by Employer Solutions Staffing Group at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to you will be returned to Employer Solutions Staffing Group for distribution. This will delay payment of funds to you.

✓ Attach a voided check HERE or photocopy of a check for checking account.
DO NOT ATTACH A DEPOSIT SLIP.

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Ruiz Rivera First Name Angela Middle Initial Ch.
 Street Address Carr 682 Km 5.5 sector El Alto Garracholes Arecibo
 City/State/Zip Arecibo Puerto Rico 00659
 Home Phone N/A Cell / Message Phone 787-996-8913
 Company/Employer Stoberman Solutions

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.

Angela Ch. Ruiz Rivera Angela Ch. Ruiz 09-09-2015
 Name (Print or type) Applicant's Signature Date

A copy or facsimile will be considered the same as an original signature.

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	5 Day Letter (If applicable) _____	ESC Application _____

**HIRE Act FICA Payroll Holiday and
Employee Retention Tax Credit
Employee Affidavit**

Employer Name: Angela Ch. Ruiz Rivera FEIN: _____

Hire Location: Abbive Barceloneta

Employee Name: _____

Social Security Number: 598-36-6911 1st Day of Work: _____

EMPLOYEE: Please check **one statement that applies to you and sign and date where indicated below.**

- I was unemployed during the entire 60 day-period prior to my first day of employment at this company.
 - I worked less than a total of 40 hours during the 60-day period prior to my first day of employment at this company.
- OR
- I worked MORE than a total of 40 hours during the 60-day period prior to my first day of employment at this company.

Under penalties of perjury, I hereby declare that the information above is true and correct to the best of my knowledge. By signing this form, I hereby authorize the release to my new employer or its agents information held by any parties needed to determine my eligibility for federal and/or state incentive programs.

Employee Signature: Angela Ch Ruiz Rivera Today's Date: 08-09-2015

For employer's use only:	
<input type="checkbox"/>	Employee is being hired for a new position within the company.
<input type="checkbox"/>	Employee is replacing an employee who either quit or was terminated with just cause.
<input type="checkbox"/>	Employee is replacing an employee who was laid off.
Hiring Manager's Signature: _____ Date: _____	



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) Ruiz		First Name (Given Name) Rivero Angela		Middle Initial C	Other Names Used (if any)	
Address (Street Number and Name) Car 682 Km S.S. Sector El			Apt. Number	City or Town Arecibo	State P.R.	Zip Code 00652
Date of Birth (mm/dd/yyyy) dic-09-1992	U.S. Social Security Number 598-34-6911		E-mail Address			Telephone Number

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):

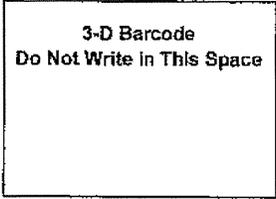
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (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)

Signature of Employee:	Date (mm/dd/yyyy):
------------------------	--------------------

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



Employer Completes Next Page

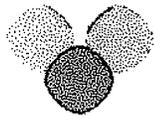


Viewing Check Stubs

You have 2 options:

1. You can view your check stub by logging into the employee portal at www.MyPayESG.com
 - Your username is **the first four letters of your last name followed by the last four numbers of your SSN.**
For example: John Woods SSN: 111-22-3333 would have a username of Wood333
 - Your password will initially be **Temp1234**, and you will be directed to change it when you first log in. Be sure to write down and keep your log-in information in a secure location.

2. You can also receive your check stub by email. Please email MyPayESG@MyPayESG.com to inform us of your email address and all of your check stubs will be sent directly to your email.
****Please include your Last Name and the Last Four Digits of your social security number (SSN#).**



employer solutions staffing group.

Leveraging Resources in a Changing Market

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):

Angela Ch Ruiz Rivero

Signature/Firma:

Angela Ch Ruiz Rivero

WOTC NEW HIRE PROCESS

Part One - Applicant

On the day the Applicant is offered and accepts the job, the applicant should:

- a. completely fill out, sign and date Form A (either the English or Spanish side),
AND
- b. completely fill out, sign and date the front of the 8850 form,
AND (if at least 16 but not yet 25 years old)
- c. completely fill out, sign and date the Disconnected Youth Self-Attestation form.

Part Two – HR Administrator

1. After the Applicant fills out the two forms listed above, the HR administrator should check for:
 - a. Legibility, especially SS#,
 - b. Completeness of forms, especially **signature** on Form 8850, Form A and Self-Attestation form,
 - c. Employee has included their **physical address, NO P.O. BOXES,**
 - d. If the Applicant is a veteran (question 6 of the Form A), please obtain a copy of their DD-214, and
 - e. If the Applicant is part of the "Ticket to Work" program (question 4 on the Form A), please obtain a copy of their ticket document.
2. HR Administrator or Manager should then complete the "For Employer's Use Only" section on the back of the Form 8850, then sign and date the form.
3. Attach a copy of the employee's **W-4 form**, Social Security Card **AND** one of the following:
 - a. Driver's License,
 - b. Resident Alien Card,
 - c. Birth Certificate, or
 - d. State ID card.
4. Completed packets should include:
 - a. Form A (**ORIGINAL SIGNATURE IS REQUIRED BY ACI/RetroTax**),
 - b. 8850 form (**ORIGINAL SIGNATURE IS REQUIRED BY ACI/RetroTax**),
 - c. Disconnected Youth Self-Attestation form (**ORIGINAL SIGNATURE REQUIRED BY ACI/RetroTax**),
 - d. Copy of Social Security Card,
 - e. Copy of W-4 form,
 - f. One other piece of identification (see list above),
 - g. Copy of DD-214, if applicable, and
 - h. Copy of Ticket to Work, if applicable.
5. Gather completed packets and mail to:

ACI/RetroTax
3730 Washington Boulevard
Indianapolis, IN 46205

Please double check the paperwork. The more thorough the HR Administrators are in providing support documentation and the completed forms, the faster ACI/RetroTax can process the forms without repeatedly contacting you.

The forms must reach ACI/RetroTax's office, be processed and ACI/RetroTax must send the forms to the State Department of Employment Services within 28 days of the employee's Job Started Date or you will lose the certification.

If you have any questions or concerns please feel free to contact Becky Huber or Lola Strode at 1-800-925-0557.

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

OMB No. 1545-1500

▶ See separate instructions.

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

Your name Angela Oh-River Rivera Social security number ▶ 598-36-6911
Street address where you live car 1682 km S.S Sector El Alto Garrochales Arceibo
City or town, state, and ZIP code Arceibo P.R P.O. Box 81 Garrochales P.R 00659
County _____ Telephone number (787) 996 8913

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

- 1 Check here if you are completing this form **before** August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.
- 2 Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 3 Check here if any of the following statements apply to you.
 - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a Received SNAP benefits (food stamps) for the past 6 months, or
 - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and**, for at least 4 weeks during the past year, I received unemployment compensation.
 - I am at least age 18 but **not** age 25 or older, **and**:
 - a During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
 - b During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
 - c I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate or I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.
- 4 Check here if you are a veteran entitled to compensation for a service-connected disability **and**, during the past year, you were:
 - Discharged or released from active duty in the U.S. Armed Forces, or
 - Unemployed for a period or periods totaling at least 6 months.
- 5 Check here if you are a member of a family that:
 - Received TANF payments for at least the past 18 months, or
 - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, or
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ _____

Date / / _____

WORK OPPORTUNITY TAX CREDIT

PLEASE CHECK "YES" OR "NO" AND ANSWER ALL QUESTIONS

Name Angela
Address Rios Rivera
City Arecibo State PR Zip 00659 Social Security # 598-36-6911
Date of Birth Dec-09-1992 Age 22

Please CHECK ONE ANSWER for each of the following questions, and complete question #5:

- 1. Have you or any family member living with you received Temporary Assistance to Needy Families (TANF) or Aid to Families with Dependent Children (AFDC) during the past 24 months?
2. Have you or any family member living with you received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) at any time during the past fifteen (15) months?
3. Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days?
4. Are you part of the Ticket to Work program?

5. Name of person who received benefits
Relationship
City & State where benefits received

6. Are you a veteran? Yes No and Disabled due to service? Yes No
Service Dates: From: To: Branch:

7. Have you been unemployed at any time during the last 12 months? Yes No
If yes, dates of unemployment: From: To:
Did you receive unemployment compensation at any point during your unemployment?
If yes, dates received compensation: From: To: Yes No

8. Have you been convicted of a felony or released from prison in the last 12 months?
Date of Conviction: Date of Release: Yes No
Parole Officer's Name: Parole Officer's Phone #

9. Have you received rehabilitation services from a State approved or Department of Veterans Affairs approved Vocational rehabilitation agency? Yes No
Name of Agency Phone #
Address of Agency Counselor's Name

10. Have you attended High School, College or Technical School for more than an average of 10 hours per week at any time during the last 6 months? Yes No

11. Did you receive a high school diploma or GED? If yes, date received: Yes No
Have you been employed or been admitted to technical school or college since then? Yes No

12. How much in gross wages have you earned TOTAL in the past six months? \$

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, or the Department of Labor.
NEW HIRE SIGNATURE DATE

Questions below to be completed by manager
Starting Wage Position
Has employee worked for this company before? If yes, date and location

WORK OPPORTUNITY TAX CREDIT

POR FAVOR INDIQUE CON "SÍ" O "NO" Y COMPLETE EL RESTO DEL FORMULARIO

Nombre Amelio Oh Ruiz Riquelme
 Dirección Carretera Km 3.5 Sector El Alto Comochales Arecho
 Ciudad Arecho Estado P.R. Código Postal 00659
 Número del Seguro Social 598-36-10911 Fecha de nacimiento dic-09-1992 Edad 22

Favor de marcar UNA RESPUESTA para cada pregunta y complete pregunta número cinco (5):

1. ¿Ha recibido usted o algún miembro de su domicilio Ayuda Provisional a Familias Necesitadas (TANF) o La Ayuda a las Familias con Hijos Dependientes (AFDC) durante los últimos veinticuatro (24) meses?

Sí No

2. ¿Ha recibido usted o algún miembro de su domicilio las Estampillas para la Comida (SNAP) alguna vez durante los últimos quince (15) meses?

Sí No

3. ¿Ha recibido usted Ingreso por Seguro Suplemental (SSI) durante los últimos sesenta (60) días?

Sí No

4. ¿Es usted miembro del programa del Boleto para trabajar?

Sí No

5. Nombre del recipiente _____ Parentesco _____
 Ciudad y estado donde recibió los beneficios _____

6. ¿Es usted veterano? Sí No ¿y discapacitado? Sí No
 Las fechas del servicio: De: _____ Hasta: _____ Rama: _____

7. ¿Ha estado usted desempleado alguna vez durante los últimos doce (12) meses?
 Fechas de desempleo: De: _____ Hasta: _____

Sí No

¿Ha recibido usted Compensación por desempleo?

Fechas que recibió Compensación por desempleo: De: _____ Hasta: _____

Sí No

8. ¿Ha estado usted condenado de un crimen o ha estado usted liberado del cárcel en los últimos doce (12) meses?

Sí No

Fecha de convicción: _____ Fecha de libertad: _____

Nombre del oficial de libertad condicional bajo palabra: _____

Número de teléfono del oficial de libertad condicional bajo palabra: _____

9. ¿Ha recibido usted ayuda de una agencia de rehabilitación *vocacional* aprobada por el estado o los veteranos?

Sí No

Nombre de la agencia: _____ Número de teléfono: _____

Dirección de la agencia: _____ Nombre del consejero: _____

10. ¿Ha asistido usted regularmente a un colegio o a una universidad para más que un promedio de diez (10) horas a la semana alguna vez durante los últimos seis (6) meses?

Sí No

11. ¿Ha recibido usted un bachillerato or GED?

Fecha cuando lo recibió: _____

Sí No

¿Ha estado usted empleado o admitado a un colegio desde entonces?

Sí No

12. ¿Cuanto en sueldos brutos ha ganado usted EN TOTAL durante los últimos seis (6) meses? \$ _____

Yo por la presente autorizo cualquier agencia, organización, o individuos a suministrar tal comprobación o información necesaria para determinar elegibilidad del crédito tributario a mi empleador, a representante del empleador, o al Departamento de Trabajo.

→ FIRMA DEL EMPLEADO _____ FECHA _____

El jefe debe responder a las siguientes preguntas

Questions below to be completed by manager

Starting Wage _____ Position _____

Has employee worked for this company before? _____ if yes, date _____



YOUTH SELF-ATTESTATION FORM
Work Opportunity Tax Credit 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 Form ETA 9061 for each certification request filed.

New Hire Name: Angela Oh Rive Rivere

Social Security Number: 598-36491 Date of Birth: dic-09-1992

Employer Name: Employer Solutions Staffing Group

Employer Federal ID (EIN) Number: -

Please check all the statements that apply to you. Sign and date this form where indicated below.

- In the past 6 months, I have not attended a secondary, technical or postsecondary school for more than an average of 10 hours per week, not counting periods during which the school is closed for scheduled vacations.
- I do not have a High School Diploma or GED certificate.
- I have a High-School diploma or GED certificate awarded more than 6 months ago and I have not attended or been admitted to a technical or post-secondary school. I also have not held a job (other than occasionally) since receiving my High-School diploma or GED certificate.

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

New Hire's Signature: Angela Oh Rive Rivere Date dic-09-1992

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, including the Social Security Number, 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 5 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 Adult Services, Room S-4209, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

YOUTH SELF-ATTESTATION FORM
(Forma de Auto-Juramentación o Declaración Personal)
"Work Opportunity Tax Credit Program"

Instrucciones: Esta forma debe ser completada, debidamente firmada, y fechada por el joven empleado. El patrón, o su representante, deberá enviar esta Auto-Juramentación o Declaración Personal junto con la forma ETA 9061 a la Agencia Estatal de Empleo o SWA.

Nombre del Empleado: _____

Numero de Seguro Social: _____ Fecha de Nacimiento: _____

Nombre del Patrono _____

Numero o ID Federal (EIN) del Patrono: _____

Por favor marque todos los encasillados que le apliquen a Usted. Luego firme y feche esta forma en los blancos al final de la forma.

- En los últimos 6 meses, no he asistido a ninguna escuela secundaria o técnica, ni he cursado estudios post secundarios durante mas de un promedio de 10 horas por semana, sin contar los periodos durante los cuales la escuela esta cerrada por vacaciones programadas.
- No tengo ni un Diploma de Escuela Secundaria ni un Certificado GED.
- Tengo un Diploma de Escuela Secundaria o un Certificado GED otorgado hace mas de 6 meses y no he asistido ni he sido aceptado en una escuela técnica o de estudios post secundarios. Tampoco he tenido ningún empleo (excepto de vez en cuando) desde que recibí mi Diploma de Escuela Secundaria o mi Certificado de GED.

Bajo las sanciones o penalidades de perjurio, declaro que esta información es correcta y verdadera.

Firma del Empleado: _____ Fecha: _____

Privacy Act Notice (Aviso): El Código de Rentas Internas (Departamento del Tesoro de EUA) de 1986, Sección 51, como legislación enmendada, y P.L. 104-188 decretan que la Agencia Estatal de Empleo es la única agencia gubernamental autorizada y responsable para administrar los procedimientos de certificación del programa WOTC. La información que usted ha proporcionado al llenar este formulario, incluyendo el Número de Seguro Social, será divulgada por su patrón a la Agencia Estatal de Empleo. La disposición de esta información es voluntaria; sin embargo la información se requiere para poder determinar la elegibilidad de su patrón para reclamar el WOTC o crédito de impuesto federal.

"Public Burden Statement (Declaración):" Las personas no están obligadas a proveer la información que esta forma pide a menos que dicha forma despliegue o muestre un número de control valido de OMB. Las personas interesadas en obtener y mantener los beneficios que este programa ofrece tienen la obligación de responder a las preguntas en esta forma. (P.L. 111-5). El tiempo que toma contestar esta forma se ha estimado que toma un promedio de 5 minutos por cada contestación, incluyendo el tiempo para leer las instrucciones, reunir y mantener los datos necesarios y completar y revisar esta colección de información. Puede enviar comentarios sobre este estimado de tiempo al Departamento del Trabajo, División de Servicios a Personas Adultas (Division of Adult Services) Room S-4209, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371).



To: All Employees
Quien: Todos Empleados

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

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

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

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

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

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

Thank you for your continued dedication and hard work!

Gracias por su dedicacion continua!

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

Signature/Firma: Angel An Ruiz Rivera
Date/Fecha: Febrero 13- 2015

February 2011

EMPLOYEE INFORMATION (Must Be Filled Out)

ENROLLMENT FORM - PLAN 2

USE BLACK or BLUE INK ONLY
ESC C1 (NAV-SAD) P2 v13.0

Social Security Number 598-36-6911
Date of Birth 12/09/1992 Sex M F
Name Angela Ch. Ruiz Rivera
Street Address Carr. 682 Km 5.5 sector El Alto
Carretera Arecibo
City Arecibo State PR Zip 00652
Home Phone 787-996-8913

Do you or any dependents have Medicare?
 Yes No If Yes:
Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date ____/____/____
Names of Covered Person(s)
1. _____
2. _____
3. _____

BENEFIT SELECTION

Weekly Rates

MEDICAL



- \$20.91 Employee Only
- \$42.44 Employee + One
- \$56.67 Employee + Family
- NO to MEDICAL, TERM LIFE, and STD benefits.**

You **MUST** enroll in the Medical Insurance Plan before adding Term Life or STD. Your coverage level for Term Life will be identical to your medical plan selection.

REQUIRED DEPENDENT INFORMATION

Name _____
Social Security Number _____
Date of Birth ____/____/____ Sex M F
Relationship: Spouse Child Domestic Partner

Name _____
Social Security Number _____
Date of Birth ____/____/____ Sex M F
Relationship: Spouse Child Domestic Partner

Name _____
Social Security Number _____
Date of Birth ____/____/____ Sex M F
Relationship: Spouse Child Domestic Partner

DENTAL



- \$ 5.99 Employee Only
- \$11.98 Employee + One
- \$19.77 Employee + Family
- NO**

TERM LIFE



- YES** \$0.60 Employee Only
- \$0.90 Employee + One
- NO** \$1.80 Employee + Family

SHORT-TERM DISABILITY



- YES**
- NO** \$4.20 Employee Only

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY

RELATIONSHIP

Accidental Death & Dismemberment is part of the Term Life Benefit.

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.

Signature Angela Ch. Ruiz Rivera

Date 02/13/2015

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: <ul style="list-style-type: none"> • 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	1
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	0
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	1
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	1
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	0
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • 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	2
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	10

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	OMB No. 1545-0074	2015
▶ 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 Angela	Last name Ruiz-Rivero	2 Your social security number 598-36-6911	
Home address (number and street or rural route) Carr 1652 Km 5.5 sector EL AHO, Arica		3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>	
City or town, state, and ZIP code P.O. Box 81 Gomerholes P.A. 00050		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 checked="" type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5	6
6 Additional amount, if any, you want withheld from each paycheck		6 \$	0
7 I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶			7 Exempt
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.) ▶ Angela Oh Ruiz-Rivero		Date ▶ 02-13-2015	
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)	

Deductions and Adjustments Worksheet

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

1 Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over \$309,300 and you are married filing jointly or are a qualifying widow(er); \$284,050 if you are head of household; \$258,250 if you are single and not head of household or a qualifying widow(er); or \$154,950 if you are married filing separately. See Pub. 505 for details 1 \$ _____

2 Enter: { \$12,600 if married filing jointly or qualifying widow(er) }
 { \$9,250 if head of household }
 { \$6,300 if single or married filing separately } 2 \$ _____

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

4 Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505) 4 \$ _____

5 Add lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.) 5 \$ _____

6 Enter an estimate of your 2015 nonwage income (such as dividends or interest) 6 \$ _____

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

8 Divide the amount on line 7 by \$4,000 and enter the result here. Drop any fraction 8 _____

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

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

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

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

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

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

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

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

4 Enter the number from line 2 of this worksheet 4 _____

5 Enter the number from line 1 of this worksheet 5 _____

6 Subtract line 5 from line 4 6 _____

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

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

9 Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$600	\$0 - \$38,000	\$600
6,001 - 13,000	1	8,001 - 17,000	1	75,001 - 135,000	1,000	38,001 - 83,000	1,000
13,001 - 24,000	2	17,001 - 26,000	2	135,001 - 205,000	1,120	83,001 - 180,000	1,120
24,001 - 26,000	3	26,001 - 34,000	3	205,001 - 360,000	1,320	180,001 - 395,000	1,320
26,001 - 34,000	4	34,001 - 44,000	4	360,001 - 405,000	1,400	395,001 and over	1,580
34,001 - 44,000	5	44,001 - 75,000	5	405,001 and over	1,580		
44,001 - 50,000	6	75,001 - 85,000	6				
50,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 100,000	10	140,001 and over	10				
100,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

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

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

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

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

Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen. If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck. The time that the money goes into your account on pay day varies by bank. Please allow until at least 10 am on your payday for the deposit to show.

Please print

Check one of the following	Effective Date
<input type="checkbox"/> Start	<input type="checkbox"/> As Soon As Possible
<input type="checkbox"/> Stop	<input type="checkbox"/> Future Paydate
<input type="checkbox"/> Change	____/____/____

Social Security Number 598-36-6911

Name (Last, First Middle Initial) Angela Ch. Ruiz Rivera			
Home Address	Street	City	State Zipcode
carr 682 Km 5.5 sector El Alto Gamochales		Arriba	00652
Date (Mo/Day/Yr) Feb-13-2015	Employee Signature Angela Ch. Ruiz Rivera	Daytime Phone Number 787-996-8913	

SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION

Financial Institution Name (Bank, Savings Institution, Credit Union, etc.) Banco Popular	Account number 021502011	Num cuenta 227241085
Type of Account	<input type="checkbox"/> Checking <input checked="" type="checkbox"/> Savings <input type="checkbox"/> Money Market Checking <input type="checkbox"/> Money Market Investment Requires Submission of ACH form from your broker	

I authorize Employer Solutions Staffing Group to direct deposit funds to my account in the financial institution listed above. If funds to which I am not entitled are deposited in my account, I authorize Employer Solutions Staffing Group to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by Employer Solutions Staffing Group at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to you will be returned to Employer Solutions Staffing Group for distribution. This will delay payment of funds to you.

✓ **Attach a voided check HERE or photocopy of a check for checking account.**
DO NOT ATTACH A DEPOSIT SLIP.

FW: Angela = Puerto Rico

Katie Roche

Sent: Friday, February 13, 2015 12:09 PM

To: Allan Ramos

Attachments: 2015 W4 Federal.pdf (113 KB) ; Direct deposit instruction~1.pdf (58 KB) ; EMP Enrollment Form - Engl~1.pdf (218 KB) ; Employee-Safety-Handbook~1.docx (1 MB) ; HIRE Act Form 2010--Eng..pdf (24 KB) ; WOTC 8850 form.pdf (2 MB)

Hi Allan.

We are missing some information from Angela and I have listed it below. The documents that need to be signed / completed are attached for her convenience. Please let me know if you have any questions.

Please have her complete the following:

- ~~W-4~~
- ~~Stop Payment Check Fee form~~
- ~~Signed Health Insurance Form (even if she is declining)~~
- ~~Voided Check or Form from Bank for direct deposit~~
- ~~Signed 8850~~
- ~~Signed A WOTC~~
- ~~Copy of 2 separate ID's (license and birth certificate OR passport)~~
- ~~Signed safety handbook~~

Katie Roche

PeopleShare MSP for Storeroom Solutions, Inc.

"Providing Great People to Great Companies."

O (484) 586-3692 | C (610) 805-6293 | E kroche@storeroomsolutions.com

2 Radnor Corporate Ctr | 100 Matsonford Rd #400 | Radnor, PA 19087