



employer solutions staffing group

# New Hire Application

Personal Data-- **PLEASE PRINT LEGIBLY IN INK**

Last Name McLaughlin First Name ARTHUR Middle Initial R  
 Street Address 127 HOW ST P.O. Box 457 Apt/Site \_\_\_\_\_  
 City/State/Zip Haverhill MA 01831 Social Security Last Four XXX-XX-6596  
 Phone Number 978-327-1288 Email Address McLAUGHLINARTH@URC.YAHOO.COM  
 Staffing Agency/Recruitment Partner \_\_\_\_\_

**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.

ARTHUR McLaughlin Arthur McLaughlin AUG 31 2017  
 Name (Print or type) Applicant's Signature Date

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

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

ESSG - CMG-NSTW4

Rev. 01/09/17

|                       |
|-----------------------|
| mclaughlin            |
| arthur                |
| r                     |
| 127 how st po box 457 |
|                       |
| haverhill             |
| mass                  |
| 6596                  |
| 9783271288            |

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# FAX COVER SHEET

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To: ATTN JAMIE READY

Company: \_\_\_\_\_

Fax Number \_\_\_\_\_

Date: 9-1-2017

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\*\*\* \*\*

From: ARTHUR McLACHLIN

Phone/ e-mail: \_\_\_\_\_

No. of pages: \_\_\_\_\_

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Please consider me for the following position(s):

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Please contact me at the address and telephone number listed on my resume. Thank you for your consideration.

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**Employment Eligibility Verification**  
 Department of Homeland Security  
 U.S. Citizenship and Immigration Services

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

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

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

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

|  |  |   |  |                            |                                 |  |
|--|--|---|--|----------------------------|---------------------------------|--|
| Last Name (Family Name)<br><b>McLaughlin</b>                       |  | First Name (Given Name)<br><b>ARTHUR</b>          |  | Middle Initial<br><b>R</b> | Other Last Names Used (if any)  |  |
| Address (Street Number and Name)<br><b>127 HOW ST P.O. BOX 457</b> |  |   |  | Apt. Number                | City or Town<br><b>HAGRHILL</b> | State<br><b>MA</b> ZIP Code<br><b>01831</b>        |
| Date of Birth (mm/dd/yyyy)<br><b>11-06-1957</b>                    |  | U.S. Social Security Number<br><b>020-43-6596</b> |  | Employee's E-mail Address  |                                 | Employee's Telephone Number<br><b>978-327-1288</b> |

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

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

|   |  |
|---|--|
| <input checked="" type="checkbox"/> 1. A citizen of the United States   |  |
| <input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)   |  |
| <input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number):   |  |
| <input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy):   |  |
| Some aliens may write "N/A" in the expiration date field. (See instructions)  |  |
| Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number. |  |
| 1. Alien Registration Number/USCIS Number:<br>OR  |  |
| 2. Form I-94 Admission Number:<br>OR  |  |
| 3. Foreign Passport Number:<br>Country of Issuance:   |  |
| OR Code - Section 1<br>Do Not Write in This Space   |  |

|   |   |
|---|---|
| Signature of Employee<br><i>Arthur McLaughlin</i> | Today's Date (mm/dd/yyyy)<br><b>Aug 31 2017</b> |
|---|---|

**Preparer and/or Translator Certification (check one):**

I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
 (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

|                                     |  |                           |                |
|-------------------------------------|--|---------------------------|----------------|
| Signature of Preparer or Translator |  | Today's Date (mm/dd/yyyy) |                |
| Last Name (Family Name)             |  | First Name (Given Name)   |                |
| Address (Street Number and Name)    |  | City or Town              | State ZIP Code |



|                       |
|-----------------------|
| mclaughlin            |
| arthur                |
|                       |
| 127 how st po box 457 |
|                       |
|                       |
| mass                  |

**LISTS OF ACCEPTABLE DOCUMENTS**

**All documents must be UNEXPIRED**

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

| LIST A<br>Documents that Establish<br>Both Identity and<br>Employment Authorization   | OR | LIST B<br>Documents that Establish<br>Identity  | AND | LIST C<br>Documents that Establish<br>Employment Authorization  |
|---|----|---|-----|---|
| 1. U.S. Passport or U.S. Passport Card  |    | 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address |     | 1. A Social Security Account Number card, unless the card includes one of the following restrictions:<br>(1) NOT VALID FOR EMPLOYMENT<br>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>(3) VALID FOR WORK ONLY WITH OHS AUTHORIZATION |
| 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)  |    | 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address                |     | 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)   |
| 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa  |    | 3. School ID card with a photograph   |     | 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal   |
| 4. Employment Authorization Document that contains a photograph (Form I-766)  |    | 4. Voter's registration card  |     | 4. Native American tribal document  |
| 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:<br>a. Foreign passport; and<br>b. Form I-94 or Form I-94A that has the following:<br>(1) The same name as the passport; and<br>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. |    | 5. U.S. Military card or draft record   |     | 5. U.S. Citizen ID Card (Form I-197)  |
|   |    | 6. Military dependant's ID card   |     | 6. Identification Card for Use of Resident Citizen in the United States (Form I-179)  |
|   |    | 7. U.S. Coast Guard Merchant Mariner Card   |     | 7. Employment authorization document issued by the Department of Homeland Security  |
|   |    | 8. Native American tribal document  |     |   |
|   |    | 9. Driver's license issued by a Canadian government authority   |     |   |
| 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI   |    | For persons under age 18 who are unable to present a document listed above:   |     |   |
|   |    | 10. School record or report card  |     |   |
|   |    | 11. Clinic, doctor, or hospital record  |     |   |
|   |    | 12. Day-care or nursery school record   |     |   |

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

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

**Section 2: Employer or Authorized Representative Review and Verification**  
*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the Table of Acceptable Documents.)*

|                              |                         |                         |      |                                |
|------------------------------|-------------------------|-------------------------|------|--------------------------------|
| Employee Info from Section 1 | Last Name (Family Name) | First Name (Given Name) | M.I. | Citizenship/Immigration Status |
|------------------------------|-------------------------|-------------------------|------|--------------------------------|

| List A<br>Identity and Employment Authorization | OR | List B<br>Identity                    | AND | List C<br>Employment Authorization                     |
|---|----|---------------------------------------|-----|--|
| Document Title                                  |    | Document Title                        |     | Document Title   |
| Issuing Authority                               |    | Issuing Authority                     |     | Issuing Authority                                      |
| Document Number                                 |    | Document Number                       |     | Document Number  |
| Expiration Date (if any) (mm/dd/yyyy)           |    | Expiration Date (if any) (mm/dd/yyyy) |     | Expiration Date (if any) (mm/dd/yyyy)                  |
| Document Title                                  |    | Additional Information                |     | OR Case - Section 2(B) 3<br>Do NOT write in This Space |
| Issuing Authority                               |    |                                       |     |  |
| Document Number                                 |    |                                       |     |  |
| Expiration Date (if any) (mm/dd/yyyy)           |    |                                       |     |  |
| Document Title                                  |    |                                       |     |  |
| Issuing Authority                               |    |                                       |     |  |
| Document Number                                 |    |                                       |     |  |
| Expiration Date (if any) (mm/dd/yyyy)           |    |                                       |     |  |

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

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions)

|   |   |   |             |                   |
|---|---|---|-------------|-------------------|
| Signature of Employer or Authorized Representative  | Today's Date (mm/dd/yyyy)                           | Title of Employer or Authorized Representative                                    |             |                   |
| Last Name of Employer or Authorized Representative  | First Name of Employer or Authorized Representative | Employer's Business or Organization Name<br>EMPLOYER SOLUTIONS STAFFING GROUP LLC |             |                   |
| Employer's Business or Organization Address (Street Number and Name)<br>7480 FLYING CLOUD DRIVE SUITE 200 |   | City or Town<br>EDEN PRAIRIE  | State<br>MN | ZIP Code<br>55344 |

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

|                |                 |                                       |
|----------------|-----------------|---------------------------------------|
| Document Title | Document Number | Expiration Date (if any) (mm/dd/yyyy) |
|----------------|-----------------|---------------------------------------|

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

|  |                           |   |
|--|---------------------------|---|
| Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Name of Employer or Authorized Representative |
| <i>[Signature]</i>                                 | AUG 31 2017               |   |



**Employment Eligibility Verification**  
 Department of Homeland Security  
 U.S. Citizenship and Immigration Services

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

**Section 2. Employer or Authorized Representative Review and Verification**

*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")*

|                              |  |  |                  |   |
|------------------------------|--|--|------------------|---|
| Employee Info from Section 1 | Last Name (Family Name)<br><u>McLaughlin</u> | First Name (Given Name)<br><u>Arthur</u> | M.I.<br><u>R</u> | Citizenship/Immigration Status<br><u>US Citizen</u> |
|------------------------------|--|--|------------------|---|

List A Identity and Employment Authorization      OR      List B Identity      AND      List C Employment Authorization

|   |                                      |                                      |
|---|--------------------------------------|--------------------------------------|
| Document Title<br><u>US Passport</u>                      | Document Title                       | Document Title                       |
| Issuing Authority<br><u>US Dept of state</u>              | Issuing Authority                    | Issuing Authority                    |
| Document Number<br><u>487377972</u>                       | Document Number                      | Document Number                      |
| Expiration Date (if any)(mm/dd/yyyy)<br><u>11/28/2021</u> | Expiration Date (if any)(mm/dd/yyyy) | Expiration Date (if any)(mm/dd/yyyy) |

|                                      |                        |  |
|--------------------------------------|------------------------|--|
| Document Title                       | Additional Information | QR Code - Sections 2 & 3<br>Do Not Write In This Space |
| Issuing Authority                    |                        |  |
| Document Number                      |                        |  |
| Expiration Date (if any)(mm/dd/yyyy) |                        |  |
| Document Title                       |                        |  |
| Issuing Authority                    |                        |  |
| Document Number                      |                        |  |
| Expiration Date (if any)(mm/dd/yyyy) |                        |  |

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

The employee's first day of employment (mm/dd/yyyy): 09/13/2017 (See instructions for exemptions)

|  |  |  |                          |
|--|--|--|--------------------------|
| Signature of Employer or Authorized Representative<br><u>Andrea Findley</u>                                      | Today's Date(mm/dd/yyyy)<br><u>09/13/2017</u>                        | Title of Employer or Authorized Representative<br><u>Executive Assistant</u>             |                          |
| Last Name of Employer or Authorized Representative<br><u>Findley</u>   | First Name of Employer or Authorized Representative<br><u>Andrea</u> | Employer's Business or Organization Name<br><u>EMPLOYER SOLUTIONS STAFFING GROUP LLC</u> |                          |
| Employer's Business or Organization Address (Street Number and Name)<br><u>7480 FLYING CLOUD DRIVE SUITE 200</u> | City or Town<br><u>MINNEAPOLIS</u>                                   | State<br><u>MN</u>   | ZIP Code<br><u>55344</u> |

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

|                                    |                         |                |  |
|------------------------------------|-------------------------|----------------|--|
| <b>A. New Name (if applicable)</b> |                         |                | <b>B. Date of Rehire (if applicable)</b> |
| Last Name (Family Name)            | First Name (Given Name) | Middle Initial | Date (mm/dd/yyyy)                        |

**C.** If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

|                |                 |                                       |
|----------------|-----------------|---------------------------------------|
| Document Title | Document Number | Expiration Date (if any) (mm/dd/yyyy) |
|----------------|-----------------|---------------------------------------|

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

|  |                           |   |
|--|---------------------------|---|
| Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Name of Employer or Authorized Representative |
|--|---------------------------|---|









SENSITIVE BUT UNCLASSIFIED

**Case Verification Number: 2017256130929YJ**

Report Prepared: 09/13/2017

**Company Information**

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Company ID: 47429

Company Name: Employer Solutions Staffing Group

**Employee Information**

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Last Name: McLaughlin

First Name: Arthur

Date of Birth: 11/06/1957

Social Security Number: \*\*\* \*\* 6596

Hire Date: 09/13/2017

Citizenship Status: A citizen of the United States

**Document Information**

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List A Document: U.S. Passport or Passport Card

Passport or Passport Card Number: 487377972

Document Expiration Date: 11/28/2021

**Case Status Information**

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Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 09/13/2017

Case Submitted By: AFIN3846

Closed On: 09/13/2017

Closed By: AFIN3846

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

SENSITIVE BUT UNCLASSIFIED

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EMPLOYER SOLUTIONS STAFFING GROUP  
BACKGROUND CHECK AUTHORIZATION

Employee Name: ARTHUR R McLaughlin  
(First) (Middle) (Last)

Former Name(s) and Dates Used: \_\_\_\_\_

Current Address Since: 2-2013 127 How St HAVERHILL MA 01831  
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: 1-2009 72 Church St Merrimac MA 01860  
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: \_\_\_\_\_  
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: 020426596 DOB: 11-06-1957

Phone Number: 978-327-1288

Driver's License Number/State: 592452665

The information contained in this application is correct to the best of my knowledge.

I hereby authorize Employer Solutions Staffing Group, LLC and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Employer Solutions Staffing Group, LLC or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Employer Solutions Staffing Group, LLC and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: Arthur R. McLaughlin Date: AUG 31 2017

**Notice to CA, MN, and OK Residents:**  
Please check the box below if you wish to receive a copy of a consumer report that is requested.  
 I wish to receive a copy of any Background Check Report on me that is requested.

|                       |
|-----------------------|
| arthur r mclaughlin   |
|                       |
| 127 how st po box 457 |
| haverhill             |
| mass                  |
| 72 church st merrimac |
|                       |

Para información en español, visite [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) o escriba a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

**A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT**

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

- You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.
- In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) for additional information.
- You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores of distribution scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) for an explanation of dispute procedures.
- Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore).
- You may limit "prescreened" offers of credit and insurance you get based on information in your credit report. Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8686.
- You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- Identity theft victims and active duty military personnel have additional rights. For more information, visit [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore). States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

| TYPE OF BUSINESS  | CONTACT   |
|---|---|
| 1. a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates.   | a. Bureau of Consumer Financial Protection<br>1700 G Street NW<br>Washington, DC 20552  |
| b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau:  | b. Federal Trade Commission: Consumer Response Center – FCRA<br>Washington, DC 20580<br>(877) 382-4357                                  |
| 2. To the extent not included in item 1 above:  |   |
| a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks   | a. Office of the Comptroller of the Currency<br>Customer Assistance Group<br>1301 McKinney Street, Suite 3450<br>Houston, TX 77010-9050 |
| b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act | b. Federal Reserve Consumer Help Center<br>P.O. Box 1200<br>Minneapolis, MN 55480   |
| c. Nonmember insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations   | c. FDIC Consumer Response Center<br>1100 Walnut Street, Box #11<br>Kansas City, MO 64106  |
| d. Federal Credit Unions  | d. National Credit Union Administration   |

## EMERGENCY CONTACT INFORMATION

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

Employee Name: ARTHUR mclaughlin  
 Address: 127 HOW ST HAVERHILL MA 01831 P.O. Box 457  
 Home Phone: 978 327 1288

| EMERGENCY CONTACTS   |  |
|--|--|
| Please list two people (in priority order) who could be contacted in case of an emergency.   |  |
| <p style="text-align: center; margin: 0;"><b>Contact #1</b></p> <p>Name: <u>CATHEY mclaughlin</u></p> <p>Relationship: <u>SISTER</u></p> | <p>Home Phone: <u>978 373 7116</u></p> <p>Cell Phone: <u>978 994 1530</u></p> <p>Work Phone:</p> |
| <p style="text-align: center; margin: 0;"><b>Contact #2</b></p> <p>Name:</p> <p>Relationship:</p>  | <p>Home Phone:</p> <p>Cell Phone:</p> <p>Work Phone:</p>   |

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

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

arthur r mclaughlin  
 127 how st po box 457  
 haverhill  
 mass  
 9783271288  
 978-373-7116  
 cathey mclaughlin



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

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

SECTION 1 BASIC INFORMATION
Employee Name: ARTHUR mCLAUGHLIN
SSN# (last 4 digits): 020 42 6596
Effective Date: AUG 31 2017
SECTION 2 PAYROLL ELECTION
[ ] Direct Deposit
[X] Payroll Debit Card
SECTION 3 DIRECT DEPOSIT
[ ] 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:
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: ARTHUR MI Last Name: mCLAUGHLIN Date of Birth: 11-06-1957
Street Address (no PO BOXES ACCEPTABLE): 5 SALLY SWEET WAY #149 Social Security #: 020-42-6596
City: SALEM State: NH Zip: 03079 Cell Phone (mobile): 978-372-1288
RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)
Payroll Debit Card Routing #: 067011294 Payroll Debit Card Account #: 94 321088 00024192
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: [Signature] Date: AUG 31 2017
SECTION 5 AUTHORIZATION
I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s). \* E-mail is required for pay stub information.
\*E-mail: mCLAUGHLINARTHUR@YAHOO.COM
(this information will only be used to send your paystubs electronically)
Employee's Signature: [Signature] Date: AUG 31 2017

arthur r mclaughlin
6596
Aug 31, 2017
[ ]
[ ]
[ ]
[ ]



Arthur McLaughlin

**Account Information Slip / Volante de Datos de Cuenta**

**Step 1: Complete the following information**

Paso 1: Completa los siguientes datos

First Name / Nombre:

Last Name / Apellido:

Employee ID Number / Número de Empleado:

**Step 2: Remove this slip at the perforation and provide to your employer**

Paso 2: Desprende este volante en el perforado y entrégaselo a tu empleador.

**Note:** You will not need the numbers below once this slip is provided to your employer.

**Nota:** Una vez que hayas entregado este volante a tu empleador, no necesitarás los números que aparecen a continuación.

**For Employer Use Only / Para uso del empleador solamente:**

**ABA Routing Number: / Núm. de ruta ABA:** 067011294

**Account Number: / Núm. de cuenta:** 9432108800024192

**Bienvenido al servicio Money Network®**

Con el servicio Money Network® ("Servicio"), tus fondos de nómina serán automáticamente depositados en una cuenta Money Network ("Cuenta"). Tienes la opción de usar la Tarjeta de pago Money Network Visa ("Tarjeta de pago") adjunta para tener acceso a los fondos de la Cuenta.

Todos tus fondos de nómina están siempre a tu disposición a través de un Cheque Money Network™ ("Cheque"); el uso de la Tarjeta de pago no es obligatorio. Para empezar a recibir tu pago a través de este Servicio, simplemente sigue las instrucciones que se encuentran a continuación.

**¡Empezar es fácil!**

- **Consentimiento.** Lee el *Consentimiento del acuerdo y firma electrónica*, más los Términos y Condiciones adjuntos.
- **Activación.** Sigue las instrucciones de la etiqueta de activación adherida a tu Tarjeta de pago. Recuerda que necesitarás tu PIN para hacer compras de débito con PIN y retiros de cajeros automáticos, y para tener acceso a la Cuenta cuando llames al Servicio al Cliente.
- **Cada día de pago.** Usa la Tarjeta de pago o un Cheque para tener acceso a tus fondos. Lee la Guía del usuario adjunta para aprender a usar tu nuevo Servicio.

**Consentimiento del acuerdo y firma electrónica.**

Reconozco que he leído los *Términos y Condiciones del servicio Money Network®* ("Términos y Condiciones") adjuntos, incluyendo las declaraciones sobre Transferencias electrónicas de fondos, Disponibilidad de fondos y Veracidad en la divulgación de los ahorros, además de la Tabla de cargos y la Tabla de límites de transacciones relacionadas con la Cuenta y el Servicio, y acepto cumplir con sus términos.

Entiendo que el retener, activar o usar la Tarjeta de pago o los Cheques, constituye mi aceptación de los Términos y Condiciones.

Reconozco que cualquier término de los Términos y Condiciones, la Tabla de cargos y la Tabla de límites de transacciones puede cambiar en cualquier momento (y se me notificará dicho cambio si la ley lo exige) y mi retención o el uso de la Cuenta después de la fecha de entrada en vigencia de cualquiera de dichos cambios constituirá mi aceptación de los nuevos términos o cargos.

Para comunicarte con el Servicio al Cliente, llama al:  
**1-800-845-8683**

Visítanos por Internet en:  
**[www.bankofamerica.com/moneynetwork](http://www.bankofamerica.com/moneynetwork)**

**Consulta tu saldo de tres maneras sencillas:**

**Cómo usar los Cheques Money Network™.**





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## **INJURY MANAGEMENT PROGRAM**

### **Injured Worker's Responsibilities**

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

#### **RESPONSIBILITIES OF THE INJURED WORKER:**

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

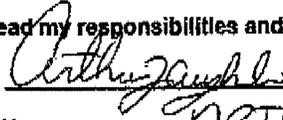
Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

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

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

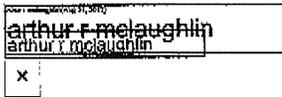
I have read my responsibilities and agree to abide by these guidelines.

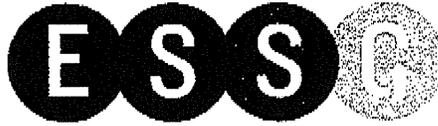
Signed: \_\_\_\_\_



Printed Name: \_\_\_\_\_

ARTHUR R. McLAUGHLIN





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## 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 policia 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):

\_\_\_\_\_

Signature/Firma:

*Arthur R. McLaughlin*

\_\_\_\_\_

arthur r mclaughlin

arthur r mclaughlin

x



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**Acknowledgement of Receipt of Workplace Safety Policy**

I certify that I have received a copy of Employer Solutions Staffing Group's ESSG WORKPLACE SAFETY POLICY. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at 952.835.1288/1.866.496.7573 with any questions I may have about this policy. I agree to comply with ESSG's policy on ESSG WORKPLACE SAFETY POLICY and I understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am believe that I am working in an unsafe or dangerous work environment, I will immediately contact my supervisor, manager, director or ESSG's Safety Director at 952.835.1288/1.866.496.7573 in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

ARTHUR R McLAUGHLIN

Employee's Signature:

Arthur Laughlin Date: AUG 31 2017

arthur r mclaughlin

arthur r mclaughlin  
Aug 31, 2017

x



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- Right to request information about safety and health hazards in the workplace, appropriate precautions to take, and procedures to follow if involved in an accident or exposed to hazardous substances
- Right to gain access to relevant personal exposure and medical records.

You can have your name withheld from the host employer and any other entity, by request, if you sign and file a written complaint. You can request to be advised of OSHA actions regarding a complaint, and request an informal review of any decision not to inspect the site or issue a citation. And, you can file a complaint if you are punished or discriminated against for acting as a "whistleblower" under the OSH Act or 13 other federal statutes for which OSHA has jurisdiction, or for refusing to work when faced with imminent danger of death or serious injury and there is insufficient time for OSHA to inspect. Retaliation or reprisal taken against anyone who has expressed concern about workplace safety is illegal.

If you believe that your right to a safe workplace has been violated, you can make a report to a manager of the host worksite employer and/or ESSG (by telephoning 952.835.1288/1.866.496.7573) and asking for the ESSG Safety Director. You can also contact OSHA directly with any concern. ESSG recognizes the serious nature of ensuring workplace safety will endeavor to protect any employee who may have been subjected to unsafe or hazardous worksite conditions.



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### **ESSG WORKPLACE SAFETY POLICY**

It is ESSG's policy that all employees should be able to enjoy a hazard free and safe work environment. It is ESSG's duty to:

- (1) Ensure that its clients provide you with a workplace free from serious recognized hazards and comply with standards, rules and regulations issued under the OSH Act.
- (2) Ensure that its clients perform a job hazard assessment in order to identify and eliminate potential safety and health hazards and to determine necessary training and protections for employees at the facility.
- (3) Make sure employees have and use safe tools and equipment.
- (4) Establish or update operating procedures and communicate them so that employees follow safety and health requirements.
- (5) Provide safety training in a language and vocabulary workers can understand.

ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

To help ensure a safe workplace, you have certain responsibilities too, which include the following:

- Responsibility to work in compliance with OSHA laws and regulations
- Responsibility to use personal protective equipment and clothing as directed by the host employer
- Responsibility to report workplace hazards and dangers
- Responsibility to work in a manner as required by the employer and use the prescribed safety equipment.

You have the following basic rights:

- Right to refuse unsafe work
- Right to know or be informed about actual and potential dangers in the workplace
- Right to review copies of appropriate standards, rules, regulations and requirements that the host employer is required to have available at the workplace.

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

OMB No. 1545-1500

Information about Form 8850 and its separate instructions is at [www.irs.gov/form8850](http://www.irs.gov/form8850).

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

Your name ARTHUR R McLAUGHLIN Social security number 020-42-6596  
 Street address where you live 127 HOW ST PO BOX 467  
 City or town, state, and ZIP code HAVERHILL MA 01831  
 County ESSEX Telephone number 978 327 1288

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

- 1  Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2  Check here if any of the following statements apply to you.
  - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
  - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
  - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
  - I am at least age 18 but not age 40 or older and I am a member of a family that:
    - a. Received SNAP benefits (food stamps) for the past 6 months; or
    - b. Received SNAP benefits (food stamps) for at least 3 of the past 6 months, but is no longer eligible to receive them.
  - During the past year, I was convicted of a felony or released from prison for a felony.
  - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
  - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3  Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4  Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5  Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6  Check here if you are a member of a family that:
  - Received TANF payments for at least the past 18 months; or
  - Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; or
  - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.
- 7  Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

**Signature—All Applicants Must Sign**

Under penalty 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 Arthur R. McLaughlin  
 For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 22801L

Date AUG 31 2017  
 Form 8850 (Rev. 3-2014)

|                       |
|-----------------------|
| arthur r mclaughlin   |
| 020-42-6596           |
| 127 how st po box 467 |
| haverhill             |
| mass                  |
| essex                 |
| 9783271288            |
| no                    |



EMPLOYER SECTION:

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

EMPLOYEE SECTION:

|                                |                           |             |  |
|--------------------------------|---------------------------|-------------|--|
| First Name: Last Name: Suffix: | Street Address:           | City/State: | Zip:   |
| ARTHUR MCLAUGHLIN              | 127 HOW ST PO BOX 457     | HAVERHILL   | 01831  |
| SS#: 020426596                 | Date of Birth: 11/06/1957 | Age: 59     | Have you worked for this company before? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| If yes, location:              |                           |             |  |

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

Yes No

|   |                          |                                     |
|---|--------------------------|-------------------------------------|
| 1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 3, 1997? (If yes, please provide information below.)<br>Name of the person receiving benefits: _____ Relationship to you: _____<br>City: _____ County: _____ State: _____   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.)<br>Name of the person receiving benefits: _____ Relationship to you: _____<br>City: _____ County: _____ State: _____   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. *If you checked yes please provide a copy of your SSI documentation.  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below:<br><input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program)<br>Name of Agency: _____ Phone #: _____<br>City: _____ County: _____ State: _____<br>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are you a Veteran of the U.S. Military? *If yes, please provide a copy of your DD-214 and letter of separation. (If yes, please provide information below. If no, please continue to question #6.)<br>Dates of Service - From: _____ To: _____<br>Branch of Service: _____<br>Are you entitled to or are you receiving compensation for a service-connected disability?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you been unemployed at any time during the last 12 months?<br>If yes, dates of unemployment - From: _____ To: _____<br>Did you receive unemployment compensation at any point during your unemployment?<br>If yes, in which state did you receive unemployment compensation? _____  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?<br>Conviction Date: _____ Release Date: _____<br>Was this a <input checked="" type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>Additional Tax Credits</b>   |                          |                                     |
| IEC (Native American): Are you or your spouse a member of a Native American Tribe? (If you checked yes please provide a copy of your CDIB card.)  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| CA Residents: <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act?<br><input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?   |                          |                                     |
| SC Residents: <input type="checkbox"/> Do you receive Family Independence Benefits?   |                          |                                     |

PLEASE READ, SIGN, AND DATE:

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

New Employee Signature: Arthur McLaughlin Date: AUG 31 2017

|                       |
|-----------------------|
| arthur r mclaughlin   |
| 127 how st po box 457 |
| haverhill             |
| mass                  |
| 020-42-6596           |
| 11/06/1957            |
| 58                    |





**LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM**  
**Work Opportunity Tax Credit (WOTC) Program**

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

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

New Hire's Signature: Arthur R McLaughlin Date AUG 31 2017

New Hire Name: ARTHUR R McLaughlin

Social Security Number: 6596 - 0000  
(Enter last four digits)

Employer Name: \_\_\_\_\_

Please check the statements below if they apply to you.

I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

I declare that I have been in a period of unemployment since \_\_\_\_\_  
(Enter start date)

**Privacy Act Notice:**  
The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

**Public Burden Statement:**  
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

ETA Form 9175 (Rev. November 2016)

Signature: Arthur R McLaughlin  
Date: AUG 31 2017  
Signature: Arthur R McLaughlin  
SSN: 6596  
\_\_\_\_\_  
\_\_\_\_\_

## Employee Keeps This Form

# Healthcare Notice of Exchange

As your employer, we are required to provide you with the following information under Section 1512 of the Affordable Care Act:

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.<sup>1</sup>

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

\*\*\*The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area\*\*\*

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information:

| Employer Name:<br>Employer Solutions Staffing Group, LLC     |  | Employer FEIN:<br>20-8084369                           |                                   |   |   |
|--|--|--|-----------------------------------|---|---|
| Employer Address:<br>PO Box 46270 Minneapolis, MN 55344-9956 |  | Phone Number for Health Benefits Team:<br>952-767-9519 |                                   |   |   |
| Insurance Plans Available:                                   | Who is Eligible?                                       | Meets Minimum Value Standard?                          | Meets Minimum Essential Coverage? | When is it effective?                       | Will I be penalized if I only have this plan? |
| Fixed Indemnity Plan   | Everyone   | No   | No                                | Available immediately—offered upon hire     | Yes   |
| MEC Plan   | Everyone   | No   | Yes                               | Available immediately—offered upon hire     | No  |
| Major Medical Plan   | Full time employees after 120 hours are met in 30 days | Yes  | Yes                               | Within 60 days of being determined eligible | No  |

For more information about ESSG's Insurance options, contact:

The Health Benefits Team  
Employer Solutions Staffing Group  
952-767-9519 | [health@employersolutionsgroup.com](mailto:health@employersolutionsgroup.com)

ESSG\_ParticipatingLocations\_REV\_12.2014

# Employee Keeps This Form

**NOTICE: ESSG Electronic Pay Stubs**

## ATTENTION

**ESSG provides employees with electronic pay stubs. You are able to view your pay stub by using either of the following methods:**

1. You can view your check stub by logging into the employee portal at [www.MyPayESG.com](http://www.MyPayESG.com)

Your username is the first four letters of your last name followed by the last four numbers of your SSN. The log-in is case sensitive, so be sure that you capitalize the first letter of your last name.

*For example: John Woods SSN: 111-22-3333 would have a username of Wood3333*

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. For support please email [MyPayESG@MyPayESG.com](mailto:MyPayESG@MyPayESG.com)

2. You can also receive your check stub by email by providing us with your email address on page 1 of this packet.
  - \*\* Your check stub will come from payroll@MyPayESG.com, be sure to check spam folder.

## Empleado Toma Copiar

## ATENCIÓN

**ESSG proporciona a los empleados con los talones de pago electrónicos. Usted puede examinar su talon de pago utilizando cualquiera de los métodos siguientes:**

1. Usted puede ver su talón de cheque por la tala en el portal electrónico del empleados en [www.MyPayESG.com](http://www.MyPayESG.com)

Su nombre de usuario son las cuatro primeras letras de su apellido seguido por los cuatro últimos dígitos de su número de seguro social.

*El portal es caso delicado, asegúrese de que la primera letra de su apellido sea mayúscula.*

*Por ejemplo: Juan Garcia SSN: 111-22-3333 tendría un nombre de usuario de Garc3333*

Su contraseña inicialmente será Temp1234, y usted será dirigido a cambiarla la primera vez que inicie sesión. Asegúrese de anotar y guardar su información de registro en un lugar seguro. para apoyar email: [MyPayESG@MyPayESG.com](mailto:MyPayESG@MyPayESG.com)

2. También puede recibir su talón de cheque por correo electrónico , al proveir su correo electronico en la **pagina 1** de este paquete
  - \*\* Su talón de cheque vienen de payroll@MyPayESG.com, asegúrate de revisar la carpeta de spam

Next

21 / 21

## Employee Acknowledgement Form (Temps)

Note: Synovos Employee Acknowledgement is attached to their Learning Center training requirement. See documentation requirements below.

I hereby acknowledge receipt of Synovos "Employee Safety Handbook" which outlines important safety requirements and information for working as safety as possible. I agree to follow the safety and health rules as outlined in this handbook. I further understand that complete safety and health program requirements are published in the "Safety Manual" that can be obtained through my Site Manager or Project Leader.

*Arthur McLaughlin*

Arthur McLaughlin (Aug 31, 2017)

Aug 31, 2017

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Employee Signature

Date

---

Employer's Representative

Date

**Important:** This receipt must be read, understood and signed by all Synovos permanent and temporary employees. Temporary employees sign this hard-copy form. Permanent employees must document their training in the Synovos Learning Center by taking the associated quiz.

**Documentation Instructions:**

**Permanent Employees:** The Synovos Site Manager, or senior Synovos employee, will ensure all personnel have read and understand the contents of this document. Please contact the Senior Director of Safety and Quality [safety@synovos.com](mailto:safety@synovos.com) if you have any questions. The employee must take the Employee Safety Handbook Quiz contained in the Synovos Learning Center.

**Temporary/Project Employees:** The project leader or hiring manager will ensure all personnel have read and understand the contents of this document. Please contact the Senior Director of Safety and Quality [safety@synovos.com](mailto:safety@synovos.com) if you have any questions. The employee and leader or manager will sign this form file it on site. This form is a special interest item during implementation audits.

**Employees:** Please retain the handbook for future reference.

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

\_\_\_\_\_, or any of its subsidiaries may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" conducted by a consumer reporting agency which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history (State and Federal records), social security verification, address trace, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any report conducted by a consumer reporting agency. Please be advised NationSearch.com, LLC (NationSearch)—11184 Huron St. Suite 13; Northglenn, CO 80234; (800)-827-9550—will be the consumer reporting agency conducting the background investigation. The scope of this notice and authorization is all encompassing, however, allowing the Company to obtain from any outside organization all manners of consumer reporting now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any report conducted by a consumer reporting agency.

ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, credit reporting agency, employer, to provide any and all background information requested by NationSearch.com, LLC—11184 Huron St. Suite 13; Northglenn, CO 80234 (800)-827-9550—another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

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

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

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

**Minnesota and Oklahoma applicants or employees only:** Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company

|  |  |   |
|--|--|---|
| Last Name:<br>mclaughlin   | First Name:<br>arthur                      | Middle Name:<br>r   |
| Other Names Used:  | SSN:<br>020-42-6596                        | Date of Birth:<br>(For Employment Purposes Only) 11/06/1957 |
| Motor Vehicle Number & State of Issue:<br>(Driver's License Number)<br>s92452655 | Current Address:<br>127 how st p o box 457 |   |

Signature: arthur mclaughlin Date: Aug 31, 2017  
arthur mclaughlin (Aug 31, 2017)

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

am

# DRUG AND ALCOHOL TESTING POLICY

## I. PURPOSE

Alcohol and drug abuse adversely affects job performance, the kind of work an employee performs and an employee's opportunities for successful employment. It is the intent of this document to provide employees with ESSG's [hereafter "the Company"] policy regarding the use of drugs and alcohol while at work. The Company does not intend to intrude into the private lives of its employees, but strongly believes that a drug-free workplace is in the best interest of employees and non-employees alike.

## II. SCOPE

This policy applies to all applicants for employment and to all employees including contract or temporary employees. The policy is applicable at Company facilities or whenever Company employees are performing company business.

## III. DISCLAIMER

Employment at the Company is at-will. This policy is not a unilateral employment contract and should not be interpreted as creating a unilateral employment contract.

## IV. PROHIBITIONS

A. No employee shall report to work under the influence of alcohol, any controlled substances, or any other drugs or medications that may affect the employee's alertness, coordination, reaction, response, judgment, decision-making, or safety.

B. No employee shall operate, use, or drive any equipment, machinery, or vehicle of the Company or any client of Company while under the influence of alcohol, any controlled substances, or any other drugs or medications that may adversely affect the employee's ability to operate such equipment, machinery, or vehicle. Employees are under an affirmative duty to immediately notify their supervisor if they are not in an appropriate mental or physical condition to operate, use, or drive any equipment machinery, or vehicle or otherwise safely perform their job duties.

C. No employee shall unlawfully manufacture, distribute, dispense, possess, transfer, or use a controlled substance in the workplace or wherever the Company's work is being performed.

D. Engaging in off-duty sale, purchase, transfer, use or possession of illegal drugs or controlled substances may have a negative effect on an employee's ability to perform his/her work for the Company. In such circumstances, the employee is subject to discipline.

E. When an employee is taking medically authorized drugs or other substances that may alter job performance, the employee is under an affirmative duty to notify their supervisor of the temporary inability to perform his or her job duties.

F. The Company shall notify the appropriate law enforcement agency, licensing boards, and other relevant authorities when it has reasonable suspicion to believe that an employee may have illegal drugs in his or her possession at work or on company premises.

G. Employees shall not consume alcoholic beverages during lunch periods, dinner periods, or breaks when returning immediately thereafter to perform work on behalf of the Company. In situations where the employee conducts the Company's business after the intake of alcohol, the employee shall be subject to discipline up to and including discharge.

## V. ALCOHOL AND DRUG TESTING

As part of the Company's commitment to an alcohol and drug-free workplace, the Company reserves the right to require that applicants and employees submit to drug or alcohol testing in accordance with the provisions of applicable law. This policy represents the notice required under applicable law and a copy will be provided to all applicants and employees who are requested to undergo testing. In the event of any conflict between this policy and applicable law in effect at the time of the test, the law will control.

### A. Who May be Subject to Testing.

1. Job Applicants. The Company may require that all applicants for a particular position be tested for drugs or alcohol after receiving a conditional offer of employment. If the applicant tests positive for drugs or alcohol, the conditional offer may be withdrawn.

2. Routine Physical Examination Testing. The Company may require employees to undergo a drug or alcohol test once a year as part of a routine physical examination. Affected employees will be given two weeks written notice that they will be tested for drugs or alcohol as part of a routine physical.

3. Random Testing. The Company may require employees in safety-sensitive positions to undergo testing on a random selection basis. Once the random selection has been made, the Company will not waive the selection of any employees identified through the random process.

4. Reasonable Suspicion Testing. The Company may require an employee to undergo drug or alcohol testing if the Company reasonably suspects that the employee:

- a. is under the influence of drugs or alcohol;
- b. has violated the Company's written work rules prohibiting drug and alcohol use;
- c. has sustained or caused another employee to sustain personal injury; or
- d. has caused a work-related accident or was operating or helping to operate machinery, equipment or vehicles involved in a work-related accident.

5. Treatment Program Testing. The Company may require an employee who has been referred for chemical dependency treatment or evaluation or is participating in a treatment program under an employee benefit plan to undergo drug or alcohol testing on a random basis and without advance notice during the evaluation or treatment period and for up to two years following the completion of any treatment program.

**B. Conducting the Testing.**

1. Consent. All employees required to undergo testing will be required to complete and sign the employee consent form attached as Appendix A.

2. Refusal to Participate. An employee or job applicant has the right to refuse testing. However, a refusal of testing will be treated as a failure to comply with Company policy and may result in withdrawal of a job offer or disciplinary action up to and including termination of employment.

3. The Laboratory. The Company will use a laboratory certified by the National Institute on Drug Abuse (NIDA) or its successor, the College of American Pathologists (CAP), or the New York State Department of Health or other licensing body recognized by applicable law to perform all drug and alcohol tests.

4. Test Results.

The laboratory will conduct both an initial test and a confirmatory test if the initial test is positive. A negative result on either the initial or confirmatory test will be deemed a negative test result (i.e. the employee passed the test). A positive result on both the initial and confirmatory test will be deemed a positive test result (i.e. the employee failed the test.)

a. Negative Test Result. An employee or applicant who tests negative for drugs or alcohol will be given written notice that they passed the test within three working days of the Company receiving the test results from the testing laboratory.

b. Positive Test Result. An employee or applicant who tests positive for drugs or alcohol will be given written notice that they have failed the test within three working days of the Company receiving the test results from the testing laboratory. The employee or applicant will then be given the opportunity to provide any information to explain the positive result, including any over-the-counter or prescription medications the employee or applicant may have taken. An employee or applicant who wishes to submit any explanatory information must do so within three working days after being notified of the positive test result.

An employee or applicant who has a positive test result may also request a retest of the original sample by the same or different certified laboratory at his or her own expense. An employee or applicant who wishes to conduct a retest must notify the Company in writing of their intention to conduct such a retest within five working days after being notified of the positive test result. If the results of the retest are negative, the test will be considered a negative test result.

c. Right to Test Result. An employee or job applicant has the right to request and receive from the Company a copy of the test result report on any drug or alcohol test.

**C. Costs.** All costs related to alcohol and drug testing will be paid by the Company, with the exception of any retests requested by the employee or applicant following a positive test result.

**D. Disciplinary Action in Response to a Positive Test Result.**

1. Interim Discipline and Action: The Company reserves the right to temporarily suspend an employee or transfer the employee to another position at the same rate of pay pending the outcome of any drug or alcohol test. An employee who is suspended without pay will be reinstated with back pay if the test or any requested retest is negative.

2. Applicants. The Company reserves the right to withdraw the conditional job offer of any job applicant with a positive test result, without the opportunity to complete evaluation or treatment.

3. Employees - First Positive Test Result - Termination: The Company will not discharge an employee for the first positive test result. Instead the employee will be given the opportunity to participate in an appropriate drug or alcohol counseling or rehabilitation program as determined by a certified chemical use counselor or physician trained in the diagnosis and treatment of chemical dependency chosen by the Company. The employee will be responsible for paying all costs associated with any evaluation and subsequent treatment themselves or pursuant to coverage under an employee benefit plan. An employee who refuses or fails to participate in, cooperate with, or complete the evaluation or recommended treatment may be terminated. An employee who successfully completes treatment may be subject to random follow-up testing for a period of up to two years in accordance with section V.A.5. of this policy.

4. Employees - First Positive Test Result—Discipline: The Company reserves the right to take any other disciplinary action short of discharge it deems warranted following a first positive test result.

5. Employees-Subsequent Positive Test Result: An employee who has more than one positive test result may be terminated immediately following any second or subsequent positive test result without referral to or the opportunity to complete additional chemical dependency counseling or rehabilitation.

**E. Privacy of Test Results.**

1. Test results and other information acquired as a result of the testing program are private and confidential information and will not be disclosed by the Company or the testing laboratory to another employee or to third party individuals, government agencies, or private organizations without written consent of the employee or applicant being tested.

2. Evidence of a positive test result, however, may be used in an arbitration proceeding pursuant to a collective bargaining agreement, an administrative hearing, or a judicial proceeding, provided the information is relevant to the hearing or proceeding. Such evidence may also be disclosed to any federal agency or other unit of the United States government as required under federal law, regulation, or order. Evidence of a positive test result may also be disclosed to a substance abuse treatment facility for the purpose of evaluation or treatment.

3. The Company will provide an employee with access to information in the employee's file relating to positive test result reports and other information acquired in the testing process as well as conclusions drawn from or actions taken based upon such information.

**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

arthur mclaughlin  
arthur mclaughlin (Aug 31, 2017)

\_\_\_\_\_  
Individual's Name

Aug 31, 2017

\_\_\_\_\_  
Date







FORM  
M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 1/12



Print full name arthur r mclaughlin  
Print home address 127 how st, p o box 457

Social Security no. 020-42-6596  
City haverhill State mass Zip 01831

Employee:

File this form or Form W-4 with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" .....
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C.....
3. Write the number of your qualified dependents. See Instruction D.....
4. Add the number of exemptions which you have claimed above and write the total.....
5. Additional withholding per pay period under agreement with employer \$ \_\_\_\_\_
  - A.  Check if you will file as head of household on your tax return.
  - B.  Check if you are blind.
  - C.  Check if spouse is blind and not subject to withholding.
  - D.  Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed \$8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date Aug 31, 2017 Signed Arthur R. McLaughlin

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

**A. Number.** If you claim more than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

**B. Changes.** You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

**C. Spouse.** If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a wife or husband, write "4" in line 2. Using "4" is the withholding system adjustment for the \$4,400 exemption for a spouse.

**D. Dependent(s).** You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

IF THE ALLOWABLE MASSACHUSETTS WITHHOLDING EXEMPTIONS ARE THE SAME AS YOU ARE CLAIMING FOR U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.



employer solutions staffing group.

Leveraging Resources in a Changing Market

**Notification of Massachusetts Law Requirement –  
Unemployment Acknowledgement**

*According to Massachusetts Code section 25—* A temporary employee of a temporary help firm shall be deemed to have voluntarily quit employment if the employee does not contact the temporary help firm for reassignment before filing for benefits and the unemployment benefits may be denied for failure to do so. Failure to contact the temporary help firm shall not be deemed a voluntary quitting unless the claimant has been advised of the obligation in writing to contact the firm upon completion of an assignment.

It is your responsibility to contact ESSG through **Corporate Management Group** (for instance by calling **303-920-1425**) for additional assignments. If you fail to do so, it may affect your reemployment assistance benefits.

I understand by signing this form that I am responsible to contact ESSG for additional assignments. I also acknowledge that I have received a separate copy of this form. am (Initial)

arthur r mclaughlin  
arthur r mclaughlin (Aug 31, 2017)

Employee Signature:

Aug 31, 2017

Date:

arthur r mclaughlin

Employee (please print your name here)

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

# Massachusetts Tax Form

Adobe Sign Document History

08/31/2017



|                 |  |
|-----------------|--|
| Created:        | 08/31/2017                                   |
| By:             | Jamie Ready (jamie@corpmgmtgroup.com)        |
| Status:         | Signed                                       |
| Transaction ID: | CBJCHBCAABAA9T4JEcO99A3srQ1PTNcxxqySfuCPC6wn |

## "Massachusetts Tax Form" History

-  Document created by Jamie Ready (jamie@corpmgmtgroup.com)  
08/31/2017 - 9:35:32 AM MDT- IP address: 96.93.208.65
-  Document emailed to arthur r mclaughlin (mclaughlinarthur@yahoo.com) for signature  
08/31/2017 - 9:35:42 AM MDT
-  Document viewed by arthur r mclaughlin (mclaughlinarthur@yahoo.com)  
08/31/2017 - 11:06:22 AM MDT- IP address: 73.149.212.95
-  Document e-signed by arthur r mclaughlin (mclaughlinarthur@yahoo.com)  
Signature Date: 08/31/2017 - 11:12:15 AM MDT - Time Source: server- IP address: 73.149.212.95
-  Signed document emailed to Jamie Ready (jamie@corpmgmtgroup.com) and arthur r mclaughlin (mclaughlinarthur@yahoo.com)  
08/31/2017 - 11:12:15 AM MDT



## Two great plans to choose from!

SIGN UP IS AVAILABLE DURING YOUR  
FIRST 30 DAYS OF EMPLOYMENT

### Enhanced MEC Wellness\_Plan 1

- MEC Wellness/Preventive Plans starting at \$24.00/week
- Covers 63 mandated benefits AND \$20 Office Visit Co-Pay, \$10 Generic Prescription Drug Co-pay, \$10 CVS Minute Clinic co-pay and more!
- Eliminates employee Individual mandate tax for those enrolled
- Options for family coverage
- Weekly payroll deduction – month by month coverage
- Visit [www.essghealth.com](http://www.essghealth.com) for info and tools
- PHCS Network

### Fixed Indemnity Plan\_Plan 2

- ESC Fixed Indemnity plans starting at \$20.25 per weekly payroll deduction
- Medical, Rx, Vision, and Dental Benefits
- Doctor Office Visit Benefit of \$100 per day
- Wellness Benefit of \$100
- No pre-existing condition limitations
- No waiting period or deductibles on medical
- First Health Network
- Unbundled choices-you do not need to have Medical to choose the Vision, Dental, Term Life, or Short Term Disability

ESSG offers a **Enhanced Minimum Essential Coverage (Plan 1)** which is administrated by Benefit Plan Administrators (BPA). The Minimum Essential Coverage (MEC) plan is ACA qualifying. There are co-pays for services like doctor's visits, x-rays, and generic prescription drugs. Please note - hospitalization is **not** a covered benefit.

ESSG offers a **Fixed Indemnity Plan (Plan 2)** which is administrated by Planned Administrators Inc. (PAI). The Fixed Indemnity Plan offers limited benefits at an affordable price, specifically for the Staffing Industry. Premiums will be automatically deducted from your weekly paycheck. This means you are buying it with pre-tax dollars. What does pre-tax dollars mean? It simply means the premium comes out before taxes are taken out, which means you're taxed on less income. Affordable medical, dental, disability, and life insurance benefits are available.

You have **30 days** from the start of your employment to change your benefit elections.

The 3rd plan is offered to only qualifying employees\*. It's a **Major Medical Plan** by Blue Cross Blue Shield. Once you qualify, you will be notified by ESSG that you are eligible, and will be given the opportunity to enroll. You should receive this after you have been on assignment for approximately 35 - 45 days. These are sent out by email from [health@employersolutionsgroup.com](mailto:health@employersolutionsgroup.com), or by mail if no email address is available. It is your responsibility to keep an updated email address with your employer. This plan is also ACA qualifying.

If you have any questions, please contact the Health Benefits Team at Employer Solutions Staffing Group.

**\*An employee will be deemed qualifying any time after 30 days on assignment (s) , and their status is working 30+ hours per week or more than 1560 total hours in a calendar year. They must be ESSG employees.\***

---

Health Benefits Team  
Employer Solutions Staffing Group  
7301 Ohms Lane Suite 405 Edina, MN 55439  
Phone: 952-767-9519 | Fax: 952-767-9515  
[health@employersolutionsgroup.com](mailto:health@employersolutionsgroup.com)  
<http://ESSGHealth.com>



## Enhanced MEC Plan\_Plan 1

### Summary of Benefits

| Benefits   | Enhanced MEC Plan   |
|--|---|
| <u>Note that this list will be updated from time to time and a current list of covered preventative services is available at all times by visiting <a href="http://www.HealthCare.gov/center/regulations/prevention.html">www.HealthCare.gov/center/regulations/prevention.html</a>.</u> |   |
| PPO Network  | PHCS<br>In Network Only   |
| Deductible   | N/A   |
| Coinsurance  | N/A   |
| Out of Pocket  | N/A   |
| 15 Preventive Services for Adults  | 100% Coverage for Preventative Care Services  |
| 22 Preventive Services for Women   |   |
| 26 Covered Preventive Services for Children  |   |
| Telephonic Primary Care Services   | 100%  |
| Office Visit Primary Care Physician  | \$20 Copay  |
| Office Visit Specialist  | \$50 Copay  |
| Diagnostic X-ray and Lab (in office)   | \$60 Copay  |
| · Cat-Scan/MRI or outpatient testing   | \$200 Copay   |
| Emergency Room   | not covered   |
| Urgent Care  | \$50 Copay  |
| Durable Medical Equipment  | \$50 Copay  |
| Psychiatric/Substance Abuse Office Visit   | not covered   |
| CVS Minute Clinic  | \$10 Copay for all Services   |
| Prescription Generic   | \$10 Copay Generic Only<br>100% Copay on Brand Name Drugs<br>Mail Order Not Covered |
| Prescription Preferred Brand Drugs   |   |
| Prescription Non-Preferred Brand Drugs   |   |
| Mail Order Copays  |   |
| <b>WEEKLY PREMIUM</b>  |   |
| Single Premium   | <b>\$ 24.00</b>   |
| Employee Spouse  | <b>\$ 38.00</b>   |
| Employee Child/Children  | <b>\$ 36.00</b>   |
| Family Premium   | <b>\$ 63.00</b>   |

**What is Not Covered: \*\*\*This is only a Summary of Benefits and Exclusions\*\*\***

- Hospital inpatient services are not covered by the plan.
- Mental Health unless covered by the MEC
- Rehabilitative Speech Therapy, Occupational and Physical Therapy
- Skilled Nursing
- Specialty Drugs
- Transplants

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