



# New Hire Application

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

Last Name Yei First Name Bee  
 Street Address 588 Reaney Ave  
 City/State/Zip St. Paul MN, 55130  
 Phone Number 651-242-4899 Email Address \_\_\_\_\_  
 Staffing Agency/Recruitment Partner \_\_\_\_\_

**All offers of employment are conditional upon satisfactory proof of identity and legal ability**

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 contain qualifications for employment. I authorize ESSG to make inquiries of my former employers, except a 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 employment. This may include but is not limited to, investigations of criminal and/or conviction records, driving records 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.

I certify that all statements made in my application are true and accurate and that I have not omitted any false or misleading information. I understand that any material omission or misrepresentation will result in my termination for 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.

Bee Yei Name (Print or type) Bee Yei Applicant's Signature

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

For ESSG Office Use Only			
DOH _____	NHW _____	I-9 _____	8850 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment (If applicable) _____
For ESSG Client Use			
DOH _____	ROP _____	Work Site Loc. _____	

# Form W-4 (2014)

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

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

**Exceptions.** An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

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

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

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

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

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## Personal Allowances Worksheet (Keep for your records)

- A** Enter "1" for yourself if no one else can claim you as a dependent . . . . .
- B** Enter "1" if: {
- You are single and have only one job; or
  - You are married, have only one job, and your spouse does not work; or
  - Your wages from a second job or your spouse's wages (or the total of both) are \$
- C** Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .
- D** Enter number of dependents (other than your spouse or yourself) you will claim on your tax return
- E** Enter "1" if you will file as head of household on your tax return (see conditions under Head of h
- F** Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expense
- G** **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more i
- If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child have three to six eligible children or less "2" if you have seven or more eligible children.
  - If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for
- H** Add lines A through G and enter total here. (Note. This may be different from the number of exemptions yo
- For accuracy, complete all worksheets that apply. {
- If you plan to itemize or claim adjustments to income and want to reduce your and Adjustments Worksheet on page 2.
  - If you are single and have more than one job or are married and you and yo earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners avoid having too little tax withheld.
  - If neither of the above situations applies, stop here and enter the number from li

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

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b> Whether you are entitled to claim a certain number of allowances or exemption from subject to review by the IRS. Your employer may be required to send a copy of this fo	
<b>1</b> Your first name and middle initial Bee		Last name Yee	
Home address (number and street or rural route) 568 Reaney Ave Apt 1		<b>3</b> <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Note. If married, but legally separated, o	
City or town, state, and ZIP code St. Paul, MN, 55130		<b>4</b> If your last name differs from t check here. You must call 1-8	
<b>5</b> Total number of allowances you are claiming (from line H above or from the applicable workshe			
<b>6</b> Additional amount, if any, you want withheld from each paycheck			
<b>7</b> I claim exemption from withholding for 2014, and I certify that I meet both of the following conc			
<ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liabi</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax</li> </ul> If you meet both conditions, write "Exempt" here			
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge an			
<b>Employee's signature</b> (This form is not valid unless you sign it.) ▶ Bee		<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	
		<b>9</b> Office code (optio	



# Employment Eligibility Verification

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

**▶ START HERE.** Read instructions carefully before completing this form. The instructions must be a **ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Err document(s) they will accept from an employee. The refusal to hire an individual because the docume expiration date may also constitute illegal discrimination.

## Section 1. Employee Information and Attestation *(Employees must complete and s than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name) <i>yei</i>		First Name (Given Name) <i>Bee</i>		Middle Initial	Other
Address (Street Number and Name) <i>588 Reaney Ave</i>			Apt. Number	City or Town <i>St. Paul</i>	
Date of Birth (mm/dd/yyyy) <i>01-20-1989</i>	U.S. Social Security Number <i>764-19-4403</i>		E-mail Address		

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

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

- A citizen of the United States
- A noncitizen national of the United States *(See instructions)*
- A lawful permanent resident (Alien Registration Number/USCIS Number): *212-390-*
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_ . Som *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Fo*

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

**OR**

2. Form I-94 Admission Number: \_\_\_\_\_

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

Foreign Passport Number: \_\_\_\_\_

Country of Issuance: \_\_\_\_\_

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance field

Signature of Employee: <i>Bee yei</i>	Date
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## Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prep employee.)*

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

Signature of Preparer or Translator:	
Last Name (Family Name)	First Name (Given Name)
Address (Street Number and Name)	City or Town



*Employer Completes Next Page*





### 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 must physically examine one document from List A OR examine a combination of one document from List B and the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the issuing authority, document number, and expiration date, if any.)

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

List A Identity and Employment Authorization	OR	List B Identity	AND
Document Title:		Document Title: <u>Instruction Permit.</u>	Docum
Issuing Authority:		Issuing Authority: <u>State of MN.</u>	Issuing
Document Number:		Document Number: <u>5080 173839 308</u>	Docum
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy): <u>9/30/2016</u>	Expira
Document Title:			
Issuing Authority:			
Document Number:			
Expiration Date (if any)(mm/dd/yyyy):			
Document Title:			
Issuing Authority:			
Document Number:			
Expiration Date (if any)(mm/dd/yyyy):			

### Certification

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

The employee's first day of employment (mm/dd/yyyy): 12/18/14 (See instruction)

Signature of Employer or Authorized Representative 		Date (mm/dd/yyyy) <u>12/8/14</u>	Title of Employer <u>Acen</u>
Last Name (Family Name) <u>Armas</u>	First Name (Given Name) <u>Maby</u>	Employer's Business or Organization Name <b>EMPLOYER SOLUTIONS</b>	
Employer's Business or Organization Address (Street Number and Name) <u>7301 OHMS LANE SUITE 405</u>		City or Town <b>EDINA</b>	

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

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial	B. C
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C. If employee's previous grant of employment authorization has expired, provide the information for the document presented that establishes current employment authorization in the space provided below.

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

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer:
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**DISCLOSURE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING]**

**DISCLOSURE REGARDING BACKGROUND INVESTIGATION**

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes through a consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" of various character, general reputation, personal characteristics, and/or mode of living, and that can involve personal information from neighbors, friends, or associates. These reports may contain information regarding your credit history, credit verification, motor vehicle records ("driving records"), verification of your education or employment history. Information will only be requested where such information is substantially related to the duties and responsibilities of the position you are applying for. You have the right, upon written request made within a reasonable time, to request whether a consumer report was compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of the report. You are advised that the nature and scope of the most common form of investigative consumer report obtained through a consumer reporting agency is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING's website is at [www.orangetreescreening.com](http://www.orangetreescreening.com), or another outside organization. The scope of this notice is limited to the information described above, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and information throughout the course of your employment to the extent permitted by law. As a result, you should carefully review this notice and your right to request disclosure of the nature and scope of any investigative consumer report.

<b>New York and Maine applicants or employees only:</b> You have the right to inspect and receive a copy of any investigative consumer report by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.
<b>New York applicants or employees only:</b> Upon request, you will be informed whether or not a consumer report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you agree to be bound by Article 23-A of the New York Correction Law.
<b>Oregon applicants or employees only:</b> Information describing your rights under federal and Oregon law regarding consumer information and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained security of your information.
<b>Washington State applicants or employees only:</b> You also have the right to request from the consumer reporting agency a written copy of the report and remedies under the Washington Fair Credit Reporting Act.

**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF THE CONSUMER REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and through the end of my employment. At this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or local government, university (public or private), information service bureau, company, or insurance company to furnish any information to Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777. ORANGE TREE EMPLOYMENT SCREENING's website is at: [www.orangetreescreening.com](http://www.orangetreescreening.com), another outside organization or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be deemed to be a true and correct copy of this document.

**New York applicants or employees only:** By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.  
**Minnesota and Oklahoma applicants or employees only:** Please check this box if you would like to receive a copy of a consumer report.

(Must include email address: \_\_\_\_\_)

Signature: Beejee

**BACKGROUND INFORMATION**

Last Name: Yes First: Bee

Other Names/Alias: \_\_\_\_\_

Social Security #: 764-19-4403 Date of Birth (mm/dd/yyyy)\*: 0

Driver's License #: J080173839308 State of Driver's License: \_\_\_\_\_

Present Address: 588 Beamey Ave Apt 1 Telephone # (Primary): \_\_\_\_\_

City/State/Zip: St. Paul, MN, 55130

\*This information will be used for background screening purposes only and will not be shared with any other agency.

# EMERGENCY CONTACT INFORMATION

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

Employee Name: Bee Yei

Address: 588 Reaney Ave # APT 1

Home Phone: 651-242-4895

### EMERGENCY CONTACTS

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

Contact #1	
Name: <u>Thomas Ritvorakun</u>	Home Phone:
Relationship:	Cell Phone: <u>651.9</u>
	Work Phone: <u>651.</u>
Contact #2	
Name:	Home Phone:
Relationship:	Cell Phone:
	Work Phone:

Additional information you want Employer Solutions Staffing Group and our client to know in case of an emergency:

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# employer solutions staff

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## STATEMENT OF CONFIDENTIALITY

This agreement made this 8 day of December  
Employer Solutions Staffing Group LLC, hereinafter referred  
and Bee Gee hereafter referred to as "employee"

### **WITNESSETH:**

For the duration of my employment and after resignation  
this employment with employer, for any reason whatsoever,  
not use or disclose to any other person or company,  
proprietary information or know-how related to the business of

In view of the difficulty of determining the amount of damages  
result to the employer from a violation of any of the provisions of this  
employee agrees to pay to the employer the sum of \$100,000  
damages for every such violation; provided, however, that the  
amount as liquidated damages shall not be construed as a waiver of  
the employer of the right to prevent any such violation in equity

Bee Gee  
\_\_\_\_\_  
Employee Signature

[Handwritten Signature]  
\_\_\_\_\_  
Employer Solutions Staffing Group LLC, Representative



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## Important/Importante

### LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail*), you must notify your staffing recruiter that the check cannot be found. Once 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 issue the check. Once you have done so, you must provide a copy of the 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, 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 con un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo antes de que podamos volver a emitir el cheque. Una vez hecho esto, 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 no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde):

Bee See

Signature/Firma:

Bee See

# Pre-Screening Notice and Certification Requirement for the Work Opportunity Credit

▶ See separate instructions.

**Job applicant: Fill in the lines below and check any boxes that apply. Complete all sections.**

Your name Bee yee Social security number \_\_\_\_\_

Street address where you live 588 Reaney Ave Apt 1

City or town, state, and ZIP code St. Paul, MN, 55130

County Ramsey Telephone number \_\_\_\_\_

If you are under age 40, enter your date of birth (month, day, year) 01-20-1989

- 1  Check here if you received a conditional certification from the state workforce 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 at least 18 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 program, or the Department of Veterans Affairs.
  - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
    - a Received SNAP benefits (food stamps) for the past 6 months, **or**
    - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but is not** eligible for SNAP benefits for the past 6 months.
  - 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 year.
  - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks during the past year.
  
- 3  Check here if you are a veteran and you were unemployed for a period or periods totaling at least 12 weeks during the past year.
  
- 4  Check here if you are a veteran entitled to compensation for a service-connected disability and you were 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 released from active duty in the U.S. Armed Forces 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 that ended after August 5, 1997, ended during the past 2 years, **or**
  - Stopped being eligible for TANF payments during the past 2 years because federal TANF payments could not be made.

**Signature — All Applicants Must Sign**

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

Job applicant's signature ▶ Bee yee

**EMPLOYER SECTION:**

<b>ESG FEIN#:</b>	<b>ESG Client Name &amp; State:</b>
<b>Hiring Manager:</b>	<b>Position:</b>

**EMPLOYEE SECTION:**

<b>Employee Name:</b> Bee Yee	<b>Street Address:</b> 588 Reaney Ave Apt - 1	<b>City:</b> St
<b>SS#:</b> - -	<b>Date of Birth:</b> 01 / 20 / 1989	<b>Age:</b> 27
<b>Have you worked for this company before?</b>		<b>If yo</b>
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

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

**1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?** (If yes, please provide information below.)  
 Name of the person receiving benefits: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

**2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 12 months?** (If yes, please provide information below.)  
 Name of the person receiving benefits: Bee Yee Relationship to you: \_\_\_\_\_  
 City: St. Paul County: Ramsey State: MN

**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.

**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.  
 Vocational Rehabilitation Agency  Dept. of Veterans Affairs  Employment Network (TANF)  
 Name of Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_  
 \*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.

**5. Are you a Veteran of the U.S. Military?** \*If yes, please provide a copy of your DD-214 and letter of release.  
 (If yes, please provide information below. If no, please continue to question #6.)  
 Dates of Service - From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Branch of Service: \_\_\_\_\_  
**Are you entitled to or are you receiving compensation for a service-connected disability?**  
**Have you been unemployed at any time during the last 12 months?**  
 If yes, dates of unemployment - From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Did you receive unemployment compensation at any point during your unemployment?**

**6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?**  
 Conviction Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Release Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Was this a  Federal or  State conviction? If State - County: \_\_\_\_\_ State: \_\_\_\_\_

**Additional Tax Credits**

**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.

**CA Residents:**  Are you the child of foster parents?  Do you receive CalWorks?  Were you ever convicted of a felony?

**SC Residents:**  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, information, and belief, and I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages, civil penalties, and imprisonment).

New Employee Signature: Bee Yee Date: \_\_\_\_\_



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## **INJURY MANAGEMENT PROGRAM**

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

As your employer, we are concerned about your full recovery. The necessary medical care will be paid for any compensable work. The authorized time away from work will be reimbursed in accordance **of Minnesota workers' compensation laws**. Wherever possible, the 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 a health care provider. Subpart 2 places limitations on your right to see primary health care providers. Discuss with your employer any restrictions on your care provider.

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

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

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this information as soon as possible. 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. You 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 return to work. Contact your employer a minimum of after every primary health care provider. Keep the claims representative advised of your status.

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

If it is necessary to miss scheduled work due to a work injury, you must be cleared 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 terms.**

Signed: Bee Yeo

Printed Name: Bee Yeo

**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

1. I have been allowed to read and inspect a written copy of the policy regarding drug and alcohol testing.

2. I have read the entire contents of this policy and I 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 how to exercise certain rights; and (d) that certain events as described in the policy, including my termination from employment, constitute an adverse personnel action. I understand that this policy in any form, and any employee handbook or policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health services provider or other persons or entities acting for or with them, to collect a body sample (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 analysis on the sample provided by me. I further voluntarily consent to the disclosure to ESSG of the results of my drug and/or alcohol test and any information related to the test.

Bee  
Individual's Name  
12-8-14  
Date

**SIGN THIS VERSION OF CONSENT—SAME AS**

**Acknowledgement of Receipt Antiharassment Policy**

I certify that I have received a copy of Employer Solutions Staffing Group's A understand that it is my responsibility to read this policy and ask my supervi management or to telephone Employer Solutions Group (ESSG) at 952.835. any questions I may have about this policy. I agree to comply with ESSG's p and understand failure to comply is grounds for disciplinary action, up to and

I also agree that if at any time during my employment I am involved in any e subjected to any type of discrimination, including discrimination because of r color, national origin, disability, marital, sexual orientation or veteran status, type of harassment including sexual harassment, I will immediately contact r director or ESSG's Human Resource Department at 952.835.1288/1.866.49 assistance in the resolution of such matters.

Employee Name (Please Print)

Bee Yeji

Employee's Signature:

Bee Yeji Date: 12.8.14

**RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT**

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

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

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

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

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

DATE 12-8-14

EMPLOYEE NAME Bee Yei  
PLEASE PRINT

EMPLOYEE SIGNATURE Bee Yei

ESSG REPRESENTATIVE [Signature]



## ACKNOWLEDGMENT

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

1. This handbook is intended as a guide and **not** an employment agreement that creates a contractual relationship, and that the employment relationship is terminated at the will of either party at any time.
2. The changing needs of the business will require alteration in methods and policies, and the company will unilaterally revise, as necessary, to meet changing needs.
3. I agree to **notify** my ESSG Consultant **immediately** of any change in contact data such as phone number, address, emergency notification, etc.
4. I am responsible for the information provided herein and will, upon request, return this handbook to my ESSG Consultant.

Date:

12/8/14

Associate's Signature:

*Bee Yei*

Associate's Printed Name:

Bee Yei

Orientation provided by:

*[Signature]*



# employer solutions staff

Leveraging Resources in a Changing Market

## Notification of Minnesota Law Regarding Unemployment Acknowledgment

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

It is your responsibility to contact ESSG (for instance, by calling or using any other form of contact) for additional assignments. If you do not, it may affect your unemployment benefits.

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

Bee x ei  
Employee Signature:

12-08-08  
Date:

Bee yei  
Employee (please print your name here)

# ENROLLMENT FORM

## REQUIRED EMPLOYEE INFORMATION

**PRINT USING BLACK or BLUE INK**

**(Must Be Filled Out)**

Social Security Number 764-19-4403

Date of Birth 01/20/1989 Sex  M  F

Name Bee Yei

Street Address 589 Reaney Ave Apt 1

City St. Paul State MN Zip 55130

Home Phone \_\_\_\_\_

Do you or any dependents have Medicare?

Yes  No If Yes:

Medicare Health Insurance Claim Number (HICN) \_\_\_\_\_

Medicare Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Names of Covered Person(s)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## REQUIRED DEPENDENT INFORMATION

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F

Relationship:  Spouse  Child  Domestic Partner

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F

Relationship:  Spouse  Child  Domestic Partner

## BENEFICIARY INFORMATION

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

**NAME OF BENEFICIARY** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_

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

## OPTION 1

### FIXED INDEMNITY PLAN

You MUST enroll in the Indemnity Plan to receive any additional Indemnity benefits, and coverage for the Term Life will be identical to the Indemnity Plan.

### FIXED INDEMNITY

\$20.91 Employee Only

\$42.44 Employee + 1

\$56.67 Employee + Family

**NO to all Indemnity benefits**  
This coverage is not available in New Hampshire, Hawaii

### DENTAL

\$5.99 Employee Only

\$11.98 Employee + 1

\$19.77 Employee + Family

**NO**

### TERM LIFE

**YES** \$0.60 Employee Only

\$0.90 Employee + 1

**NO** \$1.80 Employee + Family

### SHORT-TERM DISABILITY

**YES** \$4.20 Employee Only

**NO**

Short-Term Disability is not available in California, Hawaii, New Jersey

## OPTION 2

### MEC WELLNESS/PREVENTIVE

\$58.87 Employee Only

\$87.73 Employee + 1

\$186.99 Employee + Family

**NO to MEC Wellness/Preventive**

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

**Signature**

Bee Yei

Date 1/20/89