

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.

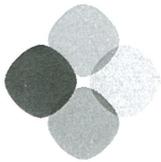
I have read my responsibilities and agree to abide by these guidelines.

Signed:



Printed Name:

Benjamin J. Perez



employer solutions staffing group ^{LLC}
Leveraging Resources in a Changing Market

Important/Importante

LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between \$25-\$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the policy report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): BENJAMIN JUNIOR PEREZ

Signature/Firma: Benjamin J. Perez

ENROLLMENT FORM

ESC NAV*SAD P2M v15.0

REQUIRED EMPLOYEE INFORMATION

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

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Name _____

Street Address _____

City _____ State ____ Zip _____

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

Weekly Rates

You MUST enroll in the Indemnity Medical Insurance Plan before adding any additional Indemnity benefits, except Dental. Your coverage level for the Term Life will be identical to your medical plan selection.

FIXED INDEMNITY MEDICAL



- \$20.91 Employee Only
- \$42.44 Employee + 1
- \$56.67 Employee + Family
- NO to all Indemnity benefits.**

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL



- \$5.99 Employee Only
- \$11.98 Employee + 1
- \$19.77 Employee + Family
- NO**

TERM LIFE



- YES \$0.60 Employee Only
- YES \$0.90 Employee + 1
- NO \$1.80 Employee + Family

SHORT-TERM DISABILITY



- YES \$4.20 Employee Only
- NO

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

OPTION 2

82193010-M-EMP

MEC WELLNESS/PREVENTIVE PLAN

Monthly Rates

- \$58.87 Employee Only
- \$87.73 Employee+ 1
- \$186.99 Employee + Family
- NO to MEC Wellness/Preventive Plan**

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

Signature

Benjamin J. Perea

Date 03/17/2015

DISCLOSURE AND AUTHORIZATION REGARDING PROCUREMENT OF BACKGROUND REPORTS

It is recognized and understood that the Fair Credit Reporting Act provides that anyone "who knowingly and willfully obtains information on a consumer from a consumer reporting agency under false pretenses" shall be fined not more than \$2,500 or imprisoned not more than a year, or both.

In connection with my application for EMPLOYMENT (including contract for services), I understand that investigative background inquiries are to be made on me which may include criminal convictions, motor vehicle, and other reports. These reports may include information as to my character, work habits, performance, education and experience along with reasons for termination of employment from previous employers. Further, I understand that you will be requesting information from various Federal, State, and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil and other experiences. *If I include a current employer for verification, I may jeopardize my position within that company.* I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from any liability and responsibility for doing so. I hereby consent to obtaining the above information from BACKGROUND SOURCE INTL and/or any of their licensed agents. This authorization and consent shall be valid in original, fax or copy form. I further authorize ongoing procurement of the above mentioned reports at any time during my employment (or contract).

Applicant Signature: Benjamin J. Perez **Date:** 3-17-15

Please PRINT clearly: Position applied for: Injection molding

Name: Benjamin Junior Perez Maiden / AKA: —
First Middle Last

Soc. Sec. #: 160-56-9612 *Sex: M *Race: H *Date of Birth: 5-16-1966

Current Address: 1600 Calgary st 104 County: Adams

City: Aurora State: CO Zip: 80010 How long: 5 years to —

Previous Address: 1781 Elmira st County: Adams

City: Aurora State: CO Zip: 80010 How long: 4 years to —

Motor Vehicle Report Fax to: (208)769-7282

Name as it appears: Benjamin Junior Perez License #: 01-876-2842 State held: CO

*Responses to these are completely voluntary. You need not respond to have your application considered. However, without this information, we may be unable to distinguish you from another in the event we discover adverse information during our background investigation.

Colorado
Driver License

Expires: 05-16-2024
Issued: 07-11-2014
DOB: 05-16-1956
Previous Type: A
Eyes: BRO Sex: M

Class: R
End:
Rest:
H: 5'04" Wt: 160
Voter: Y

01-876-2842

BENJAMIN JUNIOR PEREZ
1600 GALENA ST #104
AURORA, CO 80010

Benjamin J. Perez



SOCIAL SECURITY

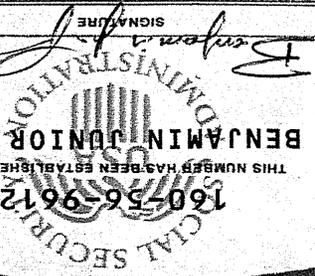
160-56-9612

THIS NUMBER HAS BEEN ESTABLISHED FOR

BENJAMIN JUNIOR PEREZ

Benjamin J. Perez
ADMINISTRATOR

SIGNATURE



SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security

Report Prepared: 03/17/2015

E-Verify

Page: 1 of 1

Case Verification Number: 2015076154144QR

Case Information:

Employee Information:	
Last Name:	Perez
Middle Initial:	
Social Security Number:	**** * 9612
Citizenship Status:	A citizen of the United States
Document Information:	
List B Document:	Driver's license or ID card issued by a U.S. state or outlying possession
Document Name:	Driver's license
Driver's License or ID Card Number:	
Alien Number:	I-94 Number:
Additional Information:	
Hire Date:	03/17/2015
Three-Day Rule Reason:	
Submitted By:	CSC4411
Initial Case Result:	
Case Result:	Employment Authorized
First Name:	Benjamin
Other Names Used:	
Date of Birth:	05/16/1966
Email Address:	
List C Document:	Social Security Card
Document State:	Colorado
Document Expiration Date:	05/16/2024
Employer Case ID:	
Three-Day Rule - Other:	
Submitted On:	03/17/2015

Employee Referred to SSA:

Referred By: Referred On:

Case Result from SSA (after SSA Tentative Nonconfirmation):

Case Result: Response Date:

Resubmitted to SSA (after Review and Update Employee Data):

Last Name:	First Name:
Middle Initial:	Other Names Used:
Social Security Number:	Date of Birth:
Resubmitted By:	Resubmitted On:

Case Result from SSA (after Resubmission):

Case Result:

Request Name Review:

Comments: Submitted On:

Case Result from DHS (after DHS Verification in Process):

Case Result: Response Date:

Employee Referred to DHS:

Referred By: Referred On:

Case Result from DHS (after DHS Tentative Nonconfirmation):

Case Result: Response Date: