

employer solutions staffing group<sub>llc</sub>

# New Hire Application

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

Last Name Bryant First Name La'vonta Middle Initial C  
 Street Address 3480 Golfview Dr Apt/Ste 1314  
 City/State/Zip Eagan, MN, 55123 Social Security Last Four XXX-XX-0719  
 Phone Number 651-252-5176 Email Address lbryant813@gmail.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.

La'vonta Bryant  
Name (Print or type)

La'vonta Bryant  
Applicant's Signature

10/5/17  
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**

DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (if applicable) _____	ESC Application _____

**For ESSG Client Use**

DOH _____	ROP _____	Work Site Loc. _____	WC Code _____
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# Form W-4 (2017)

**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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

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

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

The exceptions don't apply to supplemental wages greater than \$1,000,000.

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

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

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

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

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

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

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for yourself if no one else can claim you as a dependent . . . . .	<b>A</b>	_____
<b>B</b>	Enter "1" if: { • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } . . . . .	<b>B</b>	0
<b>C</b>	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b>	0
<b>D</b>	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	0
<b>E</b>	Enter "1" if you will file as head of household on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b>	0
<b>F</b>	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit . . . . . (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	<b>F</b>	0
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.	<b>G</b>	0
<b>H</b>	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶	<b>H</b>	0

For accuracy, complete all worksheets that apply.   
 { • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.   
 • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.   
 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <b>2017</b>
1 Your first name and middle initial Lavonta C		Last name Bryant		2 Your social security number 476-35-0719
Home address (number and street or rural route) 3480 Oakview Dr #1314		City or town, state, and ZIP code Eggenv, MA 05123		3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		6 Additional amount, if any, you want withheld from each paycheck		5 0 6 \$
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. <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 liability, and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶				7
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (This form is not valid unless you sign it.) ▶ Lavonta Bryant				Date ▶ 6/5/17
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)



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

**USCIS**  
**Form I-9**  
 OMB No. 1615-0047  
 Expires 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) <i>Bryant</i>		First Name (Given Name) <i>LaVonta</i>		Middle Initial <i>C</i>	Other Last Names Used (if any)	
Address (Street Number and Name) <i>3450 W. 10th Ave DR</i>			Apt. Number <i>1314</i>	City or Town <i>Eagan</i>		State <i>MN</i>
Date of Birth (mm/dd/yyyy) <i>4-20-1979</i>		U.S. Social Security Number <i>476-35-0719</i>		Employee's E-mail Address <i>lbryant8113@gmail.com</i>		Employee's Telephone Number <i>651-252-5176</i>

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: \_\_\_\_\_  
 OR  
 2. Form I-94 Admission Number: \_\_\_\_\_  
 OR  
 3. Foreign Passport Number: \_\_\_\_\_  
 Country of issuance: \_\_\_\_\_

QR Code - Section 1  
 Do Not Write In This Space

Signature of Employee <i>LaVonta Bryant</i>	Today's Date (mm/dd/yyyy) <i>6-5-2017</i>
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**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

Employer Completes Next Page



**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 "List of Acceptable Documents.")*

Employee Info from Section 1	Last Name (Family Name) <i>Bryant</i>	First Name (Given Name) <i>Lavonta</i>	M.I. <i>C</i>	Citizenship/Immigration Status <i>U.S. Citizen</i>
List A	OR	List B	AND	List C
Identity and Employment Authorization		Identity		Employment Authorization

Document Title	Document Title <i>Minnesota Identification Card</i>	Document Title <i>Social Security Card Receipt</i>										
Issuing Authority	Issuing Authority <i>State of Minnesota</i>	Issuing Authority <i>SSA</i>										
Document Number	Document Number <i>G727048547216</i>	Document Number <i>476-35-0719</i>										
Expiration Date (if any)(mm/dd/yyyy)	Expiration Date (if any)(mm/dd/yyyy) <i>04/20/2020</i>	Expiration Date (if any)(mm/dd/yyyy) <i>8/5/2017</i>										
Document Title	<table border="1"> <tr> <td>Additional Information</td> <td>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>		Additional Information	QR Code - Sections 2 & 3 Do Not Write In This Space								
Additional Information			QR Code - Sections 2 & 3 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): 6/5/2017 (See instructions for exemptions)

Signature of Employer or Authorized Representative <i>[Signature]</i>	Today's Date (mm/dd/yyyy) <i>6/5/2017</i>	Title of Employer or Authorized Representative <i>Recruiter</i>	
Last Name of Employer or Authorized Representative <i>Mona</i>	First Name of Employer or Authorized Representative <i>Yeng</i>	Employer's Business or Organization Name <b>EMPLOYER SOLUTIONS STAFFING GROUP LLC</b>	
Employer's Business or Organization Address (Street Number and Name) <b>7301 OHMS LANE SUITE 405</b>	City or Town <b>EDINA</b>	State <b>MN</b>	ZIP Code <b>55439</b>

**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)
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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 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
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# Social Security Administration Important Information

Social Security Administration  
SOCIAL SECURITY  
TWIN CITIES CARD CTR  
1811 CHICAGO AVE STE 2  
MINNEAPOLIS, MN 55404-1998  
Date: June 5, 2017

1-888-847-0392

LAVONTA CORVELL BRYANT  
APT 1314  
3480 GOLFVIEW DR  
EAGAN, MN 55123

This is a receipt to show that you applied for a Social Security card on June 5, 2017. You should have your card in about 2 weeks. Any document(s) you have submitted are being returned to you with this receipt.

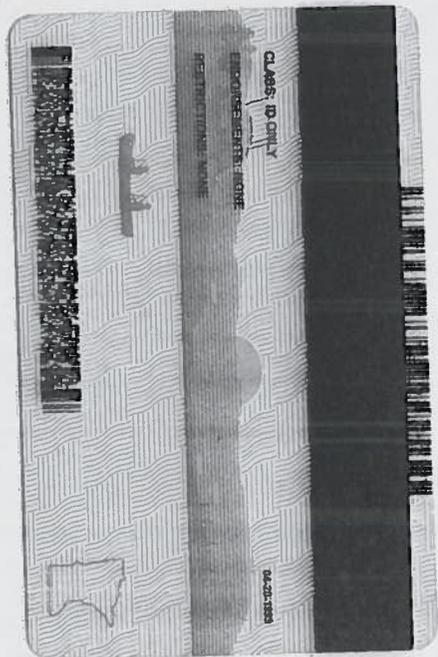
If you do not receive your Social Security card within 2 weeks, please let us know. You may call, write or visit the Minneapolis Card Center. If you choose to visit the office, please bring this receipt with you. To protect your privacy, we will not disclose a social security number over the telephone.

The Social Security Administration is required by law to limit replacement Social Security cards to three per year and ten per lifetime. Do not carry your Social Security card with you. Keep it in a safe location, not in your wallet.



Field Office Manager

KRB



# EMERGENCY CONTACT INFORMATION

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

Employee Name: Laonta C Bryant

Address: 3450 Wolfview Dr #1314 Eugene, WA 97403

Home Phone: 651-252-5174

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
<b>Contact #1</b> Name: <u>Martha Taylor</u> Relationship: <u>Grandmother</u>	Home Phone: Cell Phone: <u>651-276-1680</u> Work Phone:
<b>Contact #2</b> Name: <u>Laquita Belford</u> Relationship: <u>Mother</u>	Home Phone: Cell Phone: <u>651-216-7373</u> Work Phone:

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

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## Wage Payment Method Authorization (Minnesota)

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 paper Check.

### SECTION 1 BASIC INFORMATION

Employee Name <u>Lavonta C Bryant</u>	SSN# (last 4 digits) <u>476-35-0719</u>	Effective Date <u>6-5-17</u>
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### SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated*

Payroll Debit Card (Please complete Sections 4 and 5 below)  Paper Check (Please complete Section 5 below)

### 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 \_\_\_\_\_

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

### SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

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

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

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

First Name <u>Lavonta</u>	M.I. <u>C</u>	Last Name <u>Bryant</u>	Date of Birth <u>04/20/1999</u>
Street Address (PO BOX NOT ACCEPTABLE) <u>3480 GOLDVIEW DR #1314</u>			Social Security# <u>476-35-0719</u>
City <u>Eagan</u>	State <u>MN</u>	Zip <u>55123</u>	Cell Phone (mobile) <u>651-252-5174</u>

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

Payroll Debit Card Routing # <u>073972181</u>	Payroll Debit Card Account # <u>4853 4002 3371 0617</u>
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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: Lavonta Bryant Date: 6-5-17

### 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: \_\_\_\_\_@\_\_\_\_\_ this information will only be used to send your paystubs electronically

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization

**Authorization:** By signing below, you authorize: (a) backgroundchecks.com ("BGC") and/or Orange Tree Employment Screening to request information about you from any public or private information source; (b) anyone to provide information about you to BGC and/or Orange Tree Employment Screening; (c) BGC and/or Orange Tree Employment Screening to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) Employer Solutions Staffing Group, LLC ("ESSG") to share those reports with others for legitimate business purposes related to your employment. BGC and/or Orange Tree Employment Screening may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an employee of ESSG.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

**Personal Information:** Please print the information requested below to identify yourself for BGC.

Printed name: LaVonta C Bryant  
First Middle (  none ) Last

Other names used: \_\_\_\_\_

Current county of residence: \_\_\_\_\_

Current and former addresses:

7/15 from Mo/Yr      current to Mo/Yr      3480 Galfordview Dr #734 Street      Essex, MA 05123 City, State & Zip

\_\_\_\_\_  
from Mo/Yr      to Mo/Yr      Street      City, State & Zip

\_\_\_\_\_  
from Mo/Yr      to Mo/Yr      Street      City, State & Zip

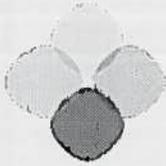
Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

4-20-1949 Date of birth      476-35-0719 Social security number

G72704854721 6 Driver's license number & state      LaVonta Corvell Bryant Name as it appears on license

**Report Copy:** If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: .

LaVonta Bryant Signature      4-5-17 Date



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## STATEMENT OF CONFIDENTIALITY

This agreement made this 5 day of June, 2017, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Laurita Bryant hereafter referred to as "employee".

### WITNESSETH:

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

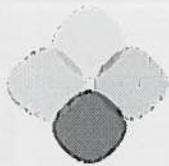
In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of \$10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

Laurita Bryant

Employee Signature

Yeng Mona

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, 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): Lavonta C Bryant

Signature/Firma: Lavonta Bryant

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: Laronta Bryant

Printed Name: Laronta Bryant

## 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 Lavonda C Bryant Social security number ► 476-35-019  
Street address where you live 3480 Wolfview Dr #1214  
City or town, state, and ZIP code Sagan, MN 55123  
County Dakota Telephone number 651-252-5776  
If you are under age 40, enter your date of birth (month, day, year) 4-20-1949

- 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 5 months, but is no longer eligible to receive them.
  - During the past year, I was convicted of a felony or released from prison for a felony.
  - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
  - I am a veteran and I was 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 penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ►

*Lavonda Bryant*

Date

*6-5-17*

**EMPLOYER SECTION:**

<b>Client:</b> Employer Solutions Group	<b>Company:</b> CMVG
<b>Location:</b> Gregory's Food	<b>Position:</b> Production
<b>Starting Wage:</b> \$ 12.00	

**EMPLOYEE SECTION:**

<b>Employee Name:</b> Lacouta Bryant	<b>Street Address:</b> 3480 Wolford Rd #1314	<b>City/State:</b> Lynn, MA	<b>Zip:</b> 01923
<b>SS#:</b> 476-35-0719	<b>Date of Birth:</b> 4/20/1999	<b>Age:</b> 18	<b>Have you worked for this company before?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>If yes, location:</b>			

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

Yes No

<b>1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?</b> (If yes, please provide information below.) Name of the person receiving benefits: <u>Lacouta Keliford</u> Relationship to you: <u>mother</u> City: <u>St. Paul</u> County: <u>Dorsey</u> State: <u>MA</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?</b> (If yes, please provide information below.) Name of the person receiving benefits: <u>Lacouta Keliford</u> Relationship to you: <u>mother</u> City: <u>St. Paul</u> County: <u>Dorsey</u> State: <u>MA</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?</b> 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"/>
<b>4. Have you received any type of vocational rehabilitation services within the past two years?</b> If yes, please indicate which type of agency you worked with and provide their location information below: <input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program) 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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>5. Are you a Veteran of the U.S. Military?</b> *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.) Dates of Service - From: ____/____/____ To: ____/____/____ Branch of Service: _____ <b>Are you entitled to or are you receiving compensation for a service-connected disability?</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6. Have you been unemployed at any time during the last 12 months?</b> If yes, dates of unemployment - From: ____/____/____ To: ____/____/____ <b>Did you receive unemployment compensation at any point during your unemployment?</b> If yes, dates received unemployment compensation - From: ____/____/____ To: ____/____/____	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</b> Conviction Date: ____/____/____ Release Date: ____/____/____ Was this a <input 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>		
<b>IEC (Native American):</b> 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 type="checkbox"/>
<b>CA Residents:</b> <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act? <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?		
<b>SC Residents:</b> <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. dba Retrotax), or the Department of Labor.

New Employee Signature: Lacouta Bryant Date: 6-5-17

**Qualified Long-Term Unemployment Recipient**

ADDENDUM TO: IRS Form 8850 Pre-Screening Notice and Certification Request for the Work Opportunity Tax Credit

<b>Client:</b> Employer Solutions Group	<b>Company:</b> CMG	
<b>Location:</b> Gregory Ford	<b>Employee Name:</b> Lawrence C Bryant	<b>SS#:</b> 476-35-0719

**EMPLOYEE:**

Please check the statement(s) that apply to you and sign where indicated below.

I have been unemployed at any time during the last 12 months.

If applicable, dates of unemployment - From: \_\_\_\_\_ To: \_\_\_\_\_  
 From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

I received unemployment compensation during my unemployment.

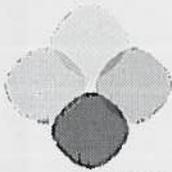
If applicable, dates you received compensation - From: \_\_\_\_\_ To: \_\_\_\_\_  
 From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please read, sign, and date:**

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

<b>Employee Signature:</b> <i>Lawrence Bryant</i>	<b>Date:</b> 6-5-17
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**RetroTax**<sup>®</sup>  
 3730 Washington Blvd.  
 Indianapolis, IN 46205  
 317-925-0553  
 wotc@retrotax-aci.com  
 www.retrotax-aci.com



# employer solutions staffing group<sup>LLC</sup>

Leveraging Resources in a Changing Market

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## Notification of Minnesota Law Requirement – Unemployment Acknowledgement

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

It is your responsibility to contact ESSG (for instance, by calling 952.277.5227 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. LB. (Initial)

Lavonta Buzard  
Employee Signature:

6/5/17  
Date:

Lavonta Buzard  
Employee (please print your name here)

**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.

Lavonta - C. Bryant  
Individual's Name

6/5/17  
Date

**SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6**

# Enhanced MEC Plan Plan 1

Benefits Enrollment Form  New Employee  Rehire Rehire Date \_\_\_\_\_

<b>Employee Information</b>	
Name (First and Last) <i>Lavonta Bryant</i>	Social Security Number <i>476-35-0719</i>
Address <i>3480 Golfview Dr #1314</i>	City <i>Eagan</i>
State <i>MN</i>	Zip Code <i>55123</i>
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Date of Birth <i>04/28/1989</i>	Date of Hire
Phone Number:	Email Address: <i>lbryant8113@optonline.com</i>

**Please Select Desired Coverage:**

Employee Only - \$24.00/Week   
  Employee+Spouse - \$38.00/Week   
  Employee+Child(ren) - \$36.00/Week   
  Family - \$63.00/Week

**Dependent**

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
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**Dependent**

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
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**Dependent**

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
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Other coverage information including Medicare/Medicaid

**NAME OF PERSON COVERED (FIRST, LAST):**

EFF. DATE

EFF. DATE

EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

**IF ENROLLING - YOU MUST SIGN HERE**

Employee Signature *Lavonta Bryant* Date *10/5/17*

**EMPLOYEES DECLINING  I am DECLINING coverage**

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

**IF DECLINING- YOU MUST SIGN HERE**

Employee Signature *Lavonta Bryant* Date *10/5/17*

Employer Solutions Staffing Group Health Benefits Team

7301 Ohms Lane Suite 405

Edina, MN 55439

Phone: 952-767-9519 Fax: 952-767-9515

Email: Health@employersolutionsgroup.com

# Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION \_\_\_\_\_ Rehire Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION		PRINT USING BLACK or BLUE INK (Must Be Filled Out)			
Name	<i>Lavonta Bryant</i>	Social Security #	<i>476-35-0719</i>	Home Phone	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Address	<i>3480 Golfview Dr. #1311</i>			Apt. #	<i>1314</i>
City	<i>Eagan</i>	State	<i>MN</i>	Zip	<i>55123</i>
				Date of Birth	<i>4/20/1999</i>

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?	
<input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, please continue.	
Medicare Health Insurance Claim Number (HICN)	Medicare Effective Date
Name of Covered Person (s):	
1.	2.
	3.

C. LIMITED BENEFITS PLAN SELECTION		Payroll Deducted Weekly Rates				
<p>You <b>MUST</b> select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.</p>						
SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL <sup>1</sup>	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY <sup>2</sup>	
Employee Only <input type="checkbox"/>	\$20.25	\$6.17	\$2.42	\$0.60	\$4.20	
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90		
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80		
NO to ALL Benefits <input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

<sup>1</sup>This coverage is not available to residents of NH, HI, or PR. <sup>2</sup>STD is not available to persons who work in CA, HI, NJ, NY, or RI.

**For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

D. REQUIRED DEPENDENT INFORMATION				
Name	Social Security #	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE		YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE
I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.		
DATE	<i>06/05/17</i>	SIGNATURE <i>Lavonta Bryant</i>