SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security
E-Verify

Report Prepared: 11/13/2014

Case Verification Number: 2014317104234VP

Case Information:

Employee Information:

Last Name:	Say	First Name:	Buay
Middle Initial:		Other Names Used:	
Social Security Number:	*** ** 8976	Date of Birth:	08/04/1991
Citizenship Status:	A lawful permanent resident	Email Address:	

Document Information:

List A Document:	Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
Card Number:	LIN1390033030	Document Expiration Date:	
Alien Number:	212556230	I-94 Number:	

Additional Information:

Hire Date:	11/13/2014		
Three-Day Rule Reason:		Employer Case ID:	
Submitted By:	MARI1344	Three-Day Rule - Other:	
		Submitted On:	11/13/2014

Initial Case Result:

Last Name (in DHS records): SAY

First Name (in DHS records): BUAY

Document Expiration Date (in DHS records): INDEFINITE

Case Result: Employment Authorized

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 By:

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:

Photo Matching Results:

Determination:

Employee Referred to DHS (Additional):

Referred By: Referred On:

Case Result from DHS (after Additional DHS Tentative Nonconfirmation):

Case Result: Response Date:

Case Closure:

Closure Statement: The employee continues to work for the employer after receiving an Employment Authorized result.
Closed By: MARI1344 Closed On: 11/13/2014

SENSITIVE BUT UNCLASSIFIED

H p l c tio

M

YE

3.

UNITED STATES OF AMERICA
PERMANENT RESIDENT
Surname
BAY
Given Name
BUAY
Category
REE
Sex
M
Card Expires:
02/15/22
Resident Since:
07/05/11

I-551
46041576
11
If found, drop in any US Mailbox. USPS: Mail to USCIS, PO Box 82521, Lincoln, NE 68501-2521
C1USA2125562308LIN1390033030<<
9108046M2302155MMR<<<<<<<<<<<6
SAY<<BUAY<<<<<<<<<<<<<<<<<<<<

DISCLOSURE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" that may include information about your character, general reputation, personal characteristics, and/or mode of living, and that can involve personal interviews with sources, such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security number validation, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been requested and compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Ohms Lane, 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, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG 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.
New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.
Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights 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 YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING's website is at: www.orangetreescreening.com, another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

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 if one is obtained by ESSG.

☑ (Must include email address: Buay3ay2212@gmail.com)

Signature: Buay Date: 11/13/2014

BACKGROUND INFORMATION

Last Name: SAY First: Buay Middle: _____

Other Names/Alias: _____

Social Security #*: 026-45-8976 Date of Birth (mm/dd/yyyy)*: 08/04/91

Driver's License #: _____ State of Driver's License: _____

Present Address: 1155 Payne Ave Telephone # (Primary): 651-352-5899

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

This information will be used for background screening purposes only and will not be used as hiring criteria.

EMERGENCY CONTACT INFORMATION

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

Employee Name: BUAY SAY

Address: 1155 Payne Ave St. Paul MN 55130

Home Phone: 651 - 352 - 5899

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: Tha Lwe Relationship: mom	Home Phone: Cell Phone: 651 - 235 - 7140 Work Phone:
Contact #2 Name: Kai Blud Relationship: Uncle	Home Phone: Cell Phone: 651 - 307 - 9694 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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Direct Deposit/Payroll Debit Card Authorization

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

SECTION 1 BASIC INFORMATION

Employee Name	SSN# (last 4 digits)	Effective Date
Buay Say	026-45-8976	11/13/2014

SECTION 2 PAYROLL ELECTION

☐ **Direct Deposit** (Please complete Sections 3 and 5 below)
☐ **Payroll Debit Card** (Please complete Sections 4 and 5 below)

SECTION 3 DIRECT DEPOSIT

ACCOUNT

☐ 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	M.I.	Last Name	Date of Birth

Street Address (PO BOX NOT ACCEPTABLE)	Social Security#

City	State	Zip	Cell Phone (mobile)

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

Payroll Debit Card Routing #	Payroll Debit Card Account #
073972181	

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: _____ Date: _____

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 adjustmentsfor 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:

employer solutions staffing group LLC

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STATEMENT OF CONFIDENTIALITY

This agreement made this_____day of_____, 201__, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and _____ 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.

_____

Employee Signature

_____

Employer Solutions Staffing Group LLC, Representative

employer solutions staffing group LLC

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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.

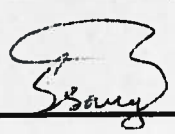
CHEQUES DE PAGO PERDIDOS O ROBADOS

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): BUAY SAY

Signature/Firma: 

Form **8850** (Rev. January 2012)
Department of the Treasury
Internal Revenue Service

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

▶ See separate instructions.

OMB No. 1545-1500

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

Your name Buay Say Social security number ▶ 026-45-8976

Street address where you live

City or town, state, and ZIP code

County Telephone number

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

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  - **a** Received SNAP benefits (food stamps) for the past 6 months, **or**
  - **b** Received SNAP benefits (food stamps) for at least 3 of the past 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.

Signature—All Applicants Must Sign

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

Job applicant's signature ▶ Date 11/13/12

Form A (rev. 08/12)

TAX CREDIT QUESTIONNAIRE

RETROTAX
Specialists in Tax Credit Administration

EMPLOYER SECTION:

ESG FEIN#:	ESG Client Name & State:	
Hiring Manager:	Position:	Starting Wage: $

EMPLOYEE SECTION:

Employee Name:	Street Address:		City/State:	Zip:
Bray Say	1155 Payne Ave		St. Paul MN	55130
SS#:	**Date of Birth:**	**Age:**	**Have you worked for this company before?**	**If yes, location:**
026-45-8976	08/04/1991	23	☐ Yes ☒ No	

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

	Yes	No
1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 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 15 months? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	☐	☑
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 (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.*	☐	☑
5. Are you a Veteran of the U.S. Military? **If yes, please provide a copy of your DD-214 and letter of separation.* (If yes, please provide information below. If no, please continue to question #6.) 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? ☐ Workforce Investment Act?		
	☐ Are you a migrant or seasonal farm worker? ☐ Have you ever been convicted of a misdemeanor?		
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, 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: _____

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INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

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

RESPONSIBILITIES OF THE INJURED WORKER:

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

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

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

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

Follow all physical restrictions at home and at work.

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

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

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

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

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

Signed: _____

Printed Name: Beray Say

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.

Bcay Say
Individual's Name

11/13/2014
Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6

☑ ACKNOWLEDGMENT

The associate handbook was reviewed with me, and I have received my personal copy. I also acknowledge that I have been given the opportunity to ask questions and express concerns 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 may be terminated at the will of either party at any time.

2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.

3. I agree to **notify** my ESSG Consultant **immediately** of any change in my personal data such as phone number, address, emergency notification, etc.

4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my ESSG Consultant.

Date: 11/13/2014

Associate's Signature: Bsay

Associate's Printed Name: Bray Say

Orientation provided by:

employer solutions staffing group LLC

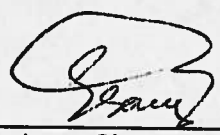
Leveraging Resources in a Changing Market

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. _____ (Initial)



Employee Signature:

11/13/2014

Date:

BUAY SAY

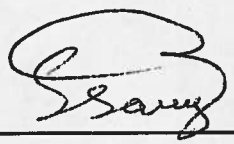
Employee (please print your name here)

Acknowledgement of Receipt Antiharassment Policy

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

I also agree that if at any time during my employment I am involved in any employment dispute or I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, marital, sexual orientation or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact my supervisor, manager, director or ESSG's Human Resource Department at **952.835.1288/1.866.496.7573** in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print) BUAY SAY

Employee's Signature:  Date: 11/13/2014

RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT

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

I also acknowledge that my employment with ESSG is not for a specified period of time and can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter 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 reserves the right to revise, delete and add to the provisions of this Employee Handbook. All such revisions, deletions or additions must be in writing and must be signed by the CEO of the company. No oral statements or representations can change the provisions of this Handbook. I also 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, with or without cause or notice, at any time. No implied contract concerning any employment-related decision, term of employment or condition of employment can be established by any other statement, conduct, policy or practice.

I understand the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and ESSG concerning the duration of my employment, the circumstances under which my employment may be terminated and the circumstances under which 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 bring them to the attention of ESSG.

DATE 11/13/2014

EMPLOYEE NAME BUAY SAY
PLEASE PRINT

EMPLOYEE SIGNATURE

ESSG REPRESENTATIVE

VSI-IND 219301-EMP | OFFICE USE ONLY LOCATION_____ Rehire Date __/__/____

ENROLLMENT FORM

ESC NAV*SAD P2M v15.0

REQUIRED EMPLOYEE INFORMATION

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

Social Security Number 026-45-8976

Date of Birth 08/04/1991 Sex [M] F

Name Bray Say

Street Address 1155 Payne Ave

City St. Paul State MN Zip 55130

Home Phone 651-352-5899

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 / $0.90 Employee + 1 / $1.80 Employee + Family
- ☑ **NO**

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
MEC WELLNESS/PREVENTIVE PLAN

82193010-M-EMP

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** [signature] Date 11/13/2014