



**SENSITIVE BUT UNCLASSIFIED**

**Case Verification Number: 2017088111609VG**

Report Prepared: 03/29/2017

**Company Information**

Company ID: 47429

Company Name: Employer Solutions Staffing Group

**Employee Information**

Last Name: casiano

First Name: Oliverio

Date of Birth: 08/02/1973

Social Security Number: \*\*\* \*\* 3102

Hire Date: 03/29/2017

Citizenship Status: A lawful permanent resident

**Document Information**

List A Document: Permanent Resident Card or Alien Registration Receipt Card (Form I-551)

Alien Number: 204673687

Card Number: MSC1390638580

Document Expiration Date:

**Case Status Information**

Current Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 03/29/2017

Case Submitted By: SGLA6832

**SENSITIVE BUT UNCLASSIFIED**



employer solutions staffing group  
Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405  
Edina, MN 55439  
Tel: 952.835.1288  
www.esgstaffingsolutions.com

## New Hire Application

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

Last Name Casiano First Name Oliverio Middle Initial \_\_\_\_\_  
Street Address 7802 Hemingway Ave S. Apt/Ste \_\_\_\_\_  
City/State/Zip Cottage Grove MN 55016 Social Security Last Four XXX-XX-3102  
Phone Number 651-410-0088 Email Address Oliverio584@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.

Oliverio Casiano  
Name (Print or type)

Oliverio Casiano  
Applicant's Signature

03/28/17  
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 _____	

# 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: <ul style="list-style-type: none"> <li>• You're single and have only one job; or</li> <li>• You're married, have only one job, and your spouse doesn't work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b> _____
<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> _____
<b>D</b>	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<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> _____
<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 . . . . . <b>(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)</b>	<b>F</b> _____
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>	<b>G</b> _____
<b>H</b>	Add lines A through G and enter total here. <b>(Note: This may be different from the number of exemptions you claim on your tax return.)</b> ▶	<b>H</b> _____

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.

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="font-size: small; margin: 5px 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; margin: 5px 0;">2017</div>
1 Your first name and middle initial <span style="float: right;">Last name</span> <div style="display: flex; justify-content: space-between;"> <span>Oliverio</span> <span>Casiano</span> </div>		2 Your social security number 100-06-3102
Home address (number and street or rural route) 7802 Hemingway Ave S City or town, state, and ZIP code Coon Rapids MN 55016		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)		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
6 Additional amount, if any, you want withheld from each paycheck	7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	5 _____ 6 \$ _____ 7 <u>1</u>
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.) ▶ Oliverio Casiano		Date ▶ 03/28/17
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) <b>CASIANO</b>		First Name (Given Name) <b>OLIVERIO</b>		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name) <b>7802 HEMINGWAY AVE</b>			Apt. Number <b>3</b>	City or Town <b>COTTAGE GROVE</b>		State <b>MN</b>
Date of Birth (mm/dd/yyyy) <b>08/02/1973</b>		U.S. Social Security Number <b>100-06-3102</b>		Employee's E-mail Address <b>olivosb4@gmail.com</b>		Employee's Telephone Number <b>651-410-0088</b>

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

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

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions)
<input checked="" type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): <b>204 673 687</b>
<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 <b>Oliverio Casiano</b>	Today's Date (mm/dd/yyyy) <b>03/28/2017</b>
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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 "Lists of Acceptable Documents.")*

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
				lawful Permanent Resident
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization

Document Title <b>USA Permanent Resid</b> Issuing Authority <b>USA</b> Document Number <b>204-673-687</b> Expiration Date (if any)(mm/dd/yyyy) <b>05-30-2023</b>	Document Title <b>MN DL</b> Issuing Authority <b>State of MN</b> Document Number <b>2936269178718</b> Expiration Date (if any)(mm/dd/yyyy) <b>08-02-2017</b>	Document Title <b>USA Perm.</b> Issuing Authority  Document Number  Expiration Date (if any)(mm/dd/yyyy)  
Document Title Issuing Authority Document Number Expiration Date (if any)(mm/dd/yyyy)		Additional Information     
Document Title Issuing Authority Document Number Expiration Date (if any)(mm/dd/yyyy)		
Document Title Issuing Authority Document Number Expiration Date (if any)(mm/dd/yyyy)		
Document Title Issuing Authority Document Number Expiration Date (if any)(mm/dd/yyyy)		
Document Title Issuing Authority Document Number Expiration Date (if any)(mm/dd/yyyy)		

QR Code - Sections 2 & 3  
 Do Not Write In This Space

**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): **03-29-2017** (See instructions for exemptions)

Signature of Employer or Authorized Representative <b>Shelby Glasby</b>	Today's Date (mm/dd/yyyy) <b>03-29-2017</b>	Title of Employer or Authorized Representative <b>Recruiter</b>	
Last Name of Employer or Authorized Representative <b>Glasby</b>	First Name of Employer or Authorized Representative <b>Shelby</b>	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)	

G. 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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**MINNESOTA  
DRIVER'S LICENSE**



**OLIVERIO CASIANO**  
7802 HEMINGWAY AVE APT 3  
COTTAGE GROVE, MN 55015

Date of Birth **08-02-1973**  
Sex **M** Eyes **BRN** Class **D**  
Height **5-5** Weight **170**  
ISSUED **04-2015** EXPIRES **02-2017**

*Oliverio Casiano*

**Z936269178718**

**UNITED STATES OF AMERICA  
PERMANENT RESIDENT**

*CASIANO OLIVERIO 02 AUG 1973*



Surname **CASIANO**  
Given Name **OLIVERIO**  
USCIS# **204-673-867** Category **E47**  
Country of Birth **Mexico**  
Date of Birth **02 AUG 1973** Sex **M**  
Card Expires: **05/30/23**  
Resident Since: **09/26/13**

*Oliverio Casiano*



## 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: Oliverio Casiano  
First Middle (  Last  
none)

Other names used: \_\_\_\_\_  
Current county of residence: \_\_\_\_\_

Current and former addresses:

from Mo/Yr	current to Mo/Yr	Street	City, State & Zip
06-15-13		7802 HEMINGWAY AVE	Cottage Grove 55016
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.

08-02-1973	100-06-3102
Date of birth	Social security number
2936269178718	Oliverio Casiano
Driver's license number & state	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: .

Oliverio Casiano  
Signature

03/28/17  
Date



# employer solutions staffing group<sub>inc</sub>

Leveraging Resources in a Changing Market

## 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.

<b>SECTION 1 BASIC INFORMATION</b>		
Employee Name <u>Oliverio Casiano</u>	SSN# (last 4 digits)	Effective Date <u>3-29-17</u>
<b>SECTION 2 PAYROLL ELECTION</b>		
<input type="checkbox"/> Direct Deposit (Please complete Sections 3 and 5 below) <i>Note: Direct Deposit accounts may take up to 7 days to be activated</i> <input checked="" type="checkbox"/> Payroll Debit Card (Please complete Sections 4 and 5 below) <input type="checkbox"/> Paper Check (Please complete Section 5 below)		
<b>SECTION 3 DIRECT DEPOSIT</b>		
ACCOUNT	<input type="checkbox"/> Update Bank Account	<p>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.</p> <p>Initial _____ Date _____</p>
	Bank Name:	
	Routing#	
	Account#	
	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other _____	
<ul style="list-style-type: none"> <li>To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work)</li> <li>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.</li> </ul>		
<b>SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)</b>		
<p>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.</p> <p>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.</p>		
<b>CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)</b>		
First Name <u>Oliverio</u>	M.I.	Last Name <u>Casiano</u>
Street Address (PO BOX NOT ACCEPTABLE) <u>7802 Hemingway Ave</u>		Date of Birth <u>03/02/73</u>
City <u>Cotta Grove</u>	State <u>MN</u>	Zip <u>55016</u>
		Cell Phone (mobile) <u>651-410-0088</u>
<b>RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)</b>		
Payroll Debit Card Routing # <u>073972181</u>	Payroll Debit Card Account # <u>4853-4002-3370-9304</u>	
<p>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.</p>		
Employee's Signature: <u>Oliverio Casiano</u>		Date: <u>03/28/17</u>
<b>SECTION 5 AUTHORIZATION</b>		
<p>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). <b>* E-mail is required for pay stub information.</b></p>		
<p>*E-mail: <u>Olive 0584 @gmail.com</u>          this information will only be used to send your paystubs electronically</p>		
Employee's Signature: <u>Oliverio Casiano</u>		Date: <u>03/28/17</u>

# EMERGENCY CONTACT INFORMATION

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

Employee Name: Oliveria Casiano

Address: 7802 Hemingway Ave S Cotta Grove MN 55016

Home Phone: 651-410-0088

<b>EMERGENCY CONTACTS</b>	
Please list two people (in priority order) who could be contacted in case of an emergency	
<p style="text-align: center;"><b>Contact #1</b></p> <p>Name: <u>Domingo Casiano</u></p> <p>Relationship: <u>Brother</u></p>	<p>Home Phone:</p> <p>Cell Phone: <u>612-479-3541</u></p> <p>Work Phone: <u>651-772-0101</u></p>
<p style="text-align: center;"><b>Contact #2</b></p> <p>Name: <u>Maria Torres</u></p> <p>Relationship: <u>Friend</u></p>	<p>Home Phone:</p> <p>Cell Phone: <u>651-334-4512</u></p> <p>Work Phone:</p>

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

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## Enhanced MEC Plan\_Plan 1

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

<b>Employee Information</b>	
<b>Name (First and Last)</b>	<b>Social Security Number</b>
<b>Address</b>	<b>City</b>
<b>State</b>	<b>Zip Code</b>
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<b>Date of Birth</b> _____ <b>Date of Hire</b> _____
<b>Phone Number:</b> _____	<b>Email Address:</b> _____

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

  

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

  

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

Other coverage information including Medicare/Medicaid

<b>NAME OF PERSON COVERED (FIRST, LAST):</b> _____	<b>EFF. DATE</b>
_____	_____
_____	_____

**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 \_\_\_\_\_ Date \_\_\_\_\_

**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 of 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 \_\_\_\_\_ Date \_\_\_\_\_

# 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	Social Security #	Home Phone	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Address			Apt. #	
City	State	Zip	Date of Birth / /	

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					

<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 \_\_\_/\_\_\_/\_\_\_

► SIGNATURE \_\_\_\_\_