

Emergency Contact Info	Background Release Form	Background Records	Unemployment Letter (if applicable)	ESSG Application
DOH	NHW	I-9	8850	WA
For ESSG Office Use Only				

A copy or facsimile will be considered the same as an original signature.

Name (Print or type) KRISTOPHER L CHARD  
 Applicant's Signature [Signature]  
 Date 06/11/13

I agree to abide by the policies and procedures of ESSG.  
 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.  
 I release ESSG and other persons or entities from any claims that might be based on ESSG's decision to conduct a background check. This may include but is not limited to, investigations of criminal and/or correction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.  
 I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. I authorize 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.

**Applicant Certification and Authorization**

Are you legally authorized to work in the United States of America?  YES  NO

All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

Last Name CHARD First Name KRISTOPHER Middle Initial L  
 Street Address 2315 LESTIE RD  
 City/State/Zip DEKER / MICHIGAN / 48426  
 Home Phone 989-529-1276 Cell / Message Phone 989-529-1276  
 Company/Employer EDF RENEWABLE

Personal Data - PLEASE PRINT LEGIBLY IN INK

**New Hire Application**

7301 Ohms Lane Suite 405  
 Edina, MN 55439  
 T: 952.835.1288 • F: 952.835.1255

employer solutions staffing group.  
 Leveraging Resources in a Changing Market



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 individual. See Pub. 501, Exemption, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowed number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowance Worksheet below. See Pub. 605 for information on converting your other credits into withholding allowances.

**Marriage deduction.** If you have a large amount of non-qualified 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, you may also want to make estimated tax payments.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 605 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 605, especially if your earnings exceed \$180,000 (single) or \$180,000 (married).

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

**Personal Allowance Worksheet (Keep for your records.)**

- A** Enter "1" for yourself if no one else can claim you as a dependent.
- B** Enter "1" if:
  - You are single and have only one job; or
  - You are married, have only one job, and your spouse does not work; or
  - Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.
- C** 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.)
- D** Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.
- E** Enter "1" if you will be the head of household (see conditions under Head of household above).
- F** Enter "1" if you have at least \$1,500 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.)
- G** Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. If your total income will be less than \$65,000 (\$65,000 if married), enter "2" for each eligible child; then take "1" if you have three to six eligible children or less "2" if you have seven or more eligible children.
- H** If your total income will be between \$65,000 and \$119,000 (if married), enter "1" for each eligible child. 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.)
- I** If you plan to transfer or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- J** If you are single and have more than one job or are married and your spouse has both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earnings/Two-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 W-4**  
Department of the Treasury  
Internal Revenue Service

▶ **Whichever you are entitled to claim is a certain number of allowances or exemptions from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074  
2013

**1** Your first name and middle initial: Christopher  
Last name: Charles

**2** Your social security number: 374-02-4480

**3**  Single  Married  Married, but withheld at higher single rate.

**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.  
City or town, state, and ZIP code: 2315 Leslie Rd  
Decker, MD 20746

**5** Total number of allowances you are claiming (from line 4 above or from the applicable worksheet on page 2): 1

**6** Additional amount, if any, you want withheld from each paycheck: 0

**7** Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and I claim exemption from withholding for 2013, and I certify that I meet both of the following conditions for exemption:  
• 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.

**8** Employer's name and address (Employer Complete lines 8 and 10 only if sending to the IRS):  
Date: 05/11/2013  
Employer's signature (This form is not valid unless you sign it.): [Signature]  
Employer's identification number (EIN): 051112013



# Employment Eligibility Verification

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

USCIS  
Form I-9  
OMB No. 1615-0047  
Expires 03/31/2016

**▶ START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

## Section 1. Employee Information and Attestation (Employers 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>CHARD</b>		First Name (Given Name) <b>Kristopher</b>		Middle Initial <b>L</b>	Other Names Used (if any)	
Address (Street Number and Name) <b>7315 Leslie Rd</b>		Apt. Number	City or Town <b>Decker</b>	State <b>M!</b>	Zip Code <b>48426</b>	
Date of Birth (mm/dd/yyyy) <b>06-05-1983</b>		U.S. Social Security Number <b>374-02-4480</b>		E-mail Address		Telephone Number <b>1-989-529-1276</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):

- A citizen of the United States
- A non-U.S. citizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_ . Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number

OR

- 1. Alien Registration Number/USCIS Number: \_\_\_\_\_
- 2. Form I-94 Admission Number: \_\_\_\_\_

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

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

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

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Signature of Employer: *[Signature]*

Date (mm/dd/yyyy): **06/11/2013**

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator: \_\_\_\_\_

Date (mm/dd/yyyy): \_\_\_\_\_

Last Name (Family Name) \_\_\_\_\_

First Name (Given Name) \_\_\_\_\_

Address (Street Number and Name) \_\_\_\_\_

City or Town \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

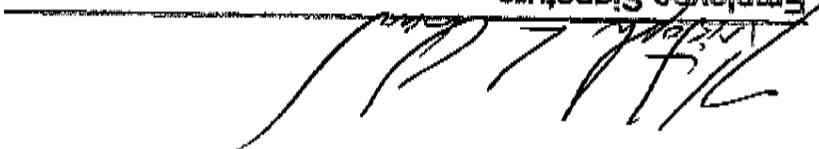
Employer Completes Next Page





Employer Solutions Staffing Group LLC, Representative

Employee Signature



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.

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.

WITNESSETH:

This agreement made this 11 day of JUNE, 2013, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and KRISTOPHER CHARD hereafter referred to as "employee".

**STATEMENT OF CONFIDENTIALITY**



**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 952-941-9041, 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.

<p>New York and other agencies 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.</p>
<p>New York agencies 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.</p>
<p>Oregon agencies 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.</p>
<p>Washington State agencies 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.</p>

**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. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING's website is at [www.orange-tree-screening.com](http://www.orange-tree-screening.com), or 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.

<p>New York agencies or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.</p>
<p>Minnesota and California agencies 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. <input type="checkbox"/> (Must include email address.)</p>
<p>California agencies or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigatory consumer report or consumer credit report if one is obtained by ESSG whenever you have a right to receive such a copy under California law. <a href="http://www.validity.com/site/privacy.cfm">www.validity.com/site/privacy.cfm</a> <input type="checkbox"/> (Must include email address.)</p>

Signature: [Signature] Date: 6-11-13

LAST NAME: CHARD FIRST: KRISTOPHER MIDDLE: LEWIS

Other Names/Alias: [Blank] Social Security #: 374-02-4480 Driver's License #: C 630 478 515 422

Present Address: 2315 LESTER RD. City/State/Zip: DEKER / MT / 43426

Telephone # (Primary): 989-529-1276 State of Driver's License: MI

Date of Birth (mm/dd/yyyy): 06/05/1983

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

### A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to [www.consumerfinance.gov/fairmore](http://www.consumerfinance.gov/fairmore) or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

- You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) for additional information.

- You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- You have the right to dispute inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) for an explanation of dispute procedures.
- Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. However, a consumer reporting agency may continue to report information it has verified as accurate. In most cases, a consumer reporting agency may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore).

- You may limit "prescreened" offers of credit and insurance you get based on information in your credit report. Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8888.
- You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- Identify theft victims and active duty military personnel have additional rights. For more information, visit [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore). For information in español, visit [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore).

escribe a lo Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

ESSG Location: CMO-SM

Rev. 01/2013

Employee's Signature: *[Signature]*

Date: 6-11-13

\*E-mail: *chadkr@yahoo.com*

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.

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

Date: \_\_\_\_\_

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.

Payroll Debit Card Routing #: 122242597

Payroll Debit Card Account #: \_\_\_\_\_

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

City	State	Zip	Primary Phone
Street Address (do not abbreviate)			
First Name	M.I.	Last Name	Date of Birth
Social Security#			

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

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. 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.

- 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.

Bank Name: <i>INDEPENDANT BANK</i>	Account Type: <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other
Routing#: <i>072402652</i>	Account#: <i>700 696 8</i>
<input checked="" type="checkbox"/> Update Bank Account <input type="checkbox"/> Direct Deposit (Please complete Sections 3 and 5 below) <input type="checkbox"/> Payroll Debit Card (Please complete Sections 4 and 5 below)	

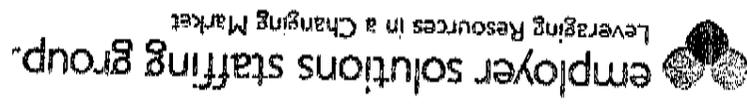
I understand and acknowledge that if I do not provide a voided check (a deposit slip will not work) with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.

Initial: *KLC* Date: 6-11-13

Employee Name: <i>KRISTOPHER CHARD</i>	SSN# (last 4 digits): <i>4480</i>	Effective Date: <i>6-17-13</i>
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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.

Direct Deposit/Payroll Debit Card Authorization



**ATTENTION: ESSG provides employees with electronic pay stubs. You are able to view your pay stub by using either of the following methods:**

1. You can view your check stub by logging into the employee portal at [www.MVPayESG.com](http://www.MVPayESG.com)  
 Your username is the first four letters of your last name followed by the last four numbers of your SSN. For example: John Woods SSN: 111-22-3333 would have a username of Wood3333  
 Your password will initially be Temp1234, and you will be directed to change it when you first log in. Be sure to write down and keep your log-in information in a secure location. For support please email [MyPayESG@MVPayESG.com](mailto:MyPayESG@MVPayESG.com)
2. You can also receive your check stub by email by providing us with your email address below.  
 Email address: Chad K @ Yahoo.com

**ATENCIÓN: ESSG proporciona a los empleados con los talones de pago electrónicos. Usted puede examinar su talon de pago utilizando cualquiera de los métodos siguientes:**

1. Usted puede ver su talón de cheque por la tala en el portal electrónico del empleados en [www.MVPayESG.com](http://www.MVPayESG.com)  
 Su nombre de usuario son las cuatro primeras letras de su apellido seguido por los cuatro últimos dígitos de su número de seguro social.  
 Por ejemplo: Juan Garcia SSN: 111-22-3333 tendría un nombre de usuario de Garcia3333
2. También puede recibir su talón de cheque por correo electrónico. Por favor contacte a [mypayesg@mvpayesg.com](mailto:mypayesg@mvpayesg.com) por correo electrónico para informarte de su dirección de correo electrónico y todos sus talones de cheque serán enviados directamente a su correo electrónico.

Correo electrónico:

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.

Follow all physical restrictions at home and at work.

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.

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.

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.

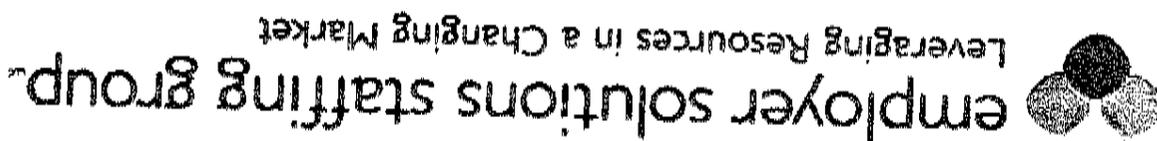
Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

**RESPONSIBILITIES OF THE INJURED WORKER:**

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.

**Injured Worker's Responsibilities**

**INJURY MANAGEMENT PROGRAM**



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: *Christopher L. Chard*

Printed Name: Christopher L. Chard

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

OMB No. 1545-1500

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

Your name: Kristopher L. Chard
Street address where you live: 2315 Leslie Rd
City or town, state, and ZIP code: Decker, MI
County: Sanilac
Telephone number: 989-529-1276
If you are under age 40, enter your date of birth (month, day, year): 06-05-1983

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 90 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: [Handwritten Signature]

TAX CREDIT QUESTIONNAIRE



EMPLOYER SECTION:

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

EMPLOYEE SECTION:

Employee Name:	Street Address:	City/State:	Zip:
SS#: Christopher L. Chard	2315 Leslie Rd	Decker, MI	48426
Date of Birth: 06/05/1983	Age: 30	Have you worked for this company before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, location:

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: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?  Yes  No

2. (If yes, please provide information below.)

Name of the person receiving benefits: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?  Yes  No

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?  Yes  No

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: 05/20/2003 To: 05/19/2007

Branch of Service: USMC

Are you entitled to or are you receiving compensation for a service-connected disability?  Yes  No

Have you been unemployed at any time during the last 12 months?  Yes  No

If yes, dates of unemployment - From: \_\_\_\_\_ To: \_\_\_\_\_

Did you receive unemployment compensation at any point during your unemployment?  Yes  No

6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?  Yes  No

Conviction Date: \_\_\_\_\_ Release Date: \_\_\_\_\_

Was this a  Federal or  State conviction? If State - County: \_\_\_\_\_ State: \_\_\_\_\_

**Additional Tax Credits**

IRC (Native American): Are you or your spouse a member of a Native American Tribe?  Yes  No

*\*If you checked yes please provide a copy of your CDIB card.*

CA Headstart: Are you the child of foster parent?  Yes  No

Do you receive CalWorks?  Yes  No

Do you receive CalWORKS?  Yes  No

Do you receive Family Independence Benefits?  Yes  No

Do you receive Family Independence Benefits?  Yes  No

Do you receive Family Independence Benefits?  Yes  No

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 individual to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. aka Retroia), or the Department of Labor.

### NOTICE OF WAIVER FROM ANNUAL LIMIT REQUIREMENT

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by BCS Insurance Company does not meet the minimum standards required by the Affordable Care Act describe above. Instead, it puts an annual limit on the following plans offered:

Annual Limit	Plan
Both inpatient & outpatient benefits	\$10,000
Outpatient benefits only	\$1,500
Prescription drugs	Subject to outpatient maximum of \$1,500

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 in 2011. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing \$750,000 in coverage for key benefits in 2011 would result in a significant increase in premiums or a significant decrease in access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to [www.HealthCare.gov](http://www.HealthCare.gov)

If you have any questions or concerns about this notice, contact the Essential STARCARE Customer Service at 866-798-0803.

In addition, you can contact:

Minnesota Department of Commerce  
Consumer Concerns

Toll-free-(800) 657-3502 / Main - (651) 296-2488

Form: ESC NV-SAD 10K v11

Date 05/17/2013

*[Signature]*  
 I have read the benefit packet and understand its limitations. I understand that making no benefit selection is a declaration of coverage.  
 I understand that making no benefit selection is a declaration of coverage.

Accidental Death & Dismemberment is part of the Medical Benefit.  
 RELATIONSHIP \_\_\_\_\_  
 NAME OF BENEFICIARY \_\_\_\_\_  
 For Term Life and Accidental Death & Dismemberment please write in your beneficiary information.

**SHORT-TERM DISABILITY**  
 Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.  
 YES  \$4.20 Employee Only  
 NO

Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Relationship:  Spouse  Domestic Partner  Child  
 Sex  M  F

**TERM LIFE**  
 YES  \$0.60 Employee Only  
 \$0.50 Employee +1  
 \$1.50 Employee + Family  
 NO

Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Relationship:  Spouse  Domestic Partner  Child  
 Sex  M  F

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

Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Relationship:  Spouse  Domestic Partner  Child  
 Sex  M  F

**MEDICAL**  
 YES  \$20.91 Employee Only  
 \$42.44 Employee +1  
 \$56.67 Employee + Family  
 NO

Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Relationship:  Spouse  Domestic Partner  Child  
 Sex  M  F

**SELECT COVERAGE LEVEL**  
 Employee Only  
 Employee + Family  
 Employee +1  
 If NO is checked, sign and date the bottom of the form and go no further.  
 NO to all benefits.

\* You MUST enroll in the Medical Insurance Plan before adding STD or Term Life.  
 \* Your coverage level for Term Life will be identical to your medical plan selection.

Do you or any dependents have Medicare?  
 Yes  No If Yes:  
 Medicare Health Insurance Claim Number (HICN) \_\_\_\_\_  
 Medicare Effective Date \_\_\_\_\_  
 Name of Covered Person(s)  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_

Social Security Number 374-02-4480  
 Date of Birth 06/05/1983 Sex  M  F  
 Name Kristopher L. Chant  
 Street Address 2315 Leslie Rd  
 City Doekery State MT Zip 59426  
 Home Phone 9189-529-1276



CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES

THIS IS AN IMPORTANT RECORD, SAFEGUARD IT.

ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME (Last, First, Middle) CHARD Christopher Lewis  
 2. DEPARTMENT, COMPONENT AND BRANCH USMC-11  
 3. SOCIAL SECURITY NUMBER 374 02 4480  
 4a. GRADE, RATE OR RANK SGT  
 b. PAY GRADE E-5  
 5. DATE OF BIRTH (YYYYMMDD) 19830605  
 6. RESERVE OBLIGATION TERMINATION DATE (YYYYMMDD) 20110227  
 7a. PLACE OF ENTRY INTO ACTIVE DUTY MBPS Lansing MI 48910  
 b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) 2315 Leslie Road Decker MI 48426

8a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND 3dBr 2dMar 2dMarDiv Camley NC 28542  
 b. STATION WHERE SEPARATED 3dBr 2dMar 2dMarDiv Camley NC (RUC 12130)  
 9. COMMAND TO WHICH TRANSFERRED Marine Corps Reserve Support Command 15303 Andrews Rd Kansas City MO 64147-1207  
 10. SGLI COVERAGE NONE AMOUNT: \$ 400,000.00

11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.)  
 3531 Motor Vehicle Operator 3 years 5 months

a. DATE ENTERED AD THIS PERIOD	b. SEPARATION DATE THIS PERIOD	c. NET ACTIVE SERVICE THIS PERIOD	d. TOTAL PRIOR ACTIVE SERVICE	e. TOTAL PRIOR INACTIVE SERVICE	f. FOREIGN SERVICE	g. SEA SERVICE	h. EFFECTIVE DATE OF PAY GRADE
2003 05 20	2007 05 19	04 00 00	00 00 00	00 02 23	01 01 03	00 00 00	2007 02 01

12. RECORD OF SERVICE

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN  
 RIBBONS AWARDED OR AUTHORIZED (All periods of service)  
 Marine Corps Good Conduct Medal, Combat Action Ribbon (Iraq), Sea Service Deployment Ribbon (2d Award), Iraq Campaign Medal, Global War on Terrorism Expeditionary Medal (Iraq), Global War on Terrorism Service Medal, National Defense Service Medal, Navy Meritorious Unit Commendation, Certificate of Commendation, Rifle Qualification Badge (Expert)

14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed)  
 Sergeant Non-Resident Program (T3W) 2006, Motor Vehicle Operation cts (35X) 2003, Marine Combat Training cts (M92) 2003.

15a. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS EDUCATIONAL ASSISTANCE PROGRAM  
 YES  NO   
 15b. HIGH SCHOOL GRADUATE OR EQUIVALENT  
 YES  NO   
 16. DAYS ACCRUED LEAVE PAID RLB 0.5 SLB 0  
 17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION  
 YES  NO

18. REMARKS  
 45020-2007-0617  
 Good Conduct Medal period commences 20060520  
 SNM contributed to the MGB \$1,200.00  
 Subject to active duty recall and or annual screening.  
 While a member of the Marine Corps Reserve, you will keep the Commanding General, MCRSC (Toll Free 1-800-255-5082) informed of any change of address, marital status, number of dependents, civilian employment, or physical standards.  
 The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or non-Federal agency for verification purposes and to determine eligibility for, and/or continued compliance with, the requirements of a Federal benefit program.

19a. MAILING ADDRESS AFTER SEPARATION (Include ZIP Code) 6916 W Sallace Rd Kingston MI 48741  
 b. NEAREST RELATIVE (Name and address - include ZIP Code) Deena M. Chard (Spouse) Same as block 19a.

20. MEMBER REQUESTS COPY & BE SENT TO  
 ML DIRECTOR OF VETERANS AFFAIRS  
 YES  NO   
 21. SIGNATURE OF MEMBER BEING SEPARATED  
 E. R. VIEBROCK, MSGT, PERSCHIEF, USMC

23. TYPE OF SEPARATION Released from active duty  
 24. CHARACTER OF SERVICE (Include upgrades) HONORABLE  
 25. SEPARATION AUTHORITY MARCORSEPMAN PAR 1005  
 26. SEPARATION CODE MBKI  
 27. REENTRY CODE RE-1A

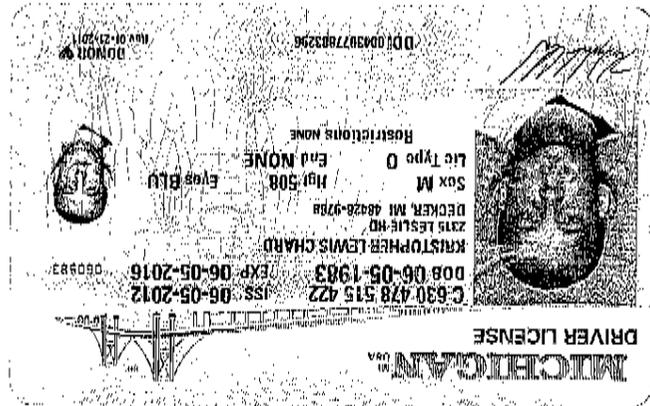
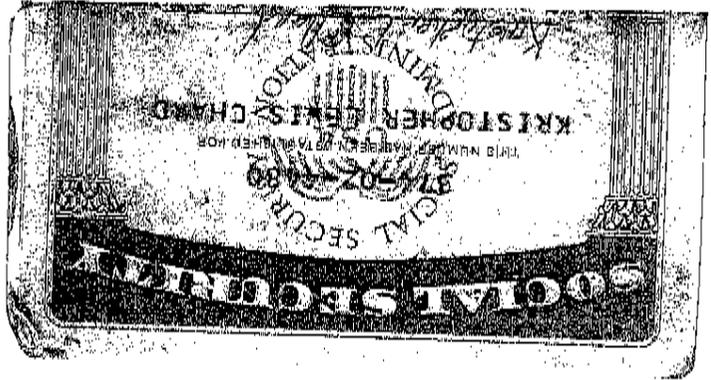
28. NARRATIVE REASON FOR SEPARATION COMPLETION OF REQUIRED ACTIVE SERVICE  
 29. DATES OF TIME LOST DURING THIS PERIOD (YYYYMMDD) None  
 30. MEMBER REQUESTS COPY 4 (Initials) *EV*

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ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

**CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY**

1. NAME (Last, First, Middle) <b>CHARL K. KRISTOPHER LEWIS</b>		2. DEPARTMENT, COMPONENT AND BRANCH <b>USMC-11</b>		3. SOCIAL SECURITY NUMBER <b>374 02 4480</b>	
4a. GRADE, RATE OR RANK <b>Sgt</b>		b. PAY GRADE <b>E-5</b>		5. DATE OF BIRTH (YYYYMMDD) <b>19830605</b>	
6. RESERVE OBLIGATION TERMINATION DATE <b>20110227</b>		6. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) <b>2315 Leslie Road Decker MI 48426</b>			
7a. PLACE OF ENTRY INTO ACTIVE DUTY <b>MEPS Lansing MI 48910</b>		7b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) <b>2315 Leslie Road Decker MI 48426</b>			
8a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND <b>3Bdn 2dMar 2dMarDiv Camley NC 28542</b>		8b. STATION WHERE SEPARATED <b>3Bdn 2dMar 2dMarDiv Camley NC (RUC 12130)</b>			
9. COMMAND TO WHICH TRANSFERRED <b>Marine Corps Reserve Support Command 15303 Andrews Rd Kansas City MO 64147-1207</b>					
10. SGLI COVERAGE <b>AMOUNT: \$ 400,000.00</b> NONE					
11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.) <b>3531 Motor Vehicle Operator 3 years 5 months</b>					
12. RECORD OF SERVICE					
a. DATE ENTERED AD THIS PERIOD	2003	05	20		
b. SEPARATION DATE THIS PERIOD	2007	05	19		
c. NET ACTIVE SERVICE THIS PERIOD	04	00	00		
d. TOTAL PRIOR ACTIVE SERVICE	00	00	00		
e. TOTAL PRIOR INACTIVE SERVICE	00	02	23		
f. FOREIGN SERVICE	01	01	03		
g. SEA SERVICE	00	00	00		
h. EFFECTIVE DATE OF PAY GRADE	2007	02	01		
13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) <b>Marine Corps Good Conduct Medal, Combat Action Ribbon (Iraq), Sea Service Deployment Ribbon (2d Awd), Iraq Campaign Medal, Global War on Terrorism Expeditionary Medal (Iraq), Global War on Terrorism Service Medal, National Defense Service Medal, Navy Meritorious Unit Commendation, Certificate of Commendation, Rifle Qualification Badge (Expert)</b>					
14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed) <b>Sergeant Non-Resident Program (T3W) 2006, Motor Vehicle Operation crs (35X) 2003, Marine Combat Training crs (M92) 2003.</b>					
15a. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS' EDUCATIONAL ASSISTANCE PROGRAM <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
b. HIGH SCHOOL GRADUATE OR EQUIVALENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
16. DAYS ACCRUED LEAVE <b>PAID RLB 0.5 SLB 0</b>					
17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
18. REMARKS <b>45020-2007-0617</b> Good Conduct Medal period commences 20060520 SNM contributed to the MGIB \$1,200.00 Subject to active duty recall and/or annual screening. While a member of the Marine Corps Reserve, you will keep the Commanding General, MCRSC (Toll Free 1-800-255-5082) informed of any change of address, marital status, number of dependents, civilian employment, or physical standards. The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or non-Federal agency for verification purposes and to determine eligibility for, and/or continued compliance with, the requirements of a Federal benefit program.					
19a. MAILING ADDRESS AFTER SEPARATION (Include ZIP Code) <b>6916 W Saniace Rd Kingston MI 48741</b>					
b. NEAREST RELATIVE (Name and address - include ZIP Code) <b>Deena M. Chard (Spouse) Same as block 19a.</b>					
20. MEMBER REQUESTS COPY 6 BE SENT TO <b>MI</b>					
22. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title and signature) <b>E. R. VIEBROCK, MSGT, PERSCHIER, USMC</b>					

DD FORM 214, FEB 2000  
PREVIOUS EDITION IS OBSOLETE  
MEMBER - 1



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PAY TO THE ORDER OF

*VOID*

2315 LESLIE ROAD  
 DECKER, MI 48426  
 (989) 529-1276

KRISTOPHER L. CHARD

Land of the Free

154

7A2057

DOLLARS