E-Verify
Employment Eligibility Verification

SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2016194091536QQ

Report Prepared: 07/12/2016

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Combs

First Name: Patrick

Date of Birth: 12/23/1970

Social Security Number: *** ** 7521

Hire Date: 07/12/2016

Citizenship Status: A citizen of the United States

Document Information

List B Document: Driver's license or ID card issued by a U.S. state or outlying possession

List C Document: U.S. birth certificate (original or certified copy)

Document Name: Driver's license

Document State: Indiana

Driver's License or ID Card Number:

Document Expiration Date: 12/23/2018

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 07/12/2016

Case Submitted By: JEIC3094

Closed On: 07/12/2016

Closed By: JEIC3094

Closure Statement: The employee continues to work for the employer after receiving an Employment Authorized result.

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 Combs **First Name** Patrick **Middle Initial** F

Street Address 424 9th Ave. N. **Apt/Ste** _____

City/State/Zip St. Cloud Mn. 56303 **Social Security Last Four** XXX-XX-____

Phone Number (320) 774-1663 **Email Address** cathymccoy66@yahoo.com

Staffing Agency/Recruitment Partner CMG

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.

Patrick Combs — Name (Print or type)

Patrick Combs — Applicant's Signature

7/12/2016 — 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 _____

CERTIFICATION OF VITAL RECORD

STATE OF ILLINOIS

DEPARTMENT OF PUBLIC HEALTH - DIVISION OF VITAL RECORDS

CHILD'S BIRTH NUMBER 112-70 667999

MATCHING IDC

REGISTRATION DISTRICT NO. 16.10

REGISTERED NUMBER

STATE OF ILLINOIS

CERTIFICATE OF LIVE BIRTH

1. CHILD—NAME: FIRST Patrick; MIDDLE Fitzgerald; LAST Comb

2a. DATE OF BIRTH (MONTH, DAY, YEAR): December 23, 1970

2b. HOUR: 5:49 A M.

3. SEX: Male

4a. THIS BIRTH—SINGLE, TWIN, TRIPLET, ETC. (SPECIFY): Single

4b. IF NOT SINGLE BIRTH—BORN FIRST, SECOND, THIRD, ETC. (SPECIFY):

5a. PLACE OF BIRTH: COUNTY: Cook

5b. CITY, TOWN, TWP. OR ROAD DISTRICT NO.: Chicago

5c. INSIDE CITY (YES/NO): Yes

5d. HOSPITAL—NAME (IF NOT IN HOSPITAL, GIVE STREET AND NUMBER): Cook County Hospital Wd. 50

6a. MOTHER—MAIDEN NAME: FIRST Patricia; MIDDLE Ann; LAST McFerson

6b. AGE (AT TIME OF THIS BIRTH): 19

6c. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Indiana

7a. RESIDENCE STATE: Illinois

7b. COUNTY: Cook

7c. CITY, TOWN, TWP. OR ROAD DISTRICT NO.: Chicago

7d. INSIDE CITY (YES/NO): Yes

7e. STREET AND NUMBER: 640 E. 47th St.

7f. MOTHER'S COMPLETE MAILING ADDRESS: STREET AND NUMBER OR R. F. D.: 640 E. 47th St.; CITY OR TOWN: Chicago; STATE: Illinois; ZIP: 60653

8a. FATHER—NAME: FIRST Marvin; MIDDLE Lee; LAST Combs

8b. AGE (AT TIME OF THIS BIRTH): 21

8c. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Illinois

9a. INFORMANT'S SIGNATURE: Patricia A. Combs

9b. RELATION TO CHILD: Mother

I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE.

10a. SIGNATURE: Sidney H. Coleman

10b. DATE SIGNED (MONTH, DAY, YEAR): December 23, 1970

10c. ATTENDANT—M.D., D.O., MIDWIFE, OTHER (SPECIFY): M.D.

10d. ILLINIS LICENSE NUMBER: 36-41965

Amended: 10/26/92

10e. CERTIFIER'S COMPLETE MAILING ADDRESS: STREET AND NUMBER OR R. F. D.: 1835 W. Harrison; CITY OR TOWN: Chicago; STATE: Illinois; ZIP: 60612

11a. LOCAL REGISTRAR'S SIGNATURE: Nancy C. Brown, M.D.

11b. DATE REC'D BY LOCAL REGISTRAR (MONTH, DAY, YEAR): DEC 29 1970

VS 100 — (1968) ILLINOIS DEPARTMENT OF PUBLIC HEALTH — BUREAU OF STATISTICS (BASED ON 1968 U. S. STANDARD CERTIFICATE)

342521

This is to certify that this is a true and correct copy of the official record filed with the Illinois Department of Public Health.

DATE ISSUED

OCT 28 1992

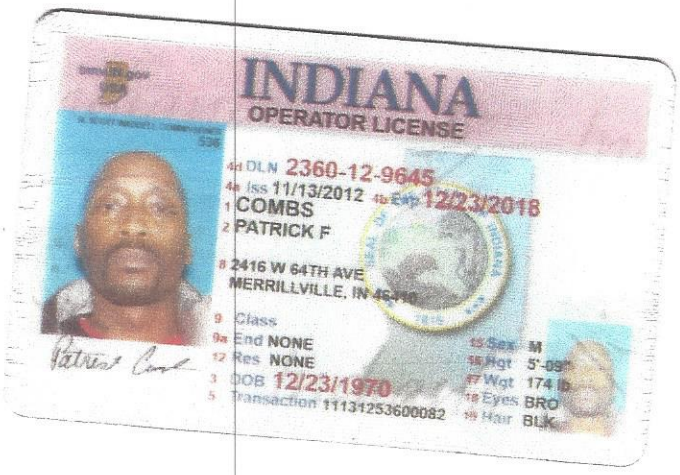
Steven L. Perry

STEVEN L. PERRY
DEPUTY STATE REGISTRAR

SEAL OF THE STATE OF ILLINOIS AUG. 26TH 1818

DEPT. OF PUBLIC HEALTH STATE OF ILLINOIS

American Banknote Company ANY ALTERATION OR ER... VOIDS THIS CERTIFICATE


INDIANA
OPERATOR LICENSE
4d DLN 2360-12-9645
4a Iss 11/13/2012
4b Exp 12/23/2018
1 COMBS
2 PATRICK F
8 2416 W 64TH AVE
MERRILLVILLE, IN 46410
9 Class
9a End NONE
12 Res NONE
3 DOB 12/23/1970
5 Transaction 11131253600082
15 Sex M
16 Hgt 5'-09"
17 Wgt 174 lb
18 Eyes BRO
19 Hair BLK

Form W-4 (2016)

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 2016 expires February 15, 2017. 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 cannot claim exemption from withholding if your 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 do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not 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 2016. 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*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
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.	B	
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.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
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 $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G	
H	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.) ▶	H	

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 **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **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.**

OMB No. 1545-0074

2016

1 Your first name and middle initial: Patrick F	Last name: Combs	2 Your social security number: 305-78-7521
Home address (number and street or rural route): 424 9th Ave. N.	3 ☑ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code: St. Cloud MN 56303	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. ▶ ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	5
6 Additional amount, if any, you want withheld from each paycheck	6	$
7 I claim exemption from withholding for 2016, 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 ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ Patrick Combs **Date** ▶ 7/12/2016

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 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 *(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*)	First Name (*Given Name*)	Middle Initial	Other Names Used (*if any*)
Combs	Patrick	F	

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code
424 9th Ave N		St Cloud	MN	56303

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
	305-78-7521	cathymccoy66@yahoo.com	(320) 774-1663

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):

- [x] A citizen of the United States
- [ ] A noncitizen 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:*

1. Alien Registration Number/USCIS Number: _____

OR

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*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (*mm/dd/yyyy*):
Patrick Combs	7/12/2016

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

STOP ***Employer Completes Next Page*** STOP

STOP **Employer Completes This Page** STOP

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1: Combs, Patrick F

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: Drivers License		Document Title: Birth Certificate
Issuing Authority:		Issuing Authority: Indiana		Issuing Authority: State of Illinois
Document Number:		Document Number: 2360-12-9645		Document Number: 112-70-667999
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: 12/23/2018		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)*:				

3-D Barcode
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)*: 07/12/2016 **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
	07/10/2016	ON-Site Rep

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Fichter	Jill	EMPLOYER SOLUTIONS STAFFING GROUP LLC

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
7301 OHMS LANE SUITE 405	EDINA	MN	55439

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

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: _____)

Signature: Patrick Combs Date: 7/12/2016

BACKGROUND INFORMATION

Last Name: Combs First: Patrick Middle: Fitzgerald

Other Names/Alias: _____

Social Security #*: 305-78-7521 Date of Birth (mm/dd/yyyy)*: 12/23/70

Driver's License #: 2360-12-9645 State of Driver's License: In

Present Address: 424 9th Ave N Telephone # (Primary): (320) 774-1663

City/State/Zip: St Cloud MN 56303

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

employer solutions staffing group
Leveraging Resources in a Changing Market

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
Patrick Combs	305-78-7521	7/12/2016

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
Patrick	F.	Combs	12-23-1970

Street Address (PO BOX NOT ACCEPTABLE)	Social Security#
329 9th Ave. North	305-78-7521

City	State	Zip	Cell Phone (mobile)
St. Cloud	MN	56303	320-774-1663

GET TEXT ALERTS, when your paycheck is deposited on your card!
All we need to know your cell phone service provider and mobile number above!

☐ Yes, sign me up, for text alerts
My mobile service provider is: ND

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	4553 4001 5319 3513

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: Patrick Combs Date: 7/12/2016

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:** CathyMcCoy166 @yahoo.com
this information will only be used to send your paystubs electronically

Employee's Signature: Patrick Combs Date: 7/12/2016

EMERGENCY CONTACT INFORMATION

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

Employee Name: Patrick Combs

Address: 424 9th Ave N St Cloud MN 56303

Home Phone: (320) 774-1663

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: Relationship:	Home Phone: Cell Phone: Work Phone:
Contact #2 Name: Relationship:	Home Phone: Cell Phone: Work Phone:

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

N/A at this point

This information will remain confidential and will only be used in the case of an emergency.

employer solutions staffing group
Leveraging Resources in a Changing Market

ESG employer solutions group

ESNG employer solutions nationwide group

bpa Benefit Plan Administrators, Inc.

New Employee
Rehire *Rehire Date*_____

For Status Change Please Check: ***You MUST provide a supporting Document***
Change of Status Birth/ Adoption Marriage Divorce
Spouse Loss of Coverage Plan Change
Cancel Employee/Dependents
Date of Status Change:

Benefits Enrollment Form

Employee Information

Name (Last, First, MI)	Date of Birth	Social Security Number
Combs Patrick F	12/23/1970	305-78-752C

Address	City	State	Zip Code
424 9th Ave N	St Cloud	~~AA~~ MN	56303

Gender	Marital Status	Phone Number:	Date of Hire
~~Male~~ Female	Married ~~Single~~ Divorced	(320) 774-1663	7/12/2016

Please Select Coverage Elected: Enhanced MEC Plan

Email Address: cathymccoy66@yahoo.com

Coverage Level :

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

Dependent Information

Dependent	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Last Name First Name M.I. Social Security #	Male Female		Medical	Add Change Waive Terminate
Dependent	**Sex**	**Birth Date**	**Coverage Elected**	**Add (Enroll) Change, or Terminate**
Last Name First Name M.I. Social Security #	Male Female		Medical	Add Change Waive Terminate
Dependent	**Sex**	**Birth Date**	**Coverage Elected**	**Add (Enroll) Change, or Terminate**
Last Name First Name M.I. Social Security #	Male Female		Medical	Add Change Waive Terminate

Other coverage information including Medicare/Medicaid

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

EFF. DATE

EFF. DATE

EFF. DATE

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

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature **Date**

EMPLOYEES DECLINING **Declining due to other 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 Patrick Combs **Date** 7/12/2016

Employer Solutions Staffing Group Health Benefits Team
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com