employer solutions staffing group.
Leveraging Resources in a Changing Market

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

New Hire Application

Personal Data-- <u>PLEASE PRINT LEGIBLY IN INK</u>

Last Name Hard **First Name** Christian **Middle Initial** F

Street Address 5127 W 67th Loop **Apt.** ____________

City/State/Zip Westminster, CO, 80030

Home Phone ____________ **Cell / Message Phone** 720-276-4811

Company/Employer ____________

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.

Christian F Hard
Name (Print or type)

Applicant's Signature

04/29/2013
Date

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

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

Form W-4 (2013)

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 2013 expires February 17, 2014. 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 $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

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 2013. 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** 1

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** 1

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** Ø

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 $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . **F**
(**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 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children.
- If your total income will be between $65,000 and $84,000 ($95,000 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** 2

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 $40,000 ($10,000 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
2013

1 Your first name and middle initial	Last name	2 Your social security number
Christian F	Hard	521-69-0142

Home address (number and street or rural route): 5127 W 69th Loop

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: Westminster CO 80030

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**

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

7 I claim exemption from withholding for 2013, 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.) ▶ [signature] **Date** ▶ 04/29/2013

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)

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

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 documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last: Hard | First: Christian | Middle Initial: F | Maiden Name:

Address *(Street Name and Number)*: 5127 W 69th Loop | Apt. #: | Date of Birth *(month/day/year)*: 12/15/1988

City: Westminster | State: CO | Zip Code: 80030 | Social Security #: 521-69-0142

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 #) ______
- [ ] An alien authorized to work (Alien # or Admission #) ______ until (expiration date, if applicable - *month/day/year*)

Employee's Signature: [signature] | Date *(month/day/year)*: 04/29/2013

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.*

Preparer's/Translator's Signature: | Print Name:

Address *(Street Name and Number, City, State, Zip Code)*: | Date *(month/day/year)*:

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:			Temp Licence		Birth Certificate
Issuing authority:			CO		CO
Document #:			04-126-0510		105198805126 2
Expiration Date *(if any)*:			12.15.18		
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* 4.29.13 **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative: [signature] | Print Name: Tina Krol | Title: Acct Mgr

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*: EMPLOYER SOLUTIONS STAFFING GROUP 7301 OHMS LANE, STE 405 EDINA, MN 55439 | Date *(month/day/year)*: 4.29.13

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)* | B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: ______ Document #: ______ Expiration Date *(if any)*: ______

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 *(month/day/year)*

COLORADO TEMPORARY DOCUMENT

Valid for 30 days from 4/22/2013

URN: 13112153524

License Number: 04-126-0510 Expiration Date: 12/15/2018

Type: Adult Identification Card

Previous License Type: NONE

CHRISTIAN FARELL HARD
5127 W 69TH LOOP
WESTMINSTER CO 80030

Mailing Address: Birth Date: 12/15/1988

Male 155 lbs 5 ft.10 inches BRO Hair BRO Eyes

Endorsements: Restrictions:

Donor: Y Voter: Medical Information:

Surrender License State:
License Number:

I agree within thirty (30) days after the date I become a resident to register any vehicle that I own and operate in Colorado pursuant to 42-2-107(2)(b)(I)(A)&(B).

For males 18 years of age and older:

By submitting this application, I am consenting to being registered with Selective Service, if so required by Federal Law.

I hereby certify that the above information given is true and correct and I understand that any false information given will be cause for cancellation of my identification card.

Signature of Applicant 4/22/2013

Fee: 10.50 Examiner
DAF: 0.00 RLL

CERTIFICATION OF VITAL RECORD

STATE OF COLORADO

COLORADO DEPARTMENT OF HEALTH
CERTIFIED ABSTRACT OF BIRTH

STATE FILE NUMBER 1051988051262	DATE FILED DECEMBER 22, 1988
NAME OF REGISTRANT CHRISTIAN FARELL HARD	
DATE AND TIME OF BIRTH DECEMBER 15, 1988 08:57 P.M.	SEX MALE
CITY OF BIRTH DENVER	COUNTY OF BIRTH DENVER
MOTHER'S MAIDEN NAME LISA LYNNE SMITH	FATHER'S NAME JAMES FARELL HARD
MOTHER'S PLACE OF BIRTH COLORADO	FATHER'S PLACE OF BIRTH COLORADO
MOTHER'S AGE 26	FATHER'S AGE 23

SS337483

THIS IS A TRUE CERTIFICATION OF NAME AND BIRTH FACTS AS RECORDED IN THIS OFFICE.

DATE ISSUED MAY 10, 1994

JOSEPH D. CARNEY
STATE REGISTRAR

Do not accept unless prepared on security paper with engraved border displaying the Colorado state seal and signature of the Registrar. PENALTY BY LAW, Section 25-2-118, Colorado Revised Statutes, 1982, if any person alters, uses, attempts to use or furnishes to another for deceptive use any vital statistics record. NOT VALID IF PHOTOCOPIED.

VR 101 8/90

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

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

Employee Name: Christian F Hard

Address: 5127 W 69th Loop, Westminster, CO, 80030

Home Phone: (720) 276-4811

Person(s) to contact in case of an emergency on the job (in order of preference):

1. **Name:** James Hard

   Phone (work): (3) 375 - 9115

   Cell ~~Phone~~ (~~home~~): (3) 204 - 4646

2. **Name:** Leslie Hard

   Phone (work): ______

   Cell ~~Phone~~ (~~home~~): (3) 903- 5370

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

______

STATEMENT OF CONFIDENTIALITY

This agreement made this 29th day of April, 2013, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Christian F Hard hereafter referred to as "employee".

WITNESSETH:

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

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

Employee Signature

Employer Solutions Staffing Group LLC, Representative

employer solutions staffing group
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
Christian F Hard	521-69-0142	04/29/2013

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: Academy Bank
Routing#
Account#
Account Type: ☒ Checking ☐ Savings ☐ Other:

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 CFH Date 04/29/2013

- 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

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 no ... a
Payroll Deb ...
so they can ... tion information

Except for tl ... t or transactions.
On your firs ... then sign
acknowledg ... ceive wages.

CARDHOL
First Name
Street Addre
City
RECEIPT (
Payroll Debi
122
I have receiv ... oll

82-148/1070

DATE

PAY TO THE ORDER OF VOID $

DOLLARS

ACADEMY BANK N.A.
877-712-2265 or academybankco.com

VOID

MEMO

⑆107001481⑆ 4359012⑈

Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature: ______________________ Date: __________

SECTION 5 AUTHORIZATION

I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s). * **E-mail is required for pay stub information.**

***E-mail:** Christianhard88@gmail.com

Employee's Signature: [signature] Date: 04/29/2013

ESSG Location: CMG-SM

Rev. 01/2013

employer solutions staffing group
Leveraging Resources in a Changing Market

INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

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

RESPONSIBILITIES OF THE INJURED WORKER:

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

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

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

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

Follow all physical restrictions at home and at work.

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

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

<u>Notify your employer immediately of any new injuries or conditions that impact your physical condition.</u>

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

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

Signed:

Printed Name: Christoan F Hard

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

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

▶ See separate instructions.

OMB No. 1545-1500

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

Your name Christian F Hard Social security number ▶ 521-69-0142

Street address where you live 5127 W 69th Loop

City or town, state, and ZIP code Westminster, CO, 80030

County Adams Telephone number 720 276 4811

If you are under age 40, enter your date of birth (month, day, year) 12 15 1988

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

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a Received SNAP benefits (food stamps) for the past 6 months, **or**
  b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months, **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

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

Job applicant's signature ▶ **Date** 04/29/2013

Form A (rev. 08/12)

TAX CREDIT QUESTIONNAIRE

RETROTAX
Specialists in Tax Credit Administration

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

Employee Name:	Street Address:	City/State:	Zip:
Christian F Hard	5127 W 69th Loop	Westminster, CO	80030

SS#:	Date of Birth:	Age:	Have you worked for this company before?	If yes, location:
521-69-0142	12/15/1988	24	[ ] Yes [X] No	

Please complete all questions, and sign and date the form. Yes / No

1. **Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?** (If yes, please provide information below.) [ ] Yes [X] No
   Name of the person receiving benefits: ______ Relationship to you: ______
   City: ______ County: ______ State: ______

2. **Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?** (If yes, please provide information below.) [ ] Yes [X] No
   Name of the person receiving benefits: ______ Relationship to you: ______
   City: ______ County: ______ State: ______

3. **Have you received Supplemental Security Income (SSI) at any time within the past 3 months?** [ ] Yes [X] 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 [X] 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.* [ ] Yes [X] No
   (If yes, please provide information below. If no, please continue to question #6.)
   Dates of Service - From: ___/___/_____ To: ___/___/_____
   Branch of Service: ______
   Are you entitled to or are you receiving compensation for a service-connected disability? [ ] Yes [X] No
   Have you been unemployed at any time during the last 12 months? [ ] Yes [X] No
   If yes, dates of unemployment - From: ___/___/_____ To: ___/___/_____
   Did you receive unemployment compensation at any point during your unemployment? [ ] Yes [X] No

6. **Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?** [ ] Yes [X] No
   Conviction Date: ___/___/_____ Release Date: ___/___/_____
   Was this a [ ] Federal or [ ] State conviction? If State - County: ______ State: ______

Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe? [ ] Yes [X] No
**If you checked yes please provide a copy of your CDIB card.*

CA Residents: [ ] Are you the child of foster parents? [ ] Do you receive CalWorks? [ ] Workforce Investment Act?
[ ] Are you a migrant or seasonal farm worker? [ ] Have you ever been convicted of a misdemeanor?

SC Residents: [ ] Do you receive Family Independence Benefits?

PLEASE READ, SIGN, AND DATE:

Under penalties of perjury, I declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. dba Retrotax), or the Department of Labor.

New Employee Signature: [signature] **Date:** [illegible]

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

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

In addition, you can contact:

Minnesota Department of Commerce
Consumer Concerns
Toll-free- (800) 657-3602 / Main – (651) 296-2488

219301-EMP | OFFICE USE ONLY

ReHire Date __/__/____

EMPLOYEE INFORMATION (Must Be Filled Out)

ENROLLMENT FORM - 10k PLAN

USE BLACK or BLUE INK ONLY

Social Security Number 521-69-0142

Date of Birth 12/15/1988 Sex [X] M [ ] F

Name Christian F Hard

Street Address 5127 W69th Loop

City Westminster State CO Zip 80030

Home Phone 720-276-4811

Do you or any dependents have Medicare?
[ ] Yes [X] No If Yes:
Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date __/__/____

Names of Covered Person(s)
1.
2.
3.
4.

- 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.

BENEFIT SELECTION

Weekly Rates

SELECT COVERAGE LEVEL

[X] **Employee Only** [ ] **Employee + Family**
[ ] **Employee +1** [ ] **NO to all benefits.**

If NO is checked, sign and date the bottom of the form and go no further.

MEDICAL

[X] YES
[ ] NO

$20.91 Employee Only
$42.44 Employee + 1
$56.67 Employee + Family

DENTAL

[X] YES
[ ] NO

$ 5.99 Employee Only
$11.98 Employee +1
$19.77 Employee + Family

TERM LIFE

[X] YES
[ ] NO

$0.60 Employee Only
$0.90 Employee +1
$1.80 Employee + Family

SHORT-TERM DISABILITY

[X] YES
[ ] NO

$4.20 Employee Only

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

REQUIRED DEPENDENT INFORMATION

Name
Social Security Number ___-__-____
Date of Birth __/__/____ Sex [ ] M [ ] F
Relationship: [ ] Spouse [ ] Domestic Partner [ ] Child

Name
Social Security Number ___-__-____
Date of Birth __/__/____ Sex [ ] M [ ] F
Relationship: [ ] Spouse [ ] Domestic Partner [ ] Child

Name
Social Security Number ___-__-____
Date of Birth __/__/____ Sex [ ] M [ ] F
Relationship: [ ] Spouse [ ] Domestic Partner [ ] Child

Name
Social Security Number ___-__-____
Date of Birth __/__/____ Sex [ ] M [ ] F
Relationship: [ ] Spouse [ ] Domestic Partner [ ] Child

BENEFICIARY INFORMATION

For Term Life and Accidental Death & Dismemberment please write in your Beneficiary information.

NAME OF BENEFICIARY
James F Hard

RELATIONSHIP
Father

Accidental Death & Dismemberment is part of the Medical Benefit.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

▶ **Signature** [signature]

Date 04/29/2013

Notification of Colorado Law Requirement – Unemployment Acknowledgement

According to Colorado Statutes section 8-73-105.3. A temporary employee who is given a notice that the employee is required to contact or notify the employer upon completion of an assignment and to be available to work, as agreed upon at the time of hire, during a specified period of time, on specified dates, or upon call by the employer on an as-needed basis and who does not contact or notify the employer upon completion of an assignment in compliance with the notice and is not available to work at the agreed-upon times is deemed to have voluntarily terminated employment for the purpose of determining benefits pursuant to section 8-73-108 (5) (e). Also, a temporary employee who agrees to work on an as-needed basis and refuses all work within three separate pay periods when contacted by the employer is deemed to have voluntarily terminated employment for reasons that may or may not allow an award of benefits pursuant to section 8-73-108.

It is your responsibility to contact or notify ESSG once your assignment ends. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact or notify ESSG once an assignment ends. I also acknowledge that I have received a separate copy of this form. CFH (Initial)

HARD
Employee Signature:

04/29/2013
Date:

Christian F Hard
Employee (please print your name here)

CMG-08/2011

employer solutions staffing group
Leveraging Resources in a Changing Market

To: All Employees
Quien: *Todos Empleados*

From: Corporate Management Group & Employer Solutions Group
De: *Corporate Management Group y Employer Solutions Group*

Re: Stop Payment Check Fee
Re: *Tarifa de cheque parado*

Effective immediately, to replace a lost or stolen check, $50.00 will be deducted from the replacement check for a stop payment fee and for a reprocessing fee. *Efectivo inmediatamente, para reemplazar un cheque de sueldo perdido o robado, $50.00 de tarifa sera deducido de el cheque reemplazado para parar el cheque original y para procesarlo denuevo.*

If you lose your check, we will first have to verify that it has not been processed through the bank. If it has not, a new check will be issued, minus the $50.00 fee. *Si usted pierde su cheque, tendremos que verificar que no ha sido procesado en el banco. Si no, un cheque nuevo sera processado, menos las tarifa de $50.00.*

If your check is stolen, we will first need a copy of the police report before a new check can be reissued. After we receive a copy of the police report, a new check will be issued following the same procedures as listed above. *Si su cheque es robado, necesitaremos una copia de el reporte de policia antes de que un cheque nuevo sera procesado. Despues de obtener una copia del reporte de policia, un cheque nuevo sera procesado usando los mismos procedimientos mencionados arriba.*

If you have any questions regarding this new policy, please contact your On-Site Representative or the Corporate Office (303-920-1425). *Si usted tiene preguntas sobre esta poliza, por favor contacte a su representante de CMG o la oficina corporal al (303-920-1425)*

Thank you for your continued dedication and hard work!

Gracias por su dedicacion continua!

By signing below you are confirming that you understand the above policy.
Con su firma abajo usted esta confirmando que entiende la poliza descrita.

Signature/Firma: [signature]

Date/Fecha: 04/29/2013

Address
7301 Ohms Lane, Suite 405
Edina, Minnesota 55439

Telephone 952.835.1288
Facsimile 952.835.1255

Web www.ESGStaffingSolutions.com
Email info@ESGStaffingSolutions.com

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.MyPayESG.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@MyPayESG.com

2. You can also receive your check stub **by email** by providing us with your email address below.

   Email address: Christianhard88@gmail.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.MyPayESG.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 Garc3333

   Su contraseña inicialmente será **Temp1234**, y usted será dirigido a cambiarla la primera vez que inicie sesión. Asegúrese de anotar y guardar su información de registro en un lugar seguro.

2. También puede recibir su talón de cheque por correo electrónico. Por favor contacte a mypayesg@mypayesg.com por correo electrónico para informarle de su dirección de correo electrónico y todos sus talones de cheque serán enviados directamente a su correo electrónico.

   Correo electrónico: ______________________________