Employer Solutions Staffing Group LLC

New Hire Application

7301 Ohms Lane / Suite 405
Edina, MN 55439
T:952.835.1288 / F:952.835.4881

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Lor **First Name** Pao Ge **Middle Initial** ____

Street Address 8371 Quigley St.

City/State/Zip Westminster CO. 80031

Home Phone _____ **Cell / Message Phone** 720-402-8975

Company/Employer Covidien

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.

Pao Ge Lor
Name (Print or type)

Applicant's Signature

7-22-13
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	5 Day Letter (If applicable)	ESC Application

Affirmation of Legal Work Status

Pursuant to § 8-2-122, Colorado Revised Statutes

Employee Name: Cov (Last) Rao Cie (First Middle) 7-3-92 (Date of Birth)

Social Security Number: 604 - 58 - 0505 Date of Hire: _____

In accordance with § 8-2-122, C.R.S., within twenty days after hiring the new employee listed above,

I affirm all four of the following:

1. I have examined the legal work status of the above named employee.
2. I have retained file copies of the documents required by 8 U.S.C. sec. 1324a.
3. I have not altered or falsified the employee's identification documents.
4. I have not knowingly hired an unauthorized alien.

_____ Print Name of Employer (or Designated Representative)

_____ Official Title

_____ Signature of Employer (or Designated Representative)

_____ Date Signed

Employer Solutions Staffing Group, LLC
7301 Ohms Lane, Suite 405
Edina, MN 55439

_____ Business or Organization Name

_____ Employer Phone Number

§ 8-2-122(2), C.R.S.: On and after January 1, 2007, within twenty days after hiring a new employee, each employer in Colorado shall affirm that the employer has examined the legal work status of such newly-hired employee and has retained file copies of the documents required by 8 U.S.C. sec. 1324a; that the employer has not altered or falsified the employee's identification documents; and that the employer has not knowingly hired an unauthorized alien. The employer shall keep a written or electronic copy of the affirmation, and of the documents required by 8 U.S.C. sec. 1324a, for the term of employment of each employee.

This affirmation and the documents required by 8 U.S.C. sec. 1324 (copies or electronic copies) will be retained for the duration of the above named individual's employment.

This affirmation is provided as a courtesy by the Colorado Division of Labor.

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*)
Lor	Pao Ge		

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code
8371 Quigley St.		Westminster	CO	80031

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
07-03-1992	604-58-0505	lorpaoge@yahoo.com	720-402-8975

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 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*):
P. L.	07-03-1992

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

COLORADO TEMPORARY DOCUMENT

Valid for 30 days from 7/19/2013

URN: 13200163102

License Number: 08-119-1034 Expiration Date: 07/03/2018

Type: Adult Driver

Previous License Type: Minor 18-21

PAOGE LOR
8371 QUIGLEY ST
WESTMINSTER CO 80031

Mailing Address: Birth Date: 07/03/1992

Male 180 lbs 5 ft.05 inches BLK Hair BRO Eyes

Endorsements: M

Restrictions: V

Donor: Voter: Medical Information:

Surrender License State:
License Number:

VERIFY THE FOLLOWING QUESTIONS HAVE BEEN ANSWERED CORRECTLY

1. Is your driving privilege under suspension, revocation or denial in Colorado or any other state? No

2. During the last two years, have you had any physical, mental or emotional condition **that would interfere with your ability to operate a motor vehicle safely** including heart problems, diabetes, paralysis, epilepsy, seizures, lapses of consciousness, or dizziness? No

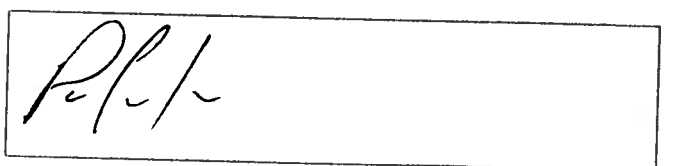
3. I have surrendered all out-of-state issued licenses in my possession. Yes

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 driving privilege.



Signature of Applicant 7/19/2013

Fee: 23.00
DAF: 1.00

Examiner
A3B

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:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		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)*: _____ *(See instructions for exemptions.)*

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative	
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name	
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code

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:

Form **8850**
(Rev. August 2009)
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 [redacted] Social security number ▶ 604-58-0505

Street address where you live 8371 Quigley St.

City or town, state, and ZIP code Westminster CO. 80031

County Adams. Telephone number (720) 402 - 8975

If you are under age 40, enter your date of birth (month, day, year) 7-3-1992

1 ☐ Check here if you are completing this form **before** August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.

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

3 ☐ 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 discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and,** for at least 4 weeks during the past year, I received unemployment compensation.
- I am at least age 16 but **not** age 25 or older, **and:**
  - **a** During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
  - **b** During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
  - **c** I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate **or** I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability **and,** during the past year, you were:

- Discharged or released from active duty in the U.S. Armed Forces, **or**
- Unemployed for a period or periods totaling at least 6 months.

5 ☐ 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 ▶ [redacted] **Date** 1/22/13

Form A (revised 07/09) **WORK OPPORTUNITY TAX CREDIT**

PLEASE CHECK "YES" OR "NO" AND ANSWER ALL QUESTIONS

Name Pao Cee Lor
Address 8371 Quigley St.
City Westminster State CO Zip 80031 Social Security # 604-58-0505
Date of Birth 7-3-1992 Age 21

Please CHECK ONE ANSWER for each of the following questions, and complete question #5:

1. Have you or any family member living with you received Temporary Assistance to Needy Families (TANF) or Aid to Families with Dependent Children (AFDC) during the past 24 months? **Yes** ☐ **No** ☒
2. Have you or any family member living with you received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) at any time during the past fifteen (15) months? **Yes** ☐ **No** ☒
3. Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days? **Yes** ☐ **No** ☒
4. Are you part of the Ticket to Work program? **Yes** ☐ **No** ☒

5. **Name of person who received benefits** _____
Relationship _____ **City & State where benefits received** _____

6. Are you a veteran? **Yes** ☐ **No** ☒ and Disabled due to service? **Yes** ☐ **No** ☒
Service Dates: From: _____ To: _____ Branch: _____

7. 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?
If yes, dates received compensation: From: _____ To: _____ **Yes** ☐ **No** ☒

8. Have you been convicted of a felony or released from prison in the last 12 months?
Date of Conviction: _____ Date of Release: _____ **Yes** ☐ **No** ☒
Parole Officer's Name: _____ Parole Officer's Phone # _____

9. Have you received rehabilitation services from a State approved or Department of Veterans Affairs approved *Vocational* rehabilitation agency? **Yes** ☐ **No** ☒
Name of Agency _____ Phone # _____
Address of Agency _____ Counselor's Name _____

10. Have you attended High School, College or Technical School for more than an average of 10 hours per week at any time during the last 6 months? **Yes** ☐ **No** ☒

11. Did you receive a high school diploma or GED? If yes, date received: 5-2010 **Yes** ☒ **No** ☐
Have you been employed or been admitted to technical school or college since then? **Yes** ☐ **No** ☐

12. How much in gross wages have you earned TOTAL in the past six months? $ 7,200

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, or the Department of Labor.

→ NEW HIRE SIGNATURE _____ DATE 7-22-13

Questions below to be completed by manager
Starting Wage _____ Position _____
Has employee worked for this company before? _____ If yes, date and location _____

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: November 30, 2011

YOUTH SELF-ATTESTATION FORM
Work Opportunity Tax Credit Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with Form ETA 9061 for each certification request filed.

New Hire Name: Rae Cee Lor

Social Security Number: 604-58-0505 Date of Birth: 7-3-1992

Employer Name: Employer Solutions Staffing Group

Employer Federal ID (EIN) Number: -

Please check all the statements that apply to you. Sign and date this form where indicated below.

☐ In the past 6 months, I have not attended a secondary, technical or postsecondary school for more than an average of 10 hours per week, not counting periods during which the school is closed for scheduled vacations.

☐ I do not have a High School Diploma or GED certificate.

☐ I have a High-School diploma or GED certificate awarded more than 6 months ago and I have not attended or been admitted to a technical or post-secondary school. I also have not held a job (other than occasionally) since receiving my High-School diploma or GED certificate.

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

New Hire's Signature: R. L. L. Date 7-22-13

Privacy Act Notice:
The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form, including the Social Security Number, will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OM B control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of Adult Services, Room S-4209, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

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 Colorado workers' compensation laws.** Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

- **I have been hurt on the job, what do I do?**

If you experience a life or limb threatening injury on the job, seek immediate medical attention at the nearest emergency room and then notify your supervisor in writing. A life or limb threatening injury means an injury that you believe threatens a portion of your body or your life in such a way that immediate medical care is needed to prevent your death or serious damage. In all other instances, notify your employer or supervisor that you have been injured before obtaining any medical care. All injuries, no matter how small, should be reported to your employer.

If your employer has designated a medical provider before or at the time of the injury, you will be required to see that provider for medical care. If you choose to seek your own medical care it may result in nonpayment of medical benefits and you may be liable for your medical costs. If your employer does not direct you to a medical provider, you may seek treatment from the provider of your choice.

By law, you must notify your employer in writing within four working days of an injury, even if you have advised them verbally. If you do not report your injury to your employer in writing within four working days, you may be penalized and lose up to one day's compensation for each day's delay, provided that your employer has posted a sign requiring four days' written notice. You may still file a claim for benefits even if you are late reporting the injury to your employer.

Your employer has the right in the first instance to designate the medical provider that injured employees must use. If your employer does not do so at the time of the injury, you may choose your own medical provider.

After the claim is filed, the insurance company may request that you be examined by another doctor of its choice, at its expense. If you do not go to this examination, the insurance company may ask the Division for permission to stop your benefits.

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. Colorado rules requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

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

Follow all physical restrictions at home and at work.

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

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

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

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

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

Printed Name: Pao Ge Lor **Signature:** [signature]

DATE: 7-22-19

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

Name: Pao Ge Lor

Address: 8371 Quigley St.

Home Phone: 720-402-8975

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

1. **Name:** Mai Lee

   Phone (work):

   Phone (home): 720-243-1050

2. **Name:** Por Lor

   Phone (work):

   Phone (home): 303-642-6516

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

Employer Solutions Staffing Group LLC

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. PGL (Initial)

Employee Signature: _____ Date: 7-22-13

Paola Gallegos
Employee (please print your name here)

Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen. If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck.
The time that the money goes into your account on pay day varies by bank.
Please allow until at least 10 am on your paydate for the deposit to show.

Please print

Check one of the following	Effective Date
☐ Start	☒ As Soon As Possible
☐ Stop	☐ Future Paydate
☐ Change	_____/_____/_____

Social Security Number: 604-58-0505

Name (Last, First Middle Initial): Lor Pao Ge

Home Address	Street	City	State	Zipcode
8371	Quigley St.	Westminster	CO	80081

Date (Mo/Day/Yr)	Employee Signature	Daytime Phone Number
7-22-13	Pao Lor	720-402-8975

SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION

Financial Institution Name (Bank, Savings Institution, Credit Union, etc.): Bank of the West

Type of Account

☒ Checking ☐ Savings ☐ Money Market Checking ☐ Money Market Investment Requires Submission of ACH form from your broker

I authorize Employer Solutions Staffing Group to direct deposit funds to my account in the financial institution listed above. If funds to which I am **not** entitled are deposited in my account, I authorize Employer Solutions Staffing Group to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by Employer Solutions Staffing Group at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to you will be returned to Employer Solutions Staffing Group for distribution. This will delay payment of funds to you.

PAOGE LOR
8371 QUIGLEY ST
WESTMINSTER, CO 80031 6915

99100

DATE 90-78/1211

PAY TO THE ORDER OF VOID $

DOLLARS

BANK of the WEST
Westminster Sheridan
9150 NORTH SHERIDAN BLVD
WESTMINSTER, CO 80030
1-800-488-2265

FOR

⑈107002147⑈ 0136205916⑈ 99100

10/4/2011

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: _____

Date/Fecha: 7-22-13

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

*219301-EMP | **OFFICE USE ONLY** | **ReHire Date** __/__/____

EMPLOYEE INFORMATION (Must Be Filled Out)

ENROLLMENT FORM - 10K PLAN

Social Security Number: 604-58-0505

Date of Birth: 07/03/1992 Sex: [X] M [ ] F

Name: Pao Ge Lor

Street Address: 8371 Quigley St.

City: Westminster State: CO Zip: 80031

Home Phone: 720-402-8975

Do you or any dependents have Medicare?

[ ] Yes [ ] No If Yes:

Medicare Health Insurance Claim Number (HICN) ______________________

Medicare Effective Date __/__/____

Names of Covered Person(s)

1. ______________________
2. ______________________
3. ______________________
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

MEDICAL

- [X] **$20.91 Employee Only**
- [ ] **$42.44 Employee +1**
- [ ] **$56.67 Employee + Family**
- [ ] **NO to MEDICAL, TERM LIFE, and STD benefits.**

DENTAL

- [X] **$5.99 Employee Only**
- [ ] **$11.98 Employee +1**
- [ ] **$19.77 Employee + Family**
- [ ] **NO**

TERM LIFE

- [X] **YES**
- [ ] **NO**

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

SHORT-TERM DISABILITY

- [X] **YES** **$4.20 Employee Only**
- [ ] **NO**

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

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

____

RELATIONSHIP

____

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 07/22/2013

Form: ESC CU(ESG) 10K v10.3

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: _____

Date/Fecha: 7-22-13

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Edina, Minnesota 55439

Telephone 952.835.1288
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Web www.ESGStaffingSolutions.com
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Employer Solutions Staffing Group LLC

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. PGL (Initial)

Employee Signature: _____ Date: 7-22-13

Paul Gene Lor

Employee (please print your name here)

*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 604-58-0505

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Sex [X] M [ ] F

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1.

2.

3.

4.

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- Your coverage level for Term Life will be identical to your medical plan selection.

BENEFIT SELECTION

Weekly Rates

MEDICAL

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- [ ] **$42.44 Employee +1**
- [ ] **$56.67 Employee + Family**
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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

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NAME OF BENEFICIARY

RELATIONSHIP

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▶ **Signature** [signature]

Date 07/22/2013