

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Zornick First Name Daniel Middle Initial R
 Street Address 380 St Lawrence Ave Apt/Ste _____
 City/State/Zip Buffalo/New York/14216 Social Security Last Four XXX-XX-1578
 Phone Number 716-907-0275 Email Address dzornick24@gmail.com @
 Staffing Agency/Recruitment Partner Caitlin Scholl

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.

Daniel Zornick
Name (Print or type)

Daniel Zornick
Daniel Zornick (Jan 13, 2016)
Applicant's Signature

Jan 13, 2016
Date

A copy or facsimile ("fax") will be considered the same as an original signature. Email will ONLY be used for employment corresponden

| For ESSG Office Use Only | | | | |
|---------------------------------|----------------------------------|-----------------------------|---|--------------------------|
| DOH _____ | NHW _____ | I-9 _____ | 8850 _____ | W4 _____ |
| Emergency Contact Info _____ | Background Release Form _____ | Background Results _____ | Unemployment Letter (If applicable) _____ | ESC Application _____ |
| For ESSG Client Use | | | | |
| DOH _____ | ROP _____ | Work Site Loc. _____ | WC Code _____ | |

Form W-4 (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 | 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 | 0 |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return | D | 0 |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) | E | 0 |
| F | Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit | F | 0 |
| 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 | 0 |
| 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 | 1 |

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 | | OMB No. 1545-0074 |
| ▶ 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. | | 2016 | | |
| 1 | Your first name and middle initial Daniel R | Last name Zornick | 2 | Your social security number 125-74-1578 |
| Home address (number and street or rural route) 380 St Lawrence Ave | | 3 | <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. | |
| City or town, state, and ZIP code Buffalo New York 14216 | | 4 | If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/> | |
| 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 | \$ | |
| 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.) ▶ <i>Daniel Zornick</i> Daniel Zornick (Jan 13, 2016) | | Date ▶ Jan 13, 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) |



Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104
(1/12)

| | | | |
|----------------------|--|----------------------|--|
| Print or type | First name and middle initial Daniel R | Last name Zornick | Your social security number 125-74-1578 |
| | Permanent home address (number and street or rural route) 380 St Lawrence Ave | | Apartment number Single or Head of household <input checked="" type="checkbox"/> Married <input type="checkbox"/> |
| | City, village, or post office Buffalo | State NY | ZIP code 14216 |

Married, but withhold at higher single rate
Note: If married but legally separated, mark an X in the Single or Head of household box.

Are you a resident of New York City? Yes No
Are you a resident of Yonkers? Yes No

Complete the worksheet on page 3 before making any entries.

| | | |
|--|----|---|
| 1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 17) | 1. | 0 |
| 2 Total number of allowances for New York City (from line 28) | 2. | 0 |

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

| | | |
|-------------------------------|----|---|
| 3 New York State amount | 3. | 0 |
| 4 New York City amount | 4. | 0 |
| 5 Yonkers amount | 5. | 0 |

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

| | |
|--------------------------|-------------------|
| Employee's signature | Date 1/13/2016 |
|--------------------------|-------------------|

Penalty — A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employers only: Mark an X in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instr.):

A. Employee claimed more than 14 exemption allowances for NYS A.

B. Employee is a new hire or a rehire.... B. First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes No

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

| | |
|--|--------------------------------|
| Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.) | Employer identification number |
|--|--------------------------------|

Instructions

Changes effective for 2012

Form IT-2104 has been revised for tax year 2012. The worksheet on page 3, the charts beginning on page 4, and the additional dollar amounts in the instructions on page 2, used to compute your withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet, charts, or the additional dollar amounts, you should complete a new 2012 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim

is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$100,000 or more during the tax year.
- The total income of you and your spouse has increased to \$100,000 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.
- You have been advised by the Internal Revenue Service that you are entitled to fewer allowances than claimed on your original federal Form W-4, and the disallowed allowances were claimed on your original Form IT-2104.

Exemption from withholding

You cannot use Form IT-2104 to claim exemption from withholding. To claim exemption from income tax withholding, you **must** file Form IT-2104-E, *Certificate of Exemption from Withholding*, with your employer. You must file a new certificate each year that you qualify for exemption. This exemption from withholding is allowable only if you had no New York income tax liability in the prior year, you expect none in the current year, **and** you are over 65 years of age, under 18, or a full-time student under 25. You may also claim exemption from withholding if you are a military spouse and meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act. If you are a dependent who is under 18 or a full-time student, you may owe tax if your income is more than \$3,000.

Withholding allowances

You may **not** claim a withholding allowance for yourself or, if married, your spouse. Claim the number of withholding allowances you compute in Part 1 and Part 3 on page 3 of this form. If you want more tax withheld, you may claim fewer allowances. **If you claim more than 14 allowances**, your employer **must send** a copy of your **Form IT-2104** to the New York State Tax Department. You may then be asked to verify your allowances. If you arrive at negative allowances (less than zero) on lines 1 or 2 and your employer cannot accommodate negative allowances, **enter 0** and see *Additional dollar amount(s)* below.

Income from sources other than wages — If you have more than \$1,000 of income from sources other than wages (such as interest, dividends, or alimony received), reduce the number of allowances claimed on line 1 and line 2 (if applicable) of the IT-2104 certificate by one for each \$1,000 of nonwage income. If you arrive at negative allowances (less than zero), see *Withholding allowances* above. You may also consider filing estimated tax, especially if you have significant amounts of nonwage income. Estimated tax requires that payments be made by the employee directly to the Tax Department on a quarterly basis. For more information, see the instructions for Form IT-2105, *Estimated Income Tax Payment Voucher for Individuals*, or see *Need help?* on page 6.

Other credits (Worksheet line 13) — If you will be eligible to claim any credits other than the credits listed in the worksheet, such as an investment tax credit, you may claim additional allowances.

Find your filing status and your New York adjusted gross income (NYAGI) in the chart below, and divide the amount of the expected credit by the number indicated. Enter the result (rounded to the nearest whole number) on line 13.

| Single and NYAGI is: | Head of household and NYAGI is: | Married and NYAGI is: | Divide amount of expected credit by: |
|-----------------------------------|-----------------------------------|-----------------------------------|--------------------------------------|
| Less than \$200,000 | Less than \$250,000 | Less than \$300,000 | 66 |
| Between \$200,000 and \$1,000,000 | Between \$250,000 and \$1,500,000 | Between \$300,000 and \$2,000,000 | 68 |
| Over \$1,000,000 | Over \$1,500,000 | Over \$2,000,000 | 88 |

Example: *You are married and expect your New York adjusted gross income to be less than \$300,000. In addition, you expect to receive a flow-through of an investment tax credit from the S corporation of which you are a shareholder. The investment tax credit will be \$160. Divide the expected credit by 66. $160/66 = 2.4242$. The additional withholding allowance(s) would be 2. Enter 2 on line 13.*

Married couples with both spouses working — If you and your spouse both work, you should each file a separate IT-2104 certificate with your respective employers. Your withholding will better match your total tax if the higher wage-earning spouse claims all of the couple's allowances and the lower wage-earning spouse claims zero allowances. **Do not** claim more total allowances than you are entitled to. If your combined wages are:

- less than \$100,000, you should each mark an **X** in the box *Married, but withhold at higher single rate* on the certificate front, and divide the total number of allowances that you compute on line 17 and line 28 (if applicable) between you and your working spouse.
- \$100,000 or more, use the chart(s) in Part 4 and enter the additional withholding dollar amount on line 3.

Taxpayers with more than one job — If you have more than one job, file a separate IT-2104 certificate with each of your employers. Be sure to claim only the total number of allowances that you are entitled to. Your withholding will better match your total tax if you claim all of your allowances at your higher-paying job and zero allowances at the lower-paying job. In addition, to make sure that you have enough tax withheld, if you are a single taxpayer or head of household with two or more jobs, and your combined wages from all jobs are under \$100,000, reduce the number of allowances by seven on line 1 and line 2 (if applicable) on the certificate you file with your higher-paying job employer. If you arrive at negative allowances (less than zero), see *Withholding allowances* above.

If you are a single or a head of household taxpayer, and your combined wages from all of your jobs are between \$100,000 and \$2,100,000, use the chart(s) in Part 5 and enter the additional withholding dollar amount from the chart on line 3.

If you are a married taxpayer, and your combined wages from all of your jobs are \$100,000 or more, use the chart(s) in Part 4 and enter the additional withholding dollar amount from the chart on line 3 (Substitute the words *Higher-paying job for Higher earner's wages* within the chart).

Dependents — If you are a dependent of another taxpayer and expect your income to exceed \$3,000, you should reduce your withholding allowances by one for each \$1,000 of income over \$2,500. This will ensure that your employer withholds enough tax.

Following the above instructions will help to ensure that you will not owe additional tax when you file your return.

Heads of households with only one job — If you will use the head-of-household filing status on your state income tax return, mark the *Single or Head of household* box on the front of the certificate. If you have only one job, you may also wish to claim two additional withholding allowances on line 14.

Additional dollar amount(s)

You may ask your employer to withhold an additional dollar amount each pay period by completing lines 3, 4, and 5 on Form IT-2104. In most instances, if you compute a negative number of allowances and your employer cannot accommodate a negative number, for each negative allowance claimed you should have an additional \$1.85 of tax withheld per week for New York State withholding on line 3, and an additional \$0.80 of tax withheld per week for New York City withholding on line 4. Yonkers residents should use 15% (.15) of the New York State amount for additional withholding for Yonkers on line 5.

Note: If you are requesting your employer to withhold an additional dollar amount on lines 3, 4, or 5 of this allowance certificate, the additional dollar amount, as determined by these instructions or by using the chart(s) in Part 4 or Part 5, is accurate for a weekly payroll. Therefore, if you are not paid on a weekly basis, you will need to adjust the dollar amount(s) that you compute. For example, if you are paid biweekly, you must double the dollar amount(s) computed.

Avoid underwithholding

Form IT-2104, together with your employer's withholding tables, is designed to ensure that the correct amount of tax is withheld from your pay. If you fail to have enough tax withheld during the entire year, you may owe a large tax liability when you file your return. The Tax Department must assess interest and may impose penalties in certain situations in addition to the tax liability. Even if you do not file a return, we may determine that you owe personal income tax, and we may assess interest and penalties on the amount of tax that you should have paid during the year.

(continued)



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) Zornick | | First Name (Given Name) Daniel | | Middle Initial R | Other Names Used (if any) | |
| Address (Street Number and Name) 380 St Lawrence Ave | | | Apt. Number | City or Town Buffalo | State NY | Zip Code 14216 |
| Date of Birth (mm/dd/yyyy) 02/21/1985 | U.S. Social Security Number 125-74-1578 | E-mail Address dzornick24@gmail.com | | | Telephone Number 716-907-0275 | |

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

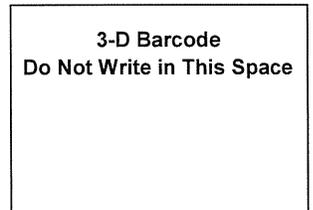
2. Form I-94 Admission Number: _____

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)



| | |
|--|---------------------------------|
| Signature of Employee: <u>Daniel Zornick</u> <small>Daniel Zornick (Jan 13, 2016)</small> | Date (mm/dd/yyyy): Jan 13, 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 | |



Employer Completes Next Page



LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

| LIST A Documents that Establish Both Identity and Employment Authorization | OR | LIST B Documents that Establish Identity | AND | LIST C Documents that Establish Employment Authorization |
|---|---------------------------------------|---|-----|---|
| 1. U.S. Passport or U.S. Passport Card | | 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | 1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION |
| 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) | | 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) |
| 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa | | 3. School ID card with a photograph | | 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| 4. Employment Authorization Document that contains a photograph (Form I-766) | | 4. Voter's registration card | | 4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | | 5. U.S. Military card or draft record | | 5. Native American tribal document |
| | | 6. Military dependent's ID card | | 6. U.S. Citizen ID Card (Form I-197) |
| | | 7. U.S. Coast Guard Merchant Mariner Card | | 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | | 8. Native American tribal document | | 8. Employment authorization document issued by the Department of Homeland Security |
| | | 9. Driver's license issued by a Canadian government authority | | |
| 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | | For persons under age 18 who are unable to present a document listed above: | | |
| | | 10. School record or report card | | |
| | | 11. Clinic, doctor, or hospital record | | |
| | 12. Day-care or nursery school record | | | |

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.



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: Zornick, Daniel R.

| List A Identity and Employment Authorization | OR | List B Identity | AND | List C Employment Authorization |
|---|----|--|-----|---|
| Document Title: | | Document Title: <u>New York Driver License</u> | | Document Title: <u>Social Security Card</u> |
| Issuing Authority: | | Issuing Authority: <u>NY DMV</u> | | Issuing Authority: <u>SSA</u> |
| Document Number: | | Document Number: <u>I 8444587</u> | | Document Number: <u>125-74-1578</u> |
| Expiration Date (if any)(mm/dd/yyyy): | | Expiration Date (if any)(mm/dd/yyyy): <u>03/11/2016</u> | | Expiration Date (if any)(mm/dd/yyyy): |
| Document Title: | | | | <div style="border: 1px solid black; padding: 5px;"> <p>3-D Barcode Do Not Write in This Space</p> </div> |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | | |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | | |

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): 01/13/2016 (See instructions for exemptions.)

| | | | | |
|---|--|--|--|--------------------------|
| Signature of Employer or Authorized Representative <u>Andrea Findley</u> | | Date (mm/dd/yyyy) <u>01/15/2016</u> | Title of Employer or Authorized Representative <u>Admin. Assistant</u> | |
| Last Name (Family Name) <u>Findley</u> | | First Name (Given Name) <u>Andrea</u> | Employer's Business or Organization Name EMPLOYER SOLUTIONS STAFFING GROUP LLC | |
| Employer's Business or Organization Address (Street Number and Name) 7301 OHMS LANE SUITE 405 | | City or Town EDINA | State MN | Zip Code 55439 |

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

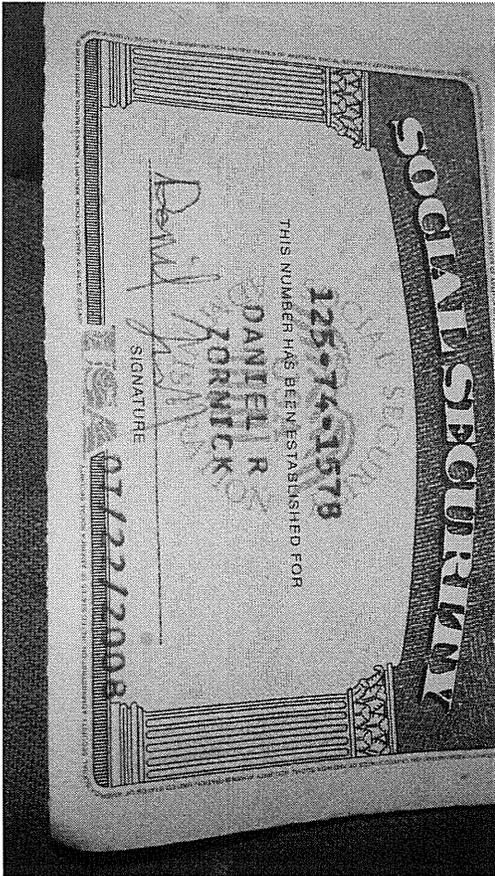
| | | |
|---|----------------|---|
| A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) | Middle Initial | B. Date of Rehire (if applicable) (mm/dd/yyyy): |
|---|----------------|---|

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: |
|---|--------------------|--|



SOCIAL SECURITY

THIS NUMBER HAS BEEN ESTABLISHED FOR

125-74-1578

**DANIEL R
ZORNICK**

Daniel Zornick
SIGNATURE

07/22/2008

THIS CARD IS NOT VALID UNLESS IT IS ACCOMPANIED BY A SOCIAL SECURITY IDENTIFICATION CARD. THIS CARD IS NOT VALID UNLESS IT IS ACCOMPANIED BY A SOCIAL SECURITY IDENTIFICATION CARD. THIS CARD IS NOT VALID UNLESS IT IS ACCOMPANIED BY A SOCIAL SECURITY IDENTIFICATION CARD.



PERSON # 30764648

Library #
2 9072 00857390 5

5081 2803 0258 4114
DANIEL R ZORNICK

STUDENT

Changing Address? If you change your residence, cross out the old address on the front of this document and write in your new address. You must notify DMV of your new address within 10 days, using DMV Form MV-232, which is available to download from the DMV web site at www.dmv.ny.gov.

- Restrictions**
- A ACCEL LEFT OF BRAKE
 - A1 TEMPORARY VISITOR
 - A2 PROBLEM DRIVER
 - A3 MED CERT EXEMPT
 - A4 IGNITION INTERLOCK DEVICE
 - B CORRECTIVE LENSES
 - C MECHANICAL AID
 - D PROSTHETIC DEVICE
 - E NO MAN TRANS EQUIPPED CMV
 - E1 AUTOMATIC TRANSMISSION
 - F OUTSIDE MIRROR
 - F1 HEARING AID OR FULL VIEW MIRROR
 - G DAYLIGHT DRIVING ONLY
 - H LIMITED TO EMPLOYMENT
 - I LIMITED USE AUTO MAX 40 MPH
 - I1 LIMITD USE MCY MAX 40 MPH
 - I2 LIMITD USE MCY MAX 30 MPH
 - I3 LIMITD USE MCY MAX 20 MPH
 - G FARM CLASS A VEHICLES
 - G FARM CLASS B VEHICLES
 - H HAZARDOUS MATERIALS
 - M METAL COIL
 - N TANK VEHICLES
 - M NO CLASS A PASSENGER VEH
 - N NO CLASS A/B PASSENGR VEH
 - R PASSENGER TRANSPORT
 - R RV GVWR OVER 26,000 LBS.
 - S SCHOOL BUS
 - T DOUBLES/TRIPLES
 - W TOW TRUCK
 - X TANK/HAZMAT
 - Z FARM/HAZMAT
- Endorsements**
- 5 NO LIMITD ACCESS RDS
 - 4 TELESCOPIC LENS 4
 - Z1 WHEEL SPINNER
 - Z NO FULL AIRBRAKE EQUIP CMV
 - Y SHOULDER HARNESS USE
 - X1 FULL HAND CONTROL
 - X NO CARGO IN CMV TANK VEH
 - V1 FOOT-OPER PARKING BRAKE
 - V MEDICAL VARIANCE
 - U HAND OPERATED BRAKE
 - R BUILT-UP SEAT/PED/SHOE
 - Q POWER STEERING
 - P1 POWER BRAKES
 - P NO PASSENGERS IN CMV BUS

NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES

Visit us at www.dmv.ny.gov

CUSTOMER RECEIPT INTERIM LICENSE

****DRIVER LICENSE*****

ZORNICK DANIEL, R 18444587 Class D 02/21/85 M JAN 11 2016 WEB 17.50 WEB CDA



NYS Department of Motor Vehicles

INTERIM LICENSE

546257621

****DRIVER LICENSE*****

18444587 JAN 11 2016 WEB Fee 17.50 WEB CDA

(FOLD ALONG THIS LINE)



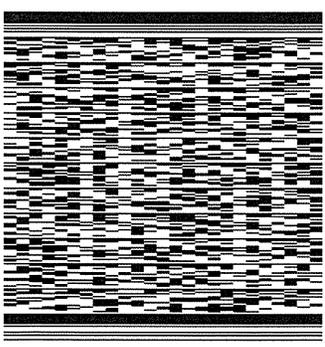
NYS Department of Motor Vehicles

INTERIM LICENSE

546257621

Class D Restrictions NONE Endorsements NONE Status terminates on 02/21/16 Probation Date NONE This document expires on 03/11/16 ZORNICK DANIEL, R 380 SAINT LAWRENCE 2 BUFFALO NY 14216 Sex M Eyes HA Birthdate 02/21/85 Additional Restrictions NONE

(FOLD ALONG THIS LINE)



Sign X Here Keep this document until you receive your Photo Document



SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2016015135052MV

Report Prepared: 01/15/2016

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Zornick

First Name: Daniel

Date of Birth: 02/21/1985

Social Security Number: *** ** 1578

Hire Date: 01/13/2016

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 List C Document: Social Security Card
outlying possession

Document Name: Driver's license

Document State: New York

Driver's License or ID Card Number:

Document Expiration Date: 03/11/2016

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 01/15/2016

Case Submitted By: AFIN3846

Closed On: 01/15/2016

Closed By: AFIN3846

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

SENSITIVE BUT UNCLASSIFIED

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: dzornick24@gmail.com)

Signature: 
Daniel Zornick (Jan 13, 2016)

Date: Jan 13, 2016

BACKGROUND INFORMATION

Last Name: Zornick First: Daniel Middle: Robert

Other Names/Alias: _____

Social Security #: 125-74-1578 Date of Birth (mm/dd/yyyy)*: 02/21/1985

Driver's License #: 546257621 State of Driver's License: New York

Present Address: 380 St Lawrence Ave Telephone # (Primary): 716-907-0275

City/State/Zip: Buffalo/New York/14216

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

A Summary of Your Rights Under the Fair Credit Reporting Act

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

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

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies.

See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See: www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

EMERGENCY CONTACT INFORMATION

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

Employee Name: Daniel Zornick

Address: 380 St Lawrence Ave

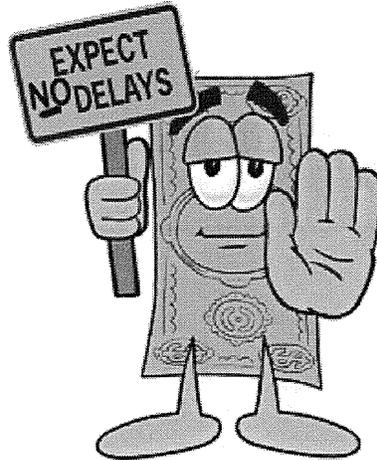
Home Phone: 716-907-0275

| EMERGENCY CONTACTS | |
|---|--------------------------|
| Please list two people (in priority order) who could be contacted in case of an emergency | |
| Contact #1 | |
| Name: Margaret Milliron | Home Phone: |
| Relationship: Mother | Cell Phone: 716-907-0275 |
| | Work Phone: |
| Contact #2 | |
| Name: Eric Loonan | Home Phone: |
| Relationship: Friend | Cell Phone: 716-445-6579 |
| | Work Phone: |

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



RECEIVE YOUR PAY WITHOUT DELAY



In order for you to continue to receive your pay each week without delay we are encouraging all employees to use direct deposit or Global Cash Card. **It is becoming more and more difficult for employees to cash checks without fees or delay due to increased security at all banks. Also, if your check is lost or stolen you will have to wait 3 days for another check.**

GLOBAL CASH CARD

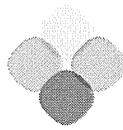
If you don't have a bank account, computer access or don't want to use direct deposit you can use **Global Cash Card** which works like a Visa.

- There are **NO FEES** for the card for your first transaction as a cash withdrawal at an ATM or if you use it like a credit card (not debit) to make individual signature purchases.
- **If you don't have access to a computer you can receive TEXT notifications for your pay check amount on pay day as well as what the current balance is. You can also receive low balance notifications set to the dollar amount that you determine on the attached form.**
- You may call Customer Service 24 hours a day, 7 days a week, 365 days a year at 888-220-4477 for balance inquiries or other questions. (Para Español, apriete dos)
- You can pay bills with the GCC (by phone/internet/in person). You can also set up your online account to make automatic payments.

Please complete the attached form and turn it in to your manager as soon as possible indicating whether you would like direct deposit or Global Cash Card. Please make sure you include an email address.

Fill Out This Form!





employer solutions staffing group^{ac}

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 | Daniel Zornick | SSN# (last 4 digits) | 1578 | Effective Date | 01/13/2016 |
|---------------|----------------|----------------------|------|----------------|------------|

SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated.*

Payroll Debit Card (Please complete Sections 4 and 5 below)

SECTION 3 DIRECT DEPOSIT

| | | |
|---------|--|--|
| ACCOUNT | <input type="checkbox"/> Update Bank Account | <p>I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.</p> <p>Initial <u>DRZ</u> Date <u>01/13/2016</u></p> |
| | Bank Name: <u>Key Bank</u> | |
| | Routing# <u>021300077</u> | |
| | Account# <u>325910625806</u> | |
| | Account Type: <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other _____ | |

- 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 |
| Street Address (PO BOX NOT ACCEPTABLE) | | | Social Security# |
| City | State | Zip | Cell Phone (mobile) |

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

| | |
|--|------------------------------------|
| Payroll Debit Card Routing # 073972181 | Payroll Debit Card Account # _____ |
|--|------------------------------------|

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: _____ Date: _____

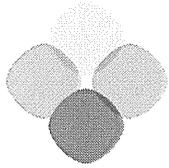
SECTION 5 AUTHORIZATION

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: dzornick24@gmail.com @ _____

this information will only be used to send your paystubs electronically

Employee's Signature: Daniel Zornick (Jan 13, 2016) Date: Jan 13, 2016



employer solutions staffing group LLC

Leveraging Resources in a Changing Market

STATEMENT OF CONFIDENTIALITY

This agreement made this 13 day of January, 2016, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Daniel Zornick 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.


Daniel Zornick (Jan 13, 2016)

Employee Signature

Employer Solutions Staffing Group LLC, Representative

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

▶ See separate instructions.

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

Your name Daniel Zornick Social security number ▶ 125-74-1578

Street address where you live 380 St Lawrence Ave

City or town, state, and ZIP code Buffalo, New York, 14216

County Erie Telephone number 716-907-0275

If you are under age 40, enter your date of birth (month, day, year) 02/21/1985

- 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 ▶ 
Daniel Zornick (Jan 13, 2016)

Date Jan 13, 2016

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

| | | | | | |
|----------------------------------|------------------------------|--|---|------------------------|---------------|
| Employee Name: Daniel Zornick | | Street Address: 380 St Lawrence Ave | | City/State: Buffalo | Zip: 14216 |
| SS#: 125-74-1578 | Date of Birth: 02/21/1985 | Age: 30 | Have you worked for this company before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If yes, location: | |

Please complete all questions, and sign and date the form.

Yes No

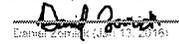
| | | |
|--|-------------------------------------|-------------------------------------|
| 1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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.) Name of the person receiving benefits: Daniel Zornick Relationship to you: self City: Buffalo County: Erie State: New York | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. <i>*If you checked yes please provide a copy of your SSI documentation.</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below: <input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program) Name of Agency: _____ Phone #: _____ City: _____ County: _____ State: _____ <i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are you a Veteran of the U.S. Military? <i>*If yes, please provide a copy of your DD-214 and letter of separation.</i> (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? Have you been unemployed at any time during the last 12 months? If yes, dates of unemployment - From: 11/18/2016 / _____ To: 01/13/2016 / _____ Did you receive unemployment compensation at any point during your unemployment? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Conviction Date: ____/____/____ Release Date: ____/____/____ Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Additional Tax Credits

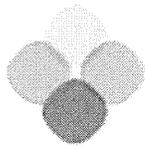
| | | |
|--|--------------------------|-------------------------------------|
| IEC (Native American): Are you or your spouse a member of a Native American Tribe? <i>*If you checked yes please provide a copy of your CDIB card.</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| CA Residents: <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor? | <input type="checkbox"/> | <input type="checkbox"/> |
| SC Residents: <input type="checkbox"/> Do you receive Family Independence Benefits? | <input type="checkbox"/> | <input type="checkbox"/> |

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: 
Daniel Zornick (DOB: 02/21/1985)

Date: Jan 13, 2016



employer solutions staffing group^{LLP}
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.

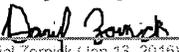
Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

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.

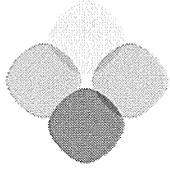
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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

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

Signed: 
Daniel Zornick (Jan 13, 2016)

Printed Name: Daniel Zornick



employer solutions staffing group^{LLC}

Leveraging Resources in a Changing Market

Important/Importante

LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between \$25-\$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the policy report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Daniel Zornick

Signature/Firma: 
Daniel Zornick (Jan 13, 2016)

Employee Keeps This Form

Healthcare Notice of Exchange

As your employer, we are required to provide you with the following information under Section 1512 of the Affordable Care Act:

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

*****The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area*****

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information:

| Employer Name: Employer Solutions Staffing Group, LLC | | Employer FEIN: 20-8084369 | | | |
|---|--|--|-----------------------------------|---|---|
| Employer Address: 7301 Ohms Lane Suite 405 Edina, MN 55439 | | Phone Number for Health Benefits Team: 952-767-9519 | | | |
| | | | | | |
| Insurance Plans Available: | Who is Eligible? | Meets Minimum Value Standard? | Meets Minimum Essential Coverage? | When is it effective? | Will I be penalized if I only have this plan? |
| Fixed Indemnity Plan | Everyone | No | No | Available immediately – offered upon hire | Yes |
| MEC Plan | Everyone | No | Yes | Available immediately – offered upon hire | No |
| Major Medical Plan | Full time employees after 120 hours are met in 30 days | Yes | Yes | Within 60 days of being determined eligible | No |

For more information about ESSG's Insurance options, contact:

The Health Benefits Team

Employer Solutions Staffing Group

952-767-9519 | health@employersolutionsgroup.com

Employee Keeps This Form

NOTICE: ESSG Electronic Pay Stubs

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**.
The log-in is case sensitive, so be sure that you capitalize the first letter of your last name.

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 on **page 1** of this packet.
** Your check stub will come from payroll@MyPayESG.com, be sure to check spam folder.

Empleado Toma Copiar

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

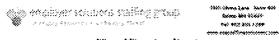
Su nombre de usuario son las cuatro primeras letras de su apellido seguido por los cuatro últimos dígitos de su número de seguro social.

El portal es caso delicado, asegúrese de que la primera letra de su apellido sea mayúscula.

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. para apoyar email: MyPayESG@MyPayESG.com

2. También puede recibir su talón de cheque por correo electrónico , al proveir su correo electronico en la **pagina 1** de este paquete
** Su talón de cheque vienen de payroll@MyPayESG.com, asegúrate de revisar la carpeta de spam



New Hire Application

Personal Data, Last Name, First Name, Middle Initial, Street Address, City/State/Zip, Phone Number, Email Address, Method of Appointment, and a signature line.

ESG New Hire Paperwork

Adobe Document Cloud Document
History

1/13/16

| | |
|-----------------|--|
| Created: | 1/12/16 |
| By: | Caitlin Scholl (Caitlin@corpmgmtgroup.com) |
| Status: | SIGNED |
| Transaction ID: | CBJCHBCAABAAnHOzXA2qJZ0lVl5li1foVu5-CerDFEB5 |

“ESG New Hire Paperwork” History

- Document created by Caitlin Scholl (Caitlin@corpmgmtgroup.com)
1/12/16 - 4:13:40 MST - IP address: 96.93.208.70
- Document emailed to Daniel Zornick (dzornick24@gmail.com) for signature
1/12/16 - 4:13:42 MST
- Document viewed by Daniel Zornick (dzornick24@gmail.com)
1/12/16 - 4:14:23 MST - IP address: 66.249.83.247
- Document e-signed by Daniel Zornick (dzornick24@gmail.com)
Signature Date: 1/13/16 - 4:35:02 MST - Time Source: server - IP address: 72.228.135.71
- Signed document emailed to Caitlin Scholl (Caitlin@corpmgmtgroup.com) and Daniel Zornick (dzornick24@gmail.com)
1/13/16 - 4:35:02 MST

**DISCLOSURE AND CONSENT CONCERNING CONSUMER
AND INVESTIGATIVE CONSUMER REPORTS**

This form, which you should read carefully, has been provided to you because CMG may request Consumer Reports and/or Investigative Consumer Reports from a consumer reporting agency. The Company will use any such report(s) solely for employment-related purposes. Consumer Reports or Investigative Consumer Reports will be obtained from CSS Test, Inc. ("CSS Test") located at 400 Laurel Oak Road, Suite 102, Voorhees NJ, 08043. They can be contacted at 856-627-5600. Under the provisions of the Fair Credit Reporting Act, 15 USC, Section 1681 et seq., the Americans with Disabilities Act, the Drivers Privacy Protection Act and all other applicable federal, state, and local laws, I hereby authorize and permit CSS Test, Inc., to obtain a consumer report and/or an investigative consumer report which may include the following: Reports may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include, but are not limited to: credit reports, social security number, criminal records checks, public court records checks, including civil, driving records, educational records, verification of employment positions held, workers compensation records, personal and professional references, licensing, certification, etc. The information contained in these reports may be obtained by CSS Test from private or public record sources including sources identified by you in your job application or through interviews or correspondence with your past or present coworkers, neighbors, friends, associates, current or former employers, educational institutions or other acquaintances.

Additional State Law Notices: If you live or are applying for a job in California, Maine, New York or Washington, please note:

California residents, under section 1786.22 of the California Civil Code, you may view the file maintained on you by CSS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at CSS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

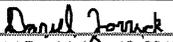
Maine: You have the right, upon request, to be informed of whether an investigative consumer report was requested, and if one was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from the Company, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any such reports.

New York: You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may inspect and receive a copy of the report by contacting that agency.

Washington State: If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

CONSENT

I have carefully read and understand this Disclosure and Consent form and, by my signature below, consent to the release of consumer and/or investigative consumer reports, as defined above, to the Company in conjunction with my application for employment. I further understand that any and all information contained in my job application or otherwise disclosed to the Company by me before, during or after my employment, if any, may be utilized for the purpose of obtaining the consumer reports or investigative consumer reports requested by the Company. I understand that if the Company hires me, it may request a consumer report and/or an investigative consumer report about me, as defined above, for employment-related purposes during the course of my employment. I understand that my consent will apply throughout my employment, to the extent permitted by law, unless I revoke or cancel my consent by sending a signed letter or statement to the Company at any time. This Disclosure and Consent form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by the Company.

Applicant Last Name Zornick First Daniel Middle Robert
Social Security # 125741578 Date of Birth (for ID purposes only) 02/21/1985
Drivers License Number and State of Issue 546257621
Present Address 380 St Lawrence Ave
City/State/Zip Buffalo/New York/14216
Applicant Signature  Date 01/13/2016
Daniel Zornick (Jan 13, 2016)

CALIFORNIA, MINNESOTA AND OKLAHOMA APPLICANTS ONLY:

I wish to receive a free copy of any Consumer Report and/or Investigative Consumer Report on me that is requested.

CSS Inc.

400 Laurel Oak Road, Suite 102, Voorhees, NJ 08043 Tel: 1-856-627-5600 Fax: 1-856-627-5699

CSS Consent

Adobe Document Cloud Document History

1/13/16

| | |
|-----------------|--|
| Created: | 1/12/16 |
| By: | Caitlin Scholl (Caitlin@corpmgmtgroup.com) |
| Status: | SIGNED |
| Transaction ID: | CBJCHBCAABAA2ozRmFERcRuu_R06OQ33tqUloSvB7-tS |

“CSS Consent” History

-  Document created by Caitlin Scholl (Caitlin@corpmgmtgroup.com)
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-  Document emailed to Daniel Zornick (dzornick24@gmail.com) for signature
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-  Document viewed by Daniel Zornick (dzornick24@gmail.com)
1/13/16 - 2:51:53 MST - IP address: 66.249.83.247
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-  Signed document emailed to Daniel Zornick (dzornick24@gmail.com) and Caitlin Scholl (Caitlin@corpmgmtgroup.com)
1/13/16 - 3:22:47 MST

ENROLLMENT FORM - PLAN 2

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK
(Must Be Filled Out)

Social Security Number 125-74-1578

Date of Birth 02/21/1985 Sex M F

Name Daniel Zornick

Street Address 380 St Lawrence Ave

City Buffalo State NY Zip 14216

Home Phone 716-907-0275

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. _____

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Relationship: Spouse Child Domestic Partner

BENEFIT SELECTION Weekly Rates

SELECT COVERAGE LEVEL

You MUST select a coverage level before adding any benefits. Your coverage level will be identical for each benefit.

- Employee Only Employee + Family
- Employee + 1 NO to all indemnity benefits.

FIXED INDEMNITY MEDICAL

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

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL

- YES \$6.17 Employee Only
\$12.34 Employee + 1
- NO \$20.36 Employee + Family

TERM LIFE

- YES \$0.60 Employee Only
\$0.90 Employee + 1
- NO \$1.80 Employee + Family

SHORT-TERM DISABILITY

- 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.

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY _____

RELATIONSHIP _____

Accidental Death & Dismemberment is part of the Term Life 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 Daniel Zornick

Date 01/13/2016

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) Zornick, David R | | Date of Birth 02/21/1985 | Social Security Number 125-74-1578 |
| Address 380 St Lawrence Ave | | City Buffalo | State NY |
| Zip Code 14216 | | Phone Number: 716-907-0275 | Date of Hire 1/12/16 |
| Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Divorced | Please Select Coverage Elected: Enhanced MEC Plan Coverage Level: <input checked="" type="checkbox"/> Single - \$24.00/Week <input type="checkbox"/> Employee+Spouse - \$38.00/Week <input type="checkbox"/> Employee+Child(ren) - \$36.00/Week <input type="checkbox"/> Family - \$63.00/Week | |
| Email Address: dzornick24@gmail.com | | | |

| Dependent Information | | | | |
|-----------------------|------------|------|---|--|
| Dependent | | | | |
| Last Name | First Name | M.I. | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Birth Date |
| Social Security # | | | | Coverage Elected <input type="checkbox"/> Medical |
| | | | | Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate |
| Dependent | | | | |
| Last Name | First Name | M.I. | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Birth Date |
| Social Security # | | | | Coverage Elected <input type="checkbox"/> Medical |
| | | | | Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate |
| Dependent | | | | |
| Last Name | First Name | M.I. | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Birth Date |
| Social Security # | | | | Coverage Elected <input type="checkbox"/> Medical |
| | | | | Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> 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 David R Zornick Date 1/13/16

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 or parting with of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature _____ Date _____