www.esgstaffingsolutions.com

employer solutions staffing group

PO Box 46270
Minneapolis, MN 55344-9956
Tel: 952.835.1288

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name kasten **First Name** denill **Middle Initial** a

Street Address 1380 3rd ave **Apt/Ste** n/a

City/State/Zip newport 55055 **Social Security Last Four** XXX-XX- 9537

Phone Number 6517687973 **Email Address** dkasten37@yahoo.com @

Staffing Agency/Recruitment Partner cmg

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

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

Applicant Certification and Authorization

I authorize Employer Solutions Staffing Group (ESSG) to use the information and statements contained in this application to determine my qualifications for employment. I authorize ESSG to make inquiries of my former employers, except as indicated in this application, regarding my previous duties, responsibilities, performance, compensation and eligibility for rehire.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.

I release ESSG and other persons or entities from any claims that might be based on ESSG's decision to conduct a background check.

I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

If hired, I agree to abide by the policies and procedures of ESSG.

denill kasten	*denill kasten* denill kasten (Jan 18, 2018)	Jan 18, 2018
Name (Print or type)	Applicant's Signature	Date

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

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

Form W-4 (2017)

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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total 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 don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't 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 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G	
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 Your social security number
denill	kasten	471749537
Home address (number and street or rural route)		3 ☐ Single ◉ Married ☐ Married, but withhold at higher Single rate.
1380 3rd ave	n/a	Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		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. ▶ ☐
newport	55055	

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5	0
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2017, 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.) denill kasten denill kasten (Jan 18, 2018) **Date ▶** Jan 18, 2018

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)

DEPARTMENT OF REVENUE

W-4MN

2017 Minnesota Employee Withholding Allowance/Exemption Certificate

Employees

You must complete and give this form to your employer if you do any of the following:

- Claim fewer Minnesota withholding allowances than your federal allowances
- Claim more than 10 Minnesota withholding allowances
- Want additional Minnesota tax withheld from your pay each pay period
- Claim to be exempt from federal withholding or claim to be exempt from Minnesota withholding

Do not complete this form if you are claiming the same number of Minnesota allowances as federal and the number claimed is 10 or less.

Employee Information

Employee's first name and initial	Last name	Employee's Social Security number
denill kasten		471749537

Permanent address: 1380 3rd ave

City: newport — State: — ZIP code: 55055

Marital status (check one box)
- ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
- ☐ Married
- ☐ Married, but withhold at higher Single rate

Minnesota Allowances

Employees: Read instructions on back, complete Section 1 OR Section 2, sign and give the completed form to your employer. (Do not complete both Section 1 and Section 2. Completing both sections will make the form invalid.)

☐ **Section 1 — Determining Minnesota allowances**

Complete Section 1 if you claim fewer Minnesota allowances than your federal allowances, AND/OR if you want additional Minnesota withholding deducted each pay period.

1 Total number of federal allowances claimed on federal Form W-4 ..... 1 _____

2 Total number of Minnesota allowances *(line 2 cannot be more than line 1)* ..... 2 _____

3 Additional Minnesota withholding you want deducted each pay period ..... 3 $_____

Exempt from Minnesota Withholding

☐ **Section 2 — Exemption from Minnesota withholding**

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate the reason why you believe you are exempt:

- ☐ I meet the requirements and claim exempt from both federal and Minnesota income tax withholding.
- ☐ Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding because I had no Minnesota income tax liability last year, I received a refund of all Minnesota income tax withheld, AND I expect to have no Minnesota income tax liability this year.
- ☐ My spouse is a military service member assigned to a military location in Minnesota, my domicile (legal residence) is in another state, AND I am in Minnesota solely to be with my spouse. My state of domicile is _____
- ☐ I am an American Indian living and working on a reservation.
- ☐ I am a member of the Minnesota National Guard or an active duty U.S. military member and claim exempt from Minnesota withholding on my military pay.
- ☐ I receive a military pension or other military retirement pay as calculated under Title 10, 1401 through 1414, 1447 through 1455, and 12733 and claim exempt from Minnesota withholding on this retirement pay.

Sign Here

I certify that all information provided in Section 1 OR Section 2 is correct. I understand there is a $500 penalty for filing a false withholding allowance/exemption certificate.

Employee's signature: denill kasten — Date: Jan 18, 2018 — Daytime phone: 6517687973

Employees: Give the completed form to your employer.

Employers

If you are required to send a copy of this form to the Department of Revenue *(see instructions)*, you must enter the employer information below and mail this form to: Minnesota Revenue, Mail Station 6501, St. Paul, MN 55146-6501. (Incomplete forms are considered invalid.) **A $50 penalty may be assessed for each required Form W-4MN not filed with the department.**

Keep a copy for your records.

Employer Information

Name of employer	Federal employer ID number (FEIN)	Minnesota tax ID number

Address — City — State — ZIP code

(Rev. 12/16) **Questions?** Website: www.revenue.state.mn.us. Email: withholding.tax@state.mn.us. Phone: 651-282-9999 or 1-800-657-3594.

MINNESOTA

DRIVER'S LICENSE

DENILL ANN KASTEN
1380 3RD AVE
NEWPORT, MN 55055

Date of Birth 03-19-1967

Sex	Eyes	Class
F	HZL	D

Height	Weight
5-4	130

ISSUED 03-2014 EXPIRES 03-19-2018

Z40E2933015810

SOCIAL SECURITY

471-74-9537

THIS NUMBER HAS BEEN ESTABLISHED FOR

DENILL ANN KASTEN

Denill Ann Kasten

SIGNATURE

Authorization

Authorization: By signing below, you authorize: (a) backgroundchecks.com ("BGC") and/or Orange Tree Employment Screening to request information about you from any public or private information source; (b) anyone to provide information about you to BGC and/or Orange Tree Employment Screening; (c) BGC and/or Orange Tree Employment Screening to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) Employer Solutions Staffing Group, LLC ("ESSG") to share those reports with others for legitimate business purposes related to your employment. BGC and/or Orange Tree Employment Screening may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an employee of ESSG.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

Personal Information: Please print the information requested below to identify yourself for BGC.

Printed name:	denill	n/a	kasten
	First	Middle (☐ none)	Last

Other names used: strantz, yates

Current county of residence:

Current and former addresses:

from Mo/Yr	to Mo/Yr	Street	City, State & Zip
03/1999	current	1380 3rd ave	newport 55055

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

03/19/1967	471749537
Date of birth	Social security number
z406293315810	denill ann kasten
Driver's license number & state	Name as it appears on license

Report Copy: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: ☑

denill kasten
denill kasten (Jan 18, 2018)

Signature

Jan 18, 2018

Date

EMERGENCY CONTACT INFORMATION

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

Employee Name: denill kasten

Address: 1380 3rd ave newport 55055

Home Phone: 6517687973

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1	Home Phone: 651-500-0117
Name: chris kasten	Cell Phone:
Relationship: husband	Work Phone:
Contact #2	Home Phone: 651-769-8571
Name: elaine oftedahl	Cell Phone:
Relationship: mother	Work Phone:

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

_____

_____

_____

_____

_____

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

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
	Austin	Lenell	A	

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title: Drivers License		Document Title: Social Security Card
Issuing Authority		Issuing Authority: State of Minn.		Issuing Authority: Social Security Administration
Document Number		Document Number: 24052933315810		Document Number: 471-74-9537
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy): 03/19/2018		Expiration Date (if any)(mm/dd/yyyy): N/A
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)				

Additional Information

QR Code - Sections 2 & 3
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): 01/18/2018 *(See instructions for exemptions)*

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative
	01/18/2018	Recruiter

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Endert	Rachel	

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing 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	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative

employer solutions staffing group

Direct Deposit/Payroll Debit Card Authorization

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card.
If you do not provide a written election, wages will be paid by Payroll Debit Card.

SECTION 1 BASIC INFORMATION

Employee Name	SSN# (last 4 digits)	Effective Date
denill kasten	9537	01/18/2018

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

- [x] Update Bank Account
- Bank Name: us bank
- Routing# 091000022
- Account# 195746540
- Account Type: [x] Checking [ ] Savings [ ] Other _____

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

Initial dk Date 01/18/2018

- 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 #	Payroll Debit Card Account #
073972181	

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: denill kasten (denill kasten (Jan 18, 2018)) Date: 01/18/2018

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: dkasten37@yahoo.com @

this information will only be used to send your paystubs electronically

Employee's Signature: denill kasten (denill kasten (Jan 18, 2018)) Date: Jan 18, 2018

employer solutions staffing group llc

STATEMENT OF CONFIDENTIALITY

This agreement made this 18 day of Jan, 2018, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and _____ 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.

denill kasten
denill kasten (Jan 18, 2018)

Employee Signature

Employer Solutions Staffing Group LLC, Representative

employer solutions staffing group

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: denill kasten
denill kasten (Jun 18, 2018)

Printed Name: denill kasten

employer solutions staffing group, llc

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): denill kasten

Signature/Firma: denill kasten
denill kasten (Jan 18, 2018)

employer solutions staffing group

ESSG WORKPLACE SAFETY POLICY

It is ESSG's policy that all employees should be able to enjoy a hazard free and safe work environment. It is ESSG's duty to:

(1) Ensure that its clients provide you with a workplace free from serious recognized hazards and comply with standards, rules and regulations issued under the OSH Act.
(2) Ensure that its clients perform a job hazard assessment in order to identify and eliminate potential safety and health hazards and to determine necessary training and protections for employees at the facility.
(3) Make sure employees have and use safe tools and equipment.
(4) Establish or update operating procedures and communicate them so that employees follow safety and health requirements.
(5) Provide safety training in a language and vocabulary workers can understand.

ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

To help ensure a safe workplace, you have certain responsibilities too, which include the following:

- Responsibility to work in compliance with OSHA laws and regulations
- Responsibility to use personal protective equipment and clothing as directed by the host employer
- Responsibility to report workplace hazards and dangers
- Responsibility to work in a manner as required by the employer and use the prescribed safety equipment.

You have the following basic rights:

- Right to refuse unsafe work
- Right to know or be informed about actual and potential dangers in the workplace
- Right to review copies of appropriate standards, rules, regulations and requirements that the host employer is required to have available at the workplace.

employer solutions staffing group

- Right to request information about safety and health hazards in the workplace, appropriate precautions to take, and procedures to follow if involved in an accident or exposed to hazardous substances
- Right to gain access to relevant personal exposure and medical records.

You can have your name withheld from the host employer and any other entity, by request, if you sign and file a written complaint. You can request to be advised of OSHA actions regarding a complaint, and request an informal review of any decision not to inspect the site or issue a citation. And, you can file a complaint if you are punished or discriminated against for acting as a "whistleblower" under the OSH Act or 13 other federal statutes for which OSHA has jurisdiction, or for refusing to work when faced with imminent danger of death or serious injury and there is insufficient time for OSHA to inspect. Retaliation or reprisal taken against anyone who has expressed concern about workplace safety is illegal.

If you believe that your right to a safe workplace has been violated, you can make a report to a manager of the host worksite employer and/or ESSG (by telephoning 952.835.1288/1.866.496.7573) and asking for the ESSG Safety Director. You can also contact OSHA directly with any concern. ESSG recognizes the serious nature of ensuring workplace safety will endeavor to protect any employee who may have been subjected to unsafe or hazardous worksite conditions.

employer solutions staffing group

Acknowledgement of Receipt of Workplace Safety Policy

I certify that I have received a copy of Employer Solutions Staffing Group's ESSG WORKPLACE SAFETY POLICY. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at **952.835.1288/1.866.496.7573** with any questions I may have about this policy. I agree to comply with ESSG's policy on ESSG WORKPLACE SAFETY POLICY and I understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am believe that I am working in an unsafe or dangerous work environment, I will immediately contact my supervisor, manager, director or ESSG's Safety Director at **952.835.1288/1.866.496.7573** in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

denill kasten

Employee's Signature:

denill kasten
denill kasten (Jan 18, 2018)

Date: Jan 18, 2018

Form **8850** (Rev. March 2016)
Department of the Treasury
Internal Revenue Service

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

▶ Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850*.

OMB No. 1545-1500

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

Your name: denill kasten — Social security number ▶ 471749537

Street address where you live: 1380 3rd ave

City or town, state, and ZIP code: newport 55055

County: washington — Telephone number: 6517687973

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

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.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

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 ▶ *denill kasten* denill kasten (Jan 18, 2018) **Date** Jan 18, 2018

Form A (rev. 03/2017)

TAX CREDIT QUESTIONNAIRE

RETROTAX
Specialists in Tax Credit Administration

EMPLOYER SECTION:

Client:	Company:	
Location:	Position:	Starting Wage: $

EMPLOYEE SECTION:

First Name: Last Name: Suffix:	Street Address:	City/State:	Zip:
denill kasten	1380 3rd ave	newport,mn	55055

SS#:	Date of Birth:	Age:	Have you worked for this company before?	If yes, location:
471749537	03/19/1967	50	Yes ○ No ◉	

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

1. **Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?** (If yes, please provide information below.) ○ ◉
   Name of the person receiving benefits: _____ Relationship to you: _____
   City: _____ County: _____ State: _____

2. **Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?** ○ ◉
   (If yes, please provide information below.)
   Name of the person receiving benefits: _____ Relationship to you: _____
   City: _____ County: _____ State: _____

3. **Have you received Supplemental Security Income (SSI) at any time within the past 3 months?** ○ ◉
   Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits.
   **If you checked yes please provide a copy of your SSI documentation.*

4. **Have you received any type of vocational rehabilitation services within the past two years?** ○ ◉
   If yes, please indicate which type of agency you worked with and provide their location information below:
   ☐ Vocational Rehabilitation Agency ☐ Dept. of Veterans Affairs ☐ Employment Network (Ticket to Work Program)
   Name of Agency: _____ Phone #: _____
   City: _____ County: _____ State: _____
   **If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.*

5. **Are you a Veteran of the U.S. Military?** **If yes, please provide a copy of your DD-214 and letter of separation.* ○ ◉
   (If yes, please provide information below. If no, please continue to question #6.)
   Dates of Service - From: _____ To: _____
   Branch of Service: _____
   Are you entitled to or are you receiving compensation for a service-connected disability? ○ ◉

6. **Have you been unemployed at any time during the last 12 months?** ○ ◉
   If yes, dates of unemployment - From: _____ To: _____
   Did you receive unemployment compensation at any point during your unemployment? ○ ◉
   If yes, in which state did you receive unemployment compensation? __

7. **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 ☐ Federal or ☐ State conviction? If State - County: _____ State: _____

Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe? ○ ◉
If you checked yes please provide a copy of your CDIB card.
CA Residents: ☐ Are you the child of foster parents? ☐ Do you receive CalWorks? ☐ Workforce Investment Act?
☐ Are you a migrant or seasonal farm worker? ☐ Have you ever been convicted of a misdemeanor?
SC Residents: ☐ Do you receive Family Independence Benefits?

PLEASE READ, SIGN, AND DATE:

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

New Employee Signature: denill kasten
denill kasten (Jan 18, 2018)

Date: Jan 18, 2018

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: January 31, 2020

LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM
Work Opportunity Tax Credit (WOTC) 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 IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

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

New Hire's Signature: denill kasten
denill kasten (Jan 13, 2018) Date Jan 18, 2018

New Hire Name: denill kasten

Social Security Number: 471-74-9537

Employer Name: _____

Please check the statements below if they apply to you.

☐ I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

☐ I declare that I have been in a period of unemployment since _____.
(Enter start date)

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 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 10 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 National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

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employer solutions staffing group

Leveraging Resources in a Changing Market

Notification of Minnesota Law Requirement – Unemployment Acknowledgement

According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment. This paragraph applies only if, at the time of beginning of employment with the staffing service, the applicant signed and was provided a copy of a separate document written in clear and concise language that informed the applicant of this paragraph and that unemployment benefits may be affected.

It is your responsibility to contact ESSG through Corporate Management Group (for instance, by calling 303-920-1425 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. dk (initial)

denill kasten
denill kasten (Jan 18, 2018)

Employee Signature:

Jan 18, 2018

Date:

denill kasten

Employee (please print your name here)

Telephone: 303-920-1425
12000 N. Washington Street Suite 350
Thornton, CO 80241

_MN_02.2013

DRUG AND ALCOHOL
TESTING CONSENT FORM

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

denill kasten
denill kasten (Jan 18, 2018)

Individual's Name

Jan 18, 2018
Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6

HEALTHEZ

Enhanced MEC_Plan 1

Benefits Enrollment Form ☐ New Employee ☐ Rehire Rehire Date n/a

Employee Information

Name (First and Last)	Social Security Number
denill kasten	471749537

Address	City	State	Zip Code
1380 3rd ave	newport	mn	55055

Gender	Marital Status	Date of Birth	Date of Hire
☐ Male ☑ Female	☑ Single ☐ Married ☐ Divorced	03/19/1967	01/18/2018

Phone Number:	Email Address:
1380 3rd ave	dkasten37@yahoo.com

Please Select Desired Coverage:

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

Dependent

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
newport			6517687973	n/a	☑ Male ☑ Female	☑ Spouse ☑ Child ☐ Domestic Partner

Dependent

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
mn					☐ Male ☐ Female	☑ Spouse ☐ Child ☑ Domestic Partner

Dependent

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
55055					☐ Male ☐ Female	☑ Spouse ☑ Child ☑ Domestic Partner

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):	
dkasten37@yahoo.com	EFF. DATE
	EFF. DATE
	EFF. DATE

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

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature **Date** 01/18/2018

EMPLOYEES DECLINING ☐ **I am DECLINING coverage**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature denill kasten denill kasten (Jan 18, 2018) **Date** 01/18/2018

Employer Solutions Staffing Group Health Benefits Team
PO Box 46270
Minneapolis, MN 55344
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com

Fixed Indemnity Medical Benefits_Plan 2

VSI **219301-ESG-1** | OFFICE USE ONLY | LOCATION _____ | Rehire Date __/__/____

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION	PRINT USING BLACK or BLUE INK (Must Be Filled Out)		
Name denill kasten	Social Security #	Home Phone	Sex ☐M ☐F
Address			Apt. #
City	State	Zip	Date of Birth / /

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? ☐ Yes ☐ No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) | Medicare Effective Date

Name of Covered Person (s):
1. 2. 3.

C. LIMITED BENEFITS PLAN SELECTION — **Payroll Deducted Weekly Rates**

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only ☐	$20.25	$6.17	$2.42	$0.60	$4.20
Employee + 1 ☐	$41.10	$12.34	$4.92	$0.90	
Employee + Family ☐	$54.88	$20.36	$6.56	$1.80	
NO to ALL Benefits ☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name | Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Sex ☐M ☐F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex ☐M ☐F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex ☐M ☐F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex ☐M ☐F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

E. REQUIRED SIGNATURE — **YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE**

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.

DATE __/__/____ ▶ **SIGNATURE**

This Plan DOES NOT Alleviate the Individual Mandate Penalty

This is an Essential StaffCARE Enrollment Form.

employersolutionsgroup

HEALTHEZ

Benefit Enrollment/Change Form

A. Employee Information (All information is required)

First Name: 471749537	MI: a	Last Name: kasten	
SSN#: n/a	Date of Hire: 1380 3rd ave		
Date of Birth: 03/19/1967	Gender: ◉ M or ◉ F	Marital Status: 01/18/2018	
Address: 1380 3rd ave	City: newport	State: mn	Zip: 55055
Daytime Phone: (6517687973	Home phone: (n/a)	Email: dkasten37@yahoo.com	

B. Change of Status/Coverage

Date of Qualifying Event:		☐ Add Dependent	☐ Change Name
☐ Open Enrollment	☐ COBRA / Term. of Employment	☐ Drop Dependent	☐ Change Address
☐ New Enrollment	☐ Medicare	☐ Birth / Death	☐ Other 01/18/2018
☐ Reduction in Hours	☐ Other Coverage	☐ Marriage / Divorce	

C. Medical Plan Options (If electing coverage please make a selection in both 1 & 2)

1. Plan Election	☐ $2,500 Copay Plan	☐ $6,000 Copay Plan	☐ $3,000 HSA Plan	☐ $6,000 HSA Plan	☐ Decline Coverage (please complete sections E. & G.)
2. Coverage Election	☐ Employee only	☐ Employee + Spouse	☐ Employee + Children	☐ Family	

D. Dependent/Spouse Information (Must be completed for coverage of dependents)

Name (Last, First, MI)	Relationship	Birth date	SSN	M/F	Disabled (Y/N)	Please check below to include on medical plan
						☐ Medical
						☐ Medical
						☐ Medical
						☐ Medical

E. Other Insurance Coverage Information Please check one:

☐ I have enrolled thru the state or federal Marketplace	☐ I have other insurance coverage	☐ I do not have other insurance coverage	☐ I have other insurance coverage, but intend to cancel that coverage

Policyholder's Name: Policyholder's Date of Birth:

Insurance Co. Name: Policy Number: Group Number:

Insurance Co. Address: Names of covered individuals:

F. Health Savings Account

☐ Yes, I would like to set up a Health Savings Account (This option is available if you enroll in the HSA plan).

Your annual deduction will be divided into equal amounts and deducted from each pay period throughout the year.

I elect to have an **ANNUAL** deduction of $ dkasten37@yahoo.com (maximum of $3,450 for employee-only coverage, or $6,900 for all other levels of coverage) reduced from my salary before taxes to reimburse me for qualified expenses which I incur during the plan year. Maximum contribution to the HSA Plan will be reduced by company contribution. Employees who are age 55 or older can make a catch-up contribution of $1,000 in addition to IRS maximums.

G. Enrollment Waiver (check box only if declining coverage)

☐ I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions.

☐ I understand by not enrolling in this plan or a Marketplace health plan as mandated by PPACA, that I may be subject to a tax penalty.

H. Employee Authorization

I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease.
I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.

To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.

denill kasten
denill kasten (Jan 18, 2018)

Employee Signature

Jan 18, 2018

Date

Signature: denill kasten
denill kasten (Jan 18, 2018)

Email: dkasten37@yahoo.com