



**CMG EMPLOYMENT NEW HIRE PAPERWORK**

Name Emilee Dawn Martinez  
First Middle Last Maiden

Present Address 515 Alpine Street Longmont CO 80504  
Street City State Zip

Telephone 970-358-9656 E-Mail live.life.peace.emy@gmail.com  
Referred by Indeed.com

Do you have any responsibilities or commitments that will prevent you from meeting a specified work schedule?

Yes  No If so, please explain \_\_\_\_\_

Do you have any pre-scheduled days off in the next three-six months?

Yes  No If so, please lists all dates \_\_\_\_\_

**Military Experience:**

Have you ever been in the Armed Forces?  Yes  No

Are you currently an active member of the Reserve or National Guard?  Yes  No

Branch \_\_\_\_\_ Specialty \_\_\_\_\_

Date Entered \_\_\_\_\_ Discharge Date \_\_\_\_\_

Application Waiver

In exchange for the consideration of my job application by Corporate Management Group, Inc.,

I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements and the like as they may exist from time to time, or other company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of Corporate Management Group, Inc. (CMG), or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by an officer of CMG. Both the undersigned and CMG may end the employment relationship at any time, without specified notice or reason. If employed, I understand that CMG may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination. I hereby give CMG permission to contact schools, all previous employers (unless otherwise indicated), references and others and hereby release CMG from any liability as a result of such contact.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by CMG. 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 CMG policies.

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

I understand that, in connection with the routine processing of your employment application, CMG may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics and mode of living. Upon written request from me, CMG will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with CMG shall be probationary for a period of ninety (90) days or 520 hours (based on the client site I am employed at) and further that at any time during the probationary period or thereafter, my employment relationship with CMG is terminable at will for any reason by either party.

Signature of applicant \_\_\_\_\_ Date: \_\_\_\_\_

# Form W-4 (2019)

**Future developments.** For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

**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.** You may claim exemption from withholding for 2019 if both of the following apply.

- For 2018 you had a right to a refund of all federal income tax withheld because you had no tax liability, and
- For 2019 you expect a refund of all federal income tax withheld because you expect to have no tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

## General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

**Filers with multiple jobs or working spouses.** If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

**Nonwage income.** If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to find out if you should adjust your withholding on Form W-4 or W-4P.

**Nonresident alien.** If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

## Specific Instructions

### Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

**Line C. Head of household please note:** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

**Line E. Child tax credit.** When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

**Line F. Credit for other dependents.** When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <b>2019</b>	
▶ Whether you're 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.					
1 Your first name and middle initial Emilee D		Last name Martinez		2 Your social security number 650-03-5570	
Home address (number and street or rural route) 519 Alpine Street			3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."		
City or town, state, and ZIP code Longmont, CO 80504			4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>		
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)				5 0	
6 Additional amount, if any, you want withheld from each paycheck				6 \$ 0.00	
7 I claim exemption from withholding for 2019, 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.					
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>Emilee D Martinez</i>				Date ▶ 7/19/19	
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.			9 First date of employment		10 Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

**Line G. Other credits.** You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

### Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App). If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

### Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you

don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make your withholding more accurate.

**Tip:** If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

### Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

**New hire reporting.** Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9,

and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to [www.acf.hhs.gov/css/employers](http://www.acf.hhs.gov/css/employers).

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

**Box 8.** Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

**Box 9.** If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

**Box 10.** Enter the employer's employer identification number (EIN).

**Personal Allowances Worksheet (Keep for your records.)**

- A Enter "1" for yourself A \_\_\_\_\_
- B Enter "1" if you will file as married filing jointly B \_\_\_\_\_
- C Enter "1" if you will file as head of household C \_\_\_\_\_
- D Enter "1" if:
  - You're single, or married filing separately, and have only one job; or
  - You're married filing jointly, 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.D \_\_\_\_\_
- E **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.
  - If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "4" for each eligible child.
  - If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "2" for each eligible child.
  - If your total income will be from \$179,051 to \$200,000 (\$345,851 to \$400,000 if married filing jointly), enter "1" for each eligible child.
  - If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" E \_\_\_\_\_
- F **Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information.
  - If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "1" for each eligible dependent.
  - If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
  - If your total income will be higher than \$179,050 (\$345,850 if married filing jointly), enter "-0-" F \_\_\_\_\_
- G **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F G \_\_\_\_\_
- H Add lines A through G and enter the total here ▶ H \_\_\_\_\_

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you have more than one job at a time or are married filing jointly and you and your spouse both work, and the combined earnings from all jobs exceed \$53,000 (\$24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

**Deductions, Adjustments, and Additional Income Worksheet**

**Note:** Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

- 1 Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details 1 \$ \_\_\_\_\_
- 2 Enter:
  - \$24,400 if you're married filing jointly or qualifying widow(er)
  - \$18,350 if you're head of household
  - \$12,200 if you're single or married filing separately2 \$ \_\_\_\_\_
- 3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$ \_\_\_\_\_
- 4 Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) 4 \$ \_\_\_\_\_
- 5 Add lines 3 and 4 and enter the total 5 \$ \_\_\_\_\_
- 6 Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest) 6 \$ \_\_\_\_\_
- 7 Subtract line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses 7 \$ \_\_\_\_\_
- 8 Divide the amount on line 7 by \$4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction 8 \_\_\_\_\_
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, above 9 \_\_\_\_\_
- 10 Add lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 of that worksheet on page 4. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 10 \_\_\_\_\_

**Two-Earners/Multiple Jobs Worksheet**

**Note:** Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1 Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) 1 \_\_\_\_\_
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" 2 \_\_\_\_\_
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet. 3 \_\_\_\_\_

**Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 \_\_\_\_\_
- 5 Enter the number from line 1 of this worksheet 5 \_\_\_\_\_
- 6 Subtract line 5 from line 4 6 \_\_\_\_\_
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ \_\_\_\_\_
- 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ \_\_\_\_\_
- 9 Divide line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ \_\_\_\_\_

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$7,000	0	\$0 - \$24,900	\$420	\$0 - \$7,200	\$420
5,001 - 9,500	1	7,001 - 13,000	1	24,901 - 84,450	500	7,201 - 36,975	500
9,501 - 19,500	2	13,001 - 27,500	2	84,451 - 173,900	910	36,976 - 81,700	910
19,501 - 35,000	3	27,501 - 32,000	3	173,901 - 326,950	1,000	81,701 - 158,225	1,000
35,001 - 40,000	4	32,001 - 40,000	4	326,951 - 413,700	1,330	158,226 - 201,600	1,330
40,001 - 46,000	5	40,001 - 60,000	5	413,701 - 617,850	1,450	201,601 - 507,800	1,450
46,001 - 55,000	6	60,001 - 75,000	6	617,851 and over	1,540	507,801 and over	1,540
55,001 - 60,000	7	75,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 95,000	8				
70,001 - 75,000	9	95,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 110,000	10				
85,001 - 95,000	11	110,001 - 115,000	11				
95,001 - 125,000	12	115,001 - 125,000	12				
125,001 - 155,000	13	125,001 - 135,000	13				
155,001 - 165,000	14	135,001 - 145,000	14				
165,001 - 175,000	15	145,001 - 160,000	15				
175,001 - 180,000	16	160,001 - 180,000	16				
180,001 - 195,000	17	180,001 and over	17				
195,001 - 205,000	18						
205,001 and over	19						

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to

cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating

to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



**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

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ 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) <b>Martinez</b>		First Name (Given Name) <b>Emilee</b>		Middle Initial <b>D</b>	Other Last Names Used (if any)	
Address (Street Number and Name) <b>515 Alpine Street</b>			Apt. Number	City or Town <b>Longmont</b>	State <b>CO</b>	ZIP Code <b>80504</b>
Date of Birth (mm/dd/yyyy) <b>02/03/1997</b>	U.S. Social Security Number <b>650-03-5075</b>		Employee's E-mail Address <b>live.life.peace.emy@gmail.com</b>		Employee's Telephone Number <b>970-388-9896</b>	

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 boxes):

1. A citizen of the United States

2. A noncitizen national of the United States *(See Instructions)*

3. A lawful permanent resident *(Alien Registration Number/USCIS Number):* \_\_\_\_\_

4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): \_\_\_\_\_  
 Some aliens may write "N/A" in the expiration date field. *(See Instructions)*

*Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:  
 An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.*

1. Alien Registration Number/USCIS Number: \_\_\_\_\_  
 OR  
 2. Form I-94 Admission Number: \_\_\_\_\_  
 OR  
 3. Foreign Passport Number: \_\_\_\_\_  
 Country of Issuance: \_\_\_\_\_

QR Code - Section 1  
 Do Not Write in This Space

Signature of Employee **[Signature]** Today's Date (mm/dd/yyyy) **7/19/19**

**Preparer and/or Translator Certification (check one):**

I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

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



**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) <b>Martinez</b>	First Name (Given Name) <b>Emilee</b>	M.I. <b>D</b>	Citizenship/Immigration Status <b>US citizen</b>
List A	OR	List B	AND	List C
Identity and Employment Authorization		Identity	Employment Authorization	

Document Title	Document Title <b>State DL</b>	Document Title <b>Social Security Card</b>
Issuing Authority	Issuing Authority <b>Colorado</b>	Issuing Authority <b>SSA</b>
Document Number	Document Number <b>13-170-1062</b>	Document Number <b>650-03-5575</b>
Expiration Date (if any)(mm/dd/yyyy)	Expiration Date (if any)(mm/dd/yyyy) <b>02/03/2023</b>	Expiration Date (if any)(mm/dd/yyyy)
Document Title	Additional Information	
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		
Document Title	QR Code - Sections 2 & 3 Do Not Write In This Space	
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): **7/24/2019** (See instructions for exemptions)

Signature of Employer or Authorized Representative <b>Jamie Ready</b>	Today's Date (mm/dd/yyyy) <b>7/24/2019</b>	Title of Employer or Authorized Representative <b>HR coordinator</b>	
Last Name of Employer or Authorized Representative <b>Ready</b>	First Name of Employer or Authorized Representative <b>Jamie</b>	Employer's Business or Organization Name <b>Corporate Management group</b>	
Employer's Business or Organization Address (Street Number and Name) <b>1200 N Washington St Suite 350</b>		City or Town <b>Thornton</b>	State <b>CO</b>
		ZIP Code <b>80241</b>	

**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
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**SOCIAL SECURITY**

650-03-5575

THIS NUMBER HAS BEEN ESTABLISHED FOR

**EMILEE DAWN MARTINEZ**

*Emilee Dawn Martinez*

REGISTRAR

SIGNATURE

**COLORADO** **DL** 

**DRIVER LICENSE**



*Emilee Dawn Martinez*

1 MARTINEZ  
 2 EMILEE DAWN  
 8 515 ALPINE ST  
 LONGMONT, CO 80504  
 3 DOB 02/03/1997 4a Iss: 02/21/2018  
 4d Customer Identifier 4b Exp: 13-170-1062  
 5 DO 1591984  
 16 Sex F  
 18 Eyes BRO  
 19 Hair BRO  
 16 Hat 4'-11"  
 17 Wgt 165 lb  
 185 lb  
 8a Endorsements  
 12 Restrictions C  
 9 Vehicle Classifications R

*Emilee Dawn Martinez*



## 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	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
OR	AND	
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  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  3. School ID card with a photograph  4. Voter's registration card  5. U.S. Military card or draft record  6. Military dependent's ID card  7. U.S. Coast Guard Merchant Mariner Card  8. Native American tribal document  9. Driver's license issued by a Canadian government authority  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	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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)  3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal  4. Native American tribal document  5. U.S. Citizen ID Card (Form I-197)  6. Identification Card for Use of Resident Citizen in the United States (Form I-179)  7. Employment authorization document issued by the Department of Homeland Security
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		
4. Employment Authorization Document that contains a photograph (Form I-766)		
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.		
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		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



# Emergency Contact Information

In the event of an emergency CMG will contact the follow contacts

Please list two people in order of priority.

Contact # 1	
Name: <i>Rose Martinez</i>	Home Phone: <i>303-678-1348</i>
Relationship: <i>Mother</i>	Cell Phone: <i>303-562-6896</i>
Contact # 2	
Name: <i>Lloyd Martinez</i>	Home Phone: <i>303-678-1348</i>
Relationship: <i>Father</i>	Cell Phone: <i>303-434-7309</i>

Additional information you would like CMG and our clients to know in the event of an emergency:

*NA*

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## Direct Deposit/Payroll Debit Card Authorization Form

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

Employee Name: EMILIE MARKOZ

### Payroll Election:

- Direct Deposit (Please see Section A)  
 Payroll Debit Card (Please see Section B)

### Section A: Direct Deposit

Bank Name: Academy Bank  
Routing Number: 107001481  
Account Number: \_\_\_\_\_  
Account Type: Check  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 information that I provided is incorrect.

Initial: EM Date: 7/19/19

### Section B: Payroll Debit Card

Routing Number: \_\_\_\_\_  
Account Number: \_\_\_\_\_

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

I have received my Payroll Debit Card, welcome brochure, program fees, conditions and disclosures. By activating my Payroll Debit Card on my first pay day 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 CMG to debit my Payroll Debit Card account for the fees described to me in the provided material.

### Section C: Additional Accounts

Bank Name: \_\_\_\_\_  
Routing Number: \_\_\_\_\_  
Account Number: \_\_\_\_\_  
Account Type: Check \_\_\_ Savings: \_\_\_ Other: \_\_\_

I request that the following funds be deposited to the account listed in Section C:

- \_\_\_\_\_ % of my original deposit  
 \$ \_\_\_\_\_ from my original deposit

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize CMG to directly deposit my wages and other payments as necessary into my account(s) as designated above and to initiate, debit entries and adjustments for any credit entries made in error to my account(s).

I have been informed how to gain access to my electronic pay stubs if needed.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**To:** All Employees  
**Quien:** Todos Empleados

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

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

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

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

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

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

Thank you for your continued dedication and hard work!

*Gracias por su dedicacion continua!*

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

Signature/Firma: \_\_\_\_\_

Date/Fecha: 7/19/19

February 2011



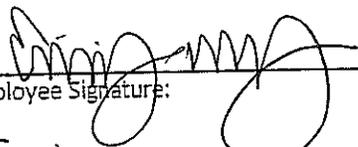
**Notification of Colorado Law Requirement**  
**Unemployment Acknowledgement**

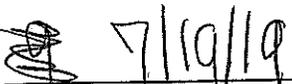
According to Colorado Statutes section 8-73-105.3. A temporary employee who is given a notice that the employee is required to contact or notify the employer upon completion of an assignment and to be available to work, as agreed upon at the time of hire, during a specified period of time, on specified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

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

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

EM (Initial)

  
Employee Signature:

  
Date:

Emilio Martinez  
Employee (please print your name here)



*'your workforce management & staffing experts'*

## **ANTI-HARASSMENT POLICY**

It is Corporate Management Group's (CMG) policy that all employees should be able to enjoy a work environment free from all forms of discrimination, including harassment. As such, CMG is committed to vigorously enforcing their Anti-harassment Policy. This policy applies to all employees of the organization (without regard to position) and individuals not directly connected to CMG (e.g., an outside vendor, consultant, customer or guest). Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, creed, religion, national origin, sex, marital status, status with regard to public assistance, membership or activity in a local commission, disability, sexual orientation or veteran status. Harassment is considered a form of discrimination and is specifically included among the prohibitions under Title VII of the Civil Rights Act of 1964. In addition, retaliation or reprisal taken against anyone who has expressed concern about harassment or discrimination against the individual raising the concern is illegal.

The Equal Employment Opportunity Commission (EEOC) defines sexual harassment as "unwelcome sexual advances, requests for sexual favors, sexual comments, or other verbal or physical acts of a sexual or sex-based nature including, but not limited to drawings, pictures, jokes, and/or teasing where (1) submission to such conduct is made either explicitly or implicitly a term or a condition of an individual's employment; (2) an employment decision is based on an individual's acceptance or rejection of such conduct; or (3) such conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment."

The Anti-harassment Policy prohibits harassment and/or retaliation by any individual employed by, doing business with or for, or visiting CMG. Employees who believe they have been the subject of harassment and/or retaliation or an employee who may have been witness to harassment and/or retaliation must report the incident immediately. Information and/or allegations must be reported to a manager of CMG (by telephoning 866.920.1425 or 303.920.1425). Only those who have an immediate need to know, including the alleged target of harassment or retaliation, the alleged harassers or retaliators, and any witnesses may find out the identity of the complainant. All individuals contacted in the course of an investigation will be advised that all persons involved in a charge are entitled to respect and that any retaliation or reprisal against an individual who is an alleged target of harassment or retaliation, who has made a complaint, or who has provided information in connection with a complaint, is a separate violation of CMG's policy. All information will be disclosed only on a need-to-know basis to allow CMG to

investigate and resolve the incident. CMG recognizes the serious nature of harassment and therefore will endeavor to protect the employee who may have been subjected to harassment, any witnesses and the party against whom allegations have been filed to every possible extent.

Harassment is unlawful and has a negative impact on employees. Violation of the Anti-harassment Policy will not be tolerated by CMG and may result in discipline up to and including termination. Offensive acts or conduct have no legitimate business purpose; accordingly, any employee, regardless of his/her position within CMG, who it is determined has engaged in such conduct will be made to bear the full responsibility for such unlawful conduct.

With respect to sexual harassment, the following is prohibited:

1. Unwelcome sexual advances, request for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, especially where:
  - Submission to such conduct is made either explicitly or implicitly a term or condition of employment;
  - Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or
  - Such conduct has the purpose or effect of creating an intimidating, hostile or offensive working environment.
2. Offensive comments, jokes, innuendoes and other sexually-oriented statements.

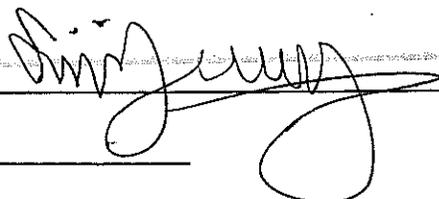
**If Harassment Occurs:**

1. When possible, confront the harasser and tell him/her to stop. Sometimes a simple confrontation will end the situation.
2. If confrontation is unsuccessful, immediately contact your CMG supervisor to report the harassment.
3. An investigation will be conducted and appropriate action taken, including disciplinary measures. We will investigate, in confidence; all reported incidents of harassment and retaliation.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

7/19/19

A handwritten signature in black ink, appearing to read "D. J. [unclear]", written over a horizontal line.



# Limited Benefit & Self-Funded Minimum Essential Coverage (MEC) Enrollment Guide

## Complete the Enrollment Form to Elect or Decline Coverage

**IMPORTANT PLAN INFORMATION:** You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

### Advantages of the Fixed Indemnity Medical Plan

- Covers Day to Day Medical Expenses 
- Satisfies the Individual Mandate
- You may still be eligible to receive a subsidy from the health insurance exchange
- Offers Dental, Vision, Term Life and STD

### Advantages of the MEC Wellness/Preventive Plan

- Covers Day to Day Medical Expenses 
- Satisfies the Individual Mandate
- You may still be eligible to receive a subsidy from the health insurance exchange
- Offers Dental, Vision, Term Life and STD

1. You **MUST** complete the Enrollment Form as part of your New Hire Process.
2. Elect or decline all benefits on the Enrollment Form.
3. You **MUST Sign** and **Date** the bottom of the form, even if you decline coverage.
4. Return the Enrollment Form to your Branch Manager.
5. Keep the Benefits at a Glance page for your records.

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**THE FIXED INDEMNITY MEDICAL PLAN IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED UNDER THE AFFORDABLE CARE ACT (ACA).**

The Essential StaffCARE Fixed Indemnity Medical, Prescription Drug, Accidental Loss of Life, Limb & Sight, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1214, 26.212, and 26.213. The Term Life and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

The **MEC Wellness/Preventive Plan** is an employer-sponsored, self-funded plan that has been deemed to be in compliance with ACA rules and regulations. More information about Preventive Services may be found on the government website at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>. For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

### Availability of Summary Health Information for MEC/Wellness Preventive Plan

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: [essentialstaffcare.com/sbcmec](http://essentialstaffcare.com/sbcmec). A paper copy is also available, free of charge, by calling Essential StaffCARE Customer Service 1-866-798-0803.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.



# Essential StaffCARE

CMG ESC/MEC ES P2DM v18.2

# ENROLLMENT FORM

ESC/MEC ES P2DM v18.2

## A. REQUIRED EMPLOYEE INFORMATION

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

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_

## B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare benefits?  
 Yes  No. If Yes:  
 Medicare Health Insurance Claim Number (HICN) \_\_\_\_\_

Medicare Effective Date \_\_\_\_\_

Name of Covered Person(s):  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_

## C. LIMITED BENEFIT PLAN SELECTION

### Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. This plan is underwritten by BCS Insurance Company.

	FIXED INDEMNITY MEDICAL <sup>1</sup>	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY <sup>2</sup>
Employee Only	<input type="checkbox"/> \$23.69	<input type="checkbox"/> \$5.40	<input type="checkbox"/> \$2.42	<input type="checkbox"/> \$0.60	<input type="checkbox"/> \$4.20
Employee + 1	<input type="checkbox"/> \$48.08	<input type="checkbox"/> \$10.80	<input type="checkbox"/> \$4.92	<input type="checkbox"/> \$0.90	<input type="checkbox"/>
Employee + Family	<input type="checkbox"/> \$64.20	<input type="checkbox"/> \$17.82	<input type="checkbox"/> \$6.56	<input type="checkbox"/> \$1.80	<input type="checkbox"/>
	<input type="checkbox"/> NO to ALL Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No			

<sup>1</sup> This coverage is not available to residents of NH, HI, or PR. <sup>2</sup> STD is not available to persons who work in CA, HI, NJ, NY, or RI. For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical 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

## E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82219000-M-CMG Direct Payment Monthly Rates

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. This plan satisfies the federal healthcare reform Individual Mandate. This is an offer of ACA compliant coverage and by purchasing this plan, you will not be taxed for failing to purchase insurance required by the Affordable Care Act. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

\$62.00 Employee Only  \$69.02 Employee + 1  \$73.67 Employee + Family  NO to MEC Wellness/Preventive

## F. REQUIRED SIGNATURE

**YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE**

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage.

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SIGNATURE \_\_\_\_\_

# LIMITED BENEFITS SUMMARY

## FIXED INDEMNITY MEDICAL BENEFIT

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by an accident or illness. If the covered event costs more, you pay the difference. But if the covered event costs less, you keep the difference.

Outpatient Benefits <sup>1</sup>		Inpatient Benefits	
Physician Office Visit	\$100 per day	Standard Care	\$500 per day
Diagnostic (Lab)	\$75 per day	Intensive Care Unit Maximum <sup>3</sup>	\$600 per day
Diagnostic (X-Ray)	\$200 per day	Inpatient Surgery	\$3,000 per day
Ambulance Services	\$300 per day	Anesthesiology	\$600 per day
Physical, Speech, or Occupational Therapy	\$50 per day	Skilled Nursing <sup>4</sup>	\$100 per day
Emergency Room Benefit - Sickness	\$200 per day	First Hospital Admission (1 per year)	\$250
Emergency Room Benefit - Accident	\$500 per day	Annual Inpatient Maximum <sup>5</sup>	No Limit
Outpatient Surgery	\$500 per day	<b>Accidental Loss of Life, Limb &amp; Sight</b>	
Anesthesiology	\$200 per day	Employee/Spouse	\$20,000
Annual Outpatient Maximum	\$2,000	Dependent (6 months to 26 years)	\$5,000
Prescription Drugs (via reimbursement) <sup>2</sup>		Dependent (15 days to 6 months)	\$2,500
Annual Maximum	\$600	<b>Wellness Care</b>	
Generic Copay / Brand Copay	\$10/\$50	Wellness Care (one per year)	\$100

<sup>1</sup> all outpatient benefits are subject to the outpatient maximum <sup>2</sup> not subject to outpatient maximum <sup>3</sup> pays in addition to standard care benefit <sup>4</sup> for stays in a skilled nursing facility after a hospital stay <sup>5</sup> Subject to internal limits of plan

DENTAL BENEFIT	Waiting Period/Coinsurance	Annual Maximum Benefit	Deductible
Coverage A	None / 80%	\$750	\$50
Coverage B	3 Months / 60%	Exams, Cleanings, Intraoral Films and Bitewings	
Coverage C	12 Months / 50%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures	
		Periodontics, Crowns, Bridges, Endodontics and Dentures	

VISION BENEFIT <sup>1</sup>	In-Network		Out-of-Network	
	You Pay	Plan Pays	You Pay	Plan Pays
Eye Examination <sup>2</sup> (including dilation)	\$10 Copay	100%	100%	\$35
Exam Options (Standard or Premium Contact Lens Fit)	Up to \$55 or 10% off Retail Price	\$0	100%	\$0
Frames <sup>3</sup>	80%, after \$110 allowance	\$110, plus 20% of remaining	100%	\$55
Standard Plastic Lenses (single, bifocal, trifocal) <sup>2</sup>	\$25 Copay	100%	100%	\$25-\$55
Lens Options	\$15-\$45 or 20% discount	100% or 20% off retail	100%	\$0
Contact Lenses (Conventional) <sup>2</sup>	\$0 Copay, 85% of remaining	\$110, plus 15% of remaining	100%	\$88
Disposable Contact Lenses <sup>2</sup>	\$0 Copay	\$110, plus balance	100%	\$88
Medically Necessary Contact Lenses <sup>2</sup>	\$0 Copay	100%	\$0	\$200

<sup>1</sup> For complete plan details, please visit [www.essentialstaffcare.com/vision](http://www.essentialstaffcare.com/vision) <sup>2</sup> Once every 12 months <sup>3</sup> Once every 24 months

TERM LIFE BENEFIT			
Employee Amount	\$10,000 (reduces to \$7,500 at 65; \$5,000 at 70)	Child Amount (6 mos to 26 yrs old)	\$5,000
Spouse Amount	\$5,000 (terminates at age 70)	Infant Amount (15 days to 6 mos)	\$1,000

SHORT-TERM DISABILITY BENEFIT	
Benefit Amount	60% of Salary up to \$150 per week
Waiting Period/Maximum Benefit Period	7 days up to 26 weeks

## OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT <sup>1</sup>

Policy Number 82219000-M-CMG

The optional MEC Wellness/Preventive Benefit **DOES NOT** cover medical services. This plan provides coverage for preventive services such as immunization and routine health screening. It does not cover conditions caused by accident or illness.

Benefit	In-Network	Non-Network	MONTHLY MEC PREMIUM	MEC
15 Preventive Services for Adults	100%	40%	Employee Only	\$62.00
22 Preventive Services for Women	100%	40%	Employee + 1	\$69.02
26 Covered Preventive Services for Children	100%	40%	Employee + Family	\$73.67

<sup>1</sup> For more information about preventive services, please visit [www.healthcare.gov](http://www.healthcare.gov)

WEEKLY LIMITED BENEFITS PREMIUM	Medical	Dental	Vision	Term Life	STD
Employee Only	\$23.69	\$5.40	\$2.42	\$0.60	\$4.20
Employee + 1	\$48.08	\$10.80	\$4.92	\$0.90	-
Employee + Family	\$64.20	\$17.82	\$6.56	\$1.80	-

## LIMITED BENEFIT EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

### FIXED INDEMNITY MEDICAL AND ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT BENEFIT

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
- Declared or undeclared war
- Serving on full-time active duty in the armed forces
- The covered person's commission of a felony
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law or
- With regard to the accidental loss of life, limb or sight benefit - sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions
- Hearing examinations or hearing aids
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force
- Services provided by a member of the covered person's immediate family.

The fixed indemnity medical plan is not available to residents of Hawaii, New Hampshire or Puerto Rico.

### PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

## DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

## VISION

No benefits will be paid for any materials, procedures or services provided under worker's compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

## SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent, or a person who resides in your home
- Declared or undeclared war or act of war
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony
- Your participation in a riot
- If you engage in an illegal occupation
- Release of nuclear energy
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

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

## TERM LIFE

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

### Member Services

For frequently asked questions and network information for the the Fixed Indemnity Medical Plan, please go to [www.essentialstaffcare.com/FAQEC](http://www.essentialstaffcare.com/FAQEC). For frequently ask questions regarding the MEC Wellness Preventive Benefit, as well as a full list of preventive services covered, please go to [www.essentialstaffcare.com/FAQMEC](http://www.essentialstaffcare.com/FAQMEC).

**PLEASE NOTE:** Your Company has chosen to take your payroll deductions on a Post-Tax basis.

**Essential StaffCARE Customer Service: 1-866-798-0803**

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit [www.paisc.com](http://www.paisc.com) and click on "Your Plan" and enter your group number.



The MEC SBC is available on the web at: [essentialstaffcare.com/sbcmec](http://essentialstaffcare.com/sbcmec). A paper copy is also available, free of charge, by calling Essential StaffCARE Customer Service 1-866-798-0803.