E-Verify
Employment Eligibility Verification

SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2016173110206EE

Report Prepared: 06/21/2016

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Abikar

First Name: Halima

Date of Birth: 01/01/1969

Social Security Number: *** ** 6699

Hire Date: 06/21/2016

Citizenship Status: A lawful permanent resident

Document Information

List A Document: Permanent Resident Card or Alien Registration Receipt Card (Form I-551)

Alien Number: 212217027

Card Number: LIN1190855285

Document Expiration Date:

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 06/21/2016

Case Submitted By: JEIC3094

Closed On: 06/21/2016

Closed By: JEIC3094

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

SENSITIVE BUT UNCLASSIFIED

employer solutions staffing group
Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405
Edina, MN 55439
Tel: 952.835.1288
www.esgstaffingsolutions.com

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Abikar **First Name** Halima **Middle Initial** M

Street Address 875 15th ave SE **Apt/Ste** 14

City/State/Zip St. Cloud **Social Security Last Four** XXX-XX-6699

Phone Number 320-455-3214 **Email Address** Kassimharun57@gmail.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.

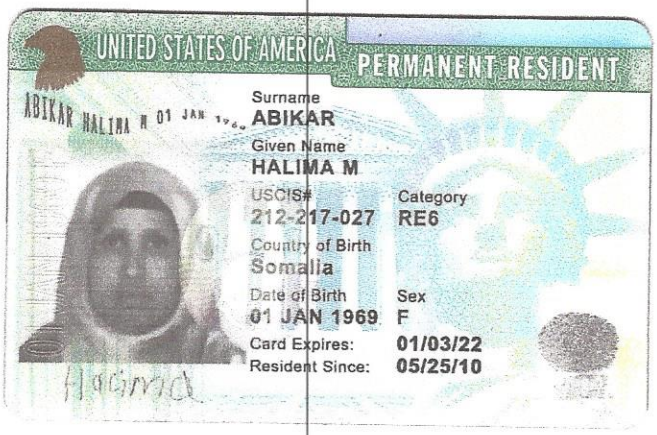
Halima Abikar — Name (Print or type)

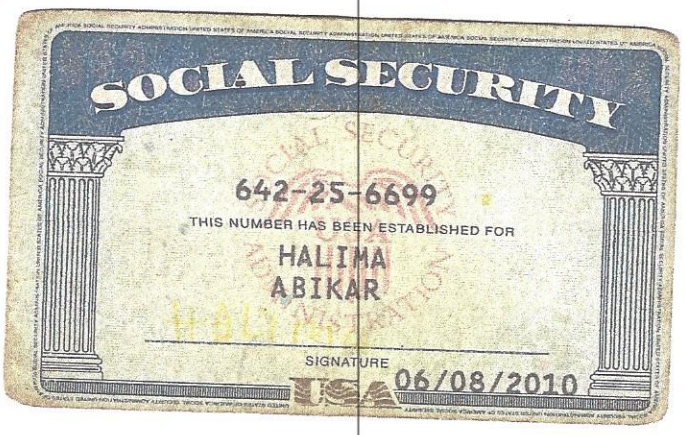
Applicant's Signature

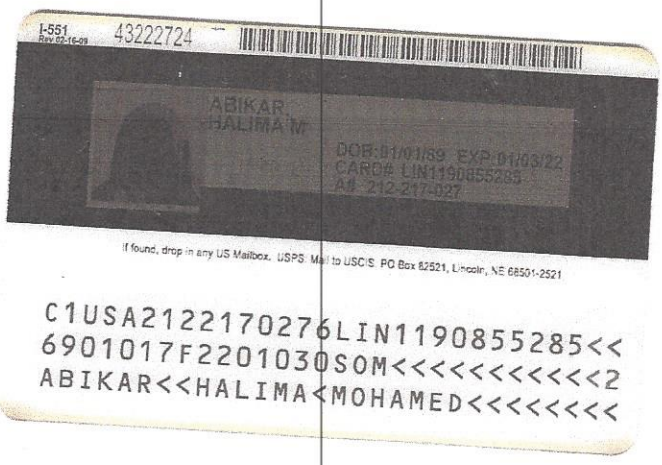
6-20-16 — Date

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


UNITED STATES OF AMERICA
PERMANENT RESIDENT
ABIKAR HALIMA M 01 JAN 196
Surname
ABIKAR
Given Name
HALIMA M
USCIS#
212-217-027
Category
RE6
Country of Birth
Somalia
Date of Birth
01 JAN 1969
Sex
F
Card Expires:
01/03/22
Resident Since:
05/25/10


SOCIAL SECURITY
642-25-6699
THIS NUMBER HAS BEEN ESTABLISHED FOR
HALIMA
ABIKAR
SIGNATURE
USA
06/08/2010


I-551
Rev.02-16-09
43222724
ABIKAR
HALIMA M
DOB:01/01/69 EXP:01/03/22
CARD# LIN1190855285
A# 212-217-027
If found, drop in any US Mailbox. USPS Mail to USCIS. PO Box 82521, Lincoln, NE 68501-2521
C1USA2122170276LIN1190855285<<
6901017F2201030SOM<<<<<<<<<<<2
ABIKAR<<HALIMA<MOHAMED<<<<<<<<

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
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	2
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

2016

1 Your first name and middle initial: Halima M	Last name: Abikar	2 Your social security number: 642-25-6699
Home address (number and street or rural route): 875 15th ave SE Apt #14	3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code: St. Cloud 56304	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	2
6 Additional amount, if any, you want withheld from each paycheck	6	$ 0.00
7 I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ [signature] **Date** ▶ 6-20-16

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)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name (*Given Name*)	Middle Initial	Other Names Used (*if any*)
Abikar	Halima	M	

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code
875 15th ave SE	14	St. Cloud	MN	56304

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
0101 1969	642-25-6699		

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):

AH ☑ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☒ A lawful permanent resident (Alien Registration Number/USCIS Number): 212-217-027

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (*mm/dd/yyyy*):
[signature]	6-20-16

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	Date (*mm/dd/yyyy*):
[signature]	6-20-16

Last Name (*Family Name*)	First Name (*Given Name*)
Abikar	Halima

Address (*Street Number and Name*)	City or Town	State	Zip Code
875 15th ave SE	St. Cloud	MN	56304

STOP **Employer Completes Next Page** STOP

STOP **Employer Completes This Page** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1: Abikar, Halima M

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title: Perm. Res. Card		Document Title:		Document Title:
Issuing Authority: USA		Issuing Authority:		Issuing Authority:
Document Number: 212-217-027		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*: 01/03/2022		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)* 06/21/2016 **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
[signature]	06/21/2016	ON-Site Rep
Last Name *(Family Name)* Fichter	**First Name *(Given Name)*** Jill	**Employer's Business or Organization Name** EMPLOYER SOLUTIONS STAFFING GROUP LLC
Employer's Business or Organization Address *(Street Number and Name)* 7301 OHMS LANE SUITE 405	**City or Town** EDINA	**State** MN / **Zip Code** 55439

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Line Check

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

Direct Deposit/Payroll Debit Card Authorization

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

SECTION 1 BASIC INFORMATION

Employee Name	SSN# (last 4 digits)	Effective Date
Halima	6699	6-20-16

SECTION 2 PAYROLL ELECTION

☐ **Direct Deposit** (Please complete Sections 3 and 5 below)

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

SECTION 3 DIRECT DEPOSIT

ACCOUNT

☐ Update Bank Account

Bank Name:

Routing#

Account#

Account Type: ☐ 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 _____ Date _____

- 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)

GET TEXT ALERTS, when your paycheck is deposited on your card!
All we need to know your cell phone service provider and mobile number above!

☐ Yes, sign me up, for text alerts
My mobile service provider is: _____

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: Halima ABikar Date: 6-21-16

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:** _____ @ _____

this information will only be used to send your paystubs electronically

Employee's Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION

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

Employee Name: Halima Abikar

Address: 873 15th ave SE APT #14

Home Phone: 320-455-3214

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: Kassim Harun Relationship: son	Home Phone: Cell Phone: 320-237-1617 Work Phone:
Contact #2 Name: Abdi Hussien Relationship: friend	Home Phone: Cell Phone: 806-471-0862 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.

DISCLOSURE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" that may include information about your character, general reputation, personal characteristics, and/or mode of living, and that can involve personal interviews with sources, such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security number validation, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been requested and compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING's website is at www.orangetreescreening.com, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.
New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.
Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING's website is at: www.orangetreescreening.com, another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by ESSG.

☑ (Must include email address: Kassim.Karua57@gmail.com

Signature: _____ Date: 6-20-16

BACKGROUND INFORMATION

Last Name: Abikar First: Halima Middle: M

Other Names/Alias: N/A

Social Security #*: 642-25-6699 Date of Birth (mm/dd/yyyy)*: 0101 1966

Driver's License #: N/A State of Driver's License: N/A

Present Address: 875 15th ave SE Apt #14 Telephone # (Primary): 320-445-3244

City/State/Zip: St. Cloud MN 56304

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

employer solutions staffing group
Leveraging Resources in a Changing Market

ESG employer solutions group

ESNG employer solutions nationwide group

bpa Benefit Plan Administrators, Inc.

New Employee
Rehire *Rehire Date*_____

For Status Change Please Check: ***You MUST provide a supporting Document***

Change of Status Birth/ Adoption Marriage Divorce

Spouse Loss of Coverage Plan Change
Cancel Employee/Dependents

Date of Status Change:

Benefits Enrollment Form

Employee Information

Name (Last, First, MI)	Date of Birth	Social Security Number
Abikar Halima M	01/07/1964	643-25-6699

Address	City	State	Zip Code
875 15th Ave SE	St. Cloud	MN	56304

Gender	Marital Status	Phone Number:	Date of Hire
Male (Female)	Married (Single) Divorced	320-455-3214	06/20/16

Please Select Coverage Elected: Enhanced MEC Plan

Email Address: Kassimhar57@gmail.com

Coverage Level :

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

Dependent Information

Dependent

Last Name	First Name	M.I.	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Harun	Kassim	M	(Male) Female	09/02/1998	Medical	Add Change Waive Terminate

Social Security #

Dependent

Last Name	First Name	M.I.	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Harun	Nasro	M	Male (Female)	09/29/2001	Medical	Add Change Waive Terminate

Social Security # 643-25-4172

Dependent

Last Name	First Name	M.I.	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
			Male Female		Medical	Add Change Waive Terminate

Social Security #

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (LAST, FIRST, MI):

EFF. DATE

EFF. DATE

EFF. DATE

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

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature **Date**

EMPLOYEES DECLINING **Declining due to other coverage.**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption 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 [signature] **Date** 6-20-16

Employer Solutions Staffing Group Health Benefits Team
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com

VSI 219301-EMP | OFFICE USE ONLY LOCATION_____ Rehire Date __/__/____

ENROLLMENT FORM - PLAN 2

ESC UNAV P2 v15.1

REQUIRED EMPLOYEE INFORMATION

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

Social Security Number 643-25-6699

Date of Birth 07/07/1969 Sex M [F]

Name Halima Abikar

Street Address 873 15th ave SE

City St. Cloud State MN Zip 56304

Home Phone ___-___-____

Do you or any dependents have Medicare?

[X] Yes [ ] No If Yes:

Medicare Health Insurance Claim Number (HICN)

1EG4TE5MK72

Medicare Effective Date __/__/____

Names of Covered Person(s)

1. Halima Abikar
2.
3.

REQUIRED DEPENDENT INFORMATION

Name Kassim Hurun

Social Security Number 643-25-4747

Date of Birth 09/02/1998 Sex [M] F

Relationship: [ ] Spouse [X] Child [ ] Domestic Partner

Name Nasro Hurun

Social Security Number 643-25-4172

Date of Birth 09/29/2001 Sex M [F]

Relationship: [ ] Spouse [X] Child [ ] Domestic Partner

Name _____

Social Security Number ___-___-____

Date of Birth __/__/____ Sex M F

Relationship: [ ] Spouse [ ] Child [ ] Domestic Partner

BENEFIT SELECTION — Weekly Rates

SELECT COVERAGE LEVEL

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

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

FIXED INDEMNITY MEDICAL

[ ] **YES** $20.91 Employee Only
[X] **NO** $42.44 Employee + 1
$56.67 Employee + Family

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

DENTAL

[ ] **YES** $6.17 Employee Only
[X] **NO** $12.34 Employee + 1
$20.36 Employee + Family

TERM LIFE

[ ] **YES** $0.60 Employee Only
[X] **NO** $0.90 Employee + 1
$1.80 Employee + Family

SHORT-TERM DISABILITY

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

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

BENEFICIARY INFORMATION

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

NAME OF BENEFICIARY

_____

RELATIONSHIP

_____

Accidental Death & Dismemberment is part of the Term Life Benefit.

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

▶ **Signature** Halima Date 06/20/2021