employer solutions staffing group
Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405
Edina, MN 55439
Tel: 952.835.1288 • Fax: 952.835.1255
www.esgstaffingsolutions.com

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Hondermann **First Name** Oskar **Middle Initial** S

Street Address 6464 Benton St. **Apt/Ste**

City/State/Zip Arvada CO, 80003

Phone Number (303) 217-6197 **Email Address** shondermlo @ gmail.com

Company/Employer Daveco Liquors

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.

Oskar Stefan Hondermann		5-15-14
Name (Print or type)	Applicant's Signature	Date

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

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

Form W-4 (2013)

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 2013 expires February 17, 2014. 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 $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

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 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	1
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	1
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	0
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	1
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	1
F	Enter "1" if you have at least $1,900 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 $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 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	4

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 $40,000 ($10,000 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.**

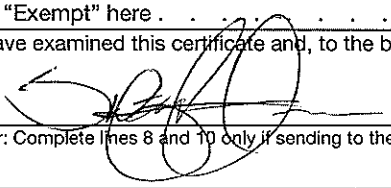
OMB No. 1545-0074

2013

1 Your first name and middle initial	Last name	2 Your social security number
OsKar S	Hondermann	841-89-7493
Home address (number and street or rural route)	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	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 $
7	I claim exemption from withholding for 2013, 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.) ►  **Date** ► 5-15-14

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)

This form cannot be used for employees hired prior to September 6, 2012.

Revision Date: 09/06/12
Expiration Date: 10/01/14

Affirmation of Legal Work Status
Pursuant to § 8-2-122, Colorado Revised Statutes

Employee Name: Hondermann (Last) Oskar (First) S (Middle) 10/03/1988 (Date of Birth)

Social Security Number: 841 - 89 - 7493 Date of Hire: 5/15/2014 (MM/DD/YYYY)

In accordance with § 8-2-122, C.R.S., within 20 days after hiring the new employee listed above,

I affirm all four of the following by signing this form:

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

Print Name of Employer (or Designated Representative) | Official Title

Signature of Employer (or Designated Representative) | Date Signed by Employer (MM/DD/YYYY)

Business or Organization Name | Employer Phone Number

The provision of false or fraudulent information on this form may subject the employer to a significant fine and/or additional penalties.

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

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

This mandatory affirmation is provided by the Colorado Division of Labor. Visit www.colorado.gov/cdle/evr for more information.

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)*
Hondermann	Oskar	S	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code
6764 Benton St.		Arvada	CO	80003

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
10/03/1988	841-89-7498	ShonderM10@gmail.com	(303) 217-6197

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

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

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☑ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) N/A . 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: 204-616-469

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)*: 5/15/2014

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

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

Signature of Preparer or Translator:			Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

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

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:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: Instruction Permit		Document Title: SS Card
Issuing Authority:		Issuing Authority: CO		Issuing Authority: SS Admin
Document Number:		Document Number: 13-323-0398		Document Number: 841-89-7493
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: 11.6.15		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)***: 5.20.14 ***(See instructions for exemptions.)***

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
[signature]	5.21.14	Acct Mgr.

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Hool	Tina	EMPLOYER SOLUTIONS STAFFING GROUP LLC

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
7301 OHMS LANE SUITE 405	EDINA	MN	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:

Department of Homeland Security **Report Prepared: 05/21/2014**
E-Verify

Case Verification Number: 2014141115652GN

Case Information:

Employee Information:

Last Name:	Hondermann	First Name:	Oskar
Middle Initial:		Other Names Used:	
Social Security Number:	*** ** 7493	Date of Birth:	10/03/1988
Citizenship Status:	An alien authorized to work	Email Address:	

Document Information:

List B Document:	Driver's license or ID card issued by a U.S. state or outlying possession	List C Document:	Social Security Card
Document Name:	Driver's license	Document State:	Colorado
Driver's License or ID Card Number:		Document Expiration Date:	11/06/2015
Alien Number:	204616469	I-94 Number:	

Additional Information:

Hire Date:	05/21/2014	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CKRO8357	Submitted On:	05/21/2014

Initial Case Result:

Last Name (in DHS records):	HONDERMANN JIMENEZ	First Name (in DHS records):	OSKAR
Case Result:	Employment Authorized		

Employee Referred to SSA:

Referred By: Referred On:

Case Result from SSA (after SSA Tentative Nonconfirmation):

Case Result: Response Date:

Resubmitted to SSA (after Review and Update Employee Data):

Last Name:	First Name:
Middle Initial:	Other Names Used:
Social Security Number:	Date of Birth:
Resubmitted By:	Resubmitted On:

Case Result from SSA (after Resubmission):

Case Result:

Request Name Review:

Comments:
Submitted By: Submitted On:

Case Result from DHS (after DHS Verification in Process):

Case Result: Response Date:

Employee Referred to DHS:

Referred By: Referred On:

Case Result from DHS (after DHS Tentative Nonconfirmation):

Case Result: Response Date:

Photo Matching Results:

Determination:

Employee Referred to DHS (Additional):

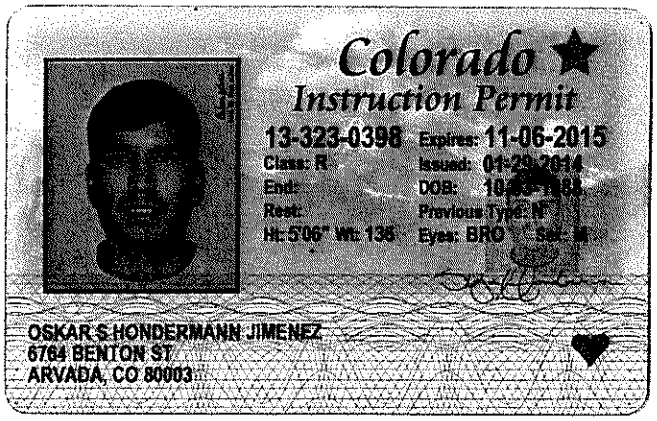
Referred By: Referred On:

Case Result from DHS (after Additional DHS Tentative Nonconfirmation):

Case Result: Response Date:

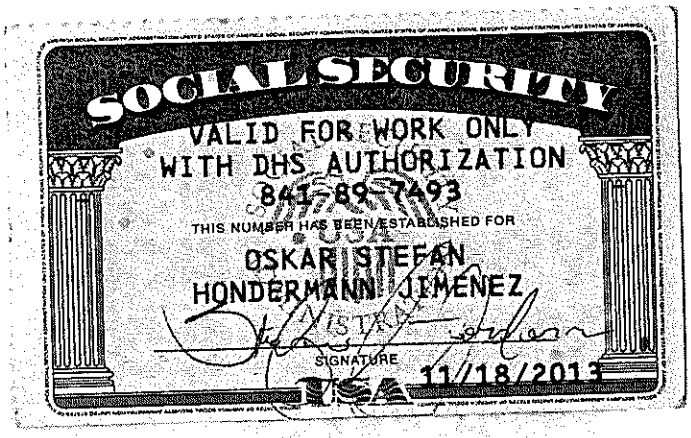
Case Closure:

Closure Statement:
Closed By: Closed On:



Colorado
Instruction Permit
13-323-0398 Expires: 11-06-2015
Class: R Issued: 01-23-2014
End: DOB: 10-03-1984
Rest: Previous Type: N
Ht: 5'06" Wt: 136 Eyes: BRO Sex: M

OSKAR S HONDERMANN JIMENEZ
6764 BENTON ST
ARVADA, CO 80003



SOCIAL SECURITY
VALID FOR WORK ONLY
WITH DHS AUTHORIZATION
841-89-7493
THIS NUMBER HAS BEEN ESTABLISHED FOR
OSKAR STEFAN
HONDERMANN JIMENEZ
SIGNATURE
11/18/2013


UNITED STATES OF AMERICA
EMPLOYMENT AUTHORIZATION CARD
Surname
HONDERMANN JIMENEZ
Given Name
OSKAR S
USCIS#
204-616-469
Category
C33
Card#
LIN1390372439
Country of Birth
Peru
Terms and Conditions
None
Sex
M
Date of Birth
03 OCT 1988
Valid From
11/07/13
Card Expires
11/06/15
NOT VALID FOR REENTRY TO U.S.

EMERGENCY CONTACT INFORMATION

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

Employee Name: Oskar Stefan Hondermann

Address: 6764 Benton St. Arvada CO, 80003

Home Phone: (303) 217-6197

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: Cecelia Hondermann Relationship: Wife	Home Phone: Cell Phone: (720) 612-3184 Work Phone:
Contact #2 Name: Ruby Hondermann Relationship: Sister	Home Phone: Cell Phone: (720) 998-4182 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.

employer solutions staffing group
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
Oskar Stefan Hondermann	7493	5-15-2014

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: Wells Fargo
Routing# 102000076
Account# 6384084205
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 OH Date 5-15-2014

- 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 #
122242597	

I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature: _____ Date: _____

SECTION 5 AUTHORIZATION

I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s). *** E-mail is required for pay stub information.**

***E-mail:** shondermann[illegible]@gmail.com
this information will only be used to send your paystubs electronically

Employee's Signature: [signature] Date: 5-15-2014

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

STATEMENT OF CONFIDENTIALITY

This agreement made this 15 day of May, 2014, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Oskar Hondermann hereafter referred to as "employee".

WITNESSETH:

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of $10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

Employee Signature

Employer Solutions Staffing Group LLC, Representative

Form **8850**
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

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

▶ See separate instructions.

OMB No. 1545-1500

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

Your name Oskar Hondermann Social security number ▶ 841-89-7495

Street address where you live 6764 Benton St.

City or town, state, and ZIP code Arvada CO, 80003

County Jefferson Telephone number (303) 217-6197

If you are under age 40, enter your date of birth (month, day, year) 10/03/1988

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

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  - **a** Received SNAP benefits (food stamps) for the past 6 months, **or**
  - **b** Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

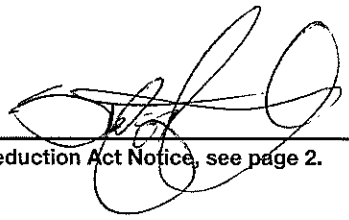
4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months, **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶  **Date** 5/15/2014

Form A (rev. 08/12)

TAX CREDIT QUESTIONNAIRE

RETROTAX
Specialists in Tax Credit Administration

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

Employee Name:	Street Address:	City/State:	Zip:
Oskar Horstermann	6764 Benton St.	Arvada / CO	80003

SS#:	Date of Birth:	Age:	Have you worked for this company before?	If yes, location:
841 - 89 - 7495	10 / 03 / 1988	25	☐ Yes ☑ No	

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

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

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

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

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

5. **Are you a Veteran of the U.S. Military?** **If yes, please provide a copy of your DD-214 and letter of separation.* ☐ ☑
   (If yes, please provide information below. If no, please continue to question #6.)
   Dates of Service - From: ____/____/____ To: ____/____/____
   Branch of Service: _____
   Are you entitled to or are you receiving compensation for a service-connected disability? ☐ ☑
   Have you been unemployed at any time during the last 12 months? ☐ ☑
   If yes, dates of unemployment - From: ____/____/____ To: ____/____/____
   Did you receive unemployment compensation at any point during your unemployment? ☐ ☑

6. **Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?** ☐ ☑
   Conviction Date: ____/____/____ Release Date: ____/____/____
   Was this a ☐ Federal or ☐ State conviction? If State - County: _____ State: _____

Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe? ☐ ☑
**If you checked yes please provide a copy of your CDIB card.*

CA Residents: ☐ Are you the child of foster parents? ☐ Do you receive CalWorks? ☐ Workforce Investment Act?
☐ Are you a migrant or seasonal farm worker? ☐ Have you ever been convicted of a misdemeanor?

SC Residents: ☐ Do you receive Family Independence Benefits?

PLEASE READ, SIGN, AND DATE:

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

New Employee Signature: _____ **Date:** 5/15/2014

employer solutions staffing group
Leveraging Resources in a Changing Market

INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

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

Follow all physical restrictions at home and at work.

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

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

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

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

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

Signed: _____

Printed Name: Oskar Stefan Hondermann

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

Notification of Colorado Law Requirement – Unemployment Acknowledgement

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

It is your responsibility to contact or notify ESSG (For example, by calling 303-920-1425, or using another means of contact) once your assignment ends. If you fail to do so, it may affect your unemployment benefits.

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

Employee Signature: _____ Date: 5/15/2014

Oskar Stefan Hondermann

Employee (please print your name here)

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

EMPLOYEE INFORMATION (Must Be Filled Out)

ENROLLMENT FORM - PLAN 2

USE BLACK or BLUE INK ONLY
ESC CU(NAV*SAD) P2 v13.0

Social Security Number 841-89-2493

Date of Birth 10/03/1988 Sex [X] M [ ] F

Name Oskar Stefan Hondermann

Street Address 6764 Benton

City Arvada State CO Zip 80003

Home Phone 303-217-6197

Do you or any dependents have Medicare?

[ ] Yes [X] No If Yes:

Medicare Health Insurance Claim Number (HICN) _____

Medicare Effective Date __/__/____

Names of Covered Person(s)

1. _____
2. _____
3. _____

BENEFIT SELECTION

Weekly Rates

MEDICAL

[X] $20.91 Employee Only

[ ] $42.44 Employee + One

[ ] $56.67 Employee + Family

[ ] **NO to MEDICAL, TERM LIFE, and STD benefits.**

DENTAL

[X] $ 5.99 Employee Only

[ ] $11.98 Employee + One

[ ] $19.77 Employee + Family

[ ] **NO**

TERM LIFE

[X] **YES** $0.60 Employee Only
$0.90 Employee + One
$1.80 Employee + Family

[ ] **NO**

SHORT-TERM DISABILITY

[X] **YES** $4.20 Employee Only

[ ] **NO**

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

You **MUST** enroll in the Medical Insurance Plan before adding Term Life or STD. Your coverage level for Term Life will be identical to your medical plan selection.

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number ___-___-____

Date of Birth __/__/____ Sex [M] [F]

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

Name _____

Social Security Number ___-___-____

Date of Birth __/__/____ Sex [M] [F]

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

Name _____

Social Security Number ___-___-____

Date of Birth __/__/____ Sex [M] [F]

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

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** _____ Date 05/15/2014