



New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Hiatt First Name Dianne Middle Initial M
 Street Address 4151 Durham Court Apt/Ste _____
 City/State/Zip Eagan, MN 55122 Social Security Last Four XXX-XX-996
 Phone Number 651-302-8112 Email Address diannehiatt @netscape.net
 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.

Dianne M. Hiatt Name (Print or type) Dianne M. Hiatt Applicant's Signature 1-5-17 Date

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

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

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

The exceptions don't apply to supplemental wages greater than \$1,000,000.

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u>1</u>
B	Enter "1" if: { • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. }	B	_____
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	_____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	_____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	_____
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	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	<u>1</u>

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

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

Form W-4 Department of the Treasury Internal Revenue Service	Employee's Withholding Allowance Certificate	OMB No. 1545-0074 2017
▶ 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.		
1 Your first name and middle initial <u>Dianne M</u>	Last name <u>Hiett</u>	2 Your social security number <u>473-19-9961</u>
Home address (number and street or rural route) <u>4151 Durham Court</u>		3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code <u>Eagan, MN 55122</u>		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5	<u>1</u>
6 Additional amount, if any, you want withheld from each paycheck	6 \$	
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ <u>7</u>		
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.) ▶ <u>Dianne M. Hiatt</u>		Date ▶ <u>1-5-17</u>
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)



employer solutions staffing group

Leveraging Resources in a Changing Market

Wage Payment Method Authorization (Minnesota)

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 paper Check.

SECTION 1 BASIC INFORMATION

Employee Name <u>Dianne M. Hiatt</u>	SSN# (last 4 digits) <u>9961</u>	Effective Date <u>1-5-17</u>
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SECTION 2 PAYROLL ELECTION

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

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

SECTION 3 DIRECT DEPOSIT

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 <u>Dianne</u>	M.I. <u>M</u>	Last Name <u>Hiatt</u>	Date of Birth <u>10-27-82</u>
Street Address (PO BOX NOT ACCEPTABLE) <u>4151 Durham Court</u>			Social Security#
City <u>Eagan</u>	State <u>MN</u>	Zip <u>55122</u>	Cell Phone (mobile) <u>651-302-8112</u>

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

Payroll Debit Card Routing # <u>073972181</u>	Payroll Debit Card Account # <u>4853400191262981</u>
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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: Dianne M. Hiatt Date: 1-5-17

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: Dianne M. Hiatt Date: 1-5-17

Enhanced MEC Plan_Plan 1

Benefits Enrollment Form New Employee Rehire Rehire Date _____

Employee Information

Name (First and Last) <i>Dianne Hiatt</i>			Social Security Number <i>473-19-9961</i>		
Address <i>4151 Durham Court</i>		City <i>Eagan</i>	State <i>MN</i>	Zip Code <i>55122</i>	
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Birth <i>10-27-82</i>		Date of Hire <i>1-5-17</i>	
Phone Number: <i>651-302-8112</i>		Email Address: <i>diannehiatt@netscape.net</i>			

Please Select Desired Coverage:

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

Dependent				
	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
First Name M.I. Last Name				
Dependent				
	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
First Name M.I. Last Name				
Dependent				
	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
First Name M.I. Last Name				

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

_____ 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 *Dianne M. Hiatt* Date *1-5-17*

EMPLOYEES DECLINING I am DECLINING coverage

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

IF DECLINING- YOU MUST SIGN HERE

Employee Signature _____ Date _____

Fixed Indemnity Medical Benefits Plan 2

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

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION		PRINT USING BLACK or BLUE INK (Must Be Filled Out)			
Name <i>Dianne M. Hiatt</i>	Social Security # <i>473-19-9961</i>	Home Phone	Sex	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	
Address <i>4151 Durham Court</i>	City <i>Eagan</i>			State <i>MN</i>	Zip <i>55122</i>
Date of Birth <i>10/27/82</i>			Apt. #		

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, please continue.	Medicare Health Insurance Claim Number (HICN)
Medicare Effective Date	
Name of Covered Person (s):	
1.	2.
	3.

C. LIMITED BENEFITS PLAN SELECTION		Payroll Deducted Weekly Rates				
<p>You MUST select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.</p>						
SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²	
Employee Only <input checked="" type="checkbox"/>	\$20.25 <input checked="" type="checkbox"/>	\$6.17 <input checked="" type="checkbox"/>	\$2.42 <input checked="" type="checkbox"/>	\$0.60 <input checked="" type="checkbox"/>	\$4.20 <input checked="" type="checkbox"/>	
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90		
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80		
NO to ALL Benefits <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No					

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

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

Name *Elaine S. Hiatt* Relationship *Grandma*
661-589-1391

D. REQUIRED DEPENDENT INFORMATION				
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE	YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE
I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.	
DATE <i>01/05/2017</i>	SIGNATURE <i>Dianne M. Hiatt</i>