

Emergency Contact Info	Background Release Form	Background Results	Unemployment Letter (if applicable)	ESC Application
DOH	NHW	I-9	8850	W4

For ESSG Office Use Only

A copy or facsimile will be considered the same as an original signature.

Name (Print or type) James Lindsey
 Applicant's Signature [Signature]
 Date 8-10-2015

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.

Applicant Certification and Authorization

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

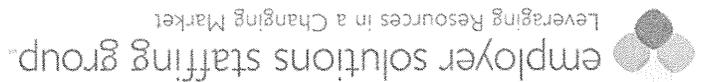
All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

Company/Employer _____
 Home Phone _____
 Cell / Message Phone 712-441-6479
 City/State/zip Aurora, Colorado 80013
 Street Address 15626 E Floyd Ave
 Apt. _____
 Last Name Lindsey First Name James Middle Initial J

Personal Data-- PLEASE PRINT LEGIBLY IN INK

New Hire Application

7301 Ohms Lane Suite 405
 Edina, MN 55439
 T: 952.835.1288 • F: 952.835.1255



STATEMENT OF CONFIDENTIALITY

This agreement made this 10th day of August, 2012, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and James Lindsey 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

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: James Lindsey SSN# (last 4 digits): 7241 Effective Date: 8-10-2015

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

I understand and acknowledge that if I do not provide a voided check (a deposit slip will not work) 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.	<input type="checkbox"/> Update Bank Account	Bank Name:	
	Account#	Routing#	
	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other:		
	Initial	Date	

SECTION 4 PAYROLL DEBIT 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>James</u>	M.I.	<u>D</u>	Last Name	<u>Lindsey</u>	Date of Birth	<u>8-10-2015</u>
Street Address (PO BOX NOT ACCEPTABLE)		<u>15626 E Floyd Ave</u>					
City	<u>Avrao</u>	State	<u>CO</u>	Zip	<u>80013</u>	Primary Phone	<u>712-441-6479</u>
RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)		Payroll Debit Card Routing #	<u>122242597</u>				
		Payroll Debit Card Account #					

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: bolindsey@agm.wilco.com Employee's Signature: James Lindsey Date: 8-10-2015

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.

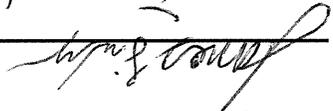
Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

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: James Lindsey

NOTICE OF WAIVER FROM ANNUAL LIMIT REQUIREMENT

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by BCS Insurance Company does not meet the minimum standards required by the Affordable Care Act describe above. Instead, it puts an annual limit on the following plans offered:

Annual Limit	Plan
Both inpatient & outpatient benefits	\$10,000
Outpatient benefits only	\$1,500
Prescription drugs	Subject to outpatient maximum of \$1,500

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 in 2011. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing \$750,000 in coverage for key benefits in 2011 would result in a significant increase in premiums or a significant decrease in access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to www.HealthCare.gov

If you have any questions or concerns about this notice, contact the Essential StaffCARE Customer Service at 866-798-0803.

In addition, you can contact:

Minnesota Department of Commerce
Consumer Concerns

Toll-free- (800) 657-3602 / Main – (651) 296-2488

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 952-941-9041. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING'S website is at www.orange treescreening.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.

<p>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.</p>
<p>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.</p>
<p>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.</p>
<p>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.</p>

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. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING'S website is at www.orange treescreening.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.

<p>New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.</p>	<p><input type="checkbox"/> (Must include email address: _____)</p>
<p>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.</p>	<p><input type="checkbox"/> (Must include email address: _____)</p>
<p>California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by ESSG whenever you have a right to receive such a copy under California law. www.validateitvscreening.com/5/ite/PrivacyPolicy</p>	
<p>(Must include email address: _____)</p>	

Signature: *[Handwritten Signature]* Date: 8-10-2015

Last Name: Lindest First: Scms Middle: Qua, P

Other Names/Aliases: 130

Social Security #: 120-39-7741

Driver's License #: 8273377

Present Address: 15696 Eloy Ave

City/State/Zip: Avondale CO 80013

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

Telephone # (Primary): 712-441-6179

State of Driver's License: Arizona

Date of Birth (mm/dd/yyyy): 7-17-1994



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

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

Employee Name: Last Lindsey First James Middle David
Date of Birth 7/17/1992
Social Security Number: 420 - 39 - 7741 Date of Hire: _____ (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) Elizabeth Paraco
Official Title National Recruiter

Signature of Employer (or Designated Representative) Elizabeth Paraco
Date Signed by Employer (MM/DD/YYYY) 8/10/2015

Business or Organization Name CMG
Employer Phone Number 303-920-1425

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.

Form W-4 (2015)

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

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 2015 expires February 16, 2016. 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.

converting your other credits into withholding allowances. **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.

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.

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.)

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).

F Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit.

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 (\$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 \$65,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.

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.)

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.

For accuracy, complete all worksheets that apply.

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)

6 Additional amount, if any, you want withheld from each paycheck

7 I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption:

- Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and
- This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, write "Exempt" here.

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

(This form is not valid unless you sign it.)

Employee's signature: *[Signature]*

Date: 8-16-2015

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)

1 Your first name and middle initial: James D

2 Your social security number: 170-39-774

3 Single Married Married, but withheld at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

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.

City or town, state, and ZIP code: Aurora, Colorado

Home address (number and street or rural route): 15626 E Floyd Ave

Last name: Lindsey

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2): 3

6 Additional amount, if any, you want withheld from each paycheck: \$ 0.00

7 I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption:



To: All Employees
Quien: Todos Empleados

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

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

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

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

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

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

Thank you for your continued dedication and hard work!

Gracias por su dedicacion continua!

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

Signature/Firma: *James Zuluaga*
Date/Fecha: *08-10-2011*

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 James Lindsey Social security number ▶ 493-39-7741

Street address where you live 15626 E Floyd Ave

City or town, state, and ZIP code Avoca, CO 80013

County _____ Telephone number 719-491-6479

If you are under age 40, enter your date of birth (month, day, year) July 17 1992

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 ▶ James Lindsey

Date

8-10-2015

TAX CREDIT QUESTIONNAIRE



EMPLOYER SECTION:

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

EMPLOYEE SECTION:

Employee Name:	Street Address:	City/State:	Zip:
SS#: 420-39-7041	Age: 23	Have you worked for this company before? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, location:
Date of Birth: 2/17/1992			

Please complete all questions, and sign and date the form.

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.) Yes No

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? Yes No

(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? Yes No

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? Yes No

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. Yes No

(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? Yes No
If yes, dates of unemployment - From: _____ / _____ / _____ To: _____ / _____ / _____
Did you receive unemployment compensation at any point during your unemployment? Yes No

6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Yes No

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? Yes No
*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? Have you ever been convicted of a misdemeanor? Are you a migrant or seasonal farm worker? Do you receive Family Independence Benefits? 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: *James Lin*

Date: 8-10-2015



8850 Tyler Blvd., Mentor, OH 44060 Phone 800-991-9694 Fax (440) 205-8355
 Visit our website at: www.backtracker.com or email us at: btsearches@backtracker.com

BACKGROUND INFORMATION FORM FOR BACKGROUND CHECK

BackTrack, Inc. is an employment screening company that conducts background checks on prospective employees/employees for our clients as part of their standard hiring procedure. In order to perform this check, we need you to provide the following information. Please be sure to fill out this form completely and legibly.

Position Applying For: _____ Expected Salary: _____	
Last Name: Lindsey	First Name: James
Middle Name: David	Maiden Name: _____ Any Other Name(s) Used: _____ Phone (712) 441-6179
Home Address: 15626 E Flays Ave	E-Mail Address: bolindsey@bigman.com
City: Aurora	State: Colorado
Social Security Number: * 420-39-7211	Date of Birth: * 5/17/1992
Driver's License Number: 8273377	State License was Issued: Alabama
High School: Citronelle High	City/State Location: Citronelle, AL
Year Graduated: 2011	Full Name Diploma Issued Under: James D. Lindsey
IF GED received, in what State: _____	City/State Location: _____
Date Received: _____	Name Used for GED: _____
College: _____	City/State Location: _____
Degree Rec'd: _____	Bachelor <input type="checkbox"/> Master <input type="checkbox"/> Other <input type="checkbox"/>
Student ID Number: _____	Full Name Used: _____
Last Previous Addresses (to cover last 7 years):	Address: 6700 Cottage Hill Rd
County: Mobile County	City/State: Mobile, AL
Address: 472 Fairford Rd	City/State: Calvert, AL
County: Mobile	From Mth/Yr: 6/2014 To Mth/Yr: 6/2015
Address: 472 Fairford Rd	City/State: Calvert, AL
County: Mobile	From Mth/Yr: 4/2007 To Mth/Yr: 6/2014

APPLICANT INFORMATION (please print clearly & accurately)

NOTE: The absence of any of the above information could result in a delay in processing your background. If necessary, a representative from BackTrack, Inc. will contact you for additional information in order to expedite the background process. Thank you for your assistance.

---FOR CLIENT USE ONLY - DO NOT WRITE BELOW THIS LINE---

CLIENT INFORMATION SERVICES REQUESTED RUSH ORDER (\$27 extra charge)

NAME: _____ TITLE: _____
 E-MAIL ADDRESS: _____
 COMPANY NAME: _____
 ADDRESS: _____
 CITY/STATE/ZIP: _____
 IF APPLICABLE, DIVISION OR CODE #: _____
 CREDIT REPORT
 EMPLOYMENT HISTORY EDUCATION DRIVING RECORD SSN SEARCH
 WORKERS' COMP. MILITARY CREDENTIAL BUS/PERSONAL REF.

YOU MUST COMPLETE AND RETURN THE BACKGROUND INFORMATION FORM, THE DISCLOSURE FORM AND THE AUTHORIZATION FORM FOR A BACKGROUND CHECK

Printed Name

James Lintsey

Company Applying To

CMG

Signature

James Lintsey

Date

8-10-2015

Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.

By requesting a copy be sent to a specified addressee by certified mail, CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

California applicants only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

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

Washington State applicants 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.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled 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 those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by Employer 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, employer, or insurance company to furnish any and all background information requested by BackTrack, Inc., 8850 Tyler Boulevard, Mentor, OH 44060, (800) 991-9694, www.backtracker.com and/or the company. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.



8850 Tyler Blvd., Mentor, OH 44060 Phone 800-991-9694 Fax (440) 205-8355 Visit our website at: www.backtracker.com or email us at: btsresearches@backtracker.com

Printed Name

James Lindsey

Company Applying To

CMG

Signature

James Lindsey

Date

8-10-2015

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run 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 is an employment history or verification. These searches will be conducted by BackTrack, Inc., 8850 Tyler Boulevard, Mentor, OH 44060, (800) 991-9694, www.backtracker.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Employer ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which 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 verification, motor vehicle records ("driving records"), verification of your education or employment history, workers compensation claims 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. Workers compensation will only be requested in compliance with the ADA and/or any other applicable laws.

DISCLOSURE REGARDING BACKGROUND INVESTIGATION





James B. Smith, Director of Education, State of Florida, Tallahassee, Florida.

Approved by the
Governor of the State of Florida



For testimony signed and sworn to before me, I hereby certify that the same are true and correct as shown to me by the said James B. Smith, Director of Education, State of Florida, Tallahassee, Florida.

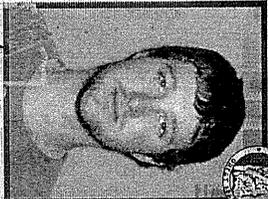
Notary Public in and for the State of Florida

Notary Public in and for the State of Florida

DRIVER LICENSE

ALABAMA

NO. 8273377 - CLASS D
 D.O.B. 07-17-1992 - EXP 01-12-2017
 JAMES DAVID
 LINDSEY
 477 FAIRFORD RD
 CALVERT AL 36513



ISS 03-29-2013

ENDORSEMENTS
RESTRICTIONS

SEX M
 HT 6-01
 WT 180
 EYES GRN
 HAIR RED

UNDER 21 UNTIL 07-17-2013

James Lindsey
 Colonel Hugh B. McCall
 Director of Public Safety

SOCIAL SECURITY BOARD

THIS NUMBER HAS BEEN ESTABLISHED FOR

420-39-7741
 JAMES DAVID
 LINDSEY

James David Lindsey



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) Kingsey		First Name (Given Name) Samuel		Middle Initial D	Other Names Used (if any) RO
Address (Street Number and Name) 15626 E FLYDAVE		Apt Number	City or Town Avron	State CO	Zip Code 80013
Date of Birth (mm/dd/yyyy) 7/17/1992		U.S. Social Security Number 440-39-7741		E-mail Address bdnky92@gmail.com	
Telephone Number 712-441-6479					

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) _____. 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:

OR

- 1. Alien Registration Number/USCIS Number: _____
- 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)

Signature of Employee: <i>Samuel Kingsey</i>	Date (mm/dd/yyyy): 8-10-15
---	--------------------------------------

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	

Employer Completes Next Page



SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security
E-Verify
Report Prepared: 08/10/2015
Page: 1 of 1

Case Verification Number: 2015222141641KC

Case Information:

Employee Information:
Last Name: Lindsey
Middle Initial:
Social Security Number: *** ** 7741
Citizenship Status: A citizen of the United States
Document Information:
List B Document: Driver's license or ID card issued by a U.S.
Document Name: Driver's license
Driver's License or ID Card Number:
List C Document: Social Security Card
Document State: Alabama
Document Expiration Date: 01/12/2017
I-94 Number:
Additional Information:
Hire Date: 08/10/2015
Three-Day Rule Reason:
Submitted By: EPOR4912
Submitted On: 08/10/2015

Initial Case Result:

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

ENROLLMENT FORM

OPTION 1 FIXED INDEMNITY PLAN

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
 NO to all indemnity benefits.

FIXED INDEMNITY MEDICAL

YES \$20.91 Employee Only
 YES \$42.44 Employee + 1
 NO \$56.67 Employee + Family

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

DENTAL

YES \$6.17 Employee Only
 YES \$12.34 Employee + 1
 NO \$20.36 Employee + Family

TERM LIFE

YES \$0.60 Employee Only
 YES \$0.90 Employee + 1
 NO \$1.80 Employee + Family

SHORT-TERM DISABILITY

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.

**OPTION 2
MEC WELLNESS/PREVENTIVE PLAN**

Monthly Rates

\$58.87 Employee Only
 \$87.73 Employee + 1
 \$186.99 Employee + Family
 NO to MEC Wellness/Preventive Plan

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK OR BLUE INK

(Must Be Filled Out)

Social Security Number 470-39-2741

Date of Birth 07/17/1992 Sex M F

Name James H. Husey

Street Address 15676 E Floy's Ave

City Aurora State CO Zip 80013

Home Phone 782-441-6479

Do you or any dependents have Medicare?
 Yes No If Yes: _____

Medicare Health Insurance Claim Number (HICN) _____

Medicare Effective Date _____

Names of Covered Person(s)
 1. _____
 2. _____
 3. _____

REQUIRED DEPENDENT INFORMATION

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 James H. Husey Date 08/10/2015