employer solutions staffing group LLC
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** URBAN **First Name** JOHN **Middle Initial** R

**Street Address** 466 N 48 AVE **Apt/Ste** _____

**City/State/Zip** BRIGHTON COLORADO 80601

**Phone Number** 720-300-9398 **Email Address** JOHNSGURBAN @ YAHOO.COM

**Staffing Agency/Recruitment Partner** _____

**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.

JOHN R. URBAN — Name (Print or type)
John R. Urban — 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 (2016)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| | | | |
|---|---|---|---|
| A | Enter "1" for **yourself** if no one else can claim you as a dependent | A | |
| B | Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. | B | |
| C | Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | C | |
| D | Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return | D | |
| E | Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) | E | |
| F | Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | F | |
| G | **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child | G | |
| H | Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶ | H | |

For accuracy, **complete all worksheets that apply.**

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

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

## Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
**2016**

| | | |
|---|---|---|
| 1 Your first name and middle initial: John R | Last name: URBAN | 2 **Your social security number:** 273-58-7679 |
| Home address (number and street or rural route): 466 N 48 AVE | 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: Brighton Colorado 80601 | 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 1 |
| 6 | Additional amount, if any, you want withheld from each paycheck | 6 $ |
| 7 | I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶ | 7 |

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

**Employee's signature**
(This form is not valid unless you sign it.) ▶ John R. Urban **Date** ▶ 05/18/2016

| 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) |
|---|---|---|
| | | |

## Deductions and Adjustments Worksheet

**Note:** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . . 1 $

2 Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately } . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . 3 $

4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) . . . 5 $

6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction . . . 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

## Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

**Note:** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" . . . 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . 3

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

4 Enter the number from line 2 of this worksheet . . . 4

5 Enter the number from line 1 of this worksheet . . . 5

6 **Subtract** line 5 from line 4 . . . 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

### Table 1

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **LOWEST** paying job are— | Enter on line 2 above | If wages from **LOWEST** paying job are— | Enter on line 2 above |
| $0 - $6,000 | 0 | $0 - $9,000 | 0 |
| 6,001 - 14,000 | 1 | 9,001 - 17,000 | 1 |
| 14,001 - 25,000 | 2 | 17,001 - 26,000 | 2 |
| 25,001 - 27,000 | 3 | 26,001 - 34,000 | 3 |
| 27,001 - 35,000 | 4 | 34,001 - 44,000 | 4 |
| 35,001 - 44,000 | 5 | 44,001 - 75,000 | 5 |
| 44,001 - 55,000 | 6 | 75,001 - 85,000 | 6 |
| 55,001 - 65,000 | 7 | 85,001 - 110,000 | 7 |
| 65,001 - 75,000 | 8 | 110,001 - 125,000 | 8 |
| 75,001 - 80,000 | 9 | 125,001 - 140,000 | 9 |
| 80,001 - 100,000 | 10 | 140,001 and over | 10 |
| 100,001 - 115,000 | 11 | | |
| 115,001 - 130,000 | 12 | | |
| 130,001 - 140,000 | 13 | | |
| 140,001 - 150,000 | 14 | | |
| 150,001 and over | 15 | | |

### Table 2

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **HIGHEST** paying job are— | Enter on line 7 above | If wages from **HIGHEST** paying job are— | Enter on line 7 above |
| $0 - $75,000 | $610 | $0 - $38,000 | $610 |
| 75,001 - 135,000 | 1,010 | 38,001 - 85,000 | 1,010 |
| 135,001 - 205,000 | 1,130 | 85,001 - 185,000 | 1,130 |
| 205,001 - 360,000 | 1,340 | 185,001 - 400,000 | 1,340 |
| 360,001 - 405,000 | 1,420 | 400,001 and over | 1,600 |
| 405,001 and over | 1,600 | | |

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

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

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

This form cannot be used for employees hired prior to September 1, 2014.

Revision Date: 09/01/14
Expiration Date: 10/01/17

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

Employee Name: URBAN JOHN ROBERT 3/7/1956
Last First Middle Date of Birth

Social Security Number: 273-58-7679 Date of Hire: 05/18/2016 (MM/DD/YYYY)

In accordance with § 8-2-122, C.R.S., within 20 calendar 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.

JOHN R. URBAN
Print Name of Employer (or Designated Representative)

Official Title

Signature of Employer (or Designated Representative)

05/18/2016 (MM/DD/YYYY)
Date Signed by Employer

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*) |
|---|---|---|---|
| URBAN | JOHN | R | |

| Address (*Street Number and Name*) | Apt. Number | City or Town | State | Zip Code |
|---|---|---|---|---|
| 466 N. 48 AVE | | BRIGHTON | CO | 80601 |

| Date of Birth (*mm/dd/yyyy*) | U.S. Social Security Number | E-mail Address | Telephone Number |
|---|---|---|---|
| 03/07/1956 | 273-58-7679 | JOHN56URBAN@yahoo.com | 720-300-9398 |

**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:*

**1.** Alien Registration Number/USCIS Number: _____

**OR**

**2.** Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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

**3-D Barcode**
**Do Not Write in This Space**

| Signature of Employee: | Date (*mm/dd/yyyy*): |
|---|---|
| John R Urban | 05/18/2016 |

## 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

## LISTS OF ACCEPTABLE DOCUMENTS
## All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

| LIST A<br>Documents that Establish Both Identity and Employment Authorization | OR | LIST B<br>Documents that Establish Identity | AND | LIST C<br>Documents that Establish Employment Authorization |
|---|---|---|---|---|
| **1.** U.S. Passport or U.S. Passport Card | | **1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | **1.** A Social Security Account Number card, unless the card includes one of the following restrictions:<br>(1) NOT VALID FOR EMPLOYMENT<br>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION |
| **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) | | **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | **2.** Certification of Birth Abroad issued by the Department of State (Form FS-545) |
| **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa | | **3.** School ID card with a photograph | | **3.** Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| **4.** Employment Authorization Document that contains a photograph (Form I-766) | | **4.** Voter's registration card | | **4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| **5.** For a nonimmigrant alien authorized to work for a specific employer because of his or her status:<br>**a.** Foreign passport; and<br>**b.** Form I-94 or Form I-94A that has the following:<br>(1) The same name as the passport; and<br>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | | **5.** U.S. Military card or draft record | | **5.** Native American tribal document |
| | | **6.** Military dependent's ID card | | **6.** U.S. Citizen ID Card (Form I-197) |
| | | **7.** U.S. Coast Guard Merchant Mariner Card | | **7.** Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | | **8.** Native American tribal document | | **8.** Employment authorization document issued by the Department of Homeland Security |
| | | **9.** Driver's license issued by a Canadian government authority | | |
| **6.** Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | | **For persons under age 18 who are unable to present a document listed above:** | | |
| | | **10.** School record or report card | | |
| | | **11.** Clinic, doctor, or hospital record | | |
| | | **12.** Day-care or nursery school record | | |

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).**

**Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.**

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:** Urban, John R.

| List A<br>Identity and Employment Authorization | OR | List B<br>Identity | AND | List C<br>Employment Authorization |
|---|---|---|---|---|
| Document Title: | | Document Title: Colorado Driver License | | Document Title: Social Security Card |
| Issuing Authority: | | Issuing Authority: Colorado DMV | | Issuing Authority: SSA |
| Document Number: | | Document Number: 06-171-1040 | | Document Number: 273-58-7679 |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | Expiration Date *(if any)(mm/dd/yyyy)*: 03/07/2020 | | 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)*:** 05/18/2016 ***(See instructions for exemptions.)***

| Signature of Employer or Authorized Representative | Date *(mm/dd/yyyy)* | Title of Employer or Authorized Representative |
|---|---|---|
| Andrea Findley | 05/20/2016 | Admin. Assistant |

| Last Name *(Family Name)* | First Name *(Given Name)* | Employer's Business or Organization Name |
|---|---|---|
| Findley | Andrea | 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.)*

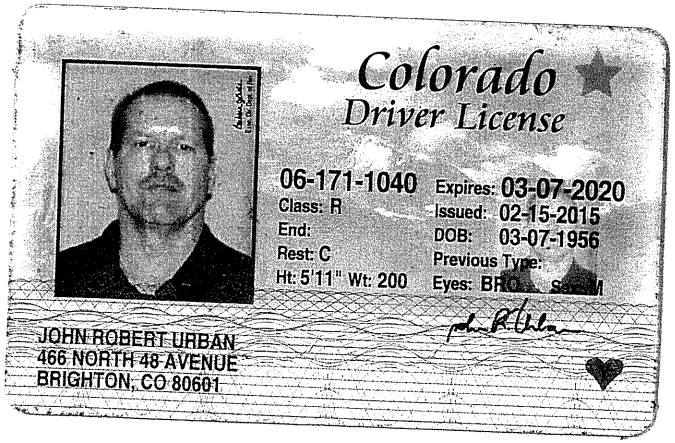
| **A.** New Name *(if applicable)* Last Name *(Family Name)* | First Name *(Given Name)* | Middle Initial | **B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*: |
|---|---|---|---|
| | | | |

**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: |
|---|---|---|
| | | |

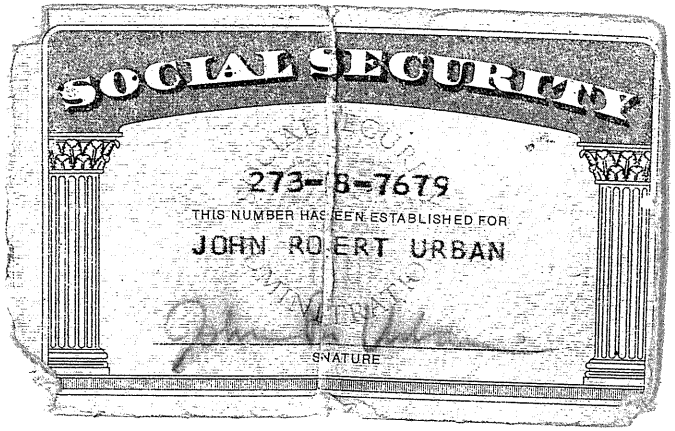


Colorado
Driver License

06-171-1040
Class: R
End:
Rest: C
Ht: 5'11" Wt: 200

Expires: 03-07-2020
Issued: 02-15-2015
DOB: 03-07-1956
Previous Type:
Eyes: BRO Sex: M

JOHN ROBERT URBAN
466 NORTH 48 AVENUE
BRIGHTON, CO 80601



SOCIAL SECURITY

273-[illegible]8-7679

THIS NUMBER HAS BEEN ESTABLISHED FOR

JOHN ROBERT URBAN

SIGNATURE

E-Verify
Employment Eligibility Verification

SENSITIVE BUT UNCLASSIFIED

# Case Verification Number: 2016141142038GR

Report Prepared: 05/20/2016

## Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

## Employee Information

Last Name: Urban

First Name: John

Date of Birth: 03/07/1956

Social Security Number: *** ** 7679

Hire Date: 05/18/2016

Citizenship Status: A citizen of the United States

## 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: 03/07/2020

## Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 05/20/2016

Case Submitted By: AFIN3846

Closed On: 05/20/2016

Closed By: AFIN3846

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

SENSITIVE BUT UNCLASSIFIED

# Authorization

**Authorization**: By signing below, you authorize: (a) backgroundchecks.com ("BGC") to request information about you from any public or private information source; (b) anyone to provide information about you to BGC; (c) BGC to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) us to share those reports with others for legitimate business purposes related to your employment. BGC may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an applicant or employee with us.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

**Personal Information**: Please print the information requested below to identify yourself for BGC.

Printed name: JOHN ROBERT URBAN

First | Middle (☐ none) | Last

Other names used: _____

Current and former addresses:

| from Mo/Yr | to Mo/Yr | Street | City, State & Zip |
|---|---|---|---|
| NOV 2006 | current | 466 N. 48 AVE | BRIGHTON CO. 80601 |
| | | | |
| | | | |

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

03/07/1956
Date of birth

273-58-7679
Social security number

06-171-1040 COLORADO
Driver's license number & state

JOHN R. URBAN
Name as it appears on license

**Report Copy**: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: ☐.

John R. Urban
Signature

05/18/2016
Date

***Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.***

## A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to** www.consumerfinance.gov/learnmore **or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

***States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:***

| TYPE OF BUSINESS: | CONTACT: |
|---|---|
| 1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.<br><br>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau: | a. Bureau of Consumer Financial Protection<br>1700 G Street NW<br>Washington, DC 20552<br><br>b. Federal Trade Commission: Consumer Response Center – FCRA<br>Washington, DC 20580<br>(877) 382-4357 |
| 2. To the extent not included in item 1 above:<br>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks | a. Office of the Comptroller of the Currency<br>Customer Assistance Group<br>1301 McKinney Street, Suite 3450 |

| | |
|---|---|
| | Houston, TX 77010-9050 |
| b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act | b. Federal Reserve Consumer Help Center<br>P.O. Box 1200<br>Minneapolis, MN 55480 |
| c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations | c. FDIC Consumer Response Center<br>1100 Walnut Street, Box #11<br>Kansas City, MO 64106 |
| d. Federal Credit Unions | d. National Credit Union Administration<br>Office of Consumer Protection (OCP)<br>Division of Consumer Compliance and Outreach (DCCO)<br>1775 Duke Street<br>Alexandria, VA 22314 |
| 3. Air carriers | Asst. General Counsel for Aviation Enforcement & Proceedings<br>Department of Transportation<br>400 Seventh Street SW<br>Washington, DC 20590 |
| 4. Creditors Subject to Surface Transportation Board | Office of Proceedings, Surface Transportation Board<br>Department of Transportation<br>1925 K Street NW<br>Washington, DC 20423 |
| 5. Creditors Subject to Packers and Stockyards Act | Nearest Packers and Stockyards Administration area supervisor |
| 6. Small Business Investment Companies | Associate Deputy Administrator for Capital Access<br>United States Small Business Administration<br>406 Third Street, SW, 8th Floor<br>Washington, DC 20416 |
| 7. Brokers and Dealers | Securities and Exchange Commission<br>100 F St NE<br>Washington, DC 20549 |
| 8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations | Farm Credit Administration<br>1501 Farm Credit Drive<br>McLean, VA 22102-5090 |
| 9. Retailers, Finance Companies, and All Other Creditors Not Listed Above | FTC Regional Office for region in which the creditor operates or<br>Federal Trade Commission: Consumer Response Center – FCRA<br>Washington, DC 20580<br>(877) 382-4357 |

**ADDITIONAL INFORMATION ABOUT THE FAIR CREDIT REPORTING ACT**

The Summary of Your Rights provided above does not reflect certain amendments contained in the Consumer Reporting Employment Clarification Act of 1998. The following additional information may be important for you:

- • Records of convictions of crimes can be reported regardless of when they occurred.
- • If you apply for a job that is covered by the Department of Transportation's authority to establish qualifications and the maximum hours for that job and you apply by mail, telephone, computer, or other similar means, your consent to a consumer report may validly be obtained orally, in writing, or electronically. If an adverse action is taken against you because of a consumer report for which you gave your consent over the telephone, computer, or similar means, you may be informed of the adverse action and the name, address and phone number of the consumer reporting agency, orally, in writing, or electronically.

ARTICLE 23-A
LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY
CONVICTED OF ONE OR MORE CRIMINAL OFFENSES

Section 750. Definitions.
Section 751. Applicability.
Section 752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.
Section 753. Factors to be considered concerning a previous criminal conviction; presumption.
Section 754. Written statement upon denial of license or employment.
Section 755. Enforcement.

§ 750. Definitions. For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.

(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§ 751. Applicability. The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

§ 752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited. No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

(1) there is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or

(2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

§ 753. Factors to be considered concerning a previous criminal conviction; presumption.

1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.

(b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.

(c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.

(d) The time which has elapsed since the occurrence of the criminal offense or offenses.

(e) The age of the person at the time of occurrence of the criminal offense or offenses.

(f) The seriousness of the offense or offenses.

(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.

(h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

§ 754. Written statement upon denial of license or employment. At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

§ 755. Enforcement.

1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

# EMERGENCY CONTACT INFORMATION

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

Employee Name: John R. Urban

Address: 466 N. 48 Ave Brighton Co. 80601

Home Phone: 720-685-0545

| EMERGENCY CONTACTS<br>Please list two people (in priority order) who could be contacted in case of an emergency | |
|---|---|
| **Contact #1**<br>Name: Janet Urban<br>Relationship: wife | Home Phone: 720-685-0545<br>Cell Phone: 720-218-9997<br>Work Phone: |
| **Contact #2**<br>Name: Carrie Urban<br>Relationship: Daughter | Home Phone: 720-685-0545<br>Cell Phone: 720-234-4339<br>Work Phone: |

Additional information you want Employer Solutions Staffing Group and our clients to know in the event of an emergency:

_____

_____

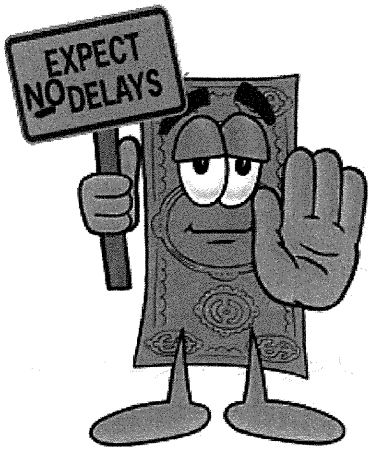
_____

_____

_____

*This information will remain confidential and will only be used in the case of an emergency.*

# RECEIVE YOUR PAY WITHOUT DELAY




In order for you to continue to receive your pay each week without delay we are encouraging all employees to use direct deposit or Global Cash Card. **It is becoming more and more difficult for employees to cash checks without fees or delay due to increased security at all banks. Also, if your check is lost or stolen you will have to wait 3 days for another check.**

**GLOBAL CASH CARD**

If you don't have a bank account, computer access or don't want to use direct deposit you can use **Global Cash Card** which works like a Visa.

- There are **NO FEES** for the card for your first transaction as a cash withdrawal at an ATM or if you use it like a credit card (not debit) to make individual signature purchases.
- **If you don't have access to a computer you can receive TEXT notifications for your pay check amount on pay day as well as what the current balance is. You can also receive low balance notifications set to the dollar amount that you determine on the attached form.**
- You may call Customer Service 24 hours a day, 7 days a week, 365 days a year at 888-220-4477 for balance inquiries or other questions. (Para Español, apriete dos)
- You can pay bills with the GCC (by phone/internet/in person). You can also set up your online account to make automatic payments.

Please complete the attached form and turn it in to your manager as soon as possible indicating whether you would like direct deposit or Global Cash Card. Please make sure you include an email address.

**Fill Out This Form!**

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

# Direct Deposit/Payroll Debit Card Authorization

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

## SECTION 1 BASIC INFORMATION

| Employee Name | SSN# (last 4 digits) | Effective Date |
|---|---|---|
| John R. Urban | 273-58-7679 | |

## SECTION 2 PAYROLL ELECTION

- [x] **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: WesTerra

Routing# 302075319

Account# 100001258520 9

Account Type: [x] 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 JRU Date 5/20/16

- To help us avoid making an error, please attach a copy of a voided check. **(a deposit slip will not work)**
- If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

## SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.

Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)

| First Name | M.I. | Last Name | Date of Birth |
|---|---|---|---|
| | | | |

| Street Address (PO BOX NOT ACCEPTABLE) | Social Security# |
|---|---|
| | |

| City | State | Zip | Cell Phone (mobile) |
|---|---|---|---|
| | | | |

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

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

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

| Payroll Debit Card Routing # | Payroll Debit Card Account # |
|---|---|
| **073972181** | |

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

Employee's Signature: _____ 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 adjustmentsfor any credit entries made in error to my account(s). *** E-mail is required for pay stub information.**

***E-mail:** JOHN56URBAN@YAHOO.COM

this information will only be used to send your paystubs electronically

Employee's Signature: John R. Urban Date: 5/20/16

**JANET PECK URBAN**
**JOHN R URBAN**
466 N 48TH AVE
BRIGHTON, CO 80601

4474

23-7531/3020
08

Date

Pay to the Order of _____ $

VOID

_____ Dollars

Security Features Details on Back.

westerra CREDIT UNION

3700 E. Alameda Ave.
Denver, CO 80209
(303)321-4209 • (800)858-7212
www.westerracu.com

For _____

MP

⑆302075319⑆ 100001258520 9⑈ 04474

Harland Clarke

INTOUCH® CUSTOM CREATIONS®

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

**STATEMENT OF CONFIDENTIALITY**

This agreement made this 05 day of 18, 2016, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and John R. Urban 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.

John R. Urban

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 JOHN R. URBAN Social security number ▶ 273-58-7679

Street address where you live 466 N. 48 AVE

City or town, state, and ZIP code BRIGHTON COLORADO 80601

County ADAMS Telephone number 720-300-9398

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

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** ▶ John R. Urban **Date** 05/18/2016

**For Privacy Act and Paperwork Reduction Act Notice, see page 2.** Cat. No. 22851L Form **8850** (Rev. 1-2012)

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: |
|---|---|---|---|
| John R. Urban | 466 N 48 AVE | BRIGHTON, CO. | 80601 |

| SS#: | Date of Birth: | Age: | Have you worked for this company before? | If yes, location: |
|---|---|---|---|---|
| 273-58-7679 | 03/07/1956 | 60 | ☐ 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:** John R. Urban **Date:** 05/18/2016

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# 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:** John R. Urban

**Printed Name:** JOHN R. URBAN

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# Important/Importante

## LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between $25-$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the policy report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

## CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre $ 25 - $ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): John R. URBAN

Signature/Firma John R. Urban

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# 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 JRU (Initial)

John R. Urban
Employee Signature:

05/18/2016
Date:

JOHN R. URBAN
Employee (please print your name here)

# DRUG AND ALCOHOL TESTING POLICY

## I. PURPOSE

Alcohol and drug abuse adversely affects job performance, the kind of work an employee performs and an employee's opportunities for successful employment. It is the intent of this document to provide employees with ESSG's [hereafter "the Company"] policy regarding the use of drugs and alcohol while at work. The Company does not intend to intrude into the private lives of its employees, but strongly believes that a drug-free workplace is in the best interest of employees and non-employees alike.

## II. SCOPE

This policy applies to all applicants for employment and to all employees including contract or temporary employees. The policy is applicable at Company facilities or whenever Company employees are performing company business.

## III. DISCLAIMER

Employment at the Company is at-will. This policy is not a unilateral employment contract and should not be interpreted as creating a unilateral employment contract.

## IV. PROHIBITIONS

A. No employee shall report to work under the influence of alcohol, any controlled substances, or any other drugs or medications that may affect the employee's alertness, coordination, reaction, response, judgment, decision-making, or safety.

B. No employee shall operate, use, or drive any equipment, machinery, or vehicle of the Company or any client of Company while under the influence of alcohol, any controlled substances, or any other drugs or medications that may adversely affect the employee's ability to operate such equipment, machinery, or vehicle. Employees are under an affirmative duty to immediately notify their supervisor if they are not in an appropriate mental or physical condition to operate, use, or drive any equipment machinery, or vehicle or otherwise safely perform their job duties.

C. No employee shall unlawfully manufacture, distribute, dispense, possess, transfer, or use a controlled substance in the workplace or wherever the Company's work is being performed.

D. Engaging in off-duty sale, purchase, transfer, use or possession of illegal drugs or controlled substances may have a negative effect on an employee's ability to perform his/her work for the Company. In such circumstances, the employee is subject to discipline.

E. When an employee is taking medically authorized drugs or other substances that may alter job performance, the employee is under an affirmative duty to notify their supervisor of the temporary inability to perform his or her job duties.

F. The Company shall notify the appropriate law enforcement agency, licensing boards, and other relevant authorities when it has reasonable suspicion to believe that an employee may have illegal drugs in his or her possession at work or on company premises.

G. Employees shall not consume alcoholic beverages during lunch periods, dinner periods, or breaks when returning immediately thereafter to perform work on behalf of the Company. In situations where the employee conducts the Company's business after the intake of alcohol, the employee shall be subject to discipline up to and including discharge.

## V. ALCOHOL AND DRUG TESTING

As part of the Company's commitment to an alcohol and drug-free workplace, the Company reserves the right to require that applicants and employees submit to drug or alcohol testing in accordance with the provisions of applicable law. This policy represents the notice required under applicable law and a copy will be provided to all applicants and employees who are requested to undergo testing. In the event of any conflict between this policy and applicable law in affect at the time of the test, the law will control.

### A. Who May be Subject to Testing.

1. Job Applicants. The Company may require that all applicants for a particular position be tested for drugs or alcohol after receiving a conditional offer of employment. If the applicant tests positive for drugs or alcohol, the conditional offer may be withdrawn.

2. Routine Physical Examination Testing. The Company may require employees to undergo a drug or alcohol test once a year as part of a routine physical examination. Affected employees will be given two weeks written notice that they will be tested for drugs or alcohol as part of a routine physical.

3. Random Testing. The Company may require employees in safety-sensitive positions to undergo testing on a random selection basis. Once the random selection has been made, the Company will not waive the selection of any employees identified through the random process.

4. Reasonable Suspicion Testing. The Company may require an employee to undergo drug or alcohol testing if the Company reasonably suspects that the employee:

   a. is under the influence of drugs or alcohol;

   b. has violated the Company's written work rules prohibiting drug and alcohol use;

   c. has sustained or caused another employee to sustain personal injury; or

   d. has caused a work-related accident or was operating or helping to operate machinery, equipment or vehicles involved in a work-related accident.

5. Treatment Program Testing. The Company may require an employee who has been referred for chemical dependency treatment or evaluation or is participating in a treatment program under an employee benefit plan to undergo drug or alcohol testing on a random basis and without advance notice during the evaluation or treatment period and for up to two years following the completion of any treatment program.

**B. Conducting the Testing.**

1. Consent. All employees required to undergo testing will be required to complete and sign the employee consent form attached as Appendix A.

2. Refusal to Participate. An employee or job applicant has the right to refuse testing. However, a refusal of testing will be treated as a failure to comply with Company policy and may result in withdrawal of a job offer or disciplinary action up to and including termination of employment.

3. The Laboratory. The Company will use a laboratory certified by the National Institute on Drug Abuse (NIDA) or its successor, the College of American Pathologists (CAP), or the New York State Department of Health or other licensing body recognized by applicable law to perform all drug and alcohol tests.

4. Test Results.

The laboratory will conduct both an initial test and a confirmatory test if the initial test is positive. A negative result on either the initial or confirmatory test will be deemed a negative test result (i.e. the employee passed the test). A positive result on both the initial and confirmatory test will be deemed a positive test result (i.e. the employee failed the test.)

a. Negative Test Result. An employee or applicant who tests negative for drugs or alcohol will be given written notice that they passed the test within three working days of the Company receiving the test results from the testing laboratory.

b. Positive Test Result. An employee or applicant who tests positive for drugs or alcohol will be given written notice that they have failed the test within three working days of the Company receiving the test results from the testing laboratory. The employee or applicant will then be given the opportunity to provide any information to explain the positive result, including any over-the-counter or prescription medications the employee or applicant may have taken. An employee or applicant who wishes to submit any explanatory information must do so within three working days after being notified of the positive test result.

An employee or applicant who has a positive test result may also request a retest of the original sample by the same or different certified laboratory at his or her own expense. An employee or applicant who wishes to conduct a retest must notify the Company in writing of their intention to conduct such a retest within five working days after being notified of the positive test result. If the results of the retest are negative, the test will be considered a negative test result.

C. Right to Test Result. An employee or job applicant has the right to request and receive from the Company a copy of the test result report on any drug or alcohol test.

**C. Costs.** All costs related to alcohol and drug testing will be paid by the Company, with the exception of any retests requested by the employee or applicant following a positive test result.

**D. Disciplinary Action in Response to a Positive Test Result.**

1. Interim Discipline and Action: The Company reserves the right to temporarily suspend an employee or transfer the employee to another position at the same rate of pay pending the outcome of any drug or alcohol test. An employee who is suspended without pay will be reinstated with back pay if the test or any requested retest is negative.

2. Applicants. The Company reserves the right to withdraw the conditional job offer of any job applicant with a positive test result, without the opportunity to complete evaluation or treatment.

3. Employees - First Positive Test Result - Termination: The Company will not discharge an employee for the first positive test result. Instead the employee will be given the opportunity to participate in an appropriate drug or alcohol counseling or rehabilitation program as determined by a certified chemical use counselor or physician trained in the diagnosis and treatment of chemical dependency chosen by the Company. The employee will be responsible for paying all costs associated with any evaluation and subsequent treatment themselves or pursuant to coverage under an employee benefit plan. An employee who refuses or fails to participate in, cooperate with, or complete the evaluation or recommended treatment may be terminated. An employee who successfully completes treatment may be subject to random follow-up testing for a period of up to two years in accordance with section V.A.5. of this policy.

4. Employees - First Positive Test Result—Discipline: The Company reserves the right to take any other disciplinary action short of discharge it deems warranted following a first positive test result.

5. Employees-Subsequent Positive Test Result: An employee who has more than one positive test result may be terminated immediately following any second or subsequent positive test result without referral to or the opportunity to complete additional chemical dependency counseling or rehabilitation.

**E. Privacy of Test Results.**

1. Test results and other information acquired as a result of the testing program are private and confidential information and will not be disclosed by the Company or the testing laboratory to another employee or to third party individuals, government agencies, or private organizations without written consent of the employee or applicant being tested.

2. Evidence of a positive test result, however, may be used in an arbitration proceeding pursuant to a collective bargaining agreement, an administrative hearing, or a judicial proceeding, provided the information is relevant to the hearing or proceeding. Such evidence may also be disclosed to any federal agency or other unit of the United States government as required under federal law, regulation, or order. Evidence of a positive test result may also be disclosed to a substance abuse treatment facility for the purpose of evaluation or treatment.

3. The Company will provide an employee with access to information in the employee's file relating to positive test result reports and other information acquired in the testing process as well as conclusions drawn from or actions taken based upon such information.

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## Summary of Benefits

| Benefits | Enhanced MEC Plan |
|---|---|
| Note that this list will be updated from time to time and a current list of covered preventative services is available at all times by visiting www.HealthCare.gov/center/regulations/prevention.html. | |
| PPO Network | PHCS |
| | In Network Only |
| Deductible | N/A |
| Coinsurance | N/A |
| Out of Pocket | N/A |
| 15 Preventive Services for Adults | 100% Coverage for Preventative Care Services |
| 22 Preventive Services for Women | |
| 26 Covered Preventive Services for Children | |
| Telephonic Primary Care Services | 100% |
| Office Visit Primary Care Physician | $20 Copay |
| Office Visit Specialist | $50 Copay |
| Diagnostic X-ray and Lab (in office)<br>· Cat-Scan/MRI or outpatient testing | $60 Copay<br>$200 Copay |
| Emergency Room | not covered |
| Urgent Care | $50 Copay |
| Durable Medical Equipment | $50 Copay |
| Psychiatric/Substance Abuse Office Visit | not covered |
| CVS Minute Clinic | $10 Copay for all Services |
| Prescription Generic | $10 Copay Generic Only<br>100% Copay on Brand Name Drugs<br>Mail Order Not Covered |
| Prescription Preferred Brand Drugs | |
| Prescription Non-Preferred Brand Drugs | |
| Mail Order Copays | |
| WEEKLY PREMIUM | |
| Single Premium | $ 24.00 |
| Employee Spouse | $ 38.00 |
| Employee Child/Children | $ 36.00 |
| Family Premium | $ 63.00 |

**What is Not Covered:** ***This is only a Summary of Benefits and Exclusions***

- Hospital inpatient services are not covered by the plan.
- Mental Health unless covered by the MEC
- Rehabilitative Speech Therapy, Occupational and Physical Therapy
- Skilled Nursing
- Specialty Drugs
- Transplants

Administered by Benefit Plan Administrators, Inc., PO Box 11746, Roanoke, VA 24022-11746800/277-8973
www.bpatpa.com

Benefit Plan Administrators, Inc.

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☐ New Employee
☐ Rehire *Rehire Date*_____

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

☐ Change of Status Birth/
☐ Adoption
☐ Marriage
☐ Divorce
☐ Spouse Loss of Coverage Plan
☐ Change
☐ Cancel Employee/Dependents

**Date of Status Change:**

**Benefits Enrollment Form**

## Employee Information

| Name (Last, First, MI) | Date of Birth | Social Security Number |
|---|---|---|
| URBAN JOHN R | 03/07/1956 | 273 58 7679 |

| Address | City | State | Zip Code |
|---|---|---|---|
| 466 N. 48 AVE | BRIGHTON | CO | 80601 |

| Gender | Marital Status | Phone Number: | Date of Hire |
|---|---|---|---|
| ☒ Male ☐ Female | ☒ Married ☐ Single ☐ Divorced | 720-300-9398 | 05/18/2016 |

Please Select Coverage Elected: Enhanced MEC Plan

**Email Address:**

**Coverage Level :**

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

## Dependent Information

| Dependent | Sex | Birth Date | Coverage Elected | Add (Enroll) Change, or Terminate |
|---|---|---|---|---|
| Last Name First Name M.I.<br>Social Security # | ☐ Male ☐ Female | | ☐ Medical | ☐ Add ☐ Change ☐ Waive ☐ Terminate |
| **Dependent** | **Sex** | **Birth Date** | **Coverage Elected** | **Add (Enroll) Change, or Terminate** |
| Last Name First Name M.I.<br>Social Security # | ☐ Male ☐ Female | | ☐ Medical | ☐ Add ☐ Change ☐ Waive ☐ Terminate |
| **Dependent** | **Sex** | **Birth Date** | **Coverage Elected** | **Add (Enroll) Change, or Terminate** |
| Last Name First Name M.I.<br>Social Security # | ☐ Male ☐ Female | | ☐ Medical | ☐ Add ☐ Change ☐ Waive ☐ Terminate |

## Other coverage information including Medicare/Medicaid

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

EFF. DATE

EFF. DATE

EFF. DATE

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

## IF ENROLLING - YOU MUST SIGN HERE

**Employee Signature** John R. Urban **Date** 05/18/2016

EMPLOYEES DECLINING ☐ Declining due to other coverage.

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

## IF DECLINING- YOU MUST SIGN HERE

**Employee Signature** **Date**

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

# DRUG AND ALCOHOL
# TESTING CONSENT FORM

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

John R. Urban
Individual's Name

05/18/2016
Date

# BENEFITS AT A GLANCE

Policy Number 219301-EMP

## Fixed Indemnity Medical Benefits

Weekly Rates

| Inpatient Benefits | | Outpatient Benefits[1] | |
|---|---|---|---|
| Standard Care Maximum | $500 per day | Annual Outpatient Maximum | $2,000 |
| Intensive Care Unit Maximum[2] | $600 per day | Physician Office Visit | $100 per day |
| Inpatient Surgery | $3,000 per day | Diagnostic Lab | $75 per day |
| Anesthesiology | $600 per day | Diagnostic X-Ray | $200 per day |
| First Hospital Admission (one per year) | $250 | Ambulance Services | $300 per day |
| Skilled Nursing payable for stays in a skilled nursing facility after a hospital stay | $100 per day | Physical, Occupational, and Speech Therapy | $50 per day |
| **Prescription Drug[3]** | | Emergency Room - Sickness | $200 per day |
| Prescription Drug Annual Maximum | $600 | Emergency Room - Accident | $500 per day |
| Prescription Drug Benefits | $20 per day | Outpatient Surgery | $500 per day |
| **Wellness Care** | | Anesthesiology | $200 per day |
| Wellness Care (one per year) | $100 | | |

[1]all outpatient benefits are subject to outpatient maximum [2]pays in addition to standard care benefit [3] not subject to outpatient maximum

| Employee Only | $20.91 | Employee + 1 | $42.44 | Employee + Family | $56.67 |
|---|---|---|---|---|---|

## Dental Benefits

Weekly Rates

| Annual Maximum Benefit | | $750 | Deductible | $50 |
|---|---|---|---|---|
| | Waiting Period | Co-Insurance | Annual Maximum Benefit | |
| Coverage A | None | 100% | Exams, Cleanings, Intraoral Films and Bitewings | |
| Coverage B | 3 Months | 60% | Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures | |
| Coverage C | 12 Months | 50% | Periodontics, Crowns, Bridges, Endodontics and Dentures | |

| Employee Only | $6.17 | Employee + 1 | $12.34 | Employee + Family | $20.36 |
|---|---|---|---|---|---|

## Term Life Benefits

Weekly Rates

| | Term Life Benefits |
|---|---|
| Employee Amount | $10,000 (reduces to $7,500 at 65; $5,000 at age 70) |
| Spouse Amount | $5,000 (terminates at age 70) |
| Child Amount (6 months to 26 years old) | $5,000 |
| Infant Amount (15 days to 6 months) | $1,000 |

| Accidental Death and Dismemberment Benefit | | | |
|---|---|---|---|
| Employee Amount | $20,000 | Child Amount (6 months to 26 years old) | $5,000 |
| Spouse Amount | $20,000 | Infant Amount (15 days to 6 months) | $2,500 |

| Employee Only | $0.60 | Employee + 1 | $0.90 | Employee + Family | $1.80 |
|---|---|---|---|---|---|

## Short-Term Disability

Weekly Rates

| Benefit | 60% of Salary up to $150 per week | Waiting Period/Maximum Benefit Period | 7 days/26 weeks |
|---|---|---|---|
| Employee Only | $4.20 | | |

YOU MUST COMPLETE THE ENROLLMENT FORM ON THE LAST PAGE

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

# ENROLLMENT FORM - PLAN 2

ESC UNAV P2 v15.1

## REQUIRED EMPLOYEE INFORMATION

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

Social Security Number __ __ __-__ __-__ __ __ __

Date of Birth __ __/__ __/__ __ __ __ Sex M F

Name _____

Street Address _____

City _____ State __ __ Zip __ __ __ __ __

Home Phone __ __ __-__ __ __-__ __ __ __

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

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

## BENEFIT SELECTION — Weekly Rates

### SELECT COVERAGE LEVEL

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

☐ Employee Only ☐ Employee + Family
☐ Employee + 1 ☐ **NO to all indemnity benefits.**

### FIXED INDEMNITY MEDICAL

☐ **YES** $20.91 Employee Only
$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
$12.34 Employee + 1
☐ **NO** *$20.36 Employee + Family

### TERM LIFE

☐ **YES** $0.60 Employee Only
$0.90 Employee + 1
☐ **NO** $1.80 Employee + Family

### SHORT-TERM DISABILITY

☐ **YES**
☐ **NO** $4.20 Employee Only

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

## BENEFICIARY INFORMATION

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

**NAME OF BENEFICIARY**

_____

**RELATIONSHIP**

_____

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

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

▶ **Signature** Date __ __/__ __/__ __ __ __