



CMG EMPLOYMENT NEW HIRE PAPERWORK

Name Jonathan Peter Gonzalez
First Middle Last Maiden

Present Address 3061 w 92nd Ave Westminster CO 80031
Street City State Zip

Telephone 5207041697 E-Mail Gonzojonathan9@gmail.com

Referred by _____

Do you have any responsibilities or commitments that will prevent you from meeting a specified work schedule?

Yes No If so, please explain No

Do you have any pre-scheduled days off in the next three-six months?

Yes No If so, please lists all dates No

Military Experience:

Have you ever been in the Armed Forces? Yes No

Are you currently an active member of the Reserve or National Guard? Yes No

Branch _____ Specialty _____

Date Entered _____ Discharge Date _____

Application Waiver

In exchange for the consideration of my job application by Corporate Management Group, Inc.,

I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements and the like as they may exist from time to time, or other company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of Corporate Management Group, Inc. (CMG), or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by an officer of CMG. Both the undersigned and CMG may end the employment relationship at any time, without specified notice or reason. If employed, I understand that CMG may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination. I hereby give CMG permission to contact schools, all previous employers (unless otherwise indicated), references and others and hereby release CMG from any liability as a result of such contact.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by CMG. 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 CMG policies.

I release CMG and other persons or entities from any claims that might be based on CMG's decision to conduct a background check.

I understand that, in connection with the routine processing of your employment application, CMG may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics and mode of living. Upon written request from me, CMG will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with CMG shall be probationary for a period of ninety (90) days or 520 hours (based on the client site I am employed at) and further that at any time during the probationary period or thereafter, my employment relationship with CMG is terminable at will for any reason by either party.

Signature of applicant



Date:

1/13/2023

Emergency Contact Information

In the event of an emergency CMG will contact the follow contacts Please list two people in order of priority.	
<p>Contact # 1</p> <p>Name: Rosa Alarcon</p> <p>Relationship: Mother</p>	<p>Home Phone:</p> <p>Cell Phone: (520) 585-0641</p>
<p>Contact # 2</p> <p>Name: Arturo</p> <p>Relationship: Cousins Husband</p>	<p>Home Phone:</p> <p>Cell Phone: (720) 233-1271</p>

Additional information you would like CMG and our clients to know in the event of an emergency:

Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
▶ Give Form W-4 to your employer.
▶ Your withholding is subject to review by the IRS.

2022

Step 1: Enter Personal Information	(a) First name and middle initial Jonathan P	Last name Gonzalez	(b) Social security number 601132694
	Address 3061 w 92nd Ave		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code Westminster Colorado 80031		
	(c) <input checked="" type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at www.irs.gov/W4App, and privacy.

Step 2: Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Multiple Jobs or Spouse Works

Do only one of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3-4); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . ▶

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ 0		
	Multiply the number of other dependents by \$500 ▶ \$ 0		
	Add the amounts above and enter the total here	3	\$ 0
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ 0
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ 0
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ 0

Step 5: Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Sign Here

▶  ▶ **1/13/2023**

▶ **Employee's signature** (This form is not valid unless you sign it.) ▶ **Date**

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

Step 2(b) - Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3.
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a.
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b.
c Add the amounts from lines 2a and 2b and enter the result on line 2c.
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld).

Step 4(b) - Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income.
2 Enter: { \$25,900 if you're married filing jointly or qualifying widow(er); \$19,400 if you're head of household; \$12,950 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-".
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information.
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4.

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 with no other entries on the form; 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.



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ 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) Gonzalez		First Name (Given Name) Jonathan		Middle Initial P	Other Last Names Used (if any) n/a	
Address (Street Number and Name) 3061 w 92nd Ave,			Apt. Number 6 D	City or Town Westminster		State Co
ZIP Code 80031		Date of Birth (mm/dd/yyyy) 12/11/1991	U.S. Social Security Number 601132694 - [] [] []	Employee's E-mail Address gonzojonathan9@gmail.com		Employee's Telephone Number 5207041697

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 boxes):

<input checked="" type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>
<input type="checkbox"/> 3. A lawful permanent resident (Allen Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR</p> <p>2. Form I-94 Admission Number: _____ OR</p> <p>3. Foreign Passport Number: _____ Country of Issuance: _____</p>
QR Code - Section 1 Do Not Write In This Space

Signature of Employee <i>[Signature]</i>	Today's Date (mm/dd/yyyy) 1/13/2023
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State
		ZIP Code	





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name) <u>Edonzalez</u>	First Name (Given Name) <u>Jonathan</u>	M.I. <u>P</u>	Citizenship/Immigration Status <u>U.S. citizen</u>
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title <u>Drivers License</u>		Document Title <u>Birth certificate</u>
Issuing Authority		Issuing Authority <u>Arizona</u>		Issuing Authority <u>State of Arizona</u>
Document Number		Document Number <u>DD6324947</u>		Document Number <u>B102-1991-12511</u>
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy) <u>12/11/2026</u>		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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): 01/19/2023 (See instructions for exemptions)

Signature of Employer or Authorized Representative <u>[Signature]</u>	Today's Date (mm/dd/yyyy) <u>01/19/2023</u>	Title of Employer or Authorized Representative <u>Senior Recruiter</u>
Last Name of Employer or Authorized Representative <u>NRSS</u>	First Name of Employer or Authorized Representative <u>T Zabala</u>	Employer's Business or Organization Name <u>CMG</u>
Employer's Business or Organization Address (Street Number and Name) <u>15DLW 124th Ave. Suite 500</u>	City or Town <u>Westminster</u>	State <u>CO</u>
		ZIP Code <u>80231</u>

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) Date (mm/dd/yyyy)

C: If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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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	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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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 Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (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. 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 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



Direct Deposit/Payroll Debit Card Authorization Form

Employees have the option of receiving wages by Direct Deposit or Payroll Debit Card.

If you do not provide a written payroll election a Payroll Debit Card will be provided.

Employee Name: Jonathan Peter Gonzalez

Payroll Election:

- Direct Deposit (Please see Section A)
 Payroll Debit Card (Please see Section B)

Section A: Direct Deposit

Bank Name: Tucson Federal Credit Union

Routing Number: 322174986

Account Number: 3000185114094

Account Type: Check 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 information that I provided is incorrect.

Initial: JPG Date: 1/13/2023

Section B: Payroll Debit Card

Routing Number: _____

Account Number: _____

Initial: JPG Date: 1/13/2023

I have received my Payroll Debit Card, welcome brochure, program fees, conditions and disclosures. By activating my Payroll Debit Card on my first pay day 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 CMG to debit my Payroll Debit Card account for the fees described to me in the provided material.

Section C: Additional Accounts

Bank Name: _____

Routing Number: _____

Account Number: _____

Account Type: Check Savings: Other:

I request that the following funds be deposited to the account listed in Section C:

- _____ % of my original deposit
 \$ _____ from my original deposit

Initial: JPG Date: 1/13/2023

I authorize CMG to directly deposit my wages and other payments as necessary into my account(s) as designated above and to initiate, debit entries and adjustments for any credit entries made in error to my account(s).

I have been informed how to gain access to my electronic pay stubs if needed.

Employee Signature: JPG

Date: 1/13/2023



ANTI-HARASSMENT POLICY

It is Corporate Management Group's (CMG) policy that all employees should be able to enjoy a work environment free from all forms of discrimination, including harassment. As such, CMG is committed to vigorously enforcing their Anti-harassment Policy. This policy applies to all employees of the organization (without regard to position) and individuals not directly connected to CMG (e.g., an outside vendor, consultant, customer or guest). Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, creed, religion, national origin, sex, marital status, status with regard to public assistance, membership or activity in a local commission, disability, sexual orientation or veteran status. Harassment is considered a form of discrimination and is specifically included among the prohibitions under Title VII of the Civil Rights Act of 1964. In addition, retaliation or reprisal taken against anyone who has expressed concern about harassment or discrimination against the individual raising the concern is illegal.

The Equal Employment Opportunity Commission (EEOC) defines sexual harassment as "unwelcome sexual advances, requests for sexual favors, sexual comments, or other verbal or physical acts of a sexual or sex-based nature including, but not limited to drawings, pictures, jokes, and/or teasing where (1) submission to such conduct is made either explicitly or implicitly a term or a condition of an individual's employment; (2) an employment decision is based on an individual's acceptance or rejection of such conduct; or (3) such conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment."

The Anti-harassment Policy prohibits harassment and/or retaliation by any individual employed by, doing business with or for, or visiting CMG. Employees who believe they have been the subject of harassment and/or retaliation or an employee who may have been witness to harassment and/or retaliation must report the incident immediately. Information and/or allegations must be reported to a manager of CMG (by telephoning 866.920.1425 or 303.920.1425). Only those who have an immediate need to know, including the alleged target of harassment or retaliation, the alleged harassers or retaliators, and any witnesses may find out the identity of the complainant. All individuals contacted in the course of an investigation will be advised that all persons involved in a charge are entitled to respect and that any retaliation or reprisal against an individual who is an alleged target of harassment or retaliation, who has made a complaint, or who has provided information in connection with a complaint, is a separate violation of CMG's policy. All information will be disclosed only on a need-to-know basis to allow CMG to



Notification of Colorado Law Requirement
Unemployment Acknowledgement

EMPLOYEE COPY

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 CMG 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 CMG once an assignment ends. I also acknowledge that I have received a separate copy of this form.

JP (Initial)

JP
Employee Signature:

1/13/2023
Date:

Jonathan Peter Gonzalez
Employee (please print your name here)

CERTIFICATION OF VITAL RECORD

"VERIFICATION BOX" (HOLD BETWEEN THUMB AND FOREFINGER, OR BREATHE ON IT. COLOR WILL CHANGE TO BLUE AND THEN RETURN.)

STATE OF ARIZONA

ORIGINAL STATE COPY

STATE OF ARIZONA DEPARTMENT OF HEALTH SERVICES -- OFFICE OF VITAL RECORDS
 CERTIFICATE OF LIVE BIRTH

BIRTH NO
 B 102-1991-065611

1 CHILD'S NAME A FIRST JONATHAN		B. MIDDLE PETER	C. LAST GONZALEZ	
2 SEX MALE	3A. PLURALITY (SPECIFY) SINGLE	3B. IF MULTIPLE BIRTH (SPECIFY)		4A. DATE OF BIRTH (MONTH DAY, YEAR) DECEMBER 11, 1991
4B. HOUR OF BIRTH 06:20 PM		5. PLACE OF BIRTH A. COUNTY PIMA		B. TOWN OR CITY TUCSON
5C. PLACE OF BIRTH <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> FREESTANDING BIRTHING CENTER <input type="checkbox"/> RESIDENCE <input type="checkbox"/> CLINIC/DOCTOR'S OFFICE <input type="checkbox"/> OTHER (SPECIFY)			D. FACILITY NAME (IF NOT INSTITUTION GIVE STREET AND NUMBER) UNIVERSITY MEDICAL CENTER - TU	
6. FATHER'S NAME (FIRST, MIDDLE, LAST, SUFFIX [Optional]) OCTAVIO, LEON, GONZALEZ				
7. DATE OF BIRTH (MONTH DAY, YEAR) MARCH 01, 1965		8. PLACE OF BIRTH (STATE OR COUNTRY) MEXICO		
9. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) ROSA, ISELA, ALARCON				
10. DATE OF BIRTH (MONTH DAY, YEAR) JUNE 22, 1971		11. PLACE OF BIRTH (STATE OR COUNTRY) MEXICO		
12. MOTHER'S USUAL RESIDENCE A. STATE ARIZONA		B. COUNTY PIMA	C. TOWN OR CITY TUCSON	
12E. STREET ADDRESS OR R.F.D.		12F. IN CITY LIMITS <input type="checkbox"/> YES <input type="checkbox"/> NO	13. MOTHER'S MAILING ADDRESS (IF DIFFERENT FROM ITEM 12)	

DATE REGISTERED: DECEMBER 27, 1991

DATE ISSUED: JULY 11, 2008

This is a true certification of the facts on file with the OFFICE OF VITAL RECORDS, ARIZONA DEPARTMENT OF HEALTH SERVICES, PHOENIX, ARIZONA issued under the authority of A.R.S. 36-341, and by direction of:

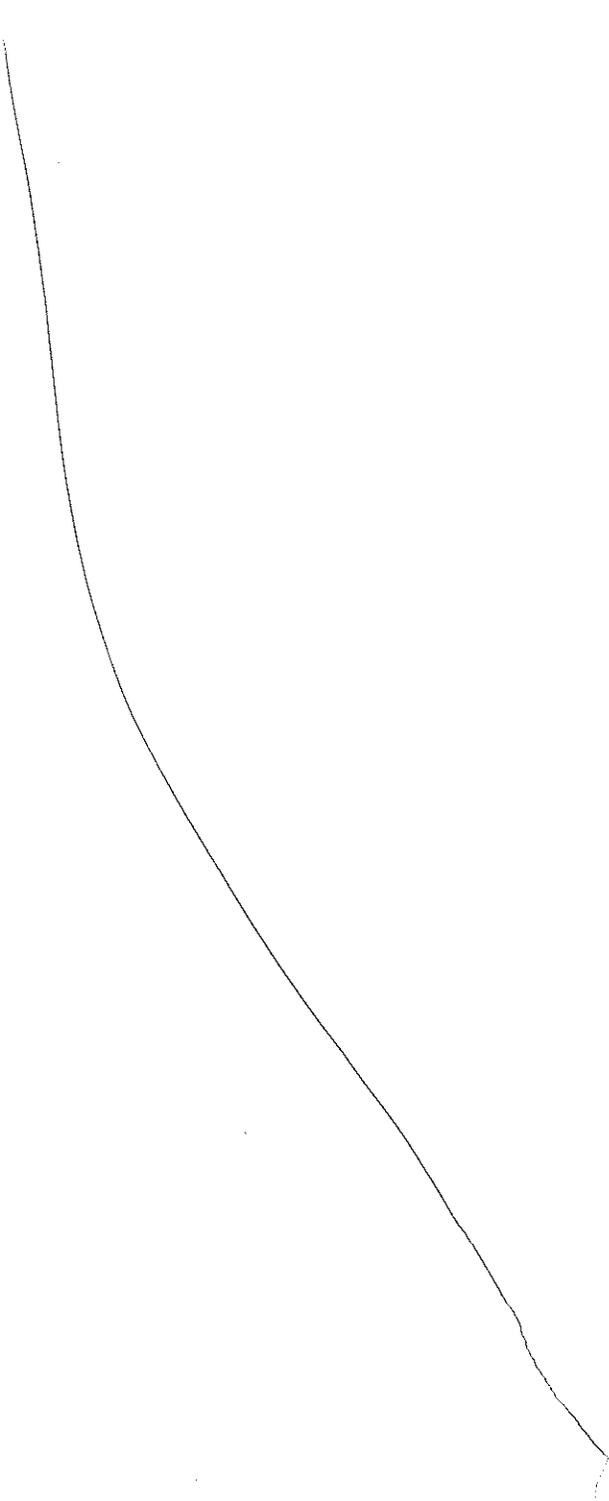
Patricia Adams

PATRICIA ADAMS
 ASSISTANT STATE REGISTRAR

This copy not valid unless prepared on a form displaying the State Seal and impressed with the raised seal of the issuing agency.

Arizona
 Department of
 Health Services

ANY ALTERATION OR ERASURE VOIDS THIS DOCUMENT



Arizona

DRIVER LICENSE

USA

NOT FOR FEDERAL IDENTIFICATION



9 CLASS D
9a END NONE 4d DLN D06324947
12 REST NONE 3 DOB 12/11/1991
1 GONZALEZ
2 JONATHAN PETER
8 1331 W PASTIME RD
TUCSON, AZ 857052548
4b EXP 12/11/2056 4a ISS 10/07/2021
15 SEX M 18 EYES BRO
16 HGT 5'-08" 19 HAIR BRO
17 WGT 140 lb

Jonathan Gonzalez

5 DD 0060029F2G030705

12/11/91





B1 221900-CMG

OFFICE USE ONLY LOCATION _____ New Hire Rehire Date ___/___/___**ENROLLMENT FORM**

ESC ES*CO P2D v23.0

A. REQUIRED EMPLOYEE INFORMATION**PRINT USING BLACK or BLUE INK (Must Be Filled Out)**

Name Jonathan P Gonzalez	Social Security # 601-13-2694	Phone 520-704-1697	Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Address 3061 w 92nd ave 6D			Apt. #
City Westminster	State CO	Zip 80031	Date of Birth 12/11/1991

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person (s):

1.

2.

3.

C. LIMITED BENEFITS PLAN SELECTION**Payroll Deducted Weekly Rates**

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only	<input checked="" type="checkbox"/> \$23.69	\$5.40	\$2.42	\$0.60	\$4.20
Employee + 1	<input type="checkbox"/> \$48.08	\$10.80	\$4.92	\$0.90	
Employee + Family	<input type="checkbox"/> \$64.20	\$17.82	\$6.56	\$1.80	
	<input type="checkbox"/> NO to ALL Benefits	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹This coverage is not available to residents of NH, HI, or PR. ²STD is not available to persons who work in CA, HI, NJ, NY, or RI.**For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.**

Name Rosa Icela Alarcon Relationship Mother

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE**YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE**

By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benefit plans. I understand that open enrollment is only available for a limited time; that making no benefit selection is a declination of benefit coverage and benefit coverage is only available to employees who are over the age of 18.

DATE ___/___/1/18/2023 ___

SIGNATURE

