

SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2015120114135AB

Case Information:

<b>Employee Information:</b>	Last Name: Laberge	First Name: Donna
	Middle Initial:	Other Names Used:
	Social Security Number: *** ** 2555	Date of Birth: 06/30/1964
	Citizenship Status: A citizen of the United States	Email Address:
<b>Document Information:</b>	Driver's license or ID card issued by a U.S. state or outlying possession	List C Document: Social Security Card
	Driver's License or ID Card Number:	Document State: Minnesota
	Alien Number:	Document Expiration Date: 06/30/2016
<b>Additional Information:</b>	Hire Date: 04/30/2015	I-94 Number:
	Three-Day Rule Reason:	Employer Case ID:
	Submitted By: JMSS3269	Three-Day Rule - Other:
<b>Initial Case Result:</b>	Case Result: Employment Authorized	Submitted On: 04/30/2015

Employee Referred to SSA:

Referred By:	Referred On:
Case Result:	Case Result from SSA (after SSA Tentative Nonconfirmation):

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

First Name:	Other Names Used:	Date of Birth:	Resubmitted On:
Middle Initial:	Social Security Number:	Resubmitted By:	Case Result from SSA (after Resubmission):
Case Result:	Case Result:		

Request Name Review:

Submitted By:	Submitted On:
Comments:	Case Result from DHS (after DHS Verification in Process):
Case Result:	Case Result:

Employee Referred to DHS:

Referred By:	Referred On:
Case Result from DHS (after DHS Tentative Nonconfirmation):	Case Result:
Case Result:	Case Result:

Photo Matching Results:

Determination:
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Employee Referred to DHS (Additional):

Referred By:

Referred On:

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

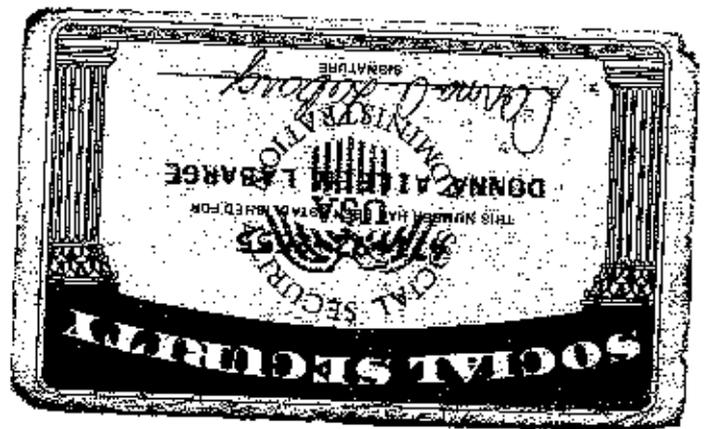
Case Result:

Response Date:

**Case Closure:**

**Closure Statement:** The employee continues to work for the employer after receiving an Employment Authorized result.  
**Closed By:** JMIS3269  
**Closed On:** 04/30/2015

**SENSITIVE BUT UNCLASSIFIED**





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 Loberg First Name Dana Middle Initial F  
 Street Address 128 Riverside Drive NE Apt/Ste \_\_\_\_\_  
 City/State/zip St Cloud, MN 56304  
 Phone Number 376 291 6251 Email Address \_\_\_\_\_ @ \_\_\_\_\_  
 Staffing Agency/Recruitment Partner Kingy Missell

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 regulation 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.

Name (Print or type) Dana Loberg Applicant's Signature Dana Loberg Date 4-30-15

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

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

The exceptions do not apply to supplemental wages greater than \$1,000.00.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The

worksheet on page 2 further adjust your withholding allowance based on itemized deductions, credits, adjustments to income,

deductions, or other multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular

wages, withholding must be based on allowances

you claim and may not be a full amount or percentage of wages.

Head of household. Generally, you can claim head

of household if your spouse or dependent child

you are unmarried and live with you for more than 50% of the

year. See Pub. 508, Child Tax Credit, for more information.

Exemption from withholding. If you are exempt,

complete only lines 1, 2, 3, 4, and 7 and sign the form

to indicate your exemption for 2015 expires

February 18, 2016. See Pub. 505, Tax Withholding

Exemption from withholding. If you are exempt,

complete only lines 1, 2, 3, 4, and 7 and sign the form

to indicate your exemption for 2015 expires

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Form W-4 (2015)

Department of the Treasury Internal Revenue Service

Employee's Withholding Allowance Certificate

OMB No. 1545-0047 2015

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.

Your first name and middle initial

Last name

Home address (number and street or rural route)

City or town, state, and ZIP code

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.

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

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

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

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

Employee's signature

Employer's name and address (Employer: Complete lines B and D only if sending to the IRS.)

Employer identification number (EIN)

Date

Form W-4 (2015)

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

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

wages 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.

Enter "1" for yourself if no one else can claim you as a dependent.

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 \$1,600 or less.

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.)

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

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

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. 508, Child and Dependent Care Expenses, for details.)

Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

If your total income will be less than \$65,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you

have two to four eligible children or less "2" if you have five or more eligible children.

If your total income will be between \$65,000 and \$84,000 (\$100,000 and \$118,000 if married), enter "1" for each eligible child.

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.

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

Employee's Withholding Allowance Certificate

OMB No. 1545-0047 2015

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.

Your first name and middle initial

Last name

Home address (number and street or rural route)

City or town, state, and ZIP code

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.

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

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

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

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

Employee's signature

Employer's name and address (Employer: Complete lines B and D only if sending to the IRS.)

Employer identification number (EIN)

Date

Form W-4 (2015)



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

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.

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

Signature of Employee: <i>Diana Kobayashi</i>	Date (mm/dd/yyyy): <i>7-26-15</i>
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Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Country of Issuance: \_\_\_\_\_  
 Foreign Passport Number: \_\_\_\_\_  
 If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:  
 2. Form I-94 Admission Number: \_\_\_\_\_  
 OR  
 1. Alien Registration Number/USCIS Number: \_\_\_\_\_



For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission 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)
- A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- A noncitizen national of the United States. (See instructions)
- A citizen of the United States

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

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.

Date of Birth (mm/dd/yyyy): <i>06-30-1964</i>		U.S. Social Security Number: <i>471-92-2555</i>		E-mail Address: _____		Telephone Number: <i>320-241-6251</i>	
Address (Street Number and Name): <i>128 Riverside Drive NE</i>		City or Town: <i>St. Louis</i>		State: <i>MO</i>		Zip Code: <i>63304</i>	
Last Name (Family Name): <i>Laberge</i>		First Name (Given Name): <i>Diana</i>		Middle Initial: <i>A</i>		Other Names Used (if any): <i>Montgomery - Referrer</i>	

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.)

Signature of Employer or Authorized Representative:	Date (m/d/yyyy):	Print Name of Employer or Authorized Representative:
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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.

Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):
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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.

**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) (m/d/yyyy):
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Last Name (Family Name) <i>Missell</i>	First Name (Given Name) <i>Jennifer</i>	Employer's Business or Organization Name <i>EMPLOYER SOLUTIONS STAFFING GROUP LLC</i>
Signature of Employer or Authorized Representative <i>[Signature]</i>	Date (m/d/yyyy) <i>04-30-2015</i>	Title of Employer or Authorized Representative <i>Office Staff</i>
Employer's Business or Organization Address (Street Number and Name) City or Town State Zip Code <i>7301 OHMS LANE SUITE 405 EDINA MN 55439</i>		

The employee's first day of employment (m/d/yyyy): *04-30-2015* (See instructions for exemptions.)

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the employee is authorized to work in the United States.

**Certification**

Document Title: <i>Drivers License</i>	Document Number: <i>W91322A157913</i>	Expiration Date (if any)(m/d/yyyy): <i>06/30/2016</i>
Document Title: <i>Social Security Card</i>	Document Number: <i>471-92-2555</i>	Expiration Date (if any)(m/d/yyyy): <i>N/A</i>
Issuing Authority: <i>State of Minnesota</i>	Issuing Authority: <i>Social Security Administration</i>	Document Title: <i>Document Title:</i>
Issuing Authority: <i>State of Minnesota</i>	Issuing Authority: <i>Social Security Administration</i>	Document Title: <i>Document Title:</i>
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Issuing Authority: <i>State of Minnesota</i>	Issuing Authority: <i>Social Security Administration</i>	Document Title: <i>Document Title:</i>

Identify and Employment Authorization OR List A AND List B AND List C

Employee Last Name, First Name and Middle Initial from Section 1: *Labarge, Donna A*

**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 the document from List A OR examine a combination of one document from List B and one document from List C as listed on the "List 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.)

3-D Barcode  
Do Not Write in This Space



**DISCLOSE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]**

**DISCLOSURE REGARDING BACKGROUND INVESTIGATION**

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" that may include information about your character, general reputation, personal characteristics, and/or mode of living, and that can involve personal interviews with sources, such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security number validation, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been requested and compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applications for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Chms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9041. Fax: 800-886-0774 or 952-941-9040. The scope of this notice and authorization is all-encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

<b>New York and Maine applicants or employees only:</b> You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.
<b>New York applicants or employees only:</b> Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
<b>Oregon applicants or employees only:</b> Information describing your rights under Federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.
<b>Washington State applicants or employees only:</b> You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and a SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Chms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING'S website is at: [www.orange treescreening.com](http://www.orange treescreening.com), another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

**New York applicants or employees only:** By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.  
**Minnesota and Oklahoma applicants or employees only:** Please check this box if you would like to receive a copy of a consumer report if one is obtained by ESSG.

Must include email address:

**BACKGROUND INFORMATION**

Signature: Norma Kobayashi Date: 4-30-15

Last Name: LeFarge First: Norma Middle: Alison

Other Names/Aliases: \_\_\_\_\_

Social Security #: 471 92 2565

Driver's License #: MJ9322215793 State of Driver's License: MN

Present Address: 128 Riverside Drive NE Telephone # (Primary): 320 241 6251

City/State/Zip: St Cloud, MN 56304

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

**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: Dana Labarge SSN# (last 4 digits): 7555 Effective Date: \_\_\_\_\_

**SECTION 2: PAYROLL ELECTION**

Payroll Debit Card (Please complete Sections 4 and 5 below)  
 Direct Deposit (Please complete Sections 3 and 5 below)

**SECTION 3: DIRECT DEPOSIT**

Update Bank Account  
 Bank Name: Great First Federal Credit Union  
 Routing#: \_\_\_\_\_  
 Account#: \_\_\_\_\_  
 Account Type:  Checking  Savings  Other  
 I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.  
 Initial: \_\_\_\_\_ Date: \_\_\_\_\_

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

**SECTION 4: PAYROLL DEBIT CARD - GLOBAL CASH CARD**

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

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

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

First Name: \_\_\_\_\_ 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!**  
 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 #: 073972181  
 Payroll Debit Card Account #: \_\_\_\_\_

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.

**SECTION 5: AUTHORIZATION**

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

\* E-mail: \_\_\_\_\_

Employee's Signature: Dana Labarge Date: 4-30-15

this information will only be used to send your pay stubs electronically

### ENROLLMENT FORM

BSC NAV\*SAD P2M \*15.0

#### REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK OR BLUE INK  
 (Must Be Filled Out)  
 Social Security Number 471-92-2455  
 Date of Birth 06/30/1964 Sex  M  F

Name Diana Lobregg  
 Street Address 128 Riverside Drive Apt 5C  
 City St Cloud State MA Zip 06304  
 Home Phone 320-241-6251

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

#### 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 declaration of coverage.  
 Signature Diana Lobregg  
 Date 04/30/01

#### OPTION 1 FIXED INDEMNITY PLAN

Weekly Rates  
 You MUST enroll in the Indemnity Medical Insurance Plan before adding any additional Indemnity benefits, except Dental. Your coverage level for the Term Life will be identical to your medical plan selection.

**FIXED INDEMNITY MEDICAL**  
 \$20.91 Employee Only  
 \$42.44 Employee + 1  
 \$56.67 Employee + Family  
 NO to all Indemnity benefits.  
 This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

#### DENTAL

\$5.99 Employee Only  
 \$11.98 Employee + 1  
 \$19.77 Employee + Family  
 NO

#### TERM LIFE

YES \$0.60 Employee Only  
 YES \$0.90 Employee + 1  
 YES \$1.80 Employee + Family  
 NO  
 Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.



#### SHORT-TERM DISABILITY

**OPTION 2 MEC WELLNESS/PREVENTIVE PLAN**  
 Monthly Rates  
 \$58.87 Employee Only  
 \$87.73 Employee + 1  
 \$186.99 Employee + Family  
 NO to MEC Wellness/Preventive Plan

**OPTION 1**  
 \$20.91 Employee Only  
 \$42.44 Employee + 1  
 \$56.67 Employee + Family  
 NO to all Indemnity benefits.

