



MINNESOTA DRIVER'S LICENSE/ENHANCED DRIVER'S LICENSE IDENTIFICATION CARD/INSTRUCTION PERMIT APPLICATION RECEIPT

2015804215068

THIS IS NOT A STANDALONE IDENTIFICATION DOCUMENT

MINNESOTA DRIVER'S LICENSE, INSTRUCTION PERMIT OR IDENTIFICATION CARD NUMBER: **7750291047012** BIRTH DATE (MONTH/DAY/YEAR): **10081970**

FULL LEGAL NAME: **Charlotte** COMPLETE FIRST NAME: **ANN** COMPLETE MIDDLE NAME: **CLAIR** COMPLETE LAST NAME: **CLAIR**

FULL RESIDENCE ADDRESS: **424 1/2 Ave N** STATE: **MN** ZIP CODE: **56303** APT#: **2** MN COUNTY: **73**

OPTIONAL MAILING ADDRESS: MAKE SURE THIS IS A VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD

NUMBER: _____ STREET: _____ STATE: _____ ZIP CODE: _____ APT#: _____ MN COUNTY: _____

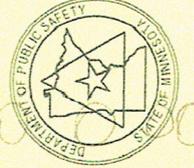
APPLICANT'S PHYSICAL DESCRIPTION

EYE COLOR: **B** IN: **5** FT. **9** HEIGHT: **140** POUNDS: **X** MALE/FEMALE

Visit dvs.dps.mn.gov to:

- Check the status of your driving privileges
- Schedule a road test

Driver's License Questions: **651-297-3298**
 License Status, available 24/7: **651-284-2000**
 General DVS Information: **651-296-6911**
 TDD/TTY: **651-282-6555**



Driver & Vehicle Services

(DVS USE ONLY)

St. Cloud D.L. Exam Station
 3333 W Division St. Ste 114
 St. Cloud, MN 56301

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SOCIAL SECURITY

477-82-7412

THIS NUMBER HAS BEEN ESTABLISHED FOR

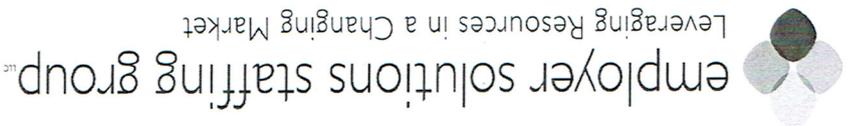
CHARLOTTE ANN
LECLATRE

Charlotte Ann LeClatre

SIGNATURE



11/04/2011



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 LeClair First Name Charlotte Middle Initial R
 Street Address 424 1/2 9th Ave Apt/Ste 2
 City/State/Zip St Cloud, MN 56303
 Phone Number (320) 828-2099 Email Address _____ @ _____
 Staffing Agency/Recruitment Partner CMG Group

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.

Name (Print or type) Charlotte LeClair
 Applicant's Signature Charlotte LeClair
 Date 7-29-15

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	

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...

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.

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.

Personal Allowances Worksheet (Keep for your records). A. Enter "1" for yourself if no one else can claim you as a dependent. B. Enter "1" if: You are single and have only one job; or You are married, have only one job, and your spouse does not work; or Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

Separate here and give Form W-4 to your employer. Keep the top part for your records. Department of the Treasury Internal Revenue Service Form W-4

1 Your first name and middle initial: Charlotte A. Last name: Legrain. 2 Your social security number: 477-82-7412. 3 Single (checked), Married, Married, or Legally separated, or spouse is a nonresident alien, check the "Single" box. Note: If married, but withholds at higher Single rate.

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): 2. 6 Additional amount, if any, you want withheld from each paycheck: \$0. 7 I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption: Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

Employee's signature: Charlotte A. Legrain. Date: 7-30-15. Employer's name and address: (This form is not valid unless you sign it.) 9 Office code (optional). 10 Employer identification number (EIN). 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.



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) Lecia		First Name (Given Name) Charlotta		Middle Initial A	Other Names Used (if any) Char
Address (Street Number and Name) 4242 9th Ave N		Apt. Number 2		City or Town St. Cloud	State MN
Zip Code 56303		Telephone Number (320) 828-2099			
Date of Birth (mm/dd/yyyy) 10-8-70		U.S. Social Security Number [27]-[87]-[7412]		E-mail Address _____	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

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

- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number.

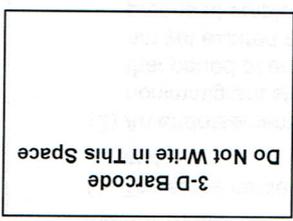
OR

- 1. Alien Registration Number/USCIS Number: _____
- 2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____
Country of Issuance: _____

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



Signature of Employee: <i>Charlotta Lecia</i>	Date (mm/dd/yyyy): 7-30-15
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Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator: _____	Date (mm/dd/yyyy): _____
--	--------------------------

Last Name (Family Name)	First Name (Given Name)
Address (Street Number and Name)	City or Town
State	Zip Code

Employer Completes Next Page



Signature of Employer or Authorized Representative:	Date (m/dd/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/dd/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/dd/yyyy):
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Employer's Business or Organization Address (Street Number and Name) 7301 OHMS LANE SUITE 405	City or Town EDINA	State MIN	Zip Code 55439
Last Name (Family Name) Misselli	First Name (Given Name) Jennifer	Employer's Business or Organization Name EMPLOYER SOLUTIONS STAFFING GROUP LLC	
Signature of Employer or Authorized Representative <i>[Signature]</i>	Date (m/dd/yyyy) 08-04-2015	Title of Employer or Authorized Representative Office Staff	

The employee's first day of employment (m/dd/yyyy): 08-04-2015 (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 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.

Certification

Document Title: Drivers License Receipt	Document Number: T750291097013	Expiration Date (if any) (m/dd/yyyy): 10-03-2015
Document Title: Social Security Card	Document Number: 477-82-7412	Expiration Date (if any) (m/dd/yyyy): N/A
Issuing Authority: State of Minnesota	Issuing Authority: Social Security Administration	
Document Title: Social Security Card	Document Number: 477-82-7412	Expiration Date (if any) (m/dd/yyyy): N/A

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

Employee Last Name, First Name and Middle Initial from Section 1: LeClair, Charlotte B

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.)

3-D Barcode
Do Not Write in This Space

DISCLOSURE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

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

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

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING'S website is at: www.orange treescreening.com, another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

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: Charles J. Clark Date: 7-30-15

Last Name: Leclair First: Charles Middle: A

Other Names/Aliases: _____

Social Security #: 477-82-7412

Date of Birth (mm/dd/yyyy)*: 10-8-70

State of Driver's License: MN

Driver's License #: T75629/647012

Present Address: 4242 9th Ave N

Telephone # (Primary): (326) 828-2039

City/State/Zip: St. Cloud, MN 56303

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



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: Charles K. Clark SSN# (last 4 digits) 7417 Effective Date: 07-30-15

SECTION 2 PAYROLL ELECTION

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

SECTION 3 DIRECT DEPOSIT

Update Bank Account
 Bank Name: _____
 Routing#: _____
 Account#: _____
 Account Type: Checking Savings Other

I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.

Initial _____ Date _____

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
 All we need to know your cell phone service provider and mobile number above!
 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.

Employee's Signature: Charles K. Clark

Date: 7-30-15

SECTION 5 AUTHORIZATION

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

*E-mail: _____

this information will only be used to send your paystubs electronically

Employee's Signature: _____ Date: _____

ENROLLMENT FORM

ESC NAV*SAD P2M v15.0

OPTION 1 FIXED INDEMNITY PLAN

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
 NO \$1.80 Employee + Family

SHORT-TERM DISABILITY

YES \$4.20 Employee Only
 NO

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

OPTION 2 MEC WELLNESS/PREVENTIVE PLAN

82193010-M-EMP Monthly Rates

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

Signature Christy L. Crain Date 07/01/2015

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.

REQUIRED EMPLOYEE INFORMATION

(Must Be Filled Out)

Social Security Number 9277-82-2412
 Date of Birth 08/19/70 Sex M F
 Name Charles Crain
 Street Address 4244 Gb Ave N
 City SALVO State CA Zip 92003
 Home Phone 320-828-2099

Do you or any dependents have Medicare?
 Yes No If Yes:
 Medicare Health Insurance Claim Number (HICN) _____
 Medicare Effective Date _____
 Names of Covered Person(s)
 1. _____
 2. _____
 3. _____

REQUIRED DEPENDENT INFORMATION

Name _____
 Social Security Number _____
 Date of Birth _____ / ____ / ____ Sex M F
 Relationship: Spouse Child Domestic Partner

BENEFICIARY INFORMATION

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