

employer solutions staffing group, LLC

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Szabla First Name Michael Middle Initial P
Street Address 14124 Pineview Drive Apt/Ste _____
City/State/Zip Becker MN 55308 Social Security Last Four XXX-XX-5672
Phone Number (763) 250-4106 Email Address _____ @ _____
Staffing Agency/Recruitment Partner CMG-BIH

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.

Michael Szabla
Name (Print or type)

Michael Szabla
Applicant's Signature

4-17-19
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 _____ | |

m MINNESOTA IDENTIFICATION CARD
 USA

NOT FOR FEDERAL IDENTIFICATION

1 SZABLA
 2 MICHAEL PAUL
 8 14124 PINEVIEW DR
 BECKER, MN 55308-9207

4d ID# V532-225-133-910 4a ISS 02/22/2019
 3d DOB 04/16/1965 4b EXP 04/16/2020

NOT A DRIVER'S LICENSE

Minnesota

15 SEX M 17 WGT 200 lb
 16 HGT 5'-10" 18 EYES BRO

5d DD 00000000592149 04/16/65





UNITED STATES OF AMERICA SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA

SOCIAL SECURITY

477-90-5672

THIS NUMBER HAS BEEN ESTABLISHED FOR

**MICHAEL PAUL
 SZABLA**

Michael Paul Szabla

SIGNATURE 10/15/2018

USA

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

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. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

| | | | | |
|--|---|---|--------|---|
| Form W-4 Department of the Treasury Internal Revenue Service | | Employee's Withholding Allowance Certificate | | OMB No. 1545-0074 2019 |
| ▶ Whether you're 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. | | | | |
| 1 | Your first name and middle initial <i>Michael P.</i> | Last name <i>Szabla</i> | 2 | Your social security number <i>477-90-5672</i> |
| Home address (number and street or rural route) <i>14124 Pineview Drive</i> | | | 3 | <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate." |
| City or town, state, and ZIP code <i>Becker MN 55308</i> | | | 4 | If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▶ <input type="checkbox"/> |
| 5 | Total number of allowances you're claiming (from the applicable worksheet on the following pages) | | | 5 |
| 6 | Additional amount, if any, you want withheld from each paycheck | | | 6 \$ |
| 7 | I claim exemption from withholding for 2019, 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 <i>Exempt</i> |
| 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.) ▶ <i>Michael Szabla</i> | | | Date ▶ | <i>4-17-19</i> |
| 8 | Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.) | | 9 | First date of employment |
| | | | 10 | Employer identification number (EIN) |



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

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ **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) Szabla | | First Name (Given Name) Michael | | Middle Initial P | Other Last Names Used (if any) N/A | |
| Address (Street Number and Name) 14124 Pineview Drive | | | Apt. Number N/A | City or Town Becker | | State MN |
| Date of Birth (mm/dd/yyyy) 04/16/1965 | | U.S. Social Security Number 4 7 7 - 9 0 - 5 6 7 2 | | Employee's E-mail Address N/A | | Employee's Telephone Number (763) 250-4106 |

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 (Alien Registration Number/USCIS Number): <u>N/A</u> |
| <input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): <u>N/A</u> Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</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.

| | |
|---|--|
| 1. Alien Registration Number/USCIS Number: <u>N/A</u> OR | QR Code - Section 1 Do Not Write In This Space  |
| 2. Form I-94 Admission Number: <u>N/A</u> OR | |
| 3. Foreign Passport Number: <u>N/A</u> Country of Issuance: <u>N/A</u> | |

| | |
|--|--|
| Signature of Employee <i>Michael Szabla</i> | Today's Date (mm/dd/yyyy) <i>04/17/2019</i> |
|--|--|

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 08/31/2019

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) Szabla | First Name (Given Name) Michael | M.I. P | Citizenship/Immigration Status 1 |
|-------------------------------------|-----------------------------------|------------------------------------|-----------|-------------------------------------|

List A
OR
List B
AND
List C

Identity and Employment Authorization
Identity
Employment Authorization

| | | |
|--|--|---|
| Document Title N/A Issuing Authority N/A Document Number N/A Expiration Date (if any)(mm/dd/yyyy) N/A | Document Title ID card issued by state/territory Issuing Authority Minnesota Document Number V532225133910 Expiration Date (if any)(mm/dd/yyyy) 04/16/2020 | Document Title Social Security Card (Unrestricted) Issuing Authority Social Security Administration Document Number 477905672 Expiration Date (if any)(mm/dd/yyyy) N/A |
| Document Title N/A Issuing Authority N/A Document Number N/A Expiration Date (if any)(mm/dd/yyyy) N/A | <div style="border: 1px solid black; padding: 5px;"> <p>Additional Information</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p align="center">QR Code - Section 2 Do Not Write In This Space</p>  </div> | |
| Document Title N/A Issuing Authority N/A Document Number N/A Expiration Date (if any)(mm/dd/yyyy) N/A | | |
| Document Title N/A Issuing Authority N/A Document Number N/A Expiration Date (if any)(mm/dd/yyyy) N/A | | |
| Document Title N/A Issuing Authority N/A Document Number N/A Expiration Date (if any)(mm/dd/yyyy) N/A | | |

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): 04/17/2019 (See instructions for exemptions)

| | | | | |
|---|--|---|---|-------------------|
| Signature of Employer or Authorized Representative <i>Lori Larson</i> | | Today's Date (mm/dd/yyyy) <u>04/17/2019</u> | Title of Employer or Authorized Representative On-Site Representative | |
| Last Name of Employer or Authorized Representative Larson | | First Name of Employer or Authorized Representative Lori | Employer's Business or Organization Name Employer Solutions Group, LLC | |
| Employer's Business or Organization Address (Street Number and Name) 7480 Flying Cloud Drive Suite 200 | | City or Town Eden Prairie | State MN | ZIP Code 55344 |

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

| | | | | |
|------------------------------------|-------------------------|----------------|--|--|
| A. New Name (if applicable) | | | B. Date of Rehire (if applicable) | |
| Last Name (Family Name) | First Name (Given Name) | Middle Initial | 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) |
|----------------|-----------------|---------------------------------------|

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 |
|--|---------------------------|---|

EMERGENCY CONTACT INFORMATION

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

Employee Name: Mike Szable

Address: 14124 Pineview Drive

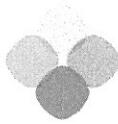
Home Phone: cell 763-250-4106

EMERGENCY CONTACTS

Please list two people (in priority order) who could be contacted in case of an emergency

| Contact #1 | |
|---|---|
| Name: <u>Sandy Anderson</u> Relationship: <u>Mom</u> | Home Phone: Cell Phone: <u>320-266-7749</u> Work Phone: |
| Contact #2 | |
| Name: <u>Bob Szabla</u> Relationship: <u>Brother</u> | Home Phone: Cell Phone: <u>763-244-4195</u> Work Phone: |

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



employer solutions staffing group inc.

Leveraging Resources in a Changing Market

Wage Payment Method Authorization (Minnesota)

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 paper Check.

SECTION 1 BASIC INFORMATION

Employee Name: Michael Szobla SSN# (last 4 digits) 5672 Effective Date 4-22-19

SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated*
 Payroll Debit Card (Please complete Sections 4 and 5 below) Paper Check (Please complete Section 5 below)

SECTION 3 DIRECT DEPOSIT

**A
C
C
O
U
N
T**
 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 _____

- 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) _____

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

Payroll Debit Card Routing # 067011294 Payroll Debit Card Account # 9432108800197691

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 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: Michael Szobla Date: 4-17-19



Enhanced MEC_Plan 1



Benefits Enrollment Form New Employee Rehire Rehire Date

Employee Information

| | | | | | |
|--|---|------------------------------------|--|--------------------------------|--|
| Name (First and Last) Michael Szabla | | | Social Security Number 477-90-5672 | | |
| Address 14124 Pineview Drive | | City Becker | State MN | Zip Code 55308 | |
| Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced | Date of Birth 04/16/1965 | | Date of Hire 4/17/19 | |
| Phone Number: (763)250-4106 | | Email Address: | | | |

Please Select Desired Coverage:

Employee Only - \$27.00/Week
 Employee+Spouse - \$41.00/Week
 Employee+Child(ren) - \$39.00/Week
 Family - \$66.00/Week

Dependent

| | | | | | | |
|------------|------|-----------|-------------------|------------|---|---|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
|------------|------|-----------|-------------------|------------|---|---|

Dependent

| | | | | | | |
|------------|------|-----------|-------------------|------------|---|---|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
|------------|------|-----------|-------------------|------------|---|---|

Dependent

| | | | | | | |
|------------|------|-----------|-------------------|------------|---|---|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
|------------|------|-----------|-------------------|------------|---|---|

Other coverage information including Medicare/Medicaid

| | |
|---------------------------------------|-----------|
| NAME OF PERSON COVERED (FIRST, LAST): | 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  Date 

EMPLOYEES DECLINING I am DECLINING 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 **4-17-19**