



SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2016067103058HZ

Report Prepared: 03/07/2016

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Mohamud

First Name: Abdifatah

Date of Birth: 01/01/1994

Social Security Number: *** ** 3523

Hire Date: 03/07/2016

Citizenship Status: A lawful permanent resident

Document Information

List A Document: Arrival/Departure Record (Form I-94) with temporary I-551 stamp or refugee admission stamp (receipt)

Alien Number: 212457834

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 03/07/2016

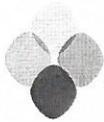
Case Submitted By: JEIC3094

Closed On: 03/07/2016

Closed By: JEIC3094

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

SENSITIVE BUT UNCLASSIFIED



employer solutions staffing group LLC
Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405
Edina, MN 55439
Tel: 952.835.1288 • Fax: 952.835.1255
www.esgstaffingsolutions.com

New Hire Application

Personal Data-- **PLEASE PRINT LEGIBLY IN INK**

Last Name Mohamud First Name Abdi Fatah Middle Initial B

Street Address 1450 5th Avenue S Apt/Ste 303

City/State/Zip St Cloud MN 56303

Phone Number 612 226 02 47 Email Address Abdi.fatah.mohamud@1234@hotmail.com

Staffing Agency/Recruitment Partner _____

All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

Are you legally authorized to work in the United States of America? YES NO

Applicant Certification and Authorization

I authorize Employer Solutions Staffing Group (ESSG) to use the information and statements contained in this application to determine my qualifications for employment. I authorize ESSG to make inquiries of my former employers, except as indicated in this application, regarding my previous duties, responsibilities, performance, compensation and eligibility for rehire.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.

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

I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

If hired, I agree to abide by the policies and procedures of ESSG.

Abdi Fatah Mohamud
Name (Print or type)

Abdi Fatah
Applicant's Signature

02/07/16
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 _____	

UNITED STATES OF AMERICA EMPLOYMENT AUTHORIZATION CARD

MOHAMUD ABDIFATAH B 01 JAN 1994



Surname: MOHAMUD
Given Name: ABDIFATAH B
USCIS#: 212-457-834 Category Card#: A03 LIN1513350337
Country of Birth: Ethiopia
Terms and Conditions: None
Date of Birth: 01 JAN 1994 Sex: M
Valid From: 05/02/15
Card Expires: 05/01/17

Signature Waived

fingerprint not available

NOT VALID FOR REENTRY TO U.S.

SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA

SOCIAL SECURITY

708-86-3523

THIS NUMBER HAS BEEN ESTABLISHED FOR
ABDIFATAH BEDEL
MOHAMUD

Abdifatah

SIGNATURE

USA 04/29/2015

26124683



**U.S. Citizenship
and Immigration
Services**

This card is not evidence of U.S. citizenship or permanent residence.
This document is void if altered, and may be revoked by the U.S. Government.
The person identified is authorized to work in the U.S. for the validity of this card.

FORM I-765 Rev. (10-2014)

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If found, drop in any US Mailbox. USPS: Mail to USCIS, PO Box 82521, Lincoln, NE 68501-2521

IAUSA2124578348LIN1513350337<<
9401013M1705014ETH<<<<<<<<<<<<5
MOHAMUD<<ABDI FATAH<BEDEL<<<<<<

Form W-4 (2016)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent **A** _____

B Enter "1" if:
 { • You are single and have only one job; or
 • You are married, have only one job, and your spouse does not work; or
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } **B** _____

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** 3

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

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

F Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) **F** _____

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
 • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children.
 • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child **G** _____

H Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ► **H** _____

For accuracy, complete all worksheets that apply.

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

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

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2016
► 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.				
1 Your first name and middle initial Abdallah B		Last name Mohamed		2 Your social security number 708 86 3523
Home address (number and street or rural route) 14505th Ave S #203			3 <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code St Cloud MN 56301			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. <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5 <u>3</u>
6 Additional amount, if any, you want withheld from each paycheck				6 \$
7 I claim exemption from withholding for 2016, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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.				
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>Abdallah B</i>				Date ► 03/07/16
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)			9 Office code (optional)	10 Employer identification number (EIN)



Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

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

Mohammed, Abdifatah B

List A Identify and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title: <i>Employee Auth.</i>		Document Title:		Document Title:
Issuing Authority: <i>USA</i>		Issuing Authority:		Issuing Authority:
Document Number: <i>212-957-834</i>		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy): <i>05/01/2017</i>		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): *03/07/2016* (See instructions for exemptions.)

Signature of Employer or Authorized Representative <i>Bill Eickler</i>		Date (mm/dd/yyyy) <i>03/07/2016</i>	Title of Employer or Authorized Representative <i>ON Site</i>	
Last Name (Family Name) <i>Eickler, Bill</i>	First Name (Given Name)	Employer's Business or Organization Name EMPLOYER SOLUTIONS STAFFING GROUP LLC		
Employer's Business or Organization Address (Street Number and Name) 7301 OHMS LANE SUITE 405		City or Town EDINA	State MN	Zip Code 55439

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

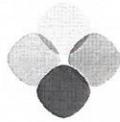
A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
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C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
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employer solutions staffing group llc

Leveraging Resources in a Changing Market

Direct Deposit/Payroll Debit Card Authorization

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

SECTION 1 BASIC INFORMATION

Employee Name	<i>Abdifatah Mohamud</i>	SSN# (last 4 digits)	<i>3523</i>	Effective Date
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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: *wellstar bank*

Routing#: *091300010*

Account#: *1642037061*

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 *AM* Date *03/07/16*

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

SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

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

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

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

First Name	M.I.	Last Name	Date of Birth
Street Address (PO BOX NOT ACCEPTABLE)			Social Security#
City	State	Zip	Cell Phone (mobile)

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

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

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

Payroll Debit Card Routing #	Payroll Debit Card Account #
<i>073972181</i>	_____

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: *Abdifatah mohamud 1234 @ hotmail.com*
 this information will only be used to send your paystubs electronically

Employee's Signature: *X Abdifatah* Date: *03/07/16*

WELLS FARGO BANK

SAINT CLOUD SOUTH 200 33RD AVE S SAINT CLOUD, MN 56301

2000

DATE

77-10913

PAY TO THE ORDER OF

VOID

\$

DOLLARS

ABDIFATAH B MOHAMUD
803 S VINE ST APT. 1
GRAND ISLAND NE 68801-8057

⑆09⑆3000⑆10⑆164203706⑆1⑆2000

New Employee
Rehire Rehire Date _____

For Status Change Please Check: **You MUST provide a supporting Document**
 Change of Status Birth/ Spouse Loss of Coverage Plan
 Adoption Change
 Marriage Cancel Employee/Dependents
 Divorce
 Date of Status Change: _____

Benefits Enrollment Form

Employee Information			
Name (Last, First, MI) <u>Mohamud Abdifatah B</u>		Date of Birth <u>01-01-1994</u>	Social Security Number
Address <u>1450 5th Ave S #303</u>		City <u>St Cloud</u>	State <u>MN</u>
Zip Code <u>56301</u>	Gender <input checked="" type="radio"/> Male <input type="radio"/> Female	Marital Status Married <input type="radio"/> Single <input checked="" type="radio"/> Divorced <input type="radio"/>	Phone Number: <u>612-226 0247</u>
Please Select Coverage Elected: Enhanced MEC Plan Coverage Level :		Email Address: <u>Abdifatah mohamud 1234@bpa.com</u>	
Single - \$24.00/Week		Employee+Spouse - \$38.00/Week	
		Employee+Child(ren) - \$36.00/Week	
		Family - \$63.00/Week	

Dependent Information				
Dependent				
Last Name <u>Abdifatah</u>	First Name <u>Abdifatah</u>	M.I. <u>Abdifatah</u>	Sex <input checked="" type="radio"/> Male <input type="radio"/> Female	Birth Date
Social Security #			Medical	Coverage Elected
				Add (Enroll) Change, or Terminate
				Add Change Waive Terminate
Dependent				
Last Name	First Name	M.I.	Sex	Birth Date
Social Security #			Male Female	Coverage Elected
				Add (Enroll) Change, or Terminate
				Add Change Waive Terminate
Dependent				
Last Name	First Name	M.I.	Sex	Birth Date
Social Security #			Male Female	Coverage Elected
				Add (Enroll) Change, or Terminate
				Add Change Waive Terminate

Other coverage information including Medicare/Medicaid
 NAME OF PERSON COVERED (LAST, FIRST, MI):

 EFF. DATE

 EFF. DATE

 EFF. DATE

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

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature X  Date 03/07/2016

EMPLOYEES DECLINING Declining due to other coverage.

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

IF DECLINING- YOU MUST SIGN HERE

Employee Signature X  Abdifatah mohamud Date 03/07/2016

ENROLLMENT FORM - PLAN 2

ESC UNAV P2 v15.1

REQUIRED EMPLOYEE INFORMATION

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

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Name _____

Street Address _____

City _____ State ____ Zip _____

Home Phone _____

Do you or any dependents have Medicare? _____

Yes No If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date ____/____/____

Names of Covered Person(s)

1. _____

2. _____

3. _____

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex M F

Relationship: Spouse Child Domestic Partner

BENEFIT SELECTION **Weekly Rates**

SELECT COVERAGE LEVEL

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

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

FIXED INDEMNITY MEDICAL

YES \$20.91 Employee Only
 YES \$42.44 Employee + 1
 NO \$56.67 Employee + Family

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL

YES \$6.17 Employee Only
 YES \$12.34 Employee + 1
 NO \$20.36 Employee + Family

TERM LIFE

YES \$0.60 Employee Only
 YES \$0.90 Employee + 1
 NO \$1.80 Employee + Family

SHORT-TERM DISABILITY

YES
 NO \$4.20 Employee Only

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

BENEFICIARY INFORMATION

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

NAME OF BENEFICIARY

RELATIONSHIP

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

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

Signature _____ Date ____/____/____

EMERGENCY CONTACT INFORMATION

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

Employee Name: Abdulah Mohamed
Address: 1450 5th Ave S Apt 303
Home Phone: 612-226 0247

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1	Home Phone:
Name: <u>Alexander Bili</u>	Cell Phone: <u>612 607 4536</u>
Relationship: <u>friend</u>	Work Phone:
Contact #2	Home Phone:
Name: <u>Abdiaziz Bili</u>	Cell Phone: <u>612-298 9201</u>
Relationship: <u>friend</u>	Work Phone:

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