



employer solutions staffing group

# New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name SALAN First Name Abdullahi Middle Initial M  
 Street Address 2905 COL FAX AVE MINNAPOLIS Apt/Ste \_\_\_\_\_  
 City/State/Zip 55411 Social Security Last Four XXX-XX-  
 Phone Number 3155278858 Email Address SULDAN1986@HOTMAIL  
 Staffing Agency/Recruitment Partner Jeymi Campos

**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.

Abdullahi  
Name (Print or type)

[Signature]  
Applicant's Signature

07/19/2018  
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 _____	

# Form W-4 (2018)

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](http://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 2018 if both of the following apply.

For 2017 you had a right to a refund of all federal income tax withheld because you had no tax liability, and

For 2018 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 2018 expires February 15, 2019. 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 2018 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](http://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 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 2018. 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 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, 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 Other Income Worksheet on page 3 or the calculator at [www.irs.gov/W4App](http://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](http://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 can 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 might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. 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, during the year.

**Line F. Credit for other dependents.** When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. 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 income includes all of

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

Form <b>W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074	
		▶ 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.		<b>2018</b>	
1 Your first name and middle initial <b>Abdulahi M</b>		Last name <b>Salan</b>		2 Your social security number <b>890-67-3806</b>	
Home address (number and street or rural route) <b>2905 Golfaxave W #2</b>		3 <input type="checkbox"/> Single <input checked="" 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 <b>Minneapolis MN 55411</b>		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 <b>4</b>	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2018, and I certify that I meet both of the following conditions for exemption. <input checked="" type="checkbox"/> Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and <input type="checkbox"/> 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	
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.) ▶ <b>[Signature]</b>		Date ▶ <b>08/01/2018</b>			
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) <b>Salan</b>		First Name (Given Name) <b>Abdullahi</b>		Middle Initial <b>M</b>	Other Last Names Used (if any) <b>N/A</b>	
Address (Street Number and Name) <b>2905 Colfax Ave N</b>			Apt. Number <b>2</b>	City or Town <b>Minneapolis</b>		State <b>MN</b>
Date of Birth (mm/dd/yyyy) <b>01/01/1986</b>		U.S. Social Security Number <b>390-67-7806</b>		Employee's E-mail Address <b>N/A</b>		Employee's Telephone Number <b>N/A</b>
				State <b>MN</b>	ZIP Code <b>55411</b>	

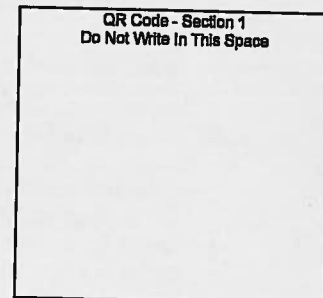
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

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

- 1. A citizen of the United States
- 2. A noncitizen national of the United States (See instructions)
- 3. A lawful permanent resident (Alien Registration Number/USCIS Number): **212-107-084**
- 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): \_\_\_\_\_  
Some aliens may write "N/A" in the expiration date field. (See instructions)

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: \_\_\_\_\_  
**OR**
- 2. Form I-94 Admission Number: \_\_\_\_\_  
**OR**
- 3. Foreign Passport Number: \_\_\_\_\_  
Country of Issuance: \_\_\_\_\_



Signature of Employee <b>[Signature]</b>	Today's Date (mm/dd/yyyy) <b>07/19/2018</b>
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**Preparer and/or Translator Certification (check one):**

I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
 (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator <b>[Signature]</b>		Today's Date (mm/dd/yyyy) <b>07/19/2018</b>	
Last Name (Family Name) <b>Campos</b>		First Name (Given Name) <b>Jeymi</b>	
Address (Street Number and Name) <b>373 Pond Court S.</b>		City or Town <b>St. Paul</b>	State <b>MN</b>
		ZIP Code <b>55119</b>	

SECP Employer Completes Next Page SECP



**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) <b>Salan</b>	First Name (Given Name) <b>Abdullahi</b>	M.I. <b>M</b>	Citizenship/Immigration Status <b>3</b>
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<b>List A</b>	<b>OR</b>	<b>List B</b>	<b>AND</b>	<b>List C</b>
<b>Identity and Employment Authorization</b>		<b>Identity</b>		<b>Employment Authorization</b>
Document Title <b>Fam. Resident Card (Form I-251)</b>		Document Title		Document Title
Issuing Authority <b>USCIS</b>		Issuing Authority		Issuing Authority
Document Number <b>1060901435995</b>		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy) <b>10/16/2027</b>		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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

The employee's first day of employment (mm/dd/yyyy): **07/19/2018** (See instructions for exemptions)

Signature of Employer or Authorized Representative <i>[Signature]</i>	Today's Date (mm/dd/yyyy) <b>07/19/2018</b>	Title of Employer or Authorized Representative <b>On-site HR Rep.</b>	
Last Name of Employer or Authorized Representative <b>Caupos</b>	First Name of Employer or Authorized Representative <b>Heuer</b>	Employer's Business or Organization Name <b>EMPLOYER SOLUTIONS STAFFING GROUP LLC</b>	
Employer's Business or Organization Address (Street Number and Name) <b>7480 FLYING CLOUD DRIVE SUITE 200</b>	City or Town <b>EDEN PRAIRIE</b>	State <b>MN</b>	ZIP Code <b>55344</b>

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

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
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)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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EMPLOYER SOLUTIONS STAFFING GROUP  
BACKGROUND CHECK AUTHORIZATION

Employee Name: abdullah . Mahamud Salan  
(First) (Middle) (Last)

Former Name(s) and Dates Used: \_\_\_\_\_

Current Address Since: 2905 Colfax AVE N 2 Minneapolis MN 554  
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: \_\_\_\_\_  
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: \_\_\_\_\_  
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: 390-67-7806 DOB: 01/01/1980

Phone Number: 612-527-8858

Driver's License Number/State: \_\_\_\_\_

The information contained in this application is correct to the best of my knowledge.

I hereby authorize Employer Solutions Staffing Group, LLC and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Employer Solutions Staffing Group, LLC or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Employer Solutions Staffing Group, LLC and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: [Signature] Date: 8/20/18

**Notice to CA, MN, and OK Residents:**

Please check the box below if you wish to receive a copy of a consumer report that is requested.

I wish to receive a copy of any Background Check Report on me that is requested.

# EMERGENCY CONTACT INFORMATION

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

Employee Name: abdullahi Salan

Address: 2905 COL FAX HAVENNEA POSCI

Home Phone: 3155278858

## EMERGENCY CONTACTS

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

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
<p style="text-align: center;"><b>Contact #1</b></p> <p>Name: <u>JAMAAL</u></p> <p>Relationship: <u>FAN</u></p>	<p>Home Phone:</p> <p>Cell Phone: <u>6129870781</u></p> <p>Work Phone:</p>
<p style="text-align: center;"><b>Contact #2</b></p> <p>Name:</p> <p>Relationship:</p>	<p>Home Phone:</p> <p>Cell Phone:</p> <p>Work Phone:</p>

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

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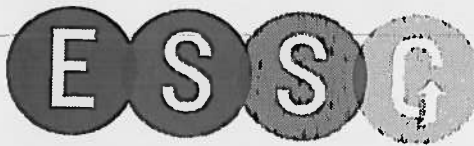
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*This information will remain confidential and will only be used in the case of an emergency.*



employer solutions staffing group.  
**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: Abdullah Salan      SSN# (last 4 digits): 7806      Effective Date: 8/2018

**SECTION 2 PAYROLL ELECTION**

Direct Deposit (Please complete Sections 3 and 5 below)  
 Payroll Debit Card (Please complete Sections 4 and 5 below)       Paper Check (Option available to GA NH and NY residents only)

**SECTION 3 DIRECT DEPOSIT**

Update Bank Account

Bank Name: \_\_\_\_\_

Routing#: \_\_\_\_\_

Account#: \_\_\_\_\_

Account Type:     Checking     Savings     Other \_\_\_\_\_

*Note: Direct Deposit accounts may take up to 7 days to be activated.*

**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**

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 # \_\_\_\_\_ 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: AS      Date: 8/2018

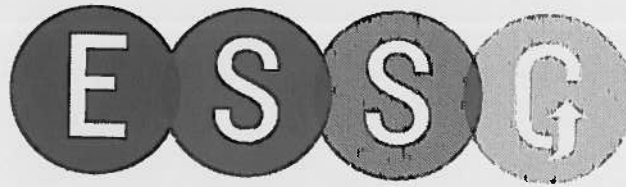
**SECTION 5 AUTHORIZATION**

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: \_\_\_\_\_





employer solutions staffing group<sub>uc</sub>

## **INJURY MANAGEMENT PROGRAM**

### **Injured Worker's Responsibilities**

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

#### **RESPONSIBILITIES OF THE INJURED WORKER:**

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

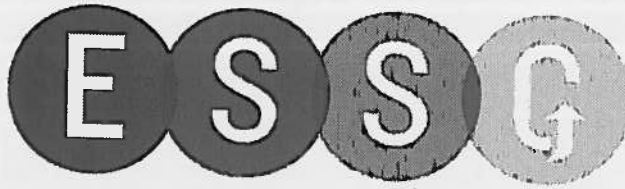
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

I have read my responsibilities and agree to abide by these guidelines.

Signed: Yim

Printed Name: Xabduhah Sa'lan



employer solutions staffing group, c.

## Important/Importante

### LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between \$25-\$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the police report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

### CHEQUES DE PAGO PERDIDOS O ROBADOS

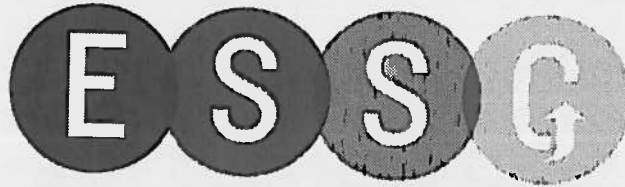
Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Abdullahi

Signature/Firma: [Handwritten Signature]



employer solutions staffing group<sub>uc</sub>

## **ESSG WORKPLACE SAFETY POLICY**

It is ESSG's policy that all employees should be able to enjoy a hazard free and safe work environment. It is ESSG's duty to:

- (1) Ensure that its clients provide you with a workplace free from serious recognized hazards and comply with standards, rules and regulations issued under the OSH Act.
- (2) Ensure that its clients perform a job hazard assessment in order to identify and eliminate potential safety and health hazards and to determine necessary training and protections for employees at the facility.
- (3) Make sure employees have and use safe tools and equipment.
- (4) Establish or update operating procedures and communicate them so that employees follow safety and health requirements.
- (5) Provide safety training in a language and vocabulary workers can understand.

ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

To help ensure a safe workplace, you have certain responsibilities too, which include the following:

- Responsibility to work in compliance with OSHA laws and regulations
- Responsibility to use personal protective equipment and clothing as directed by the host employer
- Responsibility to report workplace hazards and dangers
- Responsibility to work in a manner as required by the employer and use the prescribed safety equipment.

You have the following basic rights:

- Right to refuse unsafe work
- Right to know or be informed about actual and potential dangers in the workplace
- Right to review copies of appropriate standards, rules, regulations and requirements that the host employer is required to have available at the workplace.



employer solutions staffing group<sub>llc</sub>

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### Acknowledgement of Receipt of Workplace Safety Policy

I certify that I have received a copy of Employer Solutions Staffing Group's ESSG WORKPLACE SAFETY POLICY. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at 952.835.1288/1.866.496.7573 with any questions I may have about this policy. I agree to comply with ESSG's policy on ESSG WORKPLACE SAFETY POLICY and I understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am believe that I am working in an unsafe or dangerous work environment, I will immediately contact my supervisor, manager, director or ESSG's Safety Director at 952.835.1288/1.866.496.7573 in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

abdullah

Employee's Signature:

[Signature]

Date: 8/2/18

# Pre-Screening Notice and Certification Request for the Work Opportunity Credit

Information about Form 8850 and its separate instructions is at [www.irs.gov/form8850](http://www.irs.gov/form8850).

**Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.**

Your name \_\_\_\_\_ Social security number ► \_\_\_\_\_  
Street address where you live \_\_\_\_\_  
City or town, state, and ZIP code \_\_\_\_\_  
County \_\_\_\_\_ Telephone number \_\_\_\_\_  
If you are under age 40, enter your date of birth (month, day, year) \_\_\_\_\_

- 1  Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2  Check here if any of the following statements apply to you.
  - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
  - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
  - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
  - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
    - a. Received SNAP benefits (food stamps) for the past 6 months; or
    - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
  - During the past year, I was convicted of a felony or released from prison for a felony.
  - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
  - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3  Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4  Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5  Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6  Check here if you are a member of a family that:
  - Received TANF payments for at least the past 18 months; or
  - Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; or
  - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.
- 7  Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

**Signature—All Applicants Must Sign**

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► *[Signature]*

Date *8/18/18*

**EMPLOYER SECTION:**

<b>Client:</b>	<b>Company:</b>		
<b>Location:</b>	<b>Position:</b>	<b>Starting Wage: \$</b>	

**EMPLOYEE SECTION:**

<b>First Name: Last Name:</b>	<b>Suffix:</b>	<b>Street Address:</b>		<b>City/State:</b>	<b>Zip:</b>
<b>SS#:</b>	<b>Date of Birth:</b>	<b>Age:</b>	<b>Have you worked for this company before?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>If yes, location:</b>	

Please complete all questions, and sign and date the form.

	Yes	No
<p><b>1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?</b> (If yes, please provide information below.)                      Name of the person receiving benefits: _____ Relationship to you: _____                      City: _____ County: _____ State: _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?</b> (If yes, please provide information below.)                      Name of the person receiving benefits: _____ Relationship to you: _____                      City: _____ County: _____ State: _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?</b>                      Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits.  <i>*If you checked yes please provide a copy of your SSI documentation.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>4. Have you received any type of vocational rehabilitation services within the past two years?</b>                      If yes, please indicate which type of agency you worked with and provide their location information below:  <input type="checkbox"/> Vocational Rehabilitation Agency    <input type="checkbox"/> Dept. of Veterans Affairs    <input type="checkbox"/> Employment Network (Ticket to Work Program)                      Name of Agency: _____ Phone #: _____                      City: _____ County: _____ State: _____  <i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>5. Are you a Veteran of the U.S. Military?</b> <i>*If yes, please provide a copy of your DD-214 and letter of separation.</i>                      (If yes, please provide information below. If no, please continue to question #6.)                      Dates of Service - From: _____ To: _____                      Branch of Service: _____  <b>Are you entitled to or are you receiving compensation for a service-connected disability?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>6. Have you been unemployed at any time during the last 12 months?</b>                      If yes, dates of unemployment - From: _____ To: _____  <b>Did you receive unemployment compensation at any point during your unemployment?</b>                      If yes, in which state did you receive unemployment compensation? _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</b>                      Conviction Date: _____ Release Date: _____                      Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Additional Tax Credits</b>		
<p><b>IEC (Native American):</b> Are you or your spouse a member of a Native American Tribe?  <i>If you checked yes please provide a copy of your CDIB card.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>CA Residents:</b> <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act?  <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?</p>		
<p><b>SC Residents:</b> <input type="checkbox"/> Do you receive Family Independence Benefits?</p>		

**PLEASE READ, SIGN, AND DATE:**

Under penalties of perjury, I declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. dba Retrotax), or the Department of Labor.

New Employee Signature: 

Date: 8/2018



**LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM**  
**Work Opportunity Tax Credit (WOTC) Program**

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

New Hire's Signature: UMM Date 8/2019

New Hire Name: abdullah

Social Security Number: 390677806

Employer Name: \_\_\_\_\_

Please check the statements below if they apply to you.

I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

I declare that I have been in a period of unemployment since \_\_\_\_\_  
(Enter start date)

**Privacy Act Notice:**

The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

**Public Burden Statement:**

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

Health Plan Options  
Employee **KEEPS**  
this page



## Two great plans to choose from!

SIGN UP IS AVAILABLE DURING YOUR  
FIRST 30 DAYS OF EMPLOYMENT

### Enhanced MEC\_Plan 1

- MEC wellness/preventive plans starting at \$24.00/week
- Covers 63 mandated benefits AND \$20 office visit copay, \$10 generic prescription drug copay, \$10 CVS Minute Clinic copay and more!
- Eliminates employee individual mandate tax for those enrolled
- Options for family coverage
- Weekly payroll deduction – month by month coverage
- Visit [www.essghealth.com](http://www.essghealth.com) for info and tools
- PHCS Network

### Fixed Indemnity\_Plan 2

- ESC Fixed Indemnity plans starting at \$20.25 per weekly payroll deduction
- Medical, Rx, vision and dental benefits
- Doctor office visit benefit of \$100 per day
- Wellness benefit of \$100
- No pre-existing condition limitations
- No waiting period or deductibles on medical
- First Health Network
- Unbundled choices-you do not need to have medical to choose the vision, dental, term life, or short term disability

ESSG offers a Enhanced Minimum Essential Coverage (Plan 1) which is administrated by Health EZ. The Minimum Essential Coverage (MEC) plan is ACA qualifying. There are copays for services like doctor's visits, x-rays, and generic prescription drugs. Please note - hospitalization is not a covered benefit.

ESSG offers a Fixed Indemnity Plan (Plan 2) which is administrated by Planned Administrators Inc. (PAI). The Fixed Indemnity Plan offers limited benefits at an affordable price, specifically for the staffing industry. Premiums will be automatically deducted from your weekly paycheck. This means you are buying it with pre-tax dollars. What does pre-tax dollars mean? It simply means the premium comes out before taxes are taken out, which means you're taxed on less income. Affordable medical, dental, vision, disability, and life insurance benefits are available.

You have 30 days from the start of your employment to change your benefit elections.

The 3rd plan is offered to only qualifying employees\*. It's an ACA qualifying Bronze Plan with Essential StaffCARE (ESC). Once you qualify, you will be notified by ESC that you are eligible, and will be given the opportunity to enroll. You should receive this after you have been on assignment for approximately 35 - 45 days. The offer will be mailed to the address we have on file. It is your responsibility to update your address if needed.

If you have any questions, please contact the Health Benefits Team at Employer Solutions Staffing Group.

\*An employee will be deemed qualifying any time after 30 days on assignment(s), and their status is working 30+ hours per week or more than 1560 total hours in a calendar year. They must be ESSG employees.\*

---

Health Benefits Team  
Employer Solutions Staffing Group  
PO Box 46270 | Minneapolis, MN 55344  
Phone: 952-767-9519 | Fax: 952-767-9515  
[health@employersolutionsgroup.com](mailto:health@employersolutionsgroup.com)  
<http://ESSGHealth.com>



# Enhanced MEC\_Plan 1



Summary of Medical Benefits		
MEC EZ Plan		
	In-Network	Out-of-Network
Calendar Year Deductible	None	None
Coinsurance	None	None
Out-of-Pocket Maximum	None	None
Preventive Care	100% Covered	No Coverage
HealthiestYou Telemedicine Services	100% Covered	100% Covered
Primary Physician Office Visit	\$20 Copay	No Coverage
Specialist Office Visit	\$50 Copay	No Coverage
CVS Minute Clinic	\$10 Copay	No Coverage
Urgent Care	\$50 Copay	No Coverage
Emergency Services	No Coverage	No Coverage
Hospital Services – Inpatient & Outpatient Care	No Coverage	No Coverage
Mental Health / Chemical Dependency	No Coverage	No Coverage
Durable Medical Equipment	\$50 Copay	No Coverage
Lab & Scans		
Diagnostic Lab & X-Ray – In Office	\$60 Copay	No Coverage
CT/MRI or Outpatient Testing	\$200 Copay	No Coverage
Prescription Drug Coverage	Retail 30 Day Supply	Mail Order 90 Day Supply
Generic	\$10 Copay	No Coverage
Preferred Brand	100% Copay	No Coverage
Non-Preferred Brand	No Coverage	No Coverage
Specialty	No Coverage	No Coverage

### Weekly Premiums

Employee Only	\$24.00
Employee + Spouse	\$38.00
Employee + Child(ren)	\$36.00
Family	\$63.00

NOTES: This serves as a summary of your benefit plan only. Please refer to your Summary Plan Description for actual coverage, limitation and exclusion provisions.

## Fixed Indemnity Medical Benefits Plan 2

### LIMITED BENEFITS SUMMARY

Policy Number 219301-ESG-1

#### FIXED INDEMNITY MEDICAL BENEFIT

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by an accident or illness. If the covered event costs more, you pay the difference. But if the covered event costs less, you keep the difference.

#### Outpatient Benefits<sup>1</sup>

Physician Office Visit	\$100 per day
Diagnostic (Lab)	\$75 per day
Diagnostic (X-Ray)	\$200 per day
Ambulance Services	\$300 per day
Physical, Speech, or Occupational Therapy	\$50 per day
Emergency Room Benefit - Sickness	\$200 per day
Emergency Room Benefit - Accident	\$750 per day
Outpatient Surgery	\$750 per day
Anesthesiology	\$300 per day
Annual Outpatient Maximum	\$2,250

#### Inpatient Benefits

Standard Care	\$300 per day
Intensive Care Unit Maximum <sup>2</sup>	\$500 per day
Inpatient Surgery	\$3,500 per day
Anesthesiology	\$700 per day
Skilled Nursing <sup>3</sup>	\$100 per day
First Hospital Admission (1 per year)	\$250
Annual Inpatient Maximum <sup>4</sup>	No Limit

#### Wellness Care

Wellness Care (one per year)	\$100
Prescription Drugs (via reimbursement) <sup>5,6</sup>	
Annual Maximum	\$600
Per Day	\$30

<sup>1</sup> All outpatient benefits are subject to the outpatient maximum. <sup>2</sup> Pays in addition to standard care benefit<sup>1</sup> for stays in a skilled nursing facility after a hospital stay. <sup>3</sup> Subject to internal limits of plan. <sup>4</sup> Not subject to outpatient maximum. To file a claim for reimbursement, save your receipt and submit to Plan's Administrator, Inc.

COVERAGE	Waiting Period/Coinsurance	Annual Maximum Benefit	Deductible
Coverage A	None / 100%	\$750	\$50
Coverage B	3 Months / 60%	Exams, Cleanings, Intraoral Films and Bitewings	
Coverage C	12 Months / 50%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures	
		Periodontics, Crowns, Bridges, Endodontics and Dentures	

#### VISION BENEFIT

	In-Network		Out-of-Network	
	You Pay	Plan Pays	You Pay	Plan Pays
Eye Examination <sup>1</sup> (including dilation)	\$10 Copay	100%	100%	\$25
Exam Options (Standard or Premium Contact Lens Fit)	Up to \$55 or 10% off Retail Price	\$0	100%	up to \$40
Frames <sup>2</sup>	\$0 Copay, 80% after \$100 allowance	\$100 allowance, 20% off	100%	\$45
Standard Plastic Lenses (single, bifocal, trifocal) <sup>1</sup>	\$10 Co-pay	20% off retail	100%	\$25-\$55
Lens Options	\$15 Copay	-	100%	\$0
Contact Lenses (Conventional) <sup>1</sup>	\$0 Copay, 85% of remaining	\$80, plus 15% off	100%	\$64
Disposable Contact Lenses <sup>1</sup>	\$0 Copay	\$80 allowance	100%	\$0
Medically Necessary Contact Lenses <sup>1</sup>	\$0 Copay	100%	\$0	\$200

<sup>1</sup> Once every 12 months. <sup>2</sup> Once every 24 months.

#### TERM LIFE BENEFIT

Employee Amount	\$10,000 (reduces to \$7,500 at 65; \$5,000 at 70)	Child Amount (6 mos to 26 yrs old)	\$5,000
Spouse Amount	\$5,000 (terminates at age 70)	Infant Amount (15 days to 6 mos)	\$1,000

#### ACCIDENTAL DEATH & DISMEMBERMENT (AD&D is part of the Term Life Benefit.)

Employee Amount	\$20,000	Child Amount (6 mos to 26 yrs old)	\$5,000
Spouse Amount	\$20,000	Infant Amount (15 days to 6 mos)	\$2,500

#### SHORT-TERM DISABILITY BENEFIT

Benefit Amount	60% of Salary up to \$150 per week
Waiting Period/Maximum Benefit Period	7 days, up to 26 weeks

#### WEEKLY LIMITED BENEFITS PREMIUM

	Medical	Dental	Vision	Term Life	STD
Employee Only	\$20.25	\$6.17	\$2.42	\$0.60	\$4.20
Employee + 1	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family	\$54.88	\$20.36	\$6.56	\$1.80	

## LIMITED BENEFIT EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

### FIXED INDEMNITY MEDICAL

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
- Declared or undeclared war
- Serving on full-time active duty in the armed forces
- The covered person's commission of a felony
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions
- Hearing examinations or hearing aids
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force
- Services provided by a member of the covered person's immediate family.

The fixed indemnity medical plan is not available to residents of Hawaii, New Hampshire or Puerto Rico.

### DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

### VISION

No benefits are payable for services or materials connected with, or charges arising from:

- Orthoptic or vision training, sub-normal vision aids, and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes, or supporting structure;
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan;
- Services provided as a result of any Worker's Compensation law;
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount);

- Services or materials provided by any other group benefit providing for vision care;
- Two pair of glasses in lieu of bifocals.

### PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

### SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent, or a person who resides in your home
- Declared or undeclared war or act of war
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony
- Your participation in a riot
- If you engage in an illegal occupation
- Release of nuclear energy
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

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

### TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

For Accidental Death and Dismemberment benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

Attempted suicide or intentionally self-inflicted injury, bodily or mental infirmity; disease of any kind; or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound or accidental ingestion of poisonous food substance; voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you, your spouse or domestic partner; you, your spouse's or domestic partner's child; sibling or parent; or a person who resides in your home; declared or undeclared war or act of war; your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony; your participation in a riot; if you engage in an illegal occupation; release of nuclear energy; operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; work-related injury or sickness.

### Member Services:

For frequently asked questions and network information for the the Fixed Indemnity Medical Plan, please go to [www.essentialstaffcare.com/FAQVSI](http://www.essentialstaffcare.com/FAQVSI).

**PLEASE NOTE:** To make changes or cancel coverage by telephone call (800) 269-7783. Your pin code for enrolling/making changes is 140 + \_\_\_\_ (last four digits of your SSN). Your Company has chosen to take some/all of your payroll deductions on a Pre-Tax basis. Please contact Customer Service at 1-866-798-0803 and a Representative will assist you in identifying the deductions that are taken Pre-Tax.

**Essential StaffCARE Customer Service: 1-866-798-0803**

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets and to add, change, or cancel coverage.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit [www.paisc.com](http://www.paisc.com) and click on "Your Plan" and enter your group number.



## Frequently Asked Questions

### When can I enroll in a plan?

As a part-time or full-time employee, you are able to enroll within 30 days of your hire date, or during the annual open enrollment for the plan. If you do not enroll in one of those periods, you can only enroll if you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

### What is a qualifying life event?

A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Death of an immediate family member
- Loss of dependent status
- Loss of prior coverage

### When can I cancel off of the plan?

As our plans are pre-tax, you are only allowed to make changes/enroll/cancel during certain times of the year. The above listed times (your first 30 days of employment, during open enrollment, or within 30 days of a qualifying life event) are the only times you are able to change/enroll/cancel.

### If I fill out a form, and do not get placed on assignment right away, do I need to fill out a new form?

Your form will stay valid for 6 months. If you are placed on assignment after 6 months of the signature date, you will need to fill out a new form to enroll in the plans. If you worked for a period of time and had deductions, and then stopped working for 6 consecutive weeks, you are considered a re-hire, and would need to fill out a new form to re-enroll. If you miss less than 6 consecutive weeks, the Fixed Indemnity insurance will continue without penalty or the need to re-enroll. After 3 missed weeks the Enhanced MEC coverage will be cancelled.

### When will my deductions start and coverage begin?

Fixed Indemnity Plan – Deductions will begin about 2 weeks after we at ESSG receive the form, coverage will begin the Monday following the first deduction

Enhanced MEC Plan – Deductions will begin the first of the month after we at ESSG receive the form, coverage will begin on the first of the month following one month of deductions

### When will I receive my insurance card?

Fixed Indemnity Plan – It should come about a week after your first deduction.

Enhanced MEC Plan – It should come about 10 days prior to your effective date.

### Additional Fixed Indemnity Plan Information:

This plan does not qualify as minimum essential coverage as defined under the Affordable Care Act (ACA). This plan is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.

The Essential StaffCARE Fixed Indemnity Medical, Prescription Drug, and Dental Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1801, 26.212, and 26.213. The Term Life, Accidental Death and Dismemberment and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200. The Vision Plan is underwritten by Companion Life Insurance Company.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-793-0808.



**Essential StaffCARE**

ESG ESC CU(UNAC-MN) P1 v18.2



# Enhanced MEC\_Plan 1



Benefits Enrollment Form **New Employee** Rehire Rehire Date

<b>Employee Information</b>	
Name (First and Last)	Social Security Number
Address	City State Zip Code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Birth Date of Hire
Phone Number	Email Address

**Please Select Desired Coverage:**  
 Employee Only - \$24.00/Week  
 Employee+Spouse - \$38.00/Week  
 Employee+Child(ren) - \$38.00/Week  
 Family - \$93.00/Week

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

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 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 or 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 *XLM* Date *8/12/07*

Employer Solutions Staffing Group Health Benefits Team  
 PO Box 46270  
 Minneapolis, MN 55344  
 Phone: 952-767-8519 Fax: 952-767-8515  
 Email: Health@employersolutionsgroup.com

**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

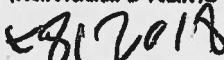
1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.



\_\_\_\_\_  
Individual's Name



\_\_\_\_\_  
Date

**SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6**

# Fixed Indemnity Medical Benefits Plan 2

VSI 2193D1-ESG-1 OFFICE USE ONLY LOCATION \_\_\_\_\_ Rehire Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ENROLLMENT FORM

ESC OJ(U)NAC-MN) P1 v16.2

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

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Medicare Health Insurance Claim Number (HICN) \_\_\_\_\_ Medicare Effective Date \_\_\_\_\_

Name of Covered Person (s):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

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

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL <sup>1</sup>	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY <sup>2</sup>
Employee Only <input type="checkbox"/>	\$20.25 <input type="checkbox"/>	\$6.17 <input type="checkbox"/>	\$2.42 <input type="checkbox"/>	\$0.60 <input type="checkbox"/>	\$4.20 <input type="checkbox"/>
Employee + 1 <input type="checkbox"/>	\$41.10 <input type="checkbox"/>	\$12.34 <input type="checkbox"/>	\$4.92 <input type="checkbox"/>	\$0.90 <input type="checkbox"/>	
Employee + Family <input type="checkbox"/>	\$54.88 <input type="checkbox"/>	\$20.36 <input type="checkbox"/>	\$6.56 <input type="checkbox"/>	\$1.80 <input type="checkbox"/>	
NO to ALL Benefits <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<sup>1</sup>This coverage is not available to residents of NH, HI, or PR. <sup>2</sup>STD is not available to persons who work in CA, HI, NJ, NY, or RI. For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

**D. REQUIRED DEPENDENT INFORMATION**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F  Relationship  Spouse  Child  Domestic Partner

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F  Relationship  Spouse  Child  Domestic Partner

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F  Relationship  Spouse  Child  Domestic Partner

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F  Relationship  Spouse  Child  Domestic Partner

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

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.

DATE 12/10/11 SIGNATURE [Signature]