



SENSITIVE BUT UNCLASSIFIED

**Case Verification Number: 2017073152434NE**

Report Prepared: 03/14/2017

**Company Information**

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Company ID: 47429

Company Name: Employer Solutions Staffing Group

**Employee Information**

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Last Name: Nunnery

First Name: Brittany

Date of Birth: 12/21/1994

Social Security Number: \*\*\* \*\* 6402

Hire Date: 03/14/2017

Citizenship Status: A citizen of the United States

**Document Information**

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List B Document: Driver's license or ID card issued by a U.S. state or outlying possession

List C Document: Social Security Card

Document Name: ID card

Document State: Minnesota

Driver's License or ID Card Number:

Document Expiration Date: 12/21/2020

**Case Status Information**

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Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 03/14/2017

Case Submitted By: AFIN3846

Closed On: 03/14/2017

Closed By: AFIN3846

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

SENSITIVE BUT UNCLASSIFIED

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# New Hire Application

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

Last Name Nunnery First Name Brittany Middle Initial D  
 Street Address 423 University Ave W Apt/Ste A  
 City/State/Zip St Paul 55103 Social Security Last Four XXX-XX-0402  
 Phone Number 651-346-9977 Email Address BrittanyNunnery@yahoo.com  
 Staffing Agency/Recruitment Partner CMG

**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.

Brittany Nunnery Name (Print or type) Brittany Nunnery Applicant's Signature 3/15/17 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 (2017)

**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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total 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 don't apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you aren't 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 2017. 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](http://www.irs.gov/w4).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for yourself if no one else can claim you as a dependent . . . . .	<b>A</b>	<u>1</u>
<b>B</b>	Enter "1" if: { • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } . . . . .	<b>B</b>	<u>0</u>
<b>C</b>	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.) . . . . .	<b>C</b>	<u>0</u>
<b>D</b>	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	<u>1</u>
<b>E</b>	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . . .	<b>E</b>	<u>1</u>
<b>F</b>	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.)	<b>F</b>	<u>0</u>
<b>G</b>	<b>Child Tax Credit</b> (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.	<b>G</b>	<u>0</u>
<b>H</b>	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.) ▶	<b>H</b>	<u>3</u>

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 <b>W-4</b> Department of the Treasury Internal Revenue Service	<b>Employee's Withholding Allowance Certificate</b>	OMB No. 1545-0074 <b>2017</b>
▶ 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 <u>Brittany D</u>	Last name <u>Nunnery</u>	2 Your social security number <u>347-90-5402</u>
Home address (number and street or rural route) <u>423 University Ave W</u>		3 <input checked="" type="checkbox"/> Single <input 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 <u>St Paul 55103</u>		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 \$	<u>0</u>
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶		
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.) ▶ <u>Brittany Nunnery</u>		Date ▶ <u>3/15/17</u>
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)



**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.

Last Name (Family Name) <b>Nunnery</b>		First Name (Given Name) <b>Brittany</b>		Middle Initial <b>D</b>	Other Last Names Used (if any)	
Address (Street Number and Name) <b>423 University Ave W</b>			Apt. Number <b>A</b>	City or Town <b>St Paul</b>		State <b>MIN</b>
Date of Birth (mm/dd/yyyy) <b>12/21/1994</b>		U.S. Social Security Number <b>347-90-5402</b>		Employee's E-mail Address <b>brittany.nunnery@yahoo.com</b>		Employee's Telephone Number <b>651-346-9977</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):

<input checked="" type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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)	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:          An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____  <b>OR</b>          2. Form I-94 Admission Number: _____  <b>OR</b>          3. Foreign Passport Number: _____</p> <p>Country of Issuance: _____</p>	
OR Code - Section 1 Do Not Write in This Space	

Signature of Employee <b>Brittany Nunnery</b>	Today's Date (mm/dd/yyyy) <b>03/14/2007</b>
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I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

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



*Employer Completes Next Page*





**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**  
 Review the document(s) presented by the employee and determine if the 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.

<b>Employee info from Section 1</b>	<b>Last Name (Family Name)</b> Nunnery	<b>First Name (Given Name)</b> Brittany	<b>M.I.</b> D	<b>Citizenship/Immigration Status</b>
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**List A** OR **List B** AND **List C**  
**Identify and Employment Authorization**      **Identity**      **Employment Authorization**

<b>Document Title</b>	<b>Document Title</b> IDENTIFICATION CARD	<b>Document Title</b> Social Security Card
<b>Issuing Authority</b>	<b>Issuing Authority</b> State of Minnesota	<b>Issuing Authority</b> S.S.A
<b>Document Number</b>	<b>Document Number</b> H361083924010	<b>Document Number</b> 347-90-5402
<b>Expiration Date (if any)(mm/dd/yyyy)</b>	<b>Expiration Date (if any)(mm/dd/yyyy)</b> 12-21-2020	<b>Expiration Date (if any)(mm/dd/yyyy)</b> NA
<b>Document Title</b>	<b>Additional Information</b>	
<b>Issuing Authority</b>		
<b>Document Number</b>		
<b>Expiration Date (if any)(mm/dd/yyyy)</b>		
<b>Document Title</b>		
<b>Issuing Authority</b>	<b>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</b>	
<b>Document Number</b>		
<b>Expiration Date (if any)(mm/dd/yyyy)</b>		
<b>Document Title</b>		
<b>Issuing Authority</b>		
<b>Document Number</b>		
<b>Expiration Date (if any)(mm/dd/yyyy)</b>		

**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): 3.14.17 (See instructions for exemptions)

<b>Signature of Employer or Authorized Representative</b> Kate Ritter	<b>Today's Date(mm/dd/yyyy)</b> 3.14.17	<b>Title of Employer or Authorized Representative</b> On-site Rep.
<b>Last Name of Employer or Authorized Representative</b> Ritter	<b>First Name of Employer or Authorized Representative</b> Kate	<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> 7301 OHMS LANE SUITE 405	<b>City or Town</b> EDINA	<b>State</b> MN
		<b>ZIP Code</b> 55439

**Section 3: New Hire Information** (To be completed and signed by employer or authorized representative)

<b>Last Name (Family Name)</b>	<b>First Name (Given Name)</b>	<b>Middle Initial</b>	<b>Date of Hire (if applicable)</b>

**Q. 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.**

<b>Document Title</b>	<b>Document Number</b>	<b>Expiration Date (if any) (mm/dd/yyyy)</b>

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.

<b>Signature of Employer or Authorized Representative</b>	<b>Today's Date (mm/dd/yyyy)</b>	<b>Name of Employer or Authorized Representative</b>

**MINNESOTA**  
**IDENTIFICATION CARD**  
**NOT A DRIVER'S LICENSE**



BRITTANY DENISE NUNNERY  
 209 E 4TH ST #305  
 HASTINGS, MN 55033

Date of Birth 12-21-1984  
 Sex F Eye BRN Class ID  
 Height 5-8 Weight 126  
 ISSUED 04-2016 EXPIRES 12-21-2020

*Brittany Nunnery*

A381083924010

**SOCIAL SECURITY**

SOCIAL SECURITY  
 947-90-5402  
 THIS NUMBER HAS BEEN ESTABLISHED FOR  
 USA

BRITTANY DENISE NUNNERY

*Brittany Nunnery*  
 SIGNATURE





# employer solutions staffing group<sub>LLC</sub>

Leveraging Resources in a Changing Market

## Wage Payment Method Authorization (Minnesota)

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card.

If you do not provide a written election, wages will be paid by paper Check.

### SECTION 1 BASIC INFORMATION

Employee Name <u>Brittany Nunnery</u>	SSN# (last 4 digits) <u>5402</u>	Effective Date
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### SECTION 2 PAYROLL ELECTION

**Direct Deposit** (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated*

**Payroll Debit Card** (Please complete Sections 4 and 5 below)       **Paper Check** (Please complete Section 5 below)

### SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: Metabank

Routing# 073972181

Account# 7874100271447951

Account Type:  Checking  Savings  Other Debit

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 BN Date 3/15/17

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

### SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

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

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

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

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

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

Payroll Debit Card Routing # <u>073972181</u>	Payroll Debit Card Account # _____
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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: BrittanyNunnery@yahoo.com  
this information will only be used to send your paystubs electronically

Employee's Signature: Brittany Nunnery

Date: 3/15/17

# EMERGENCY CONTACT INFORMATION

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

Employee Name: Brittany Nunnery  
Address: 423 University Ave W3  
Home Phone: 651-346-9977

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
<b>Contact #1</b> Name: <u>Nicky Sheegog</u> Relationship: <u>Mother in law</u>	Home Phone: Cell Phone: <u>651-285-5125</u> Work Phone:
<b>Contact #2</b> Name: <u>Dashaun Harris</u> Relationship: <u>Boyfriend</u>	Home Phone: Cell Phone: <u>651-319-6819</u> Work Phone:

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

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# Enhanced MEC Plan Plan 1

Benefits Enrollment Form  New Employee  Rehire Rehire Date

<b>Employee Information</b>	
Name (First and Last) <i>Brittany Nunnery</i>	Social Security Number <i>347 905402</i>
Address <i>423 University Ave W</i>	City <i>St Paul</i>
State <i>MN</i>	Zip Code <i>55103</i>
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Date of Birth <i>12/21/1994</i>	Date of Hire
Phone Number <i>651-346-9977</i>	Email Address <i>BrittanyNunnery@yahoo.com</i>

**Please Select Desired Coverage:**

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

**Dependent**

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

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

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
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Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

EFF. DATE
EFF. DATE
EFF. DATE

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

**IF ENROLLING - YOU MUST SIGN HERE**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

EMPLOYEES DECLINING  I am DECLINING coverage

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

**IF DECLINING- YOU MUST SIGN HERE**

Employee Signature *Brittany Nunnery* Date *3/15/17*

Employer Solutions Staffing Group Health Benefits Team  
7301 Ohms Lane Suite 405  
Edina, MN 55439

Phone: 952-767-9519 Fax: 952-767-9515  
Email: Health@employersolutionsgroup.com

# Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION \_\_\_\_\_ Rehire Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION		PRINT USING BLACK or BLUE INK (Must Be Filled Out)			
Name	<i>Brittany Nunnery</i>	Social Security #	<i>347905402</i>	Home Phone	Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F
Address	<i>423 University Ave W</i>			Apt. #	<i>A</i>
City	<i>St Paul</i>	State	<i>MN</i>	Zip	<i>55103</i>
				Date of Birth	<i>12/21/1994</i>

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 <b>MUST</b> 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"/>	<b>\$20.25</b>	<b>\$6.17</b>	<b>\$2.42</b>	<b>\$0.60</b>	<b>\$4.20</b>	
Employee + 1 <input type="checkbox"/>	<b>\$41.10</b>	<b>\$12.34</b>	<b>\$4.92</b>	<b>\$0.90</b>		
Employee + Family <input type="checkbox"/>	<b>\$54.88</b>	<b>\$20.36</b>	<b>\$6.56</b>	<b>\$1.80</b>		
NO to ALL Benefits <input type="checkbox"/>	<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 <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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	<i>03/15/2017</i>	SIGNATURE <i>Brittany Nunnery</i>