



SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2017198154602GL

Report Prepared: 07/17/2017

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: ojulu

First Name: agebo

Date of Birth: 01/01/1981

Social Security Number: *** ** 4944

Hire Date: 07/17/2017

Citizenship Status: An alien authorized to work

Document Information

List A Document: Employment Authorization Document (Form I-786)

Alien Number: 212890322

Card Number: LIN1703860449

Document Expiration Date: 12/12/2018

Case Status Information

Current Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 07/17/2017

Case Submitted By: 8GLA6832

SENSITIVE BUT UNCLASSIFIED



employer solutions staffing group
Leveraging Resources in a Changing Market

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

New Hire Application

Personal Data - PLEASE PRINT LEGIBLY IN INK

Last Name OSULEW First Name AGERU Middle Initial D
 Street Address 1743 Thomas Ave Apt/Ste 5
 City/State/Zip Spaulding, MN, 55404 Social Security Last Four XXX-XX-4344
 Phone Number 651-404-3765 Email Address _____ @ _____
 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.

AGERU
Name (Print or type)

MMA
Applicant's Signature

6/20/17
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 _____
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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.

Personal Allowances Worksheet (Keep for your records.)

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

B Enter "1" if:
 • You'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** _____

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

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

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

F Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit **F** _____

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

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

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

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

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2017	
1 Your first name and middle initial AREBO D			Last name OTULY		
Home address (number and street or rural route) 1743 Thomas Ave			2 Your social security number 790-43-4344		
City or town, state, and ZIP code St Paul MN 55404			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.		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)			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"/>		
6 Additional amount, if any, you want withheld from each paycheck			5 2		
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.			6 \$		
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.					7
Employee's signature (This form is not valid unless you sign it.) 			Date 6/20/17		
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.

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) OJULIU		First Name (Given Name) AGEBO		Middle Initial O	Other Last Names Used (if any) Y	
Address (Street Number and Name) 1650 Marion Street			Apt. Number 303	City or Town St. Paul		State MN
Date of Birth (mm/dd/yyyy) 01-01-1981		U.S. Social Security Number 790-13-4364		Employee's E-mail Address		Employee's Telephone Number 6514043765
ZIP Code 55117						

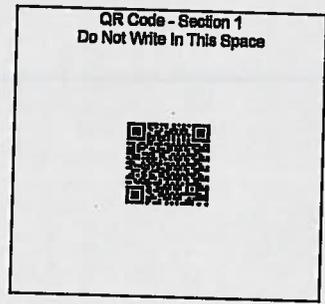
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

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):
- 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): N/A
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: **212-890-320**
 OR
 2. Form I-94 Admission Number: _____
 OR
 3. Foreign Passport Number: _____
 Country of issuance: _____



Signature of Employee: [Signature] Today's Date (mm/dd/yyyy): **7-17-2017**

Preparer and/or Translator Certification (check one):

- I did not use a preparer or translator.
- A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)
 I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator: _____ Today's Date (mm/dd/yyyy): _____

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

STOP Employer Completes Next Page **STOP**



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) Osulu	First Name (Given Name) Agebo	M.I. U	Citizenship/Immigration Status 4
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List A	OR	List B	AND	List C
Identity and Employment Authorization		Identity		Employment Authorization
Document Title <i>Employment Auth</i>		Document Title		Document Title
Issuing Authority <i>USA</i>		Issuing Authority		Issuing Authority
Document Number <i>LIN1703850449</i>		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy) <i>12-12-2018</i>		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Section 2 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): *07-17-2017* (See instructions for exemptions)

Signature of Employer or Authorized Representative <i>[Signature]</i>	Today's Date (mm/dd/yyyy) <i>07-17-2017</i>	Title of Employer or Authorized Representative Recruiter	
Last Name of Employer or Authorized Representative Glasby	First Name of Employer or Authorized Representative Shelby	Employer's Business or Organization Name Employer Solution Staffing Gro	
Employer's Business or Organization Address (Street Number and Name) 7480 Flying Cloud Drive Suite 200	City or Town Eden Prairie	State MN	ZIP Code 55344

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

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

Ⓒ. 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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UNITED STATES OF AMERICA

EMPLOYMENT AUTHORIZATION CARD

VALID ACCORD TO JAN 1998



X m

Surname
OJULU

Given Name
AGEBO O

USCIS#
212-690-322

Category Code
A03

LIN1703050440

Country of Birth
Ethiopia

Terms and Conditions
None

Date of Birth
01 JAN 1965

Sex
F

Valid From
12/12/10

Card Expires
12/12/11



NOT VALID FOR REENTRY TO U.S.

EMERGENCY CONTACT INFORMATION

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

Employee Name: AGEBO OJUMA

Address: 1743 CHOMAS AVE ST PAUL MN

Home Phone: 657-2404-3765

EMERGENCY CONTACTS

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

Contact #1

Name: ANITA OJUMA

Relationship: COUSIN

Home Phone: 612-404-3765

Cell Phone: 612-404-3765

Work Phone:

Contact #2

Name:

Relationship:

Home Phone:

Cell Phone:

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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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 AGERD OTUM	SSN# (last 4 digits) 790-43-4344	Effective Date 6/20/2017
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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

**A
C
C
O
U
N
T**

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

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

Initial _____ Date _____

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

SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

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

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

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

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

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

Payroll Debit Card Routing # 073972181	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: _____@_____ this information will only be used to send your paystubs electronically

Employee's Signature: **X mm** Date: **06/20/17**



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STATEMENT OF CONFIDENTIALITY

This agreement made this 6 day of 20, 2017, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Agebo Ojula hereafter referred to as "employee".

WITNESSETH:

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

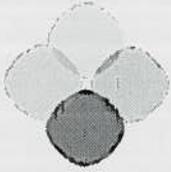
In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of \$10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

ms

Employee Signature

As D

Employer Solutions Staffing Group LLC, Representative



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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): AG-EB0 0 01111

Signature/Firma: mmj

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: MA

Printed Name: AG-EBQ O OJULU

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.

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

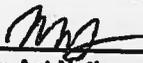
Your name AREBO Ogula Social security number ► 790-43-434
Street address where you live 1743 Thomas Ave #5
City or town, state, and ZIP code St Paul MN 55404
County Ramsey Telephone number 651-404-3765
If you are under age 40, enter your date of birth (month, day, year) _____

- 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 ►



Date 6/20/17

EMPLOYER SECTION:

Client: Employer Solutions Group	Company:	
Location:	Position:	Starting Wage: \$

EMPLOYEE SECTION:

Employee Name: AGEBO OJULU	Street Address: 1743 Thomas St	City/State: St Paul MN	Zip: 55409
SS#: 790-43-4346	Date of Birth: 01/01/1981	Age: 34	Have you worked for this company before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, location:

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

	Yes	No
1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. *If you checked yes please provide a copy of your SSI documentation.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Have you received any type of vocational rehabilitation services within the past two years? 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: _____ *If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Are you a Veteran of the U.S. Military? *If yes, please provide a copy of your DD-214 and letter of separation. (If yes, please provide information below. If no, please continue to question #6.) Dates of Service - From: ___/___/___ To: ___/___/___ Branch of Service: _____ Are you entitled to or are you receiving compensation for a service-connected disability?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Have you been unemployed at any time during the last 12 months? If yes, dates of unemployment - From: ___/___/___ To: ___/___/___ Did you receive unemployment compensation at any point during your unemployment? If yes, dates received unemployment compensation - From: ___/___/___ To: ___/___/___	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Conviction Date: ___/___/___ Release Date: ___/___/___ Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe?
 *If you checked yes please provide a copy of your CDIB card. Yes No

CA Residents: Are you the child of foster parents? Do you receive CalWorks? Workforce Investment Act?

Are you a migrant or seasonal farm worker? Have you ever been convicted of a misdemeanor?

SC Residents: Do you receive Family Independence Benefits?

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: MA

Date: 6/20/17

Qualified Long-Term Unemployment Recipient

ADDENDUM TO: IRS Form 8850 Pre-Screening Notice and Certification Request for the Work Opportunity Tax Credit

Client: Employer Solutions Group	Company:	
Location:	Employee Name: ALEBO	SS#: 790-43-4344

EMPLOYEE:

Please check the statement(s) that apply to you and sign where indicated below.

I have been unemployed at any time during the last 12 months.

If applicable, dates of unemployment - From: _____ To: _____
 From: ____/____/____ To: ____/____/____
 From: ____/____/____ To: ____/____/____

I received unemployment compensation during my unemployment.

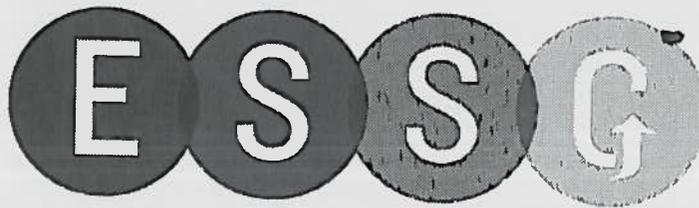
If applicable, dates you received compensation - From: _____ To: _____
 From: ____/____/____ To: ____/____/____
 From: ____/____/____ To: ____/____/____

Please read, sign, and date:

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

Employee Signature: 	Date: 6/20/17
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RetroTax[®]
 3730 Washington Blvd.
 Indianapolis, IN 46205
 317-925-0553
 wotc@retrotax-aci.com
 www.retrotax-aci.com



employer solutions staffing group_{uc}

**Notification of Minnesota Law Requirement –
Unemployment Acknowledgement**

According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment.

It is your responsibility to contact ESSG (for instance, by calling 952.277.5227 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. AO (Initial)

AO
Employee Signature:

6/20/17
Date:

AERO DILLI
Employee (please print your name here)

**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.

Agbe Ojulu
Individual's Name

6/20/17
Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6



ACKNOWLEDGMENT

The associate handbook was reviewed with me, and I have received my personal copy. I also acknowledge that I have been given the opportunity to ask questions and express concerns during my orientation. Additionally, I understand and support the following:

1. This handbook is intended as a guide and **not** an employment agreement that creates a contractual relationship, and that the employment relationship may be terminated at the will of either party at any time.
2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.
3. I agree to **notify** my ESSG Consultant **immediately** of any change in my personal data such as phone number, address, emergency notification, etc.
4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my ESSG Consultant.

Date:

6/21/17

Associate's Signature:

[Handwritten Signature]

Associate's Printed Name:

ALBERTO AQUINO

Orientation provided by:

[Handwritten Signature]

Enhanced MEC Plan Plan 1

Benefits Enrollment Form

New Employee Rehire Rehire Date _____

Employee Information

Name (First and Last) Agebo OJUUU			Social Security Number 790-43-4384		
Address 1743 Thomas Ave			City St. Paul	State MN	Zip Code 55404
Gender <input checked="" type="radio"/> Male <input checked="" type="radio"/> Female	Marital Status <input checked="" type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced	Date of Birth 01-01-1981	Date of Hire 06/20/2017		
Phone Number: 657-404-3765		Email Address: N/A			

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

Agebo O	0	0 July	790-43-4384	Male	Relationship Spouse Child Domestic Partner
--------------------	--------------	-------------------	------------------------	-----------------	--

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex Male Female	Relationship Spouse Child Domestic Partner
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First Name	M.I.	Last Name	Social Security #	Birth Date	Sex Male Female	Relationship Spouse Child 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 *[Signature]* Date *6/20/17*

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 *[Signature]* Date *6/20/17*

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	<u>HGEBO</u>	Social Security #	<u>790-43-4344</u>	Home Phone	<u>651-404-3765</u>
Address	<u>1743 Thomas Ave</u>	Sex	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	Apt. #	<u>5</u>
City	<u>St Paul</u>	State	<u>MN</u>	Zip	<u>55404</u>
		Date of Birth	<u>01/01/1981</u>		

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

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 ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only <input checked="" type="checkbox"/>	\$20.25 <input checked="" type="checkbox"/>	\$6.17 <input checked="" type="checkbox"/>	\$2.42 <input checked="" type="checkbox"/>	\$0.60 <input checked="" type="checkbox"/>	\$4.20 <input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				

¹This coverage is not available to residents of NH, HI, or PR. ²STD 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 Daniel Odde Relationship Cousin

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<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 6-12-2017 SIGNATURE [Signature]