



10000 Lake Ave. Suite 400  
Edina, MN 55439  
612-421-1200  
ESSG@ESSG.com

# New Hire Application

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

Last Name Oxello First Name Onof Middle Initial O  
 Street Address 1320 E St. Germain st Apt 63 Apt/Ste 63  
 City/State/Zip St. Cloud, MN 56304 Social Security Last Four XXX-XX-1069  
 Phone Number 320-291-7689 Email Address raucocomod @ hotmail.com  
 Staffing Agency/Recruitment Partner CMG-BIH

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

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

### Applicant Certification and Authorization

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

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

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

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

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

Onof Oxello  
Name (Print or type)

[Signature]  
Applicant's Signature

05/09/18  
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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**MINNESOTA**  
**DRIVER'S LICENSE**

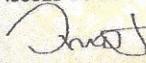


OMOT OCHOJI OKELLO  
1520 E ST GERMAIN ST APT 63  
ST CLOUD, MN 56304

Date of Birth **06-06-1992**  
Sex Eyes Class  
M BLK D  
Height Weight **DONOR** **M**  
6-2 145

ISSUED 03-2017 EXPIRES 06-06-2021

X404241817008



**SOCIAL SECURITY**

475-53-1069

THIS NUMBER HAS BEEN ESTABLISHED FOR

OMOT OCHOJI  
OKELLO

*Omot Okello*

SIGNATURE 10/28/2009



# 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 <i>Dmitri O</i>	Last name <i>Okello</i>	2 Your social security number <i>475-53-1069</i>	
Home address (number and street or rural route) <i>1520 E St. Germain St APT 63</i>		3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."		
City or town, state, and ZIP code <i>St. Cloud MN</i>		4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>		
5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5	<i>2</i>	
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 <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> 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.) ▶ <i>[Signature]</i>		Date ▶	<i>03/09/18</i>	
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)		9 First date of employment	10 Employer identification number (EIN)	

# 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 Omot Oreeo Social Security # 415-53-1069 Home Phone 320-291-7685 Sex  M  F  
 Address 1520 E St. Germain St Apt 63 Apt. # 63  
 City St Cloud State MN Zip 56304 Date of Birth 06/06/92

### 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 checked="" type="checkbox"/>	<u>\$20.25</u>	<u>\$6.17</u>	\$2.42	\$0.60	\$4.20
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
NO to ALL Benefits <input type="checkbox"/>	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" 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

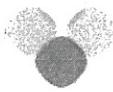
YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

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 06/14/2018 SIGNATURE \_\_\_\_\_

\*This Plan DOES NOT Alleviate the Individual Mandate Penalty\*

This is an Essential StaffCARE Enrollment Form.



# employer solutions staffing group

Leveraging Resources in a Changing Market

## Direct Deposit/Payroll Debit Card Authorization

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

If you do not provide a written election, wages will be paid by Payroll Debit Card.

### SECTION 1 BASIC INFORMATION

Employee Name	<u>Omot Okello</u>	SSN# (last 4 digits)	<u>1069</u>	Effective Date	<u>5-21-18</u>
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### SECTION 2 ELECTRONIC PAY OPTIONS

**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)

### SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: see attached

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

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

**Paper Check** (Option available to GA NH and NY residents only)

### 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: Omot Okello Date: 05/14/18



OMOT O OKELLO  
1520 E SAINT GERMAIN ST APT 63  
SAINT CLOUD MN 56304-0625

Date \_\_\_\_\_

PAY TO THE  
ORDER OF \_\_\_\_\_

\$ \_\_\_\_\_

Dollars



Security Features  
Include  
Details on Back.



Memo \_\_\_\_\_

MP

⑆091000022⑆ 104782838767⑈ 64

# EMERGENCY CONTACT INFORMATION

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

Employee Name: Onot Okello

Address: 1520 E St. Germain St Apt 63 St. Cloud MN 56304

Home Phone: 320-291-7685

## 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	
<b>Contact #1</b>	<b>Home Phone:</b>
<b>Name:</b> <u>Oliver Onot</u>	<b>Cell Phone:</b> <u><del>612-272-6379</del></u> <u>612-226-3791</u>
<b>Relationship:</b> <u>Friends</u>	<b>Work Phone:</b>
<b>Contact #2</b>	<b>Home Phone:</b>
<b>Name:</b> <u>Quinn Okello</u>	<b>Cell Phone:</b> <u>816-382-7830</u>
<b>Relationship:</b> <u>Coowner</u>	<b>Work Phone:</b>

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

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