



**SENSITIVE BUT UNCLASSIFIED**

**Case Verification Number: 2017076082202KV**

Report Prepared: 03/17/2017

**Company Information**

Company ID: 47429

Company Name: Employer Solutions Staffing Group

**Employee Information**

Last Name: schoer

First Name: deborah

Date of Birth: 11/05/1971

Social Security Number: \*\*\* \*\* 4238

Hire Date: 03/17/2017

Citizenship Status: A citizen of the United States

**Document Information**

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: Driver's license

Document State: Minnesota

Driver's License or ID Card Number:

Document Expiration Date: 11/05/2020

**Case Status Information**

Current Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 03/17/2017

Case Submitted By: SGLA6832

**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 Schoer First Name Deborah Middle Initial D.  
Street Address 9870 71st St. S. Apt/Ste \_\_\_\_\_  
City/State/Zip Collage Grove, Mn. 55016 Social Security Last Four XXX-XX-4238  
Phone Number 612-757-9243 Email Address ddschoer@aol.com  
Staffing Agency/Recruitment Partner \_\_\_\_\_

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

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

### Applicant Certification and Authorization

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

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

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

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

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

Deb Schoer Name (Print or type) Deborah Schoer 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: <ul style="list-style-type: none"> <li>• You're single and have only one job; or</li> <li>• You're married, have only one job, and your spouse doesn't work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b>	<u>1</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>0</u>
<b>E</b>	Enter "1" if you will file as head of household on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b>	<u>0</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. <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>	<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>2</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	<h2>Employee's Withholding Allowance Certificate</h2> <p>▶ 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.</p>	OMB No. 1545-0074  <h1 style="font-size: 2em;">2017</h1>
1 Your first name and middle initial Deborah D.		Last name Schoer
Home address (number and street or rural route) 9870 71st St. S.		2 Your social security number 470-92-4238
City or town, state, and ZIP code Cottage Grove, Mn. 55016		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)		5 <u>2</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.) ▶ Deborah D. Schoer		Date ▶ 3/15/17
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) <b>Schoer</b>		First Name (Given Name) <b>Deborah</b>		Middle Initial <b>D.</b>	Other Last Names Used (if any) <b>Sandin</b>	
Address (Street Number and Name) <b>9870 71st St S.</b>			Apt. Number	City or Town <b>Cottage Grove</b>		State <b>Mn</b>
Date of Birth (mm/dd/yyyy) <b>11-05-1971</b>		U.S. Social Security Number <b>470-92-4238</b>		Employee's E-mail Address <b>ddschoer@aol.com</b>		Employee's Telephone Number <b>612-759-9243</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>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.</p> <p>1. Alien Registration Number/USCIS Number: _____ OR          2. Form I-94 Admission Number: _____ OR          3. Foreign Passport Number: _____</p> <p>Country of issuance: _____</p>
QR Code - Section 1 Do Not Write in This Space

Signature of Employee <b>Deborah D Schoer</b>	Today's Date (mm/dd/yyyy) <b>03-15-2017</b>
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**Preparer and/or Translator Certification (check one):**

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

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

Signature of Preparer or Translator		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**

*(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 the document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")*

Employee Info from Section 1	Last Name (Family Name) <b>Schoer</b>	First Name (Given Name) <b>Deborah</b>	M.I. <b>D</b>	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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

The employee's first day of employment (mm/dd/yyyy): **03/15/2017** (See instructions for exemptions)

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

**Section 3. Reverification and Rehire (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)	

**O.** 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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MINNESOTA DEPARTMENT OF PUBLIC SAFETY  
 MINNESOTA DRIVER'S LICENSE/IDENTIFICATION CARD APPLICATION  
**TENNESSEN WARNING**

**IMPORTANT: READ THIS NOTICE BEFORE  
 YOU COMPLETE THE APPLICATION**

**NOTICE**

Why are you being asked to share this information and how will it be used?

The Department of Public Safety (DPS) will use the information to identify you as a person, to identify your driving record, to determine your eligibility for a driver's permit, license or identification card, prevent fraud, to access your record for any future service transactions and/or inquiries, and to comply with state and federal laws.

State and federal laws require collection of this information.

Minnesota Statutes §§ 171.06, 221.031, and 221.0314, and federal motor carrier safety regulations (49 C.F.R. §§ 383.71 and 383.153) require collection of this information.

Consequences of supplying or refusing to supply requested information.

If you supply the requested information, DPS will be able to determine whether to issue you a driver's permit, license, or identification card. The information may be used by other states to make decisions about whether to issue you a driver license, permit, or identification card. The requested information may also be used by insurance providers to determine eligibility for automobile insurance coverage.

If you don't provide the information requested, DPS cannot issue you a driver's permit, license, or identification card, and your existing driving privileges, if any, may be affected.

How is the requested information shared with other agencies?

DPS releases this information to local, state, and federal government agencies only as authorized or required by state and federal law. This means that the information may be shared with the following:

- Social Security Administration
- Selective Service System
- Federal Department of Labor
- MN Department of Human Services
- MN Department of Revenue
- MN Department of Commerce
- MN Attorney General's Office
- MN Office of the Secretary of State
- MN Department of Natural Resources
- MN Department of Veterans Affairs

In addition, your personal information may be disclosed as authorized by United States Code, title 18, section 2721.

A note about your Social Security number.

You must provide your Social Security number according to M.S. § 171.06 and the Social Security Act, 42 U.S.C. § 686(a) (13). Your Social Security number is also required to determine your eligibility for a commercial driver's license under federal motor carrier safety regulations, 49 C.F.R. § 383.153. It is used to administer child support enforcement programs and locate individuals to establish paternity. It is also used to confirm your identity and residential address with the Social Security Administration, the Minnesota Department of Revenue, the Internal Revenue Service, Minnesota Department of Natural Resources, and the Minnesota Department of Human Services.

**PERMISSIBLE USES OF MOTOR VEHICLE DATA AS PROVIDED IN  
 UNITED STATES CODE, TITLE 18, SECTION 2721**

- For use by any government agency including any court or law enforcement agency in carrying out its functions, or any private person or entity acting on behalf of a federal, state, or local agency in carrying out its functions.
- For use in connection with matters of motor vehicle or driver safety and theft; motor vehicle emissions; motor vehicle product alterations, recalls, or advisories; performance monitoring of motor vehicles, motor vehicle parts, and dealers; motor vehicle market research activities, including survey research; and removal of non-owner records from the original owner records of motor vehicle manufacturers.
- For use in the normal course of business by a legitimate business or its agents, employees, or contractors, but only:
  - (A) to verify the accuracy of personal information submitted by the individual to the business or its agencies, employees, or contractors; and
  - (B) if such information as so submitted is not correct or is no longer correct, to obtain correct information, but only for the purposes of preventing fraud by pursuing legal remedies against, or recovering on a debt or security interest against, the individual.
- For use in connection with any civil, criminal, administrative or arbitral proceeding in any federal, state, or local court or agency or before any self-regulatory body, including the service of process, investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, or pursuant to an order of a federal, state, or local court.
- For use in research activities, and for use in producing statistical reports, so long as the personal information is not published, re-disclosed, or used to contact individuals.
- For use by any insurer or insurance support organization, or by a self-insured entity, or its agents, employees, or contractors, in connection with claims investigation activities, antifraud activities, rating, or underwriting.
- For use in providing notice to the owners of towed or impounded vehicles.
- For use by any licensed private investigative agency or licensed security service for any purpose permitted under this subsection.
- For use by an employer or its agent or insurer to obtain or verify information relating to a holder of a commercial driver's license that is required under the Commercial Motor Vehicle Safety Act, 49 U.S.C. §§ 31301-17.
- For use in connection with the operation of private toll transportation facilities.
- For any other use in response to requests for individual motor vehicle records if the state has obtained the express consent of the person to whom such personal information pertains.
- For bulk distribution for surveys, marketing, or solicitations if the state has obtained the express consent of the person to whom such personal information pertains.
- For use by any requester, if the requester demonstrates it has obtained the written consent of the individual to whom the information pertains.
- For any other use specifically authorized under the law of the state that holds the record, if such use is related to the operation of a motor vehicle or public safety.

**MINNESOTA**  
**DRIVER'S LICENSE**



DEBORAH DARLENE SCHOER  
9768 82ND ST SO  
COTTAGE GROVE, MN 55018

Date of Birth 11-06-1971  
Sex Eyes Class  
F HZL 0  
Height Weight  
6-1 185

ISSUED 09-2012 EXPIRES 11-06-2018

*Deborah D. Schoer*

F196061494716

**SOUTH CAROLINA**



470-92-5238

THIS NUMBER HAS BEEN ESTABLISHED FOR

DEBORAH DARLEEN SCHOER

*Deborah D. Schoer*  
SIGNATURE

**MINNESOTA**  
**DRIVER'S LICENSE**



DEBORAH DARLENE SCHOER  
9768 82ND ST SO  
COTTAGE GROVE, MN 55018

Date of Birth 11-08-1971  
Sex F Eyes HAZ Class D  
Height 5-4 Weight 185  
ISSUED 09-2012 EXPIRES 11-08-2018

*Deborah D. Schoer*

F196051484716

**SOCIETY OF ACCOUNTANTS**

470-92-4238

THIS NUMBER HAS BEEN ESTABLISHED FOR

**DEBORAH DARLEEN SCHOER**

*Deborah D. Schoer*  
SIGNATURE

## Authorization

**Authorization:** By signing below, you authorize: (a) backgroundchecks.com ("BGC") and/or Orange Tree Employment Screening to request information about you from any public or private information source; (b) anyone to provide information about you to BGC and/or Orange Tree Employment Screening; (c) BGC and/or Orange Tree Employment Screening to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) Employer Solutions Staffing Group, LLC ("ESSG") to share those reports with others for legitimate business purposes related to your employment. BGC and/or Orange Tree Employment Screening may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an employee of ESSG.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

**Personal Information:** Please print the information requested below to identify yourself for BGC.

Printed name: Deborah Darlene Schoer  
First Middle (  Last  
none)

Other names used: Sandin  
Current county of residence:

Current and former addresses:

1 yr. current 9870 71<sup>st</sup> St. S. Cottage Grove, Mn 55016  
from Mo/Yr to Mo/Yr Street City, State & Zip

from Mo/Yr to Mo/Yr Street City, State & Zip

from Mo/Yr to Mo/Yr Street City, State & Zip

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

11-05-1971 470-92-4238  
Date of birth Social security number

F1960S1484716 Deborah Darlene Schoer  
Driver's license number & state Name as it appears on license

**Report Copy:** If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box:

Deborah D Schoer 3/15/17  
Signature Date



# employer solutions staffing group

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>Deborah D Schoer</u>	SSN# (last 4 digits) <u>4238</u>	Effective Date <u>3-15-17</u>
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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: \_\_\_\_\_

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 <u>Deborah</u>	M.I. <u>D.</u>	Last Name <u>Schoer</u>	Date of Birth <u>11-05-1971</u>
Street Address (PO BOX NOT ACCEPTABLE) <u>9870 71st St S. Cottage Grove, Mn. 55016</u>			Social Security#
City <u>Cottage Grove</u>	State <u>Mn</u>	Zip <u>55016</u>	Cell Phone (mobile) <u>612-759-9243</u>

### 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: Deborah D Schoer

Date: 3-15-17

### 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: ddschoer@aol.com

this information will only be used to send your paystubs electronically

Employee's Signature: Deborah D Schoer

Date: 3-15-17

# EMERGENCY CONTACT INFORMATION

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

Employee Name: Deborah D Schoer  
Address: 9870 71<sup>st</sup> St.S. Cottage Grove, Mn. 55016  
Home Phone: 612-759-9243

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
<b>Contact #1</b> Name: <u>Sharon Sandin</u> Relationship: <u>mother</u>	Home Phone: <u>651-459-8082</u> Cell Phone: <u>612-323-5916</u> Work Phone:
<b>Contact #2</b> Name: <u>Dana Carney</u> Relationship: <u>Sister</u>	Home Phone: Cell Phone: <u>763-233-8190</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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# 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	Social Security #	Home Phone	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address		Apt. #	
City	State	Zip	Date of Birth / /

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?	
<input type="checkbox"/> Yes <input 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"/>	\$20.25	\$6.17	\$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 checked="" type="checkbox"/>	<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 <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 <b>03/15/2017</b>	SIGNATURE <i>Deborah Schuer</i>	

# Enhanced MEC Plan\_Plan 1

Benefits Enrollment Form  New Employee  Rehire Rehire Date \_\_\_\_\_

Employee Information	
Name (First and Last) <b>Deborah Schoer</b>	Social Security Number <b>471-86-7541</b>
Address <b>9870 71st St. S.</b>	City <b>Cottage Grove Mn</b>
State <b>Mn</b>	Zip Code <b>55016</b>
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 <b>11-05-1971</b>	Date of Hire <b>3-15-17</b>
Phone Number: <b>612-759-9243</b>	Email Address: <b>ddschoer@aol.com</b>

**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 **Deborah Schoer** Date **3-15-17**

**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.

Deborah Schoer  
Individual's Name

3-15-17  
Date

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