



New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Eggleston First Name Scott Middle Initial S.
 Street Address 153 Brookins Road Apt/Ste _____
 City/State/Zip Smyrna, New York 13464 Social Security Last Four XXX-XX- 8535
 Phone Number 607-373-9097 Email Address effects1972@gmail.com @
 Staffing Agency/Recruitment Partner MRO Logistix

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.

Scott S. Eggleston

Sep 7, 2017

Name (Print or type)

Applicant's Signature

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.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	1
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	1
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	0
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	0
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	1
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	0
(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)			
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 0		
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	H	1
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 W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074	
▶ 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.				2017	
1 Your first name and middle initial Scott S.		Last name Eggleston		2 Your social security number 109-50-8535	
Home address (number and street or rural route) 153 Brookins Road		3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.			
City or town, state, and ZIP code Smyrna, New York 13464		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. ▶ ☐			
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 0			
6 Additional amount, if any, you want withheld from each paycheck		6 \$ 0			
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 ▶ 7 0					
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>Scott S. Eggleston</i> Scott S. Eggleston (Sep 7, 2017)				Date ▶ Sep 7, 2017	
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)	



New York State Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104
(1/12)

Print or type	First name and middle initial Scott S.	Last name Eggleston	Your social security number 109-50-8535
	Permanent home address (number and street or rural route) 153 Brookins Road		Apartment number
	City, village, or post office Smyrna	State NY	ZIP code 13464
Single or Head of household ☒ Married ☐ Married, but withhold at higher single rate ☐ Note: If married but legally separated, mark an X in the Single or Head of household box.			
Are you a resident of New York City? Yes ☐ No ☒ Are you a resident of Yonkers? Yes ☐ No ☒			
Complete the worksheet on page 3 before making any entries. 1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 17) 1. 0 2 Total number of allowances for New York City (from line 28) 2. 0			
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer. 3 New York State amount 3. 0 4 New York City amount 4. 0 5 Yonkers amount 5. 0			

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature

Scott S. Eggleston

Date

09/08/2017

Penalty — A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employers only: Mark an X in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instr.):

A. Employee claimed more than 14 exemption allowances for NYS A. ☐

B. Employee is a new hire or a rehire.... B. ☐ First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes ☐ No ☐

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)	Employer identification number

Instructions**Changes effective for 2012**

Form IT-2104 has been revised for tax year 2012. The worksheet on page 3, the charts beginning on page 4, and the additional dollar amounts in the instructions on page 2, used to compute your withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet, charts, or the additional dollar amounts, you should complete a new 2012 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim

is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$100,000 or more during the tax year.
- The total income of you and your spouse has increased to \$100,000 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.
- You have been advised by the Internal Revenue Service that you are entitled to fewer allowances than claimed on your original federal Form W-4, and the disallowed allowances were claimed on your original Form IT-2104.

Exemption from withholding

You cannot use Form IT-2104 to claim exemption from withholding. To claim exemption from income tax withholding, you **must** file Form IT-2104-E, *Certificate of Exemption from Withholding*, with your employer. You must file a new certificate each year that you qualify for exemption. This exemption from withholding is allowable only if you had no New York income tax liability in the prior year, you expect none in the current year, **and** you are over 65 years of age, under 18, or a full-time student under 25. You may also claim exemption from withholding if you are a military spouse and meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act. If you are a dependent who is under 18 or a full-time student, you may owe tax if your income is more than \$3,000.

Withholding allowances

You may **not** claim a withholding allowance for yourself or, if married, your spouse. Claim the number of withholding allowances you compute in Part 1 and Part 3 on page 3 of this form. If you want more tax withheld, you may claim fewer allowances. **If you claim more than 14 allowances**, your employer **must send** a copy of your **Form IT-2104** to the New York State Tax Department. You may then be asked to verify your allowances. If you arrive at negative allowances (less than zero) on lines 1 or 2 and your employer cannot accommodate negative allowances, **enter 0** and see *Additional dollar amount(s)* below.

Income from sources other than wages — If you have more than \$1,000 of income from sources other than wages (such as interest, dividends, or alimony received), reduce the number of allowances claimed on line 1 and line 2 (if applicable) of the IT-2104 certificate by one for each \$1,000 of nonwage income. If you arrive at negative allowances (less than zero), see *Withholding allowances* above. You may also consider filing estimated tax, especially if you have significant amounts of nonwage income. Estimated tax requires that payments be made by the employee directly to the Tax Department on a quarterly basis. For more information, see the instructions for Form IT-2105, *Estimated Income Tax Payment Voucher for Individuals*, or see *Need help?* on page 6.

Other credits (Worksheet line 13) — If you will be eligible to claim any credits other than the credits listed in the worksheet, such as an investment tax credit, you may claim additional allowances.

Find your filing status and your New York adjusted gross income (NYAGI) in the chart below, and divide the amount of the expected credit by the number indicated. Enter the result (rounded to the nearest whole number) on line 13.

Single and NYAGI is:	Head of household and NYAGI is:	Married and NYAGI is:	Divide amount of expected credit by:
Less than \$200,000	Less than \$250,000	Less than \$300,000	66
Between \$200,000 and \$1,000,000	Between \$250,000 and \$1,500,000	Between \$300,000 and \$2,000,000	68
Over \$1,000,000	Over \$1,500,000	Over \$2,000,000	88

Example: You are married and expect your New York adjusted gross income to be less than \$300,000. In addition, you expect to receive a flow-through of an investment tax credit from the S corporation of which you are a shareholder. The investment tax credit will be \$160. Divide the expected credit by 66. $160/66 = 2.4242$. The additional withholding allowance(s) would be 2. Enter **2** on line 13.

Married couples with both spouses working — If you and your spouse both work, you should each file a separate IT-2104 certificate with your respective employers. Your withholding will better match your total tax if the higher wage-earning spouse claims all of the couple's allowances and the lower wage-earning spouse claims zero allowances. **Do not** claim more total allowances than you are entitled to. If your combined wages are:

- less than \$100,000, you should each mark an **X** in the box *Married, but withhold at higher single rate* on the certificate front, and divide the total number of allowances that you compute on line 17 and line 28 (if applicable) between you and your working spouse.
- \$100,000 or more, use the chart(s) in Part 4 and enter the additional withholding dollar amount on line 3.

Taxpayers with more than one job — If you have more than one job, file a separate IT-2104 certificate with each of your employers. Be sure to claim only the total number of allowances that you are entitled to. Your withholding will better match your total tax if you claim all of your allowances at your higher-paying job and zero allowances at the lower-paying job. In addition, to make sure that you have enough tax withheld, if you are a single taxpayer or head of household with two or more jobs, and your combined wages from all jobs are under \$100,000, reduce the number of allowances by seven on line 1 and line 2 (if applicable) on the certificate you file with your higher-paying job employer. If you arrive at negative allowances (less than zero), see *Withholding allowances* above.

If you are a single or a head of household taxpayer, and your combined wages from all of your jobs are between \$100,000 and \$2,100,000, use the chart(s) in Part 5 and enter the additional withholding dollar amount from the chart on line 3.

If you are a married taxpayer, and your combined wages from all of your jobs are \$100,000 or more, use the chart(s) in Part 4 and enter the additional withholding dollar amount from the chart on line 3 (Substitute the words *Higher-paying job for Higher earner's wages* within the chart).

Dependents — If you are a dependent of another taxpayer and expect your income to exceed \$3,000, you should reduce your withholding allowances by one for each \$1,000 of income over \$2,500. This will ensure that your employer withholds enough tax.

Following the above instructions will help to ensure that you will not owe additional tax when you file your return.

Heads of households with only one job — If you will use the head-of-household filing status on your state income tax return, mark the *Single or Head of household* box on the front of the certificate. If you have only one job, you may also wish to claim two additional withholding allowances on line 14.

Additional dollar amount(s)

You may ask your employer to withhold an additional dollar amount each pay period by completing lines 3, 4, and 5 on Form IT-2104. In most instances, if you compute a negative number of allowances and your employer cannot accommodate a negative number, for each negative allowance claimed you should have an additional \$1.85 of tax withheld per week for New York State withholding on line 3, and an additional \$0.80 of tax withheld per week for New York City withholding on line 4. Yonkers residents should use 15% (.15) of the New York State amount for additional withholding for Yonkers on line 5.

Note: If you are requesting your employer to withhold an additional dollar amount on lines 3, 4, or 5 of this allowance certificate, the additional dollar amount, as determined by these instructions or by using the chart(s) in Part 4 or Part 5, is accurate for a weekly payroll. Therefore, if you are not paid on a weekly basis, you will need to adjust the dollar amount(s) that you compute. For example, if you are paid biweekly, you must double the dollar amount(s) computed.

Avoid underwithholding

Form IT-2104, together with your employer's withholding tables, is designed to ensure that the correct amount of tax is withheld from your pay. If you fail to have enough tax withheld during the entire year, you may owe a large tax liability when you file your return. The Tax Department must assess interest and may impose penalties in certain situations in addition to the tax liability. Even if you do not file a return, we may determine that you owe personal income tax, and we may assess interest and penalties on the amount of tax that you should have paid during the year.

(continued)

Employers

Box A — If you are required to submit a copy of an employee's Form IT-2104 to the Tax Department because the employee claimed more than 14 allowances, mark an **X** in box A and send a copy of Form IT-2104 to: **NYS Tax Department, Income Tax Audit Administrator, Withholding Certificate Coordinator, W A Harriman Campus, Albany NY 12227.**

Due dates for sending certificates received from employees claiming more than 14 allowances are:

Quarter	Due date	Quarter	Due date
January – March	April 30	July – September	October 31
April – June	July 31	October – December	January 31

Box B — If you are submitting a copy of this form to comply with New York State's New Hire Reporting Program, mark an **X** in box B. Enter the first day any services are performed for which the employee will be paid wages, commissions, tips and any other type of compensation. For services based solely on commissions, this is the first day an employee working for commissions is eligible to earn commissions. Also, mark an **X** in the Yes or No box indicating if dependent health insurance benefits are available to this employee. If Yes, enter the date the employee qualifies for coverage. Mail the completed form, within 20 days of hiring, to: **NYS Tax Department, New Hire Notification, PO Box 15119, Albany NY 12212-5119.** To report newly-hired or rehired employees online instead of submitting this form, go to www.nynewhire.com.

Worksheet

See the instructions before completing this worksheet.

Part 1 — Complete this part to compute your withholding allowances for New York State and Yonkers (line 1).

6 Enter the number of dependents that you will claim on your state return (<i>do not include yourself or, if married, your spouse</i>) ...	6.	0
For lines 7, 8, and 9, enter 1 for each credit you expect to claim on your state return.		
7 College tuition credit	7.	0
8 New York State household credit	8.	0
9 Real property tax credit	9.	0
For lines 10, 11, and 12, enter 3 for each credit you expect to claim on your state return.		
10 Child and dependent care credit	10.	0
11 Earned income credit	11.	0
12 Empire State child credit	12.	0
13 Other credits (<i>see instructions</i>)	13.	0
14 Head of household status and only one job (<i>enter 2 if the situation applies</i>)	14.	0
15 Enter an estimate of your federal adjustments to income, such as alimony you will pay for the tax year and deductible IRA contributions you will make for the tax year. Total estimate \$	15.	0
Divide this estimate by \$1,000. Drop any fraction and enter the number		
16 If you expect to itemize deductions on your state tax return, complete Part 2 below and enter the number from line 25. All others enter 0	16.	0
17 Add lines 6 through 16. Enter the result here and on line 1. If you have more than one job, or if you and your spouse both work, see instructions for <i>Taxpayers with more than one job</i> and <i>Married couples with both spouses working</i>	17.	0

Part 2 — Complete this part only if you expect to itemize deductions on your state return.

18 Enter your estimated federal itemized deductions for the tax year	18.	
19 Enter your estimated state, local, and foreign income taxes or state and local general sales taxes included on line 18 (<i>if your estimated New York AGI is over \$1 million, you must enter on line 19 all estimated federal itemized deductions included on line 18 except charitable contributions</i>)	19.	
20 Subtract line 19 from line 18	20.	
21 Enter your estimated college tuition itemized deduction	21.	
22 Add lines 20 and 21	22.	
23 Based on your federal filing status, enter the applicable amount from the table below	23.	

Single (cannot be claimed as a dependent) ...	\$ 7,500	Qualifying widow(er)	\$15,000
Single (can be claimed as a dependent)	\$ 3,000	Married filing jointly	\$15,000
Head of household	\$10,500	Married filing separate returns	\$ 7,500

24 Subtract line 23 from line 22 (<i>if line 23 is larger than line 22, enter 0 here and on line 16 above</i>)	24.	
25 Divide line 24 by \$1,000. Drop any fraction and enter the result here and on line 16 above	25.	

Part 3 — Complete this part to compute your withholding allowances for New York City (line 2).

26 Enter the amount from line 6 above	26.	
27 Add lines 14 through 16 above and enter total here	27.	
28 Add lines 26 and 27. Enter the result here and on line 2	28.	

Part 4 — These charts are only for married couples with both spouses working or married couples with one spouse working more than one job, and whose combined wages are between \$100,000 and \$2,100,000.

Enter the additional withholding dollar amount on line 3.

The additional dollar amount, as shown below, is accurate for a weekly payroll. If you are not paid on a weekly basis, you will need to adjust these dollar amount(s). For example, if you are paid biweekly, you must double the dollar amount(s) computed.

[illegible][illegible]

		Combined wages between \$1,100,000 and \$1,600,000									
Higher earner's wages		\$1,100,000 \$1,150,000	\$1,150,000 \$1,200,000	\$1,200,000 \$1,250,000	\$1,250,000 \$1,300,000	\$1,300,000 \$1,350,000	\$1,350,000 \$1,400,000	\$1,400,000 \$1,450,000	\$1,450,000 \$1,500,000	\$1,500,000 \$1,550,000	\$1,550,000 \$1,600,000
\$550,000	\$600,000	\$13	\$16								
\$600,000	\$650,000	\$13	\$16	\$19	\$22						
\$650,000	\$700,000	\$13	\$16	\$19	\$22	\$25	\$28				
\$700,000	\$750,000	\$13	\$16	\$19	\$22	\$25	\$28	\$31	\$34		
\$750,000	\$800,000	\$13	\$16	\$19	\$22	\$25	\$28	\$31	\$34	\$37	\$39
\$800,000	\$850,000	\$21	\$16	\$19	\$22	\$25	\$28	\$31	\$34	\$37	\$39
\$850,000	\$900,000	\$19	\$24	\$19	\$22	\$25	\$28	\$31	\$34	\$37	\$39
\$900,000	\$950,000	\$17	\$22	\$27	\$22	\$25	\$28	\$31	\$34	\$37	\$39
\$950,000	\$1,000,000	\$24	\$20	\$25	\$30	\$25	\$28	\$31	\$34	\$37	\$39
\$1,000,000	\$1,050,000	\$27	\$26	\$22	\$26	\$31	\$26	\$29	\$32	\$35	\$38
\$1,050,000	\$1,100,000	\$18	\$27	\$26	\$22	\$26	\$31	\$26	\$29	\$32	\$35
\$1,100,000	\$1,150,000	\$8	\$18	\$27	\$26	\$22	\$26	\$31	\$26	\$29	\$32
\$1,150,000	\$1,200,000		\$8	\$18	\$27	\$26	\$22	\$26	\$31	\$26	\$29
\$1,200,000	\$1,250,000			\$8	\$18	\$27	\$26	\$22	\$26	\$31	\$26
\$1,250,000	\$1,300,000				\$8	\$18	\$27	\$26	\$22	\$26	\$31
\$1,300,000	\$1,350,000					\$8	\$18	\$27	\$26	\$22	\$26
\$1,350,000	\$1,400,000						\$8	\$18	\$27	\$26	\$22
\$1,400,000	\$1,450,000							\$8	\$18	\$27	\$26
\$1,450,000	\$1,500,000								\$8	\$18	\$27
\$1,500,000	\$1,550,000									\$8	\$18
\$1,550,000	\$1,600,000										\$8

		Combined wages between \$1,600,000 and \$2,100,000									
Higher earner's wages		\$1,600,000 \$1,650,000	\$1,650,000 \$1,700,000	\$1,700,000 \$1,750,000	\$1,750,000 \$1,800,000	\$1,800,000 \$1,850,000	\$1,850,000 \$1,900,000	\$1,900,000 \$1,950,000	\$1,950,000 \$2,000,000	\$2,000,000 \$2,050,000	\$2,050,000 \$2,100,000
\$800,000	\$850,000	\$42	\$45								
\$850,000	\$900,000	\$42	\$45	\$48	\$51						
\$900,000	\$950,000	\$42	\$45	\$48	\$51	\$54	\$57				
\$950,000	\$1,000,000	\$42	\$45	\$48	\$51	\$54	\$57	\$60	\$62		
\$1,000,000	\$1,050,000	\$41	\$44	\$47	\$50	\$52	\$55	\$58	\$61	\$452	\$850
\$1,050,000	\$1,100,000	\$38	\$41	\$44	\$47	\$50	\$52	\$55	\$58	\$449	\$850
\$1,100,000	\$1,150,000	\$35	\$38	\$41	\$44	\$47	\$50	\$52	\$55	\$446	\$847
\$1,150,000	\$1,200,000	\$32	\$35	\$38	\$41	\$44	\$47	\$50	\$52	\$444	\$844
\$1,200,000	\$1,250,000	\$29	\$32	\$35	\$38	\$41	\$44	\$47	\$50	\$441	\$841
\$1,250,000	\$1,300,000	\$26	\$29	\$32	\$35	\$38	\$41	\$44	\$47	\$438	\$838
\$1,300,000	\$1,350,000	\$31	\$26	\$29	\$32	\$35	\$38	\$41	\$44	\$435	\$836
\$1,350,000	\$1,400,000	\$26	\$31	\$26	\$29	\$32	\$35	\$38	\$41	\$432	\$833
\$1,400,000	\$1,450,000	\$22	\$26	\$31	\$26	\$29	\$32	\$35	\$38	\$429	\$830
\$1,450,000	\$1,500,000	\$26	\$22	\$26	\$31	\$26	\$29	\$32	\$35	\$426	\$827
\$1,500,000	\$1,550,000	\$27	\$26	\$22	\$26	\$31	\$26	\$29	\$32	\$423	\$824
\$1,550,000	\$1,600,000	\$18	\$27	\$26	\$22	\$26	\$31	\$26	\$29	\$421	\$821
\$1,600,000	\$1,650,000	\$8	\$18	\$27	\$26	\$22	\$26	\$31	\$26	\$418	\$818
\$1,650,000	\$1,700,000		\$8	\$18	\$27	\$26	\$22	\$26	\$31	\$415	\$815
\$1,700,000	\$1,750,000			\$8	\$18	\$27	\$26	\$22	\$26	\$420	\$813
\$1,750,000	\$1,800,000				\$8	\$18	\$27	\$26	\$22	\$415	\$817
\$1,800,000	\$1,850,000					\$8	\$18	\$27	\$26	\$410	\$813
\$1,850,000	\$1,900,000						\$8	\$18	\$27	\$414	\$808
\$1,900,000	\$1,950,000							\$8	\$18	\$415	\$812
\$1,950,000	\$2,000,000								\$8	\$406	\$813
\$2,000,000	\$2,050,000									\$202	\$415
\$2,050,000	\$2,100,000										\$13

Note: These charts do not account for additional withholding in the following instances:

- a married couple with both spouses working, where one spouse's wages are more than \$1,050,000 but less than \$2,100,000, and the other spouse's wages are also more than \$1,050,000 but less than \$2,100,000;
- married taxpayers with only one spouse working, and that spouse works more than one job, with wages from each job under \$2,100,000 but combined wages from all jobs is over \$2,100,000.

If you are in one of these situations and you would like to request an additional dollar amount of withholding from your wages, please contact the Tax Department for assistance (see *Need help?* on page 6).

Part 5 — These charts are only for single taxpayers and head of household taxpayers with more than one job, and whose combined wages are between \$100,000 and \$2,100,000.

Enter the additional withholding dollar amount on line 3.

The additional dollar amount, as shown below, is accurate for a weekly payroll. If you are not paid on a weekly basis, you will need to adjust these dollar amount(s). For example, if you are paid biweekly, you must double the dollar amount(s) computed.

		Combined wages between \$100,000 and \$500,000										
Higher wage		\$100,000 \$120,000	\$120,000 \$140,000	\$140,000 \$160,000	\$160,000 \$180,000	\$180,000 \$220,000	\$220,000 \$260,000	\$260,000 \$300,000	\$300,000 \$350,000	\$350,000 \$400,000	\$400,000 \$450,000	\$450,000 \$500,000
\$50,000	\$70,000	\$12	\$17									
\$70,000	\$90,000	\$12	\$18	\$24								
\$90,000	\$110,000	\$8	\$16	\$22	\$24	\$26						
\$110,000	\$120,000	\$2	\$10	\$17	\$20	\$23	\$26					
\$120,000	\$130,000		\$4	\$14	\$17	\$21	\$26					
\$130,000	\$140,000		\$2	\$10	\$13	\$18	\$26	\$24				
\$140,000	\$150,000			\$4	\$10	\$14	\$26	\$22				
\$150,000	\$160,000			\$2	\$8	\$12	\$25	\$23	\$20			
\$160,000	\$180,000				\$3	\$10	\$23	\$26	\$20			
\$180,000	\$220,000					\$8	\$19	\$27	\$25	\$22		
\$220,000	\$260,000						\$8	\$15	\$22	\$17	\$17	\$12
\$260,000	\$300,000							\$6	\$14	\$21	\$14	\$15
\$300,000	\$350,000								\$7	\$15	\$21	\$14
\$350,000	\$400,000									\$7	\$15	\$21
\$400,000	\$450,000										\$7	\$15
\$450,000	\$500,000											\$7

		Combined wages between \$500,000 and \$1,100,000											
Higher wage		\$500,000 \$550,000	\$550,000 \$600,000	\$600,000 \$650,000	\$650,000 \$700,000	\$700,000 \$750,000	\$750,000 \$800,000	\$800,000 \$850,000	\$850,000 \$900,000	\$900,000 \$950,000	\$950,000 \$1,000,000	\$1,000,000 \$1,050,000	\$1,050,000 \$1,100,000
\$260,000	\$300,000	\$9											
\$300,000	\$350,000	\$16	\$8	\$8									
\$350,000	\$400,000	\$14	\$16	\$8	\$8	\$8							
\$400,000	\$450,000	\$21	\$14	\$16	\$8	\$8	\$8	\$8					
\$450,000	\$500,000	\$15	\$21	\$14	\$16	\$8	\$8	\$8	\$8	\$8			
\$500,000	\$550,000	\$7	\$15	\$21	\$14	\$16	\$8	\$8	\$8	\$8	\$8	\$208	\$419
\$550,000	\$600,000		\$7	\$15	\$21	\$14	\$16	\$8	\$8	\$8	\$8	\$208	\$419
\$600,000	\$650,000			\$7	\$15	\$21	\$14	\$16	\$8	\$8	\$8	\$208	\$419
\$650,000	\$700,000				\$7	\$15	\$21	\$14	\$16	\$8	\$8	\$208	\$419
\$700,000	\$750,000					\$7	\$15	\$21	\$14	\$16	\$8	\$208	\$419
\$750,000	\$800,000						\$7	\$15	\$21	\$14	\$16	\$208	\$419
\$800,000	\$850,000							\$7	\$15	\$21	\$14	\$216	\$419
\$850,000	\$900,000								\$7	\$15	\$21	\$214	\$427
\$900,000	\$950,000									\$7	\$15	\$221	\$425
\$950,000	\$1,000,000										\$7	\$215	\$432
\$1,000,000	\$1,050,000											\$108	\$226
\$1,050,000	\$1,100,000												\$13

(Part 5 continued on page 7)

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Manager of Document Management, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone (518) 457-5181.

Need help?



Visit our Web site at **www.tax.ny.gov**

- get information and manage your taxes online
- check for new online services and features



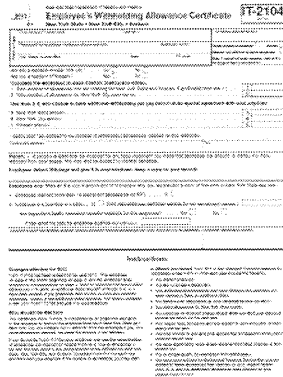
Telephone assistance

Automated income tax refund status: (518) 457-5149

Personal Income Tax Information Center: (518) 457-5181

To order forms and publications: (518) 457-5431

Text Telephone (TTY) Hotline (for persons with hearing and speech disabilities using a TTY): (518) 485-5082



New York IT 2104

Adobe Sign Document History

09/08/2017

Created:	09/06/2017
By:	Jamie Ready (jamie@corpmgmtgroup.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAiLJE5PT3FHFVcFetYMD6xbISpOiMsXcd

"New York IT 2104" History



Document created by Jamie Ready (jamie@corpmgmtgroup.com)

09/06/2017 - 1:55:17 PM MDT- IP address: 96.93.208.65



Document emailed to Scott S. Eggleston (effects1972@gmail.com) for signature

09/06/2017 - 1:55:20 PM MDT



Document viewed by Scott S. Eggleston (effects1972@gmail.com)

09/06/2017 - 2:14:54 PM MDT- IP address: 66.102.6.223



Document e-signed by Scott S. Eggleston (effects1972@gmail.com)

Signature Date: 09/08/2017 - 6:06:03 AM MDT - Time Source: server- IP address: 24.213.191.90



Signed document emailed to Jamie Ready (jamie@corpmgmtgroup.com) and Scott S. Eggleston (effects1972@gmail.com)

09/08/2017 - 6:06:03 AM MDT



Adobe Sign



SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2017254161251HU

Report Prepared: 09/11/2017

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Eggleston

First Name: Scott

Date of Birth: 06/15/1972

Social Security Number: *** ** 8535

Hire Date: 09/11/2017

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: New York

Driver's License or ID Card Number:

Document Expiration Date: 06/16/2018

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 09/11/2017

Case Submitted By: AFIN3846

Closed On: 09/11/2017

Closed By: AFIN3846

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

SENSITIVE BUT UNCLASSIFIED

NEW YORK STATE

David J. Santoro
Commissioner of Motor Vehicles



DRIVER LICENSE

ID: 716 917 983 CLASS D

EGGLESTON
SCOTT, S
153 BROOKINS RD
SMYRNA NY 13464

DOB: 06-15-72

SEX: M EYES: BL HT: 5-07

E: NONE

R: B

ISSUED: 06-09-10 EXPIRES: 06-16-18 UQPHBYKC06



ORGAN
DONOR

SOCIAL SECURITY

ACCOUNT

NUMBER

108-50-8535
WAS BEEN ESTABLISHED FOR

SCOTT, S. EGGLESTON

SIGNATURE

Scott Eggleston

FOR SOCIAL SECURITY AND TAX PURPOSES - NOT FOR IDENTIFICATION



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) Eggleston		First Name (Given Name) Scott		Middle Initial S.	Other Last Names Used (if any) N/A	
Address (Street Number and Name) 153 Brookins Road		Apt. Number N/A	City or Town Smyrna		State NY	ZIP Code 13464
Date of Birth (mm/dd/yyyy) 06/15/1972	U.S. Social Security Number 109-50-8535 - [][][][][][]		Employee's E-mail Address effects1972@gmail.com		Employee's Telephone Number 607-373-9097	

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): N/A
☐ 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: N/A OR 2. Form I-94 Admission Number: N/A OR 3. Foreign Passport Number: N/A Country of Issuance: N/A
QR Code - Section 1 Do Not Write In This Space

Signature of Employee <u>Scott S. Eggleston</u> Scott S. Eggleston (Sep 7, 2017)	Today's Date (mm/dd/yyyy) Sep 7, 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 N/A		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



LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
- U.S. Passport or U.S. Passport Card - Permanent Resident Card or Alien Registration Receipt Card (Form I-551) - Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa - Employment Authorization Document that contains a photograph (Form I-766) - For a nonimmigrant alien authorized to work for a specific employer because of his or her status: - Foreign passport; and - Form I-94 or Form I-94A that has the following: - The same name as the passport; and - An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. - Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		- Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address - ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address - School ID card with a photograph - Voter's registration card - U.S. Military card or draft record - Military dependent's ID card - U.S. Coast Guard Merchant Mariner Card - Native American tribal document - Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: - School record or report card - Clinic, doctor, or hospital record - Day-care or nursery school record	- A Social Security Account Number card, unless the card includes one of the following restrictions: - NOT VALID FOR EMPLOYMENT - VALID FOR WORK ONLY WITH INS AUTHORIZATION - VALID FOR WORK ONLY WITH DHS AUTHORIZATION - Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) - Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal - Native American tribal document - U.S. Citizen ID Card (Form I-197) - Identification Card for Use of Resident Citizen in the United States (Form I-179) - Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



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) <u>Eagleton</u>	First Name (Given Name) <u>Scott</u>	M.I. <u>S.</u>	Citizenship/Immigration Status <u>US Citizen</u>
List A Identity and Employment Authorization		List B Identity	List C Employment Authorization	

Document Title	Document Title <u>NY Driver License</u>	Document Title <u>Social Security Card</u>
Issuing Authority	Issuing Authority <u>State of NY</u>	Issuing Authority <u>SSA</u>
Document Number	Document Number <u>716 917 983</u>	Document Number <u>109-50-8535</u>
Expiration Date (if any)(mm/dd/yyyy)	Expiration Date (if any)(mm/dd/yyyy) <u>06/16/2018</u>	Expiration Date (if any)(mm/dd/yyyy)
Document Title	Additional Information	
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		
Document Title	QR Code - Sections 2 & 3 Do Not Write In This Space	
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): 09/11/2017 (See instructions for exemptions)

Signature of Employer or Authorized Representative <u>Andrea Findley</u>	Today's Date (mm/dd/yyyy) <u>09/11/2017</u>	Title of Employer or Authorized Representative <u>Executive Assistant</u>	
Last Name of Employer or Authorized Representative <u>Findley</u>	First Name of Employer or Authorized Representative <u>Andrea</u>	Employer's Business or Organization Name <u>EMPLOYER SOLUTIONS STAFFING GROUP LLC</u>	
Employer's Business or Organization Address (Street Number and Name) <u>7480 FLYING CLOUD DRIVE SUITE 200</u>		City or Town <u>EDEN PRAIRIE</u>	State <u>MN</u>
		ZIP Code <u>55344</u>	

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)

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

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
--	---------------------------	---

**EMPLOYER SOLUTIONS STAFFING GROUP
BACKGROUND CHECK AUTHORIZATION**

Employee Name: Scott S. Eggleston
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: 153 Brookins Road Smyrna, New York 13464
(Mo/Yr) (Street) (City) (State/Zip)

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

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

Social Security Number: 109-50-8535 DOB: 06/15/1972

Phone Number: 607-373-9097

Driver's License Number/State: 716917983

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

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

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

Signature: Scott S. Eggleston Date: Sep 7, 2017
Scott S. Eggleston, Sep 7, 2017

Notice to CA, MN, and OK Residents:

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

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

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identity theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates.	a. Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above:	
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration

EMERGENCY CONTACT INFORMATION

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

Employee Name: Scott S. Eggleston

Address: 153 Brookins Road Smyrna, New York 13464

Home Phone: 607-373-9097

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: Bill Eggleston Relationship: Father	Home Phone: Cell Phone: 607-371-0599 Work Phone:
Contact #2 Name: Tammy Powell Relationship: Sister	Home Phone: 607-244-4922 Cell Phone: Work Phone:

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



employer solutions staffing group, inc.

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 Scott S. Eggleston	SSN# (last 4 digits) 8535	Effective Date Sep 7, 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)

SECTION 3 DIRECT DEPOSIT

**A
C
C
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U
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T**

☒ Update Bank Account

Bank Name: **GHS Federal Credit Union**

Routing# **221373707**

Account# **10958000750028**

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 **S.E.** Date **Sep 7, 2017**

- 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.

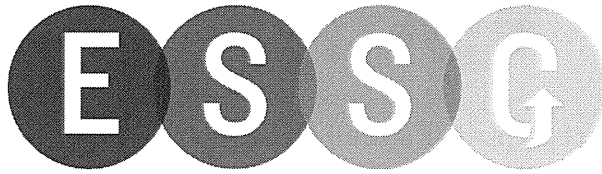
Employee's Signature: _____ Date: **Sep 7, 2017**

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:** **effects1972@gmail.com** @
this information will only be used to send your paystubs electronically

Employee's Signature: Scott S. Eggleston Date: **Sep 7, 2017**
Scott S. Eggleston (Sep 7, 2017)



employer solutions staffing group, LLC

STATEMENT OF CONFIDENTIALITY

This agreement made this _____ day of _____, 201____, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and _____ 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.

Scott S. Eggleston
Scott S. Eggleston (Sep 7, 2017)

Employee Signature

Employer Solutions Staffing Group LLC, Representative



INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

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

RESPONSIBILITIES OF THE INJURED WORKER:

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

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

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

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

Follow all physical restrictions at home and at work.

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

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

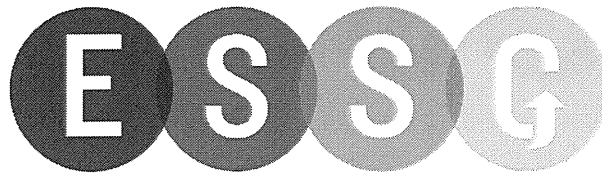
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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

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

Signed: Scott S. Eggleston
Scott S. Eggleston (Sep 3, 2017)

Printed Name: Scott S. Eggleston



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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

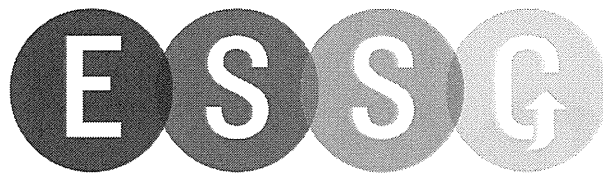
Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, 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): Scott S. Eggleston

Signature/Firma: Scott S. Eggleston
Scott S. Eggleston (Sep 7, 2017)



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ESSG WORKPLACE SAFETY POLICY

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

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

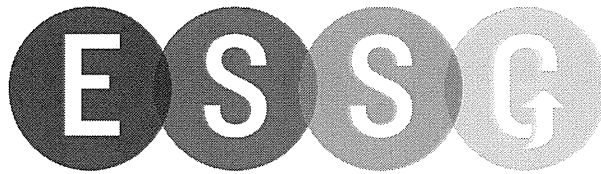
ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

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

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

You have the following basic rights:

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



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- Right to request information about safety and health hazards in the workplace, appropriate precautions to take, and procedures to follow if involved in an accident or exposed to hazardous substances
- Right to gain access to relevant personal exposure and medical records.

You can have your name withheld from the host employer and any other entity, by request, if you sign and file a written complaint. You can request to be advised of OSHA actions regarding a complaint, and request an informal review of any decision not to inspect the site or issue a citation. And, you can file a complaint if you are punished or discriminated against for acting as a “whistleblower” under the OSH Act or 13 other federal statutes for which OSHA has jurisdiction, or for refusing to work when faced with imminent danger of death or serious injury and there is insufficient time for OSHA to inspect. Retaliation or reprisal taken against anyone who has expressed concern about workplace safety is illegal.

If you believe that your right to a safe workplace has been violated, you can make a report to a manager of the host worksite employer and/or ESSG (by telephoning **952.835.1288/1.866.496.7573**) and asking for the ESSG Safety Director. You can also contact OSHA directly with any concern. ESSG recognizes the serious nature of ensuring workplace safety will endeavor to protect any employee who may have been subjected to unsafe or hazardous worksite conditions.



Acknowledgement of Receipt of Workplace Safety Policy

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

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

Employee Name (Please Print)

Scott S. Eggleston

Employee's Signature:

Scott S. Eggleston
Scott S. Eggleston (Sep 7, 2017)

Date: Sep 7, 2017

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

OMB No. 1545-1500

► 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 Scott S. Eggleston Social security number ► 109-50-8535

Street address where you live 153 Brookins Road

City or town, state, and ZIP code Smyrna, New York 13464

County Chenango Telephone number 607-373-9097

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.

Scott S. Eggleston
Scott S. Eggleston (Sep 7, 2017)

Job applicant's signature ►

Date Sep 7, 2017

EMPLOYER SECTION:

Client:	Company:	
Location:	Position:	Starting Wage: \$

EMPLOYEE SECTION:

First Name: Last Name: Scott S. Eggleston	Suffix:	Street Address: 153 Brookins Road	City/State: Smyrna, New York	Zip: 13464
SS#: 109-50-8535	Date of Birth: 06/15/1972	Age:	Have you worked for this company before? Yes ☐ 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: _____	☐	☒
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: _____	☐	☒
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. <i>*If you checked yes please provide a copy of your SSI documentation.</i>	☐	☒
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: ☐ Vocational Rehabilitation Agency ☐ Dept. of Veterans Affairs ☐ Employment Network (Ticket to Work Program) Name of Agency: _____ Phone #: _____ City: _____ County: _____ State: _____ <i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i>	☐	☒
5. Are you a Veteran of the U.S. Military? <i>*If yes, please provide a copy of your DD-214 and letter of separation.</i> (If yes, please provide information below. If no, please continue to question #6.) Dates of Service - From: _____ To: _____ Branch of Service: _____ Are you entitled to or are you receiving compensation for a service-connected disability?	☐	☒
6. Have you been unemployed at any time during the last 12 months? If yes, dates of unemployment - From: <u>8/2016</u> To: <u>9/2017</u> Did you receive unemployment compensation at any point during your unemployment? If yes, in which state did you receive unemployment compensation? <u>NY</u>	☒	☐
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 ☐ Federal or ☐ State conviction? If State - County: _____ State: _____	☐	☒
Additional Tax Credits		
IEC (Native American): Are you or your spouse a member of a Native American Tribe? <i>If you checked yes please provide a copy of your CDIB card.</i>	☐	☒
CA Residents: ☐ Are you the child of foster parents? ☐ Do you receive CalWorks? ☐ Workforce Investment Act?	☐	☐
SC Residents: ☐ 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: Scott S. Eggleston
Scott S. Eggleston, SSN: 109-50-8535
Date: Sep 7, 2017



U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: January 31, 2020

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

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

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

New Hire's Signature: Scott S. Eggleston Date Sep 7, 2017
Scott S. Eggleston (Sep 7, 2017)

New Hire Name: Scott S. Eggleston

Social Security Number: - 8535
(Enter last four digits)

Employer Name: _____

Please check the statements below if they apply to you.

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

☒ I declare that I have been in a period of unemployment since 8/2016.
(Enter start date)

Privacy Act Notice:

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

Public Burden Statement:

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

Employee Keeps This Form

Healthcare Notice of Exchange

As your employer, we are required to provide you with the following information under Section 1512 of the Affordable Care Act:

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

*****The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area*****

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information:

Employer Name: Employer Solutions Staffing Group, LLC				Employer FEIN: 20-8084369	
Employer Address: PO Box 46270 Minneapolis, MN 55344-9956				Phone Number for Health Benefits Team: 952-767-9519	
Insurance Plans Available:	Who is Eligible?	Meets Minimum Value Standard?	Meets Minimum Essential Coverage?	When is it effective?	Will I be penalized if I only have this plan?
Fixed Indemnity Plan	Everyone	No	No	Available immediately – offered upon hire	Yes
MEC Plan	Everyone	No	Yes	Available immediately – offered upon hire	No
Major Medical Plan	Full time employees after 120 hours are met in 30 days	Yes	Yes	Within 60 days of being determined eligible	No

For more information about ESSG's Insurance options, contact:

The Health Benefits Team

Employer Solutions Staffing Group

952-767-9519 | health@employersolutionsgroup.com

Employee Keeps This Form

NOTICE: ESSG Electronic Pay Stubs

ATTENTION

ESSG provides employees with electronic pay stubs. You are able to view your pay stub by using either of the following methods:

1. You can view your check stub by logging into the employee portal at www.MyPayESG.com

Your username is the **first four letters of your last name followed by the last four numbers of your SSN.**
The log-in is case sensitive, so be sure that you capitalize the first letter of your last name.

For example: John Woods SSN: 111-22-3333 would have a username of Wood3333

Your password will initially be **Temp1234**, and you will be directed to change it when you first log in. Be sure to write down and keep your log-in information in a secure location. For support please email MyPayESG@MyPayESG.com

2. You can also receive your check stub **by email** by providing us with your email address on **page 1** of this packet.
** Your check stub will come from payroll@MyPayESG.com, be sure to check spam folder.

Empleado Toma Copiar

ATENCIÓN

ESSG proporciona a los empleados con los talones de pago electrónicos. Usted puede examinar su talon de pago utilizando cualquiera de los métodos siguientes:

1. Usted puede ver su talón de cheque por la tala en el portal electrónico del empleados en www.MyPayESG.com

Su nombre de usuario son las cuatro primeras letras de su apellido seguido por los cuatro últimos dígitos de su número de seguro social.

El portal es caso delicado, asegúrese de que la primera letra de su apellido sea mayúscula.

Por ejemplo: Juan Garcia SSN: 111-22-3333 tendría un nombre de usuario de Garc3333

Su contraseña inicialmente será **Temp1234**, y usted será dirigido a cambiarla la primera vez que inicie sesión. Asegúrese de anotar y guardar su información de registro en un lugar seguro. para apoyar email: MyPayESG@MyPayESG.com

2. También puede recibir su talón de cheque por correo electrónico , al proveir su correo electronico en la **pagina 1** de este paquete
** Su talón de cheque vienen de payroll@MyPayESG.com, asegúrate de revisar la carpeta de spam

Employee Acknowledgement Form (Temps)

Note: Synovos Employee Acknowledgement is attached to their Learning Center training requirement. See documentation requirements below.

I hereby acknowledge receipt of Synovos "*Employee Safety Handbook*" which outlines important safety requirements and information for working as safely as possible. I agree to follow the safety and health rules as outlined in this handbook. I further understand that complete safety and health program requirements are published in the "*Safety Manual*" that can be obtained through my Site Manager or Project Leader.

Scott S. Eggleston
Scott S. Eggleston (Sep 7, 2017)

Sep 7, 2017

Employee Signature

Date

Employer's Representative

Date

Important: This receipt must be read, understood and signed by all Synovos permanent and temporary employees. Temporary employees sign this hard-copy form. Permanent employees must document their training in the Synovos Learning Center by taking the associated quiz.

Documentation Instructions:

Permanent Employees: The Synovos Site Manager, or senior Synovos employee, will ensure all personnel have read and understand the contents of this document. Please contact the Senior Director of Safety and Quality safety@synovos.com if you have any questions. The employee must take the Employee Safety Handbook Quiz contained in the Synovos Learning Center.

Temporary/Project Employees: The project leader or hiring manager will ensure all personnel have read and understand the contents of this document. Please contact the Senior Director of Safety and Quality safety@synovos.com if you have any questions. The employee and leader or manager will sign this form file it on site. This form is a special interest item during implementation audits.

Employees: Please retain the handbook for future reference.

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

_____, or any of its subsidiaries may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" conducted by a consumer reporting agency which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history (State and Federal records), social security verification, address trace, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any report conducted by a consumer reporting agency. Please be advised NationSearch.com, LLC (NationSearch)—11184 Huron St. Suite 13; Northglenn, CO 80234; (800)-827-9550—will be the consumer reporting agency conducting the background investigation. The scope of this notice and authorization is all encompassing, however, allowing the Company to obtain from any outside organization all manners of consumer reporting now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any report conducted by a consumer reporting agency.

ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, credit reporting agency, employer, to provide any and all background information requested by NationSearch.com, LLC—11184 Huron St. Suite 13; Northglenn, CO 80234 (800)-827-9550—another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

Notice to California Applicants: Notice to California Applicants: Under section 1786.22 of California Civil Code, you have the right to request from NationSearch, upon proper identification, the nature and substance of all information in files pertaining to you, including the sources of information, and recipients of any reports on you, which NationSearch has previously furnished within the two-year period preceding your request. You may view the file maintained on you by contacting NationSearch during normal business hours. You may also obtain a copy of this report(s) upon submitting proper identification. Upon making a written request, you may receive a summary of your report.

New York applicants or employees only: You have the right to inspect and receive a copy of any report conducted by a consumer reporting agency and requested by the Company by contacting the consumer reporting agency identified above directly.

Notice to Maine Applicants: Under Chapter 210 Section 1314 of Maine revised Statutes, you have the right, upon request, to be informed within 5 business days of such a request to whether or not a consumer report was requested. If such report was obtained, you may contact the consumer reporting agency, NationSearch, and request a copy of the report(s) compiled.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company ☒

Last Name: Eggleston	First Name: Scott	Middle Name: S.
Other Names Used: N/A	SSN: 109-50-8535	Date of Birth: (For Employment Purposes Only) 06/15/1972
Motor Vehicle Number & State of Issue: (Driver's License Number) 716917983	Current Address: 153 Brookins Road, Smyrna, NY 13464	

Signature: Scott S. Eggleston
Scott S. Eggleston (Sep 7, 2017)

Date: Sep 7, 2017

Please initial this box in affirmation that you have been advised of your rights as it pertains to this consumer report, and are aware of the consumer reporting agency conducting the background investigation:

S.E.

DRUG AND ALCOHOL TESTING POLICY

I. PURPOSE

Alcohol and drug abuse adversely affects job performance, the kind of work an employee performs and an employee's opportunities for successful employment. It is the intent of this document to provide employees with ESSG's [hereafter "the Company"] policy regarding the use of drugs and alcohol while at work. The Company does not intend to intrude into the private lives of its employees, but strongly believes that a drug-free workplace is in the best interest of employees and non-employees alike.

II. SCOPE

This policy applies to all applicants for employment and to all employees including contract or temporary employees. The policy is applicable at Company facilities or whenever Company employees are performing company business.

III. DISCLAIMER

Employment at the Company is at-will. This policy is not a unilateral employment contract and should not be interpreted as creating a unilateral employment contract.

IV. PROHIBITIONS

A. No employee shall report to work under the influence of alcohol, any controlled substances, or any other drugs or medications that may affect the employee's alertness, coordination, reaction, response, judgment, decision-making, or safety.

B. No employee shall operate, use, or drive any equipment, machinery, or vehicle of the Company or any client of Company while under the influence of alcohol, any controlled substances, or any other drugs or medications that may adversely affect the employee's ability to operate such equipment, machinery, or vehicle. Employees are under an affirmative duty to immediately notify their supervisor if they are not in an appropriate mental or physical condition to operate, use, or drive any equipment machinery, or vehicle or otherwise safely perform their job duties.

C. No employee shall unlawfully manufacture, distribute, dispense, possess, transfer, or use a controlled substance in the workplace or wherever the Company's work is being performed.

D. Engaging in off-duty sale, purchase, transfer, use or possession of illegal drugs or controlled substances may have a negative effect on an employee's ability to perform his/her work for the Company. In such circumstances, the employee is subject to discipline.

E. When an employee is taking medically authorized drugs or other substances that may alter job performance, the employee is under an affirmative duty to notify their supervisor of the temporary inability to perform his or her job duties.

F. The Company shall notify the appropriate law enforcement agency, licensing boards, and other relevant authorities when it has reasonable suspicion to believe that an employee may have illegal drugs in his or her possession at work or on company premises.

G. Employees shall not consume alcoholic beverages during lunch periods, dinner periods, or breaks when returning immediately thereafter to perform work on behalf of the Company. In situations where the employee conducts the Company's business after the intake of alcohol, the employee shall be subject to discipline up to and including discharge.

V. ALCOHOL AND DRUG TESTING

As part of the Company's commitment to an alcohol and drug-free workplace, the Company reserves the right to require that applicants and employees submit to drug or alcohol testing in accordance with the provisions of applicable law. This policy represents the notice required under applicable law and a copy will be provided to all applicants and employees who are requested to undergo testing. In the event of any conflict between this policy and applicable law in effect at the time of the test, the law will control.

A. Who May be Subject to Testing.

1. Job Applicants. The Company may require that all applicants for a particular position be tested for drugs or alcohol after receiving a conditional offer of employment. If the applicant tests positive for drugs or alcohol, the conditional offer may be withdrawn.

2. Routine Physical Examination Testing. The Company may require employees to undergo a drug or alcohol test once a year as part of a routine physical examination. Affected employees will be given two weeks written notice that they will be tested for drugs or alcohol as part of a routine physical.

3. Random Testing. The Company may require employees in safety-sensitive positions to undergo testing on a random selection basis. Once the random selection has been made, the Company will not waive the selection of any employees identified through the random process.

4. Reasonable Suspicion Testing. The Company may require an employee to undergo drug or alcohol testing if the Company reasonably suspects that the employee:

- a. is under the influence of drugs or alcohol;
- b. has violated the Company's written work rules prohibiting drug and alcohol use;
- c. has sustained or caused another employee to sustain personal injury; or
- d. has caused a work-related accident or was operating or helping to operate machinery, equipment or vehicles involved in a work-related accident.

5. Treatment Program Testing. The Company may require an employee who has been referred for chemical dependency treatment or evaluation or is participating in a treatment program under an employee benefit plan to undergo drug or alcohol testing on a random basis and without advance notice during the evaluation or treatment period and for up to two years following the completion of any treatment program.

B. Conducting the Testing.

1. Consent. All employees required to undergo testing will be required to complete and sign the employee consent form attached as Appendix A.

2. Refusal to Participate. An employee or job applicant has the right to refuse testing. However, a refusal of testing will be treated as a failure to comply with Company policy and may result in withdrawal of a job offer or disciplinary action up to and including termination of employment.

3. The Laboratory. The Company will use a laboratory certified by the National Institute on Drug Abuse (NIDA) or its successor, the College of American Pathologists (CAP), or the New York State Department of Health or other licensing body recognized by applicable law to perform all drug and alcohol tests.

4. Test Results.

The laboratory will conduct both an initial test and a confirmatory test if the initial test is positive. A negative result on either the initial or confirmatory test will be deemed a negative test result (i.e. the employee passed the test). A positive result on both the initial and confirmatory test will be deemed a positive test result (i.e. the employee failed the test.)

a. Negative Test Result. An employee or applicant who tests negative for drugs or alcohol will be given written notice that they passed the test within three working days of the Company receiving the test results from the testing laboratory.

b. Positive Test Result. An employee or applicant who tests positive for drugs or alcohol will be given written notice that they have failed the test within three working days of the Company receiving the test results from the testing laboratory. The employee or applicant will then be given the opportunity to provide any information to explain the positive result, including any over-the-counter or prescription medications the employee or applicant may have taken. An employee or applicant who wishes to submit any explanatory information must do so within three working days after being notified of the positive test result.

An employee or applicant who has a positive test result may also request a retest of the original sample by the same or different certified laboratory at his or her own expense. An employee or applicant who wishes to conduct a retest must notify the Company in writing of their intention to conduct such a retest within five working days after being notified of the positive test result. If the results of the retest are negative, the test will be considered a negative test result.

C. Right to Test Result. An employee or job applicant has the right to request and receive from the Company a copy of the test result report on any drug or alcohol test.

C. Costs. All costs related to alcohol and drug testing will be paid by the Company, with the exception of any retests requested by the employee or applicant following a positive test result.

D. Disciplinary Action in Response to a Positive Test Result.

1. Interim Discipline and Action: The Company reserves the right to temporarily suspend an employee or transfer the employee to another position at the same rate of pay pending the outcome of any drug or alcohol test. An employee who is suspended without pay will be reinstated with back pay if the test or any requested retest is negative.

2. Applicants. The Company reserves the right to withdraw the conditional job offer of any job applicant with a positive test result, without the opportunity to complete evaluation or treatment.

3. Employees - First Positive Test Result - Termination: The Company will not discharge an employee for the first positive test result. Instead the employee will be given the opportunity to participate in an appropriate drug or alcohol counseling or rehabilitation program as determined by a certified chemical use counselor or physician trained in the diagnosis and treatment of chemical dependency chosen by the Company. The employee will be responsible for paying all costs associated with any evaluation and subsequent treatment themselves or pursuant to coverage under an employee benefit plan. An employee who refuses or fails to participate in, cooperate with, or complete the evaluation or recommended treatment may be terminated. An employee who successfully completes treatment may be subject to random follow-up testing for a period of up to two years in accordance with section V.A.5. of this policy.

4. Employees - First Positive Test Result—Discipline: The Company reserves the right to take any other disciplinary action short of discharge it deems warranted following a first positive test result.

5. Employees-Subsequent Positive Test Result: An employee who has more than one positive test result may be terminated immediately following any second or subsequent positive test result without referral to or the opportunity to complete additional chemical dependency counseling or rehabilitation.

E. Privacy of Test Results.

1. Test results and other information acquired as a result of the testing program are private and confidential information and will not be disclosed by the Company or the testing laboratory to another employee or to third party individuals, government agencies, or private organizations without written consent of the employee or applicant being tested.

2. Evidence of a positive test result, however, may be used in an arbitration proceeding pursuant to a collective bargaining agreement, an administrative hearing, or a judicial proceeding, provided the information is relevant to the hearing or proceeding. Such evidence may also be disclosed to any federal agency or other unit of the United States government as required under federal law, regulation, or order. Evidence of a positive test result may also be disclosed to a substance abuse treatment facility for the purpose of evaluation or treatment.

3. The Company will provide an employee with access to information in the employee's file relating to positive test result reports and other information acquired in the testing process as well as conclusions drawn from or actions taken based upon such information.

**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.

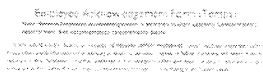
3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG 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.

Scott S. Eggleston
Scott S. Eggleston (Sep 7, 2017)

Individual's Name

Sep 7, 2017

Date



Adobe Sign Document History

Created: 09/06/2017

By: Jamie Ready (jamie@corpmgmtgroup.com)

Status: Signed

Transaction ID: CBJCHBCAABAA9huFzCmV6MtNSXSuvelqrBd6Nb2Dpfm4

09/06/2017 - 1:53:57 PM MDT- IP address: 96.93.208.65



09/06/2017 - 1:54:01 PM MDT



09/06/2017 - 2:14:46 PM MDT- IP address: 66.102.6.201



Signature Date: 09/07/2017 - 2:46:20 PM MDT - Time Source: server- IP address: 24.213.191.90



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