

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security
E-Verify
Report Prepared: 05/19/2015
Page: 1 of 1

Case Verification Number: 201513909173SS

Case Information:

Employee Information:
 Last Name: Skanlerud
 Middle Initial:
 Social Security Number: *** ** 9615
 Citizenship Status: A citizen of the United States
 Document Information:
 Last B Document: ID card issued by a U.S. Federal, state or local government agency
 Alien Number:
 Additional Information:
 Hire Date: 05/18/2015
 Employer Case ID: JMS3269
 Three-Day Rule Reason: Submitted By: 05/19/2015
 Initial Case Result: Employment Authorized

Employee Referred to SSA:

Referred By: Referred On:
 Case Result from SSA (after SSA Tentative Nonconfirmation):
 Case Result: Response Date:

Resubmitted to SSA (after Review and Update Employee Data):

Last Name: First Name: Other Names Used: Date of Birth: Resubmitted On:
 Middle Initial: Social Security Number: Resubmitted By:
 Case Result from SSA (after Resubmission):
 Case Result: Comments: Submitted By: Submitted On:

Request Name Review:

Case Result:
 Request Name Review:
 Comments: Submitted By: Submitted On:

Employee Referred to DHS:

Referred By: Referred On:
 Case Result from DHS (after DHS Tentative Nonconfirmation):
 Case Result: Response Date:

Photo Matching Results:

Determination:
 Photo Matching Results:
 Employee Referred to DHS (Additional):
 Referred By: Referred On:

Case Result from DHS (after Additional DHS Tentative Nonconfirmation):

Case Result:

Response Date:

Case Closure:

Closure Statement:

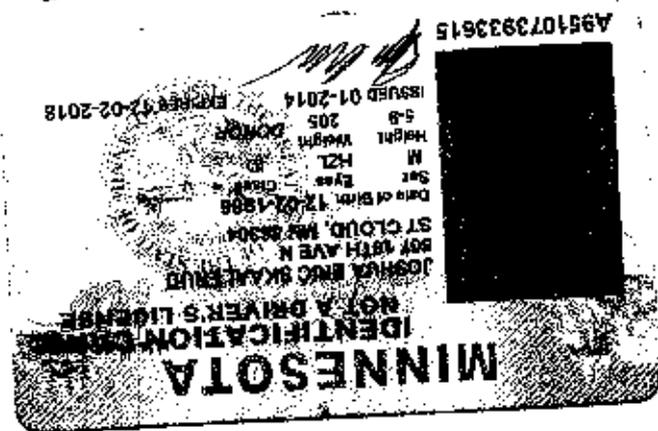
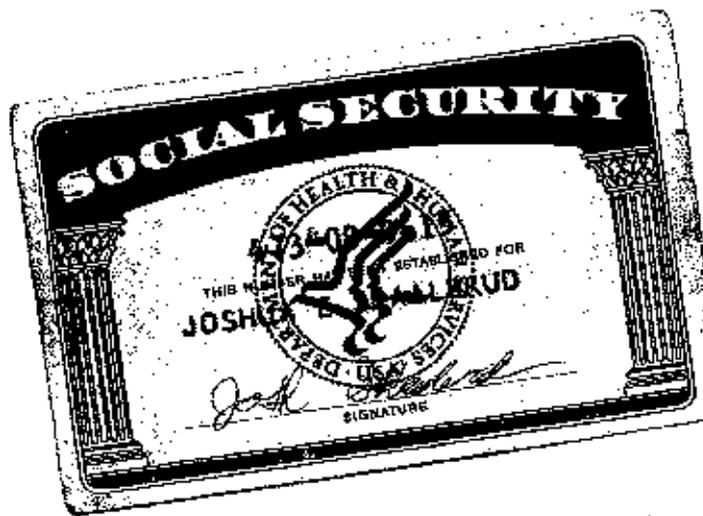
The employee continues to work for the employer after receiving an Employment Authorized result.
Closed On: 03/19/2015

JMIS3269

Closed On:

03/19/2015

SENSITIVE BUT UNCLASSIFIED



DOH _____		RDP _____	Work Site Loc. _____	WC Code _____
For ESSG Client Use				
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (if applicable) _____	ESSG Application _____
DOH _____	NHW _____	I-9 _____	8850 _____	WA _____
For ESSG Office Use Only				

A copy or facsimile ("fax") will be considered the same as an original signature. Email will ONLY be used for employment correspondence

Name (Print or type) Josh Skoglerud
 Applicant's Signature [Signature]
 Date 5-18-15

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

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.

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 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 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.

Applicant Certification and Authorization

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

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

Staffing Agency/Recruitment Partner CMG
 Phone Number 320-203-1962
 Email Address [Redacted]
 City/State/zip St. Cloud, MN 56303
 Street Address 529 16th Ave N
 Apt/Site _____
 Last Name Skoglerud First Name Joshua Middle Initial E

Personal Data - PLEASE PRINT LEGIBLY IN INK

New Hire Application

7301 Ohms Lane Suite 405
 Edina, MN 55439
 Tel: 952.835.1288 • Fax: 952.835.1255
 www.esgstaffingsolutions.com

empoyer solutions staffing group.
 Leveraging Resources in a Changing Market



The exceptions do not apply to supplemental wages greater than \$1,000,000. Base imputations. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheet on page 2 further adjust your withholding allowance based on limited deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Enter "1" for yourself if no one else can claim you as a dependent. A You are single and have only one job; or B Enter "1" if: You are married, have only one job, and your spouse does not work; or Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 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.) D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return. E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above). F Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit. (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) 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 \$85,000 (\$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 \$55,000 and \$84,000 (\$100,000 and \$118,000 if married), enter "1" for each eligible child. 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.)

For accuracy, and adjustments Worksheet on page 2. If you are eligible and have more than one job or are married 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 signature (This form is not valid unless you sign it.)

Employee's Withholding Allowance Certificate

OMB No. 1545-0074 2015

1 Your last name and middle initial: Johnson
2 Your social security number: 473-08-9615
3 Single Married Married, but withheld at higher single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
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): 2
6 Additional amount, if any, you want withheld from each paycheck
7 If you meet both conditions, write "Exempt" here. If this year I expect a refund of all federal income tax withheld because I expect to have no tax liability. Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption.

8 City or town, state, and ZIP code: St. Cloud, MN 56303
9 Office code (optional):
10 Employer identification number (EIN):

Employer's name and address (Employer completes lines 8 and 10 only if sending to the IRS):
Employer's signature: [Signature]
Date: 5-18-15

Employment Eligibility Verification

U.S. Citizenship and Immigration Services



USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶ START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire 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) Skaland		First Name (Given Name) Toshua		Middle Initial E	Other Names Used (if any)	
Address (Street Number and Name) 528 16th Ave N		Apt. Number	City or Town St Cloud	State	Zip Code	
Date of Birth (m/d/yyyy) 12-02-1986		U.S. Social Security Number 475-08-9615		E-mail Address N/A		Telephone Number 320-203-1962

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):

- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, m/d/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Signature of Employee: _____

Date (m/d/yyyy): **05-18-2015**

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator: _____

Date (m/d/yyyy): _____

Last Name (Family Name): _____

First Name (Given Name): _____

Address (Street Number and Name): _____

City or Town: _____

State: _____

Zip Code: _____



DISCLOSURE AND AUTHORIZATION (IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION)

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" that may include information about your character, general reputation, personal characteristics, and/or mode of living, and that can involve personal interviews with sources, such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security number validation, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been requested and compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING'S website is at www.orange-treescreening.com, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports 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 investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.
New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.
Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

ACKNOWLEDGMENT 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 these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING'S website is at: www.orange-treescreening.com, 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.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law. **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 ESSG. (Must include email address: _____)

BACKGROUND INFORMATION

Signature: 

Date: 5-18-15

Last Name: Skoalend
First: Joshua
Middle: Eric

Other Names/Aliases: _____
Social Security #: 473-08-9615
Driver's License #: A951073933615
State of Driver's License: WA

Present Address: 529 16th Ave N
City/State/Zip: St. Cloud, MN 56303

Telephone # (Primary): 820-203-1962

*This information will be used for background screening purposes only and will not be used as hiring criteria.

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: Joshua Skarland SSN# (last 4 digits): 9615 Effective Date: _____

SECTION 2 - PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below)

Payroll Debit Card (Please complete Sections 1 and 5 below)

SECTION 3 - DIRECT DEPOSIT

Update Bank Account

Bank Name: _____

Routing#: _____

Account#: _____

Account Type: Checking Savings Other _____

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

Initial: _____ Date: _____

SECTION 4 - PAYROLL DEBIT CARD (GLOBAL CASH CARD)

- 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 5 - PAYROLL DEBIT CARD (to be issued)

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, ESSGI 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: Joshua M.I.: E Last Name: Skarland

Street Address (no box or apartment): 529 16th Ave N City: St. Cloud State: MN Zip: 56303

Cell Phone (mobile): 520-263-1962

Social Security #: 473-08-9615

Date of Birth: 12-02-86

GET TEXT ALERTS, when your paycheck is deposited on your card! All we need to know your cell phone service provider and mobile number above!

Yes, sign me up for text alerts

My mobile service provider is: _____

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

Payroll Debit Card Routing #: 073972181

Payroll Debit Card Account #: 4853-4001-5319-3522

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: 5-18-15

SECTION 6 - AUTHORIZATION

I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings and authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s).

* E-mail is required for pay stub information.

E-mail: _____

This information will only be used to send your pay stubs electronically.

Employee's Signature: _____ Date: 5-18-15

ENROLLMENT FORM

ESC NAV*SAD P2M V15J

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK

(Must Be Filled Out)

Social Security Number 423-08-9615

Date of Birth 12/02/1986 Sex M F

Name Sethu Steelend

Street Address 529 W 4th Ave W

City St Albans State MA Zip 56503

Home Phone 820-203-1962

Do you or any dependents have Medicare? Yes No If Yes:

Medicare Health Insurance Claim Number (HICN) _____

Medicare Effective Date _____

Names of Covered Person(s) _____

1. _____

2. _____

3. _____

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number _____

Date of Birth _____ Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth _____ Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth _____ Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth _____ Sex M F

Relationship: Spouse Child Domestic Partner

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY _____

RELATIONSHIP _____

Accidental Death & Dismemberment is part of the Term Life Benefit.

OPTION 1 FIXED INDEMNITY PLAN

Weekly Rates

You MUST enroll in the Indemnity Medical Insurance Plan before adding any additional Indemnity benefits, except Dental. Your coverage level for the Term Life will be identical to your medical plan selection.

FIXED INDEMNITY MEDICAL \$20.91 Employee Only

\$42.44 Employee + 1

\$56.67 Employee + Family

NO to all Indemnity benefits.

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL

\$5.99 Employee Only

\$11.98 Employee + 1

\$19.77 Employee + Family

NO

TERM LIFE

YES \$0.60 Employee Only

YES \$0.90 Employee + 1

NO \$1.80 Employee + Family

SHORT-TERM DISABILITY

YES \$4.20 Employee Only

NO

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

OPTION 2 MEC WELLNESS/PREVENTIVE PLAN

Monthly Rates

\$58.87 Employee Only

\$87.73 Employee + 1

\$186.99 Employee + Family

NO to MEC Wellness/Preventive Plan

RELATIONSHIP

NAME OF BENEFICIARY _____

RELATIONSHIP _____

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY _____

RELATIONSHIP _____

Accidental Death & Dismemberment is part of the Term Life Benefit.

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY _____

RELATIONSHIP _____

Accidental Death & Dismemberment is part of the Term Life Benefit.

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY _____

RELATIONSHIP _____

Accidental Death & Dismemberment is part of the Term Life Benefit.

NAME OF BENEFICIARY _____

RELATIONSHIP _____

Date 05/18/2015

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declaration of coverage.

Signature 