Comstock – Tom Messicci

CMG
CORPORATE MANAGEMENT GROUP

New Employee Acknowledgement Form

Welcome to CMG and ESSG!

As a new employee, you will be provided with the website, username and password to view the new hire forms that you signed during your CMG interview. Please sign and date the bottom of the sheet stating that you received your login *information.*

CMG/ ESSG

Healthcare Notice of Exchange and Website for Enrollment

Safety Policy

Drug and Alcohol Testing Policy

View Paystubs

Website: https://zenople.esgazure.com/login/cmg

** do not fill out the below login name and password, CMG will provide you with this information **

Login Name: _____

Login Password: _____

I hereby acknowledge that I have been provided with the login information to view the items listed above. I understand that it is my responsibility to read and follow each document provided to me and that if I have any questions concerning the times or its content, that it is my responsibility to address my questions with my supervisor o CMG representative, and hereby waive any claim, now or in the future, that I did not receive, did not read or did not comprehend the items or their contents.

Signature: _____ Date: _____

Authorization to Enter New Hire Information

By signing below, I authorize a member of Corporate Management Group – Rochester Office – to enter my new hire paperwork into the online Zenopole (NHO) site. I understand that I will be provided access via login name and password to view the forms that they have completed on my behalf.

Employee Signature: Thomas M Messina Date: 8-10-23

Insurance Information

I understand that the CMG Staff defaults to decline insurance when entering my new hire paperwork unless specified otherwise during my interview.

I understand that I have 30 days after my employment starts to apply for insurance through ESSG via the login information provided to me.

I agree: TM **(initial)**

Employee Photo Consent Form

I, Thomas Messina, agree to let CMG –to take and upload my photo for security purposes.

Employee Signature Name: Thomas M Messina

Date: 8-10-23

Electronic W-2 Consent:

The IRS has approved employers to send W-2 electronically to employees. Employees who choose to receive their W-2 statements electronically will have the following advantages. Faster access to your W-2. Ongoing availability to view the W-2. Ability to reprint as many times as needed.

Would you like to receive your W-2 statement electronically? Yes X No_____

*By completing the box below, you are consenting to receive your W-2 by email to only the email address that you list. A paper copy will **NOT** be provided. This option can be changed at any time but remains in effect until you inform ESSG that you would like to revoke your consent.*

I consent to receive my W-2 by email at the address listed below from this date forward.

Email: tmessicci@gmail.com

I agree: TM **(initial)**

Applicant Certification and Authorization for Background Check

Please read the below statements and initial on the indicated line

(This information will be inputted onto the online NHO form – you will be provided the login information during your interview)

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

I understand that comprehensive background checks may be conducted to determine my eligibility for my 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 my employment, will result in my termination.

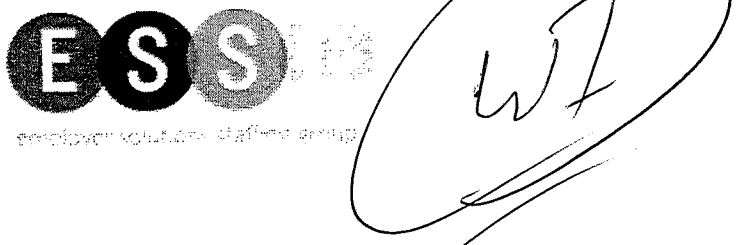
If hired, I agree to abide by the policies and procedures of ESSG.

I have read and agree _____ **(initial)**

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, country jurisdictions, driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge 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.

I have read and agree _____ **(initial)**



Notification of Minnesota Law Requirement – Unemployment Acknowledgement

According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment. This paragraph applies only if, at the time of beginning of employment with the staffing service, the applicant signed and was provided a copy of a separate document written in clear and concise language that informed the applicant of this paragraph and that unemployment benefits may be affected.

It is your responsibility to contact ESSG through the recruiter stated below for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG through the recruiter stated below within 5 calendar days once an assignment ends. I also acknowledge that I have been provided a copy of this form.

_____ (Initial)

Employee Signature: _____

Date: _____

Print your name: _____

EMERGENCY CONTACT INFORMATION

Employer Solutions Staffing Group In-Case of an Emergency – Notification Information

Please list at least one person with one working phone number.

We will only contact the name(s) listed below if we are unable to get ahold of you or if there is an emergency.

Contact # 1:

Name: Patricia Messicci

Relationship: wife

Phone Number: 715-641-1374

Contact # 2

Name: Nick Messicci

Relationship: Son

Phone Number: 715-641-2383

Additional information you want ESSG and our client to know in the event of an emergency:

This information will remain confidential and will only be used in the case of an emergency.

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	SSN# (last 4 digits)	Effective Date:
Thomas Messicci	xxx-xx-7092	8-10-23

SECTION 2 ELECTRONIC PAY OPTIONS

- o Direct Deposit (Please complete Sections 3 and 5 below) Note: Direct Deposit accounts may take up to 7 days to be activated.
- o Payroll Debit Card (Please complete Sections 4 and 5 below)
- o Paper Check (Option available to GA, NH, and NY residents only)

SECTION 3 DIRECT DEPOSIT ACCOUNT

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.

TM (Initial)

Date: 8-10-23

Bank Name: Westconsin Credit Union

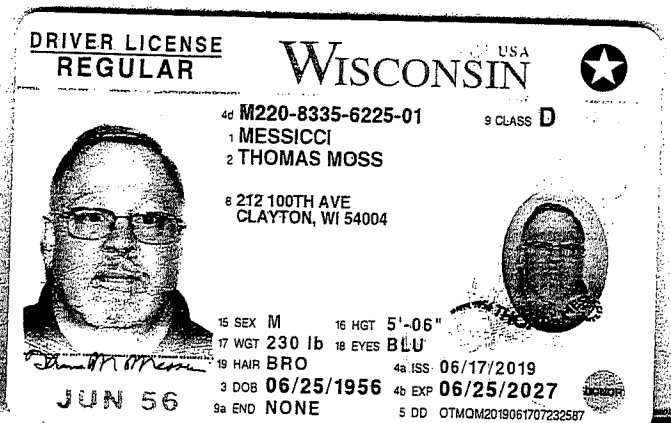
Routing#: 291880589

Account#: 0745632844

Account Type: (Checking) -or- Savings

* To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work) Attached

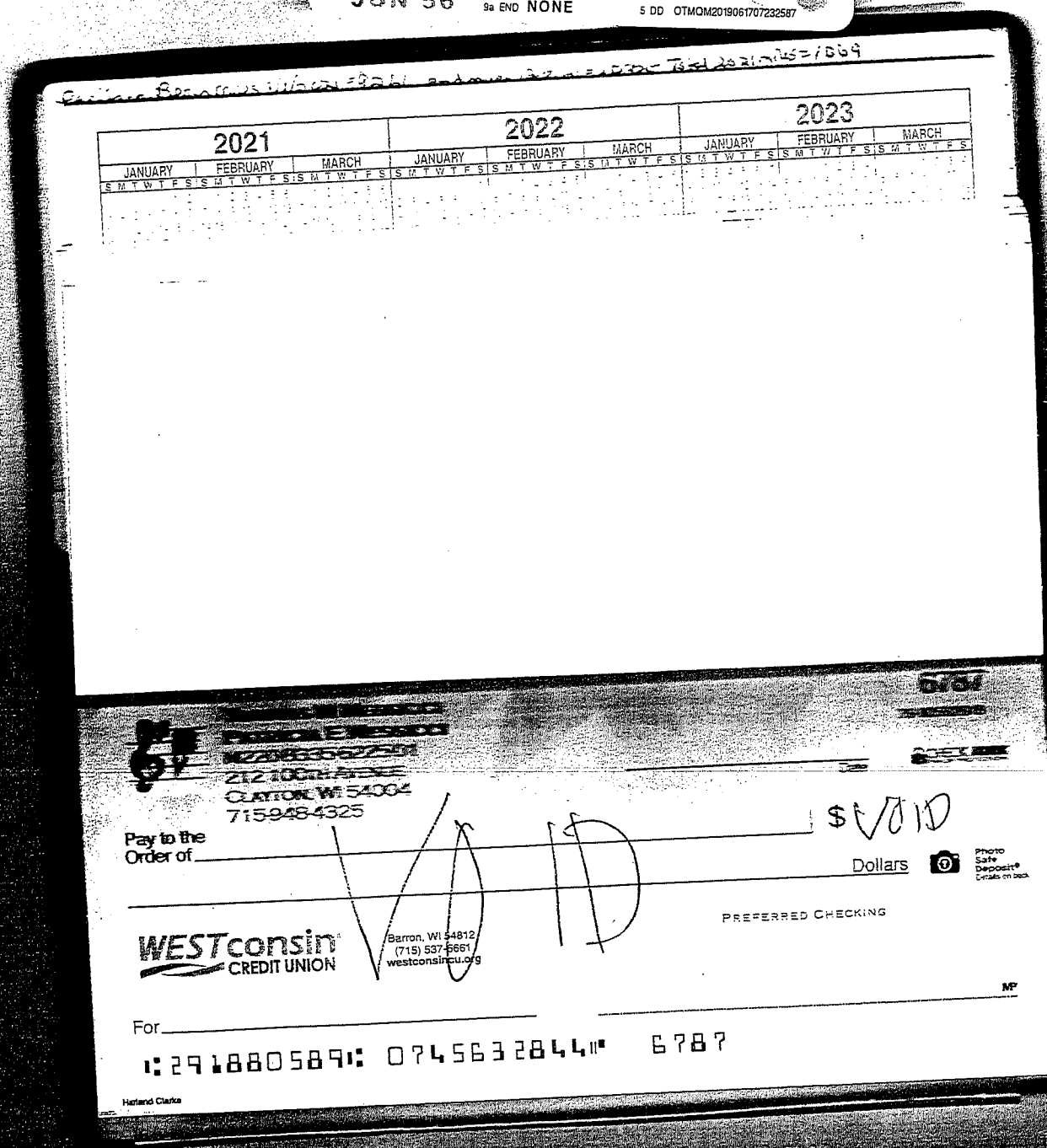
* If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.


DRIVER LICENSE
REGULAR

WISCONSIN USA

4d M220-8335-6225-01
1 MESSICCI
2 THOMAS MOSS
8 212 100TH AVE
CLAYTON, WI 54004
9 CLASS D
15 SEX M
16 HGT 5'-06"
17 WGT 230 lb
18 EYES BLU
19 HAIR BRO
4a ISS 06/17/2019
3 DOB 06/25/1956
4b EXP 06/25/2027
9a END NONE
5 DD OTMQM20190617072325B7

JUN 56


2021 2022 2023

JANUARY FEBRUARY MARCH JANUARY FEBRUARY MARCH JANUARY FEBRUARY MARCH

S M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S

Paula Blesci
212 100th Ave
Clayton WI 54004
7159484325

6787

Pay to the Order of _____ $ VOID

_____ Dollars

Photo Safe Deposit® Details on back

PREFERRED CHECKING

WESTconsin CREDIT UNION
Barron, WI 54812
(715) 537-5661
westconsincu.org

For _____

MP

⑆291880589⑆ 074563284411 6787

Harland Clarke

SECTION 4 PAYROLL DEBIT CARD

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. To request a Payroll Debit Card for you, we must provide all 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. Upon hire, you will receive your new Payroll Debit Card, and a packet containing all 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.

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

Payroll Debit Card Routing # _____

Payroll Debit Card Account # _____

I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature: _____

Date: _____

SECTION 5 AUTHORIZATION

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

Employees Signature: Thomas M Mosher Date: 8-10-23

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)
Messicci	Thomas	M	

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
212 100th Avenue		Clayton	WI	54004

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
6-25-56	468-70-7092	tmessicci@gmail.com	715-491-7602

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the Instructions.):

- [x] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See Instructions.)
- [ ] 3. A lawful permanent resident (Enter USCIS or A-Number.)
- [ ] 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)
Thomas M Messicci	8-10-23

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

WT-4

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

Employee's Section

Employee's Name (last, first, middle initial)	Social Security Number		Date of Birth
Messick, Thomas M	468-70-7092		6-25-56
Employee's address (number and street)	**City**	**State**	**Zip Code**
212 100th Avenue	~~Clayton~~ Clayton	WI	54004
☐ Single ☒ Married ☐ Married, but withhold at higher Single rate. **Note:** *If married, but legally separated, check the Single box.*			Date of Hire 8-10-23

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3 only if your Wisconsin exemptions are different than your federal allowances.

1. (a) Exemption for yourself – enter 1 ..... _____
   (b) Exemption for your spouse – enter 1 ..... _____
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent ..... _____
   (d) Total – add lines (a) through (c) 0
2. Additional amount per pay period you want deducted (if your employer agrees) ..... _____
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" ..... _____

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

Signature _____ Date Signed _____ , _____

EMPLOYEE INSTRUCTIONS:

- WHO MUST FILE:
  Every Employee is required to file a completed Form WT-4 with each of his or her employers unless the Employee claims the same number of withholding exemptions for Wisconsin withholding tax purpose as for federal withholding tax purpose. Form WT-4 (or federal Form W-4 if a Form WT-4 is not filed) will be used by your employer to determine the amount of Wisconsin income tax to be withheld from your paychecks. If you have more than one employer, you should claim a smaller number or no exemptions on each Form WT-4 filed with employers other than your principal employer so that the total amount withheld will be closer to your actual income tax liability.
  Your employer may also require you to complete this form to report your hiring to the Department of Workforce Development.
  You may file a new Form WT-4 any time you wish to change the amount of withholding from your paychecks, providing the number of exemptions you claim does not exceed the number you are entitled to claim.
- UNDER WITHHOLDING:
  If sufficient tax is not withheld from your wages, you may incur additional interest charges under the tax laws. In general, 90% of the net tax shown on your income tax return should be withheld.
- OVER WITHHOLDING:
  If you are using Form WT-4 to claim the maximum number of exemptions to which you are entitled and your withholding exceeds your expected income tax liability, you may use Form WT-4A to minimize the over withholding.
- WHEN TO FILE IF YOUR EXEMPTIONS CHANGE:
  You must file a new certificate within 10 days if the number of exemptions previously claimed by you DECREASES.
  You may file a new certificate at any time if the number of your exemptions INCREASES.

- **HOW TO COMPLETE FORM WT-4**
  Clearly print your full name (last, first, middle initial), address, social security number and date of birth.
- LINE 1:
  (a)-(c) Number of exemptions — Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).
  (c) Dependents — Those persons who qualify as your dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term "dependents" does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.
- LINE 2:
  Additional withholding — If you have claimed "zero" exemptions on line 1, but still expect to have a balance due on your tax return for the year, you may wish to request your employer to withhold an additional amount of tax for each pay period. If your employer agrees to this additional withholding, enter the additional amount you want deducted from each of your paychecks on line 2.
- LINE 3:
  Exemption from withholding — You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax for last year, and you anticipate that you will incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.
  You must revoke this exemption (1) within 10 days from the time you anticipate you will incur income tax liability for the year or (2) on or before December 1 if you anticipate you will incur Wisconsin income tax liabilities for the next year. If you want to stop or are required to revoke this exemption, you must file a new Form WT-4 with your employer showing the number of withholding exemption you are entitled to claim. This certificate for exemption from withholding will expire on April 30 of next year unless a new Form WT-4 is filed before that date.

Employer's Section

Employer's Name		Federal Employer ID Number	
Employer's payroll address (number and street)	**City**	**State**	**Zip Code**

EMPLOYER INSTRUCTIONS for Department of Revenue:

- If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.
- If the Employee has claimed more than 10 exemptions OR has claimed complete exemption from withholding and earns more than $200.00 a week or is believed to have claimed more exemptions than he or she is entitled to, mail a copy of this certificate to: Wisconsin Department of Revenue, Audit Bureau, P.O. Box 8906, Madison, WI 53708 or fax (608)-267-0834.
- Keep a copy of this certificate with your records. If you have questions about the Department of Revenue requirements, call (608) 266-8646 or (608) 266-2776.

EMPLOYER INSTRUCTIONS for New Hire Reporting:

- This report contains the required information for reporting New Hire to Wisconsin. Mail the original form to the Department of Workforce Development, New Hire Reporting, PO Box 14431, Madison, WI 53708-0431 or fax toll free to 1-800-277-8075.
- If you are reporting New Hires electronically, you do not need to forward a copy of this report to Department of Workforce Development.
- If you have questions about New Hire requirements, call toll free (888) 300-HIRE (888-300-4473).

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial: Thomas M
Last name: Messicci
(b) Social security number: ~~468-70-7092~~

Address: 212 100th Avenue
468-70-7092
Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.

City or town, state, and ZIP code: Clayton, WI 54004

(c) ☐ Single or Married filing separately
☒ Married filing jointly or Qualifying surviving spouse
☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

~~Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5.~~ See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . 3 $ 0

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) Extra withholding. Enter any additional tax you want withheld each pay period . . 4(c) $

Step 5: Sign Here

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

Thomas M Messicci — 8-10-23

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Form **8850** (Rev. March 2016)
Department of the Treasury
Internal Revenue Service

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

▶ Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.*

OMB No. 1545-1500

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

Your name Thomas Messina Social security number ▶ xxx-xx-7092

Street address where you live 212 100th Avenue

City or town, state, and ZIP code Clayton, WI 54004

County Polk Telephone number 715-491-7602

If you are under age 40, enter your date of birth (month, day, year) N/A

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.

N/A

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ Thomas M Messina **Date** 8-10-23

Comstock – Tom Messina

Customize your Health Benefits with these Two Affordable Plans!

Plan 1: Enhanced MEC

administered by: HEALTHEZ

All preventative services are covered 100%. Other medical services have a flat copay. All generic prescriptions are covered for a $10 copay. This plan does not cover any hospitalization or emergency room services. It does cover urgent care services.

Network:

iPHCS

- ACA qualifying plan for Minimum Essential Coverage (MEC)
- Covers all 63 preventative and wellness services
- Copay only plan. No deductible or out-of-pocket maximum
- PHCS Network
- Month-to-month coverage
- Premiums are collected pretax

Plan 2: Fixed Indemnity

administered by: ESC pai

Employees will get a flat dollar amount back per service. The employee would be responsible for the difference. For example, if an employee goes to a doctor's office visit and the overall bill comes to $300, the insurance company would take $120 off, meaning the employee would owe out of pocket $180.

Networks:

First Health. eyemed DENTEMAX CVS caremark

- Offers medical, dental, vision, term life, and short-term disability benefits.
- Unbundled selections. Enrolling in medical coverage is not a requirement to enroll in the other benefit options.
- Covers hospitalization and emergency room services
- First Health Network
- Week-to-week coverage
- Medical, dental and vision premiums are collected pretax

Major Medical Coverage

New employees may be offered a major medical plan after meeting certain eligibility requirements. Contact the Health Benefits Team if you would like more information.

Health Benefits Team
952.767.9519
health@employersolutionsgroup.com
www.essghealth.com

ESSG
employer solutions staffing group

Frequently Asked Questions

Is there a waiting period to enroll?

No. there is no waiting period. There is a processing time of 1-2 business weeks to fully process the enrollment form and get everything set up with the insurance companies.

When will my plan become effective?

Both plans have different timelines. The Enhanced MEC plan becomes effective the 1st day of the following month once the enrollment form has been processed. The Fixed Indemnity plan becomes effective the following Monday after deductions have started.

Is my enrollment form processed right away?

No. Your enrollment form(s) will be processed once you receive your first paycheck.

When will I receive my insurance card?

Both insurance companies will mail out the insurance cards on/around the first week of coverage being effective.

I completed an enrollment form, but why haven't deductions started coming out of my paycheck?

Deductions for the Enhanced MEC plan will not start until your plan has become effective. For example, if your effective date was 8/1/2021, your deductions would start being collected from your August paychecks.

Deductions for the Fixed Indemnity plan will typically begin on your 2nd or 3rd paycheck depending on how quickly your enrollment form is processed. Each time you have a deduction for this plan, that's giving you coverage for the following Monday-Sunday.

I filled out an enrollment form, but I'm not sure when I'll start working. Do I need to complete a new enrollment form when I start my assignment?

Enrollment and change forms are valid for 60 days. If you receive your first paycheck within 60 days of completing your forms, no additional action would be required. If it has been more than 60 days, you'll need to complete new forms.

How do I cancel my plan?

A change form needs to be completed. Change forms are located on our website www.essghealth.com. You have within your first 30 days of working, during open enrollment, or within 30 days of a qualifying life event occurring to enroll, cancel, or makes changes.

What is a qualifying life event (QLE)?

The most common types of qualifying life events are marriage, divorce, birth/adoption of a child, gaining new coverage, or lose of previous insurance.

Health Benefits Team
962.767.9519
health@employersolutionsgroup.com
www.essghealth.com

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Summary of Medical Benefits

ESG Care Copper™ (MEC+)

	In-Network	Out-of-Network
Deductible & Out-of-Pocket Maximum	None	
Preventive Care - Children		
Assessments & Screenings	100% Covered	No Coverage
Immunizations & Supplements	100% Covered	No Coverage
Preventive Care - Women		
Breastfeeding Support	100% Covered	No Coverage
Contraception	100% Covered	No Coverage
Screenings	100% Covered	No Coverage
Folic Acid Supplements	100% Covered	No Coverage
Routine Prenatal & Well-Woman Visits	100% Covered	No Coverage
Preventive Care - Adults		
Assessments, Screenings & Immunizations	100% Covered	No Coverage
Office Visits		
Primary Services	$20 Copay	No Coverage
Specialist Services	$50 Copay	No Coverage
CVS Minute Clinic	$10 Copay	No Coverage
Urgent Care	$50 Copay	No Coverage
Chiropractic Services *(10 visit limit)*	$75 Copay	No Coverage
Labs & Scans		
Diagnostic Lab & X-ray *(In office)*	$60 Copay	No Coverage
CT/MRI or Outpatient Testing	$200 Copay	No Coverage
Durable Medical Equipment	$50 Copay	No Coverage
Mental Health Outpatient *(10 visit limit)*	$75 Copay	No Coverage
HealthiestYou Services		
General Consultations	100% Covered	
Dermatology	$75 Copay	
Mental Health - Therapist	$85 Copay	
Mental Health - Psychiatrist, initial evaluation	$200 Copay	
Mental Health - Psychiatrist, ongoing session	$95 Copay	
Emergency Services	No Coverage	
Hospital Services	No Coverage	

Summary of Pharmacy Benefits

Prescription Drug Coverage	Retail 30 Day Supply	Mail Order 90 Day Supply
Generic	$10 Copay	Not available
Preferred brand	100% Copay	Not available
Non-preferred brand	Not available	Not available
Specialty	Not available	Not available

Note: Please refer to your Summary Plan Description for actual coverage, limitation, and exclusion provisions.

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WEEKLY RATES:
Employee Only: $27
Employee + Child(ren): $39
Employee + Spouse: $41
Employee + Family: $66

Policy Number **219300-ESG**

LIMITED BENEFITS SUMMARY

FIXED INDEMNITY MEDICAL BENEFIT

For more details, please see your Summary Plan Description.

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by an accident or illness. If the covered event costs more, you pay the difference. But if the covered event costs less, you keep the difference.

Outpatient Benefits[1]		**Inpatient Benefits**	
Physician Office Visit (Virtual or In-Person)	$120 per day	Standard Care	$700 per day
Diagnostic (Lab)	$200 per day	Intensive Care Unit Maximum[3]	$800 per day
Diagnostic (X-Ray)	$300 per day	Inpatient Surgery	$4,000 per day
Ambulance Services	$300 per day	Anesthesia	$800 per day
Physical, Speech, or Occupational Therapy	$75 per day	Skilled Nursing[4]	$100 per day
Emergency Room Benefit—Sickness	$200 per day	First Hospital Admission (1 per year)	$375
Emergency Room Benefit—Accident[2]	$1,000 per day	Annual Inpatient Maximum[5]	No Limit
Outpatient Surgery	$1,000 per day	**Prescription Drugs (via reimbursement)**[6,7]	
Anesthesia	$400 per day	Annual Maximum	$700
Annual Outpatient Maximum	$2,300	Per Day	$40
Wellness Care			
Wellness Care (one per year)	$125		

[1]all outpatient benefits are subject to the outpatient maximum [2]covers treatment for off the job accidents only [3]pays in addition to standard care benefit [4]for stays in a skilled nursing facility after a hospital stay [5]subject to internal limits of plan [6]not subject to outpatient maximum [7]To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc.

DENTAL BENEFIT

Annual Maximum Benefit $750 **Deductible** $50

	Waiting Period/Coinsurance	
Coverage A	None / 100%	Exams, Cleanings, Intraoral Films, and Bitewings
Coverage B	3 Months / 60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures
Coverage C	12 Months / 50%	Periodontics, Crowns, Endodontics, Bridges and Dentures

VISION BENEFIT

	In-Network		**Out-of-Network**	
	You Pay	Plan Pays	You Pay[3]	Plan Pays
Eye Examination [1] (including dilation)	$10 Copay	100%	100%	$35
Exam Options (Standard or Premium Contact Lens Fit)	Up to $55 or 10% off Retail Price	$0	100%	up to $40
Frames [2]	$0 Copay, 80%, after $100 allowance	$100 allowance, 20% off	100%	$45
Standard Plastic Lenses (single, bifocal, trifocal) [1]	$10 Co-pay	20% off retail	100%	$25-$55
Lens Options	$15 Copay	-	100%	$0
Contact Lenses (Conventional) [1]	$0 Copay, 85% of remaining	$80, plus 15% off	100%	$64
Disposable Contact Lenses [1]	$0 Copay	$80 allowance	100%	$0
Medically Necessary Contact Lenses [1]	$0 Copay	100%	$0	$200

[1]Once every 12 months [2]Once every 24 months [3]After plan payment

GROUP TERM LIFE BENEFIT

Employee Amount	$10,000 (reduces to $7,500 at 65; $5,000 at 70)	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$5,000 (terminates at age 70)	**Infant Amount (15 days to 6 mos)**	$1,000

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D is part of the Group Term Life Benefit.)

Employee Amount	$20,000	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$20,000	**Infant Amount (15 days to 6 mos)**	$2,500

SHORT-TERM DISABILITY BENEFIT

Benefit Amount	60% of base pay up to $150 per week
Waiting Period/Maximum Benefit Period	7 days for injury or sickness / up to 26 weeks

LIMITED BENEFITS PREMIUM	**Medical**			**Dental**			**Vision**			**Term Life**			**STD**		
	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly
Employee Only	$19.96	$39.92	$43.25	$6.17	$12.34	$13.37	$1.67	$3.33	$3.61	$0.60	$1.20	$1.30	$4.20	$8.40	$9.10
Employee + 1	$40.51	$81.02	$87.77	$12.34	$24.68	$26.74	$3.33	$6.66	$7.22	$0.90	$1.80	$1.95	-	-	-
Employee + Family	$54.09	$108.18	$117.20	$20.36	$40.72	$44.11	$5.28	$10.57	$11.45	$1.80	$3.60	$3.90	-	-	-

HEALTHEZ

Enhanced MEC Medical_Plan 1

Benefits Enrollment Form ☐ New Employee ☐ Rehire Rehire Date Comstock 8-10-23

Employee Information

First Name	Last Name	Social Security Number
Thomas	Messicci	xxx-xx-7092

Address	City	State	Zip Code
212 100th Ave	Clayton	WI	54004

Gender	Marital Status	Date of Birth	Date of Hire
☒ Male ☐ Female	☐ Single ☐ Married ☐ Divorced		

Phone Number:	Email Address:
715-491-7602	tmessicci@gmail.com

Please Select Desired Coverage:

☐ Employee Only - $27.00/Week ☐ Employee+Spouse - $41.00/Week ☐ Employee+Child(ren) - $39.00/Week ☐ Family - $66.00/Week

Dependent

First Name M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child

Dependent

First Name M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child

Dependent

First Name M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

EFF. DATE

EFF. DATE

EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature Date

EMPLOYEES DECLINING ☒ I am DECLINING coverage

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING - YOU MUST SIGN HERE

Employee Signature Thomas M Messicci Date 8-10-23

Employer Solutions Staffing Group Health Benefits Team
PO Box 46270
Eden Prairie, MN 55344
Phone: 952-767-9519 Fax: 952-767-9515
Email: health@employersolutionsgroup.com

VSI **219300-ESG** OFFICE USE ONLY LOCATION Comstock 8-10-23 Rehire Date ___/___/_____

ENROLLMENT FORM

ESC UNACwbi*MN P1 v23.1

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name Thomas Messicci Social Security # ~~XXX-XX-7092~~ Phone 715-491-7602 Gender [M] [F]

Address 212 100th Avenue Apt. #

City Comstock State WI Zip 54004 Date of Birth / /

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?

[X] Yes [ ] No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) Medicare Effective Date

Name of Covered Person (s):
1. 2. 3.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Rates

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

	FIXED INDEMNITY MEDICAL [1]			DENTAL			VISION			TERM LIFE			SHORT-TERM DISABILITY [2]		
	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly	weekly	biweekly	semi-monthly
Employee Only [ ]	$19.96	$39.92	$43.25	$6.17	$12.34	$13.37	$1.67	$3.33	$3.61	$0.60	$1.20	$1.30	$4.20	$8.40	$9.10
Employee + 1 [ ]	$40.51	$81.02	$87.77	$12.34	$24.68	$26.74	$3.33	$6.66	$7.22	$0.90	$1.80	$1.95	-	-	-
Employee + Family [ ]	$54.09	$108.18	$117.20	$20.36	$40.72	$44.11	$5.28	$10.57	$11.45	$1.80	$3.60	$3.90	-	-	-
NO to ALL Benefits [X]	[ ] Yes [ ] No			[ ] Yes [ ] No			[ ] Yes [ ] No			[ ] Yes [ ] No			[ ] Yes [ ] No		

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] STD is not available to persons who reside in **CA, HI, NJ, NY,** or **RI.**

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Group Term Life Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Gender	Relationship
		/ /	[M] [F]	[ ] Spouse [ ] Child [ ] Domestic Partner
		/ /	[M] [F]	[ ] Spouse [ ] Child [ ] Domestic Partner
		/ /	[M] [F]	[ ] Spouse [ ] Child [ ] Domestic Partner
		/ /	[M] [F]	[ ] Spouse [ ] Child [ ] Domestic Partner

E. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benefit plans. I understand that open enrollment is only available for a limited time; that making no benefit selection is a declination of benefit coverage and benefit coverage is only available to employees who are over the age of 18.

DATE 08/10/2023 ▶ **SIGNATURE** Thomas M Messicci