



New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name perkins First Name torrence Middle Initial m
 Street Address 3105 zenith ave north Apt/Ste _____
 City/State/Zip minneapolis mn 55422 Social Security Last Four XXX-XX-3575
 Phone Number 6124079019 Email Address torrence.perkins@yahoo.com
 Staffing Agency/Recruitment Partner none

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.

torrence perkins
 Name (Print or type)

torrence perkins
torrence perkins (Mar 15, 2018)
 Applicant's Signature

Mar 15, 2018
 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 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2018 if both of the following apply.

- For 2017 you had a right to a refund of all federal income tax withheld because you had no tax liability, and
- For 2018 you expect a refund of all federal income tax withheld because you expect to have no tax liability.

If you're exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 9 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1992, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

| | | | | | |
|--|--|---|---|---|--|
| Form W-4 Department of the Treasury Internal Revenue Service | | Employee's Withholding Allowance Certificate | | OMB No. 1545-0074 2018 | |
| ▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS. | | | | | |
| 1 Your first name and middle initial torrence | | Last name perkins | | 2 Your social security number 394083575 | |
| Home address (number and street or rural route) 3105 zenith ave north | | | 3 <input checked="" type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate." | | |
| City or town, state, and ZIP code minneapolis mn 55422 | | | 4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/> | | |
| 5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) | | | | 5 4 | |
| 6 Additional amount, if any, you want withheld from each paycheck | | | | 6 \$ | |
| 7 I claim exemption from withholding for 2018, and I certify that I meet 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 | |
| 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>torrence perkins</i> <small>(written perkins 18 15, 2018)</small> | | Date ▶ Mar 15, 2018 | |
| 8 Employer's name and address (Employer complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.) | | | 9 First date of employment | | 10 Employer identification number (EIN) |

2018 Minnesota Employee Withholding Allowance/Exemption Certificate

Employees

You must complete and give this form to your employer if you do any of the following:

- Claim fewer Minnesota withholding allowances than your federal allowances
- Claim more than 10 Minnesota withholding allowances
- Want additional Minnesota tax withheld from your pay each pay period
- Claim to be exempt from federal withholding or claim to be exempt from Minnesota withholding

Do not complete this form if you are claiming the same number of Minnesota allowances as federal and the number claimed is 10 or less.

| | | |
|--|-----------|---|
| Employee's first name and initial torrence perkins | Last name | Employee's Social Security number 394083575 |
| Permanent address 3105 zenith ave north | | Marital status (check one box) |
| City minneapolis mn 55422 | State | <input checked="" type="radio"/> Single; Married, but legally separated; or Spouse is a nonresident alien |
| | ZIP code | <input type="radio"/> Married |
| | | <input type="radio"/> Married, but withhold at higher Single rate |

Employees: Read instructions on back, complete Section 1 OR Section 2, sign and give the completed form to your employer. (Do not complete both Section 1 and Section 2. Completing both sections will make the form invalid.)

Section 1 — Determining Minnesota allowances

Complete Section 1 if you claim fewer Minnesota allowances than your federal allowances, AND/OR if you want additional Minnesota withholding deducted each pay period.

| | | |
|--|---|---|
| 1 Total number of federal allowances claimed on federal Form W-4 | 1 | 4 |
| 2 Total number of Minnesota allowances (line 2 cannot be more than line 1) | 2 | 4 |
| 3 Additional Minnesota withholding you want deducted each pay period | 3 | 0 |

Section 2 — Exemption from Minnesota withholding

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding (see Section 2 instructions for qualifications). If applicable, check one box below to indicate the reason why you believe you are exempt:

- I meet the requirements and claim exempt from both federal and Minnesota income tax withholding.
- Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding because I had no Minnesota income tax liability last year, I received a refund of all Minnesota income tax withheld, AND I expect to have no Minnesota income tax liability this year.
- My spouse is a military service member assigned to a military location in Minnesota, my domicile (legal residence) is in another state, AND I am in Minnesota solely to be with my spouse. My state of domicile is _____
- I am an American Indian living and working on a reservation.
- I am a member of the Minnesota National Guard or an active duty U.S. military member and claim exempt from Minnesota withholding on my military pay.
- I receive a military pension or other military retirement pay as calculated under Title 10, 1401 through 1414, 1447 through 1455, and 12733 and claim exempt from Minnesota withholding on this retirement pay.

I certify that all information provided in Section 1 OR Section 2 is correct. I understand there is a \$500 penalty for filing a false withholding allowance/exemption certificate.

| | | |
|---|--------------------------|---------------------------------|
| Employee's signature <u><i>torrence perkins</i></u> <small>torrence perkins (Mar 13, 2013)</small> | Date Mar 15, 2018 | Daytime phone 6124079019 |
|---|--------------------------|---------------------------------|

Employees: Give the completed form to your employer.

Employers

If you are required to send a copy of this form to the Department of Revenue (see instructions), you must enter the employer information below and mail this form to: Minnesota Revenue, Mail Station 6501, St. Paul, MN 55146-6501. (Incomplete forms are considered invalid.) A \$50 penalty may be assessed for each required Form W-4MN not filed with the department.

Keep a copy for your records.

| | | |
|------------------|-----------------------------------|-------------------------|
| Name of employer | Federal employer ID number (FEIN) | Minnesota tax ID number |
| Address | City | State |
| | | ZIP code |

Form W-4MN Instructions

Do not complete this form if you are claiming the same number of Minnesota allowances as federal and the number claimed is 10 or less.

Employee Instructions

Should I complete Form W-4MN?

Complete Form W-4MN and provide it to your employer, if you do any of the following:

- Claim fewer Minnesota allowances than federal allowances (You may not claim more Minnesota allowances than federal allowances)
- Claim more than 10 Minnesota allowances
- Request additional Minnesota withholding be deducted each pay period
- Claim to be exempt from Minnesota income tax withholding (see Section 2 instructions)

Before you complete Form W-4MN, determine the number of federal withholding allowances you are claiming on federal Form W-4. Then, determine the number of your Minnesota withholding allowances.

Consider completing a new Form W-4MN if your personal or financial situation changes. If you have not had sufficient income tax withheld from your wages, interest and/or penalty charges may be assessed when you file your individual income tax return.

Your employer may be required to submit copies of your Form W-4MN to the department.

Note: You may be subject to a \$500 penalty if you submit a false Form W-4MN.

Section 1 — Minnesota Allowances
Claim the correct number of allowances. If you expect to owe more income tax for the year than will be withheld:

- claim fewer allowances
- request additional Minnesota taxes to be withheld from your wages (complete line 3)

Section 2 — Minnesota Exemption

Your employer will not withhold Minnesota taxes from your pay if you are exempt from withholding. To claim exemption, you must meet one of the following requirements:

- You meet the federal requirements; you claim exempt from federal withholding on Form W-4; you had no Minnesota income tax liability in the prior year; you received a full refund of Minnesota tax withheld; and you expect to have no Minnesota income tax liability for the current year.
- You are the spouse of a military member assigned to duty in Minnesota, you and your spouse are domiciled in another state (the same state as one another) and are present in Minnesota solely to be with your active duty military member spouse.
- You are a member of an American Indian tribe living and working on the reservation of which you are an enrolled member.
- Your wages are for Minnesota National Guard (MNG) pay or for active duty U.S. military pay. MNG and active duty U.S. military members can claim exempt from Minnesota withholding on these wages, even if taxable federally. For additional information, see Income Tax Fact Sheet 5. *Military Personnel*.
- You receive a military pension or other military retirement pay calculated under Title 10, 1401 through 1414, 1447 through 1455, and 12733. If you receive this income, you may claim exempt from Minnesota withholding on this income even if taxable federally.

Note: In order to avoid owing tax at the end of the year, you may not want to claim exempt if you (and/or your spouse when filing a joint return) expect to have other forms of income subject to Minnesota tax.

If you claim exempt from Minnesota withholding, you must provide your employer with a new Form W-4MN by February 15th of each year.

If another person can claim you as a dependent on his or her federal tax return, you cannot claim exempt from Minnesota withholding if your annual income exceeds \$950 and includes more than \$300 of unearned income.

Use of Information

All information on Form W-4MN is private by state law. It cannot be given to others without your consent, except to the Internal Revenue Service and to other states that guarantee the same privacy. Your name, address and Social Security number are required for identification. Information about your allowances is required to determine your correct tax. We ask for your phone number so we can call you if we have a question.

Employer instructions are on the next page.



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ **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) perkins | | First Name (Given Name) torrence | | Middle Initial m | Other Last Names Used (if any) n/a | |
| Address (Street Number and Name) 3105 zenith ave north | | | Apt. Number n/a | City or Town minneapolis | | State mn |
| Date of Birth (mm/dd/yyyy) 08/19/1991 | | U.S. Social Security Number 394 03 575 | | Employee's E-mail Address torrence.perkins@yahoo.com | | Employee's Telephone Number 6124079019 |

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

| |
|--|
| <input checked="" type="radio"/> 1. A citizen of the United States |
| <input type="radio"/> 2. A noncitizen national of the United States (See Instructions) |
| <input type="radio"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): <u>n/a</u> |
| <input type="radio"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): <u>n/a</u> Some aliens may write "N/A" in the expiration date field. (See Instructions) |
| <p>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</p> <p>1. Alien Registration Number/USCIS Number: <u>n/a</u> OR</p> <p>2. Form I-94 Admission Number: <u>n/a</u> OR</p> <p>3. Foreign Passport Number: <u>n/a</u> Country of Issuance: <u>n/a</u></p> |
| |

| | |
|---|---|
| Signature of Employee <u>torrence perkins</u> <small>torrence perkins (Mar 11, 2018)</small> | Today's Date (mm/dd/yyyy) Mar 15, 2018 |
|---|---|

Preparer and/or Translator Certification (check one):

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

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

| | | | |
|-------------------------------------|--|---------------------------|----------------|
| Signature of Preparer or Translator | | Today's Date (mm/dd/yyyy) | |
| Last Name (Family Name) | | First Name (Given Name) | |
| Address (Street Number and Name) | | City or Town | State ZIP Code |

Employer Completes Next Page



MINNESOTA DRIVER'S LICENSE/ENHANCED DRIVER'S LICENSE IDENTIFICATION CARD/INSTRUCTION PERMIT APPLICATION

THIS IS NOT A STANDALONE IDENTIFICATION DOCUMENT

MINNESOTA DRIVER'S LICENSE, INSTRUCTION PERMIT OR IDENTIFICATION CARD NUMBER: **D1064065169370** Birth Date (Month/Day/Year): **08/19/1991**

FULL LEGAL NAME: **TORRENCE MONTRELL PERKINS** Complete Last Name: **Perkins**

PREVIOUS LEGAL NAME (ONLY APPLIES IF YOU CHANGED IT SINCE LAST MN DRIVER'S LICENSE, EDL, ID OR IP APPLICATION): **Montrell** Complete Last Name: **Perkins**

COMPLETE FIRST NAME: **TORRENCE** COMPLETE MIDDLE NAME: **MONTRELL** COMPLETE LAST NAME: **PERKINS**

FIELD RESIDENCE ADDRESS (WHERE YOU LIVE) Note: Make sure this is your CURRENT and valid address. The post office will NOT forward your card.

Number: **3105** Street: **Zenith ave North** Apt #: **411**

City: **MINNEAPOLIS** State: **MN** Zip Code: **55417** MN County: **RAM**

OPTIONAL MAILING ADDRESS (USE #1 ON BACK OF WHITE COPY) MAKE SURE THIS IS A VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD. I Agree that this U.S. Postal Service will not deliver mail to my residence address shown here, INITIAL HERE TO HAVE YOUR CARD SENT TO THE ADDRESS BELOW.

NUMBER: _____ STREET: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____ MN COUNTY: _____

APPLICANT'S PHYSICAL DISQUALIFICATION: **DBDN** (Fr. 00) Hr. 160

Without or Position: **MALE** FINAL

Visit dvs.dps.mn.gov to:

| | | | | | | | | | |
|-----|--------|------------|--------|--------------|------------|---------|---------|---------|-----|
| REG | EDL | DUP | DUP | DUP | DUP | DUP | DUP | DUP | DUP |
| CLP | REG IP | INDICATORS | SENIOR | LTD MOBILITY | SNOWMOBILE | FIREARM | S or TC | VETERAN | |

RESTRICT/ENDORSE

MC ORIG/AL

MC RENEWAL

ADD/REMOVE

FEES PAID APPLICATION: \$ **144.75**

OTHER FEES: SB PHYS \$ **5**

MC \$ **5**

REIN FEE \$ **5**

OTHER \$ **5**

ORGAN DONATION \$ **5**

TESTS PASSED (STATE EXAM USE ONLY)

D

MC

MBOP

GK

AIR

COMB

DBL/TRIPLE

PASSENGER

SCHOOL BUS

TANKER

HAZMAT

DWI

RT Passed

RT Waived

TYPE

REG

EDL

A

B

C

D

PROV

ID

MBOP

CLP

REG IP

NOTES: **LOST, ID/COA**

I was provided all agency warnings as required by state and federal law. Submission of this application constitutes consent to registration with the selective service system. If required by federal law, I consent that the information on this application is correct. If I am applying for driving privileges, I am aware of my duties, responsibilities, and penalties outlined in M.S. § 169.444 regarding the safety of children around vehicles.

2018 582 075

Application Date: **02/28/2018**

Application Signature: **Torrence Perkins**

Application Date: **02/28/2018**

THIS DOCUMENT IS A RECEIPT FOR THE TYPE OF CARD INDICATED AND IS NOT A STANDALONE IDENTIFICATION DOCUMENT

- This receipt, in conjunction with an invalidated previous license, instruction permit or ID card, may be used as identification.
- This receipt is valid for the type of card indicated, when stamped with the proper validation stamp, for a maximum of 60 days from the application date shown above.

Henepin Coun

Date: 3/16/2018 10:47 AM

Batch: 100818

Trans

Receipt # 02619906

Brooklyn Center MN 55430

612-349-8240

6125 Shingle Creek Pe

Transaction Total: _____

Cash Tended: _____

Change Tended: _____

HOW DID WE DO TODAY? Complete our survey

Not valid as Enhanced Driver's License (EDL) for border crossings. Lost, stolen and duplicate EDL cards are deactivated and may not be used for border crossings.

This receipt is not in compliance with testing requirements indicated on the driving record

This card belongs to the Social Security Administration and you must return it if we ask for it.

If you find a card that isn't yours, please return it to:
Social Security Administration

P.O. Box 33008, Baltimore, MD 21290-3008

For any other Social Security business information, contact your local Social Security office. If you write to the above address for any business other than returning a found card you will not receive a response.

Social Security Administration
Form SSA-3000 (08-2011)



G47518609

CLASS ID ONLY

ENDORSEMENTS PAGE
NEFTICKETS FORM



01 01 01

SOCIAL SECURITY

394-08-3375

THIS NUMBER HAS BEEN ESTABLISHED FOR

TORRENCE MONTRELL PERKINS

Torrence Montrell Perkins

SIGNATURE



04/10/2015

MINNESOTA

IDENTIFICATION CARD NOT A DRIVER'S LICENSE

TORRENCE MONTRELL PERKINS
3100 THOMAS AVE N
MINNEAPOLIS, MN 55411

Date of Birth: 08-18-1981
Sex: M
Eyes: BRN
Class: ID
Height: 5-0
Weight: 150

ISSUED 02-2013 EXPIRES 08-19-2017



D064066164310



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) | First Name (Given Name) | M.I. | Citizenship/Immigration Status |
|-------------------------------------|-------------------------|-------------------------|------|--------------------------------|

| | | | | |
|--|-----------|---|------------|--|
| List A | OR | List B | AND | List C |
| Identity and Employment Authorization | | Identity | | Employment Authorization |
| Document Title | | Document Title | | Document Title |
| Issuing Authority | | Issuing Authority | | Issuing Authority |
| Document Number | | Document Number | | Document Number |
| Expiration Date (if any)(mm/dd/yyyy) | | Expiration Date (if any)(mm/dd/yyyy) | | Expiration Date (if any)(mm/dd/yyyy) |
| Document Title | | <div style="border: 1px solid black; padding: 5px;"> Additional Information </div> | | <div style="border: 1px solid black; padding: 5px; text-align: center;"> <small>QR Code - Sections 2 & 3 Do Not Write In This Space</small> </div> |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |

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

The employee's first day of employment (mm/dd/yyyy): _____ (See Instructions for exemptions)

| | | | | |
|--|---|-------------------------------------|--|--------------------------|
| Signature of Employer or Authorized Representative | | Today's Date (mm/dd/yyyy) | Title of Employer or Authorized Representative | |
| Last Name of Employer or Authorized Representative | First Name of Employer or Authorized Representative | | Employer's Business or Organization Name EMPLOYER SOLUTIONS STAFFING GROUP LLC | |
| Employer's Business or Organization Address (Street Number and Name) 7490 FLYING CLOUD DRIVE SUITE 200 | | City or Town EDEN PRAIRIE | State MN | ZIP Code 55344 |

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: torrence perkins
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: 3105 zenith ave north Minneapolis MN 55422
(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: 394083575 DOB: 08/19/1991

Phone Number: 6124079019

Driver's License Number/State: _____

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: *torrence perkins*
torrence perkins (Mar 15, 2018) Date: Mar 15, 2018

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 lo 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: |
|--|---|
| <p>1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates.</p> <p>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau:</p> | <p>a. Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20552</p> <p>b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357</p> |
| <p>2. To the extent not included in Item 1 above:</p> <p>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks</p> <p>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</p> <p>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and Insured state savings associations</p> <p>d. Federal Credit Unions</p> | <p>a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050</p> <p>b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480</p> <p>c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106</p> <p>d. National Credit Union Administration</p> |

EMERGENCY CONTACT INFORMATION

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

Employee Name: torrence perkins

Address: 3105 zenith ave north

Home Phone: 6124079019

| EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency | |
|---|--|
| <p style="text-align: center;">Contact #1</p> <p>Name: <u>ulonda forest</u></p> <p>Relationship: <u>mother</u></p> | <p>Home Phone: <u>6122633189</u></p> <p>Cell Phone:</p> <p>Work Phone:</p> |
| <p style="text-align: center;">Contact #2</p> <p>Name: <u>deja mosley</u></p> <p>Relationship: <u>spouse</u></p> | <p>Home Phone: <u>6124079019</u></p> <p>Cell Phone:</p> <p>Work Phone:</p> |

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

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

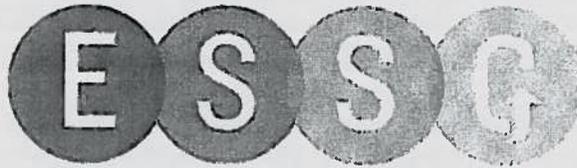


employer solutions staffing group

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 | torrence perkins | SSN# (last 4 digits) | 3575 |
| | | Effective Date | Mar 15, 2018 |
| SECTION 2 PAYROLL ELECTION | | | |
| <input type="radio"/> Direct Deposit (Please complete Sections 3 and 5 below) | | <input type="checkbox"/> Paper Check (Option available to GA NH and NY residents only) | |
| <input checked="" type="radio"/> Payroll Debit Card (Please complete Sections 4 and 5 below) | | | |
| SECTION 3 DIRECT DEPOSIT | | | |
| ACCOUNT | <input type="checkbox"/> Update Bank Account | | |
| | Bank Name: | | |
| | Routing# | | |
| | Account# | | |
| | Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other | | |
| <p><i>Note: Direct Deposit accounts may take up to 7 days to be activated.</i></p> <p>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.</p> <p>Initial _____ Date _____</p> | | | |
| <ul style="list-style-type: none"> 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 | | | |
| <p>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.</p> <p>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.</p> | | | |
| CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued) | | | |
| First Name | torrence | M.I. | m |
| | | Last Name | perkins |
| | | Date of Birth | 08/19/1991 |
| Street Address (PO BOX NOT ACCEPTABLE) | | 3105 zenith ave north | |
| | | Social Security# | 394083575 |
| City | minneapolis | State | mn |
| | | Zip | 55422 |
| | | Cell Phone (mobile) | 6512103654 |
| RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card) | | | |
| Payroll Debit Card Routing # | Payroll Debit Card Account # <u>4853 4002 7248 2284</u> | | |
| <p>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.</p> | | | |
| Employee's Signature: <u>torrence perkins</u> | | Date: <u>Mar 15, 2018</u> | |
| SECTION 5 AUTHORIZATION | | | |
| <p>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.</p> | | | |
| *E-mail: <u>torrence.perkins@yahoo.com</u> @ | | | |
| this information will only be used to send your paystubs electronically | | | |
| Employee's Signature: <u>torrence perkins</u> | | Date: <u>Mar 15, 2018</u> | |



employer solutions staffing group, llc

STATEMENT OF CONFIDENTIALITY

This agreement made this 16 day of March, 2018, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Torrence hereafter referred to as "employee".

WITNESSETH:

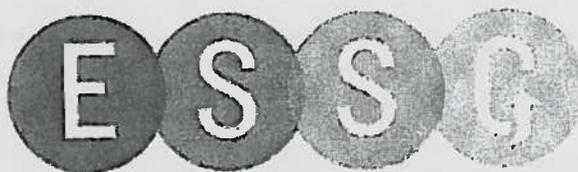
For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

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.

torrence perkins
torrence perkins (Mar 15, 2018)

Employee Signature

Employer Solutions Staffing Group LLC, Representative



employer solutions staffing group

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: *torrence perkins*
torrence perkins (Mar 15, 2018)

Printed Name: torrence perkins



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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 policy 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): torrence perkins

Signature/Firma: *torrence perkins*
torrence perkins (Mar 15, 2018)



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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.

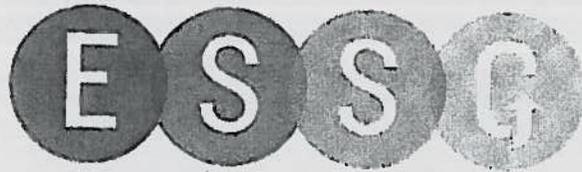
ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

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.



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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)

torrence perkins

Employee's Signature:

torrence perkins
torrence perkins (Mar 15, 2018)

Date: Mar 15, 2018

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 torrence perkins Social security number ► 394083575
Street address where you live 3105 zenith ave north
City or town, state, and ZIP code minneapolis mn 55422
County _____ Telephone number 6124079019
If you are under age 40, enter your date of birth (month, day, year) 08/19/1991

- 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.

Job applicant's signature ► torrence perkins
torrence.perkins (Mar 15, 2018)

Date Mar 15, 2018



EMPLOYER SECTION:

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

EMPLOYEE SECTION:

| | | | | |
|--|------------------------------|--|---|--------------------------|
| First Name: Last Name: torrence parkins | Suffix: | Street Address: 3105 zenith ave north | City/State: minneapolis mn | Zip: 55422 |
| SS#: 394083575 | Date of Birth: 08/19/1991 | Age: 26 | Have you worked for this company before? Yes <input type="radio"/> No <input checked="" type="radio"/> | If yes, location: n/a |

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: _____ | <input type="radio"/> | <input checked="" type="radio"/> |
| 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: _____ | <input type="radio"/> | <input checked="" type="radio"/> |
| 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. *If you checked yes please provide a copy of your SSI documentation. | <input type="radio"/> | <input checked="" type="radio"/> |
| 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: <input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program) Name of Agency: _____ Phone #: _____ City: _____ County: _____ State: _____ *If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation. | <input type="radio"/> | <input checked="" type="radio"/> |
| 5. Are you a Veteran of the U.S. Military? *If yes, please provide a copy of your DD-214 and letter of separation. (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? | <input type="radio"/> | <input checked="" type="radio"/> |
| 6. Have you been unemployed at any time during the last 12 months? If yes, dates of unemployment - From: _____ To: _____ Did you receive unemployment compensation at any point during your unemployment? If yes, in which state did you receive unemployment compensation? _____ | <input type="radio"/> | <input checked="" type="radio"/> |
| 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 <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____ | <input type="radio"/> | <input checked="" type="radio"/> |
| Additional Tax Credits | | |
| IEC (Native American): Are you or your spouse a member of a Native American Tribe? If you checked yes please provide a copy of your CDIB card. | <input type="radio"/> | <input checked="" type="radio"/> |
| CA Residents: <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act? <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor? | | |
| SC Residents: <input type="checkbox"/> 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: torrence parkins
torrence parkins (Rev. 12, 2016)

Date: Mar 15, 2018



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: *torrence perkins* Date Mar 15, 2018
torrence perkins (Mar 15, 2018)

New Hire Name: torrence perkins

Social Security Number: 394083575

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 _____
(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-4610, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

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.

torrence perkins
torrence perkins (Mar 15, 2018)

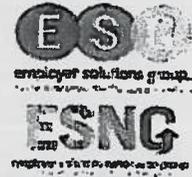
Individual's Name

Mar 15, 2018

Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6

Health Plan Options
Employee **KEEPS**
this page



Two great plans to choose from!

SIGN UPS AVAILABLE DURING YOUR
FIRST 30 DAYS OF EMPLOYMENT

Enhanced MEC_Plan 1

- MEC wellness/preventive plans starting at \$24.00/week
- Covers 63 mandated benefits AND \$20 office visit copay, \$10 generic prescription drug copay, \$10 CVS Minute Clinic copay and more!
- Eliminates employee individual mandate tax for those enrolled
- Options for family coverage
- Weekly payroll deduction – month by month coverage
- Visit www.essghealth.com for info and tools
- PHCS Network

Fixed Indemnity_Plan 2

- ESC Fixed Indemnity plans starting at \$20.25 per weekly payroll deduction
- Medical, Rx, vision and dental benefits
- Doctor office visit benefit of \$100 per day
- Wellness benefit of \$100
- No pre-existing condition limitations
- No waiting period or deductibles on medical
- First Health Network
- Unbundled choices-you do not need to have medical to choose the vision, dental, term life, or short term disability

ESSG offers a **Enhanced Minimum Essential Coverage (Plan 1)** which is administrated by Health EZ. The Minimum Essential Coverage (MEC) plan is ACA qualifying. There are copays for services like doctor's visits, x-rays, and generic prescription drugs. Please note - hospitalization is not a covered benefit.

ESSG offers a **Fixed Indemnity Plan (Plan 2)** which is administrated by Planned Administrators Inc. (PAI). The Fixed Indemnity Plan offers limited benefits at an affordable price, specifically for the staffing industry. Premiums will be automatically deducted from your weekly paycheck. This means you are buying it with pre-tax dollars. What does pre-tax dollars mean? It simply means the premium comes out before taxes are taken out, which means you're taxed on less income. Affordable medical, dental, vision, disability, and life insurance benefits are available.

You have **30 days** from the start of your employment to change your benefit elections.

The 3rd plan is offered to only qualifying employees*. It's an ACA qualifying **Bronze Plan** with Essential StaffCARE (ESC). Once you qualify, you will be notified by ESC that you are eligible, and will be given the opportunity to enroll. You should receive this after you have been on assignment for approximately 35 - 45 days. The offer will be mailed to the address we have on file. It is your responsibility to update your address if needed.

If you have any questions, please contact the Health Benefits Team at Employer Solutions Staffing Group.

An employee will be deemed qualifying any time after 30 days on assignment(s), and their status is working 30+ hours per week or more than 1560 total hours in a calendar year. They must be ESSG employees.

Health Benefits Team
Employer Solutions Staffing Group
PO Box 46270 | Minneapolis, MN 55344
Phone: 952-767-9519 | Fax: 952-767-9515
health@employersolutionsgroup.com
<http://ESSGHealth.com>



Enhanced MEC_Plan 1



| Summary of Medical Benefits | | |
|---|-------------------------|-----------------------------|
| MEC EZ Plan | | |
| | In-Network | Out-of-Network |
| Cover for Year Deductible | None | None |
| Coinsurance | None | None |
| Out-of-Pocket Maximum | None | None |
| Preventive Care | 100% Covered | No Coverage |
| NextBestYou Telemedicine Services | 100% Covered | 100% Covered |
| Primary Physician Office Visit | \$20 Copay | No Coverage |
| Specialist Office Visit | \$30 Copay | No Coverage |
| CVS Minute Clinic | \$10 Copay | No Coverage |
| Urgent Care | \$50 Copay | No Coverage |
| Emergency Services | No Coverage | No Coverage |
| Hospital Services – Inpatient & Outpatient Care | No Coverage | No Coverage |
| Mental Health / Chemical Dependency | No Coverage | No Coverage |
| Durable Medical Equipment | \$50 Copay | No Coverage |
| Labs & Scans | | |
| Diagnostic Lab & X-Ray – In Office | \$50 Copay | No Coverage |
| CT/MRI or Outpatient Testing | \$200 Copay | No Coverage |
| Prescription Drug Coverage | Retail 30 Day Supply | Mail Order 90 Day Supply |
| | Generic | No Coverage |
| | Preferred Brand | No Coverage |
| | Non-Preferred Brand | No Coverage |
| Specialty | No Coverage | No Coverage |

Weekly Premiums

| | |
|-----------------------|---------|
| Employee Only | \$24.00 |
| Employee + Spouse | \$38.00 |
| Employee + Child(ren) | \$36.00 |
| Family | \$63.00 |

NOTES: This serves as a summary of your benefit plan only. Please refer to your Summary Plan Description for actual coverage, limitation and exclusion provisions.

Fixed Indemnity Medical Benefits_Plan 2

LIMITED BENEFITS SUMMARY

Policy Number 219301-ESG-1

FIXED INDEMNITY MEDICAL BENEFIT

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

| | |
|---|---------------|
| Physician Office Visit | \$100 per day |
| Diagnostic (Lab) | \$75 per day |
| Diagnostic (X-Ray) | \$200 per day |
| Ambulance Services | \$300 per day |
| Physical, Speech, or Occupational Therapy | \$50 per day |
| Emergency Room Benefit - Sickness | \$200 per day |
| Emergency Room Benefit - Accident | \$750 per day |
| Outpatient Surgery | \$750 per day |
| Anesthesiology | \$300 per day |
| Annual Outpatient Maximum | \$2,250 |

Inpatient Benefits

| | |
|--|-----------------|
| Standard Care | \$300 per day |
| Intensive Care Unit Maximum ² | \$500 per day |
| Inpatient Surgery | \$3,500 per day |
| Anesthesiology | \$700 per day |
| Skilled Nursing ³ | \$100 per day |
| First Hospital Admission (1 per year) | \$250 |
| Annual Inpatient Maximum ⁴ | No Limit |
| Wellness Care | |
| Wellness Care (one per year) | \$100 |
| Prescription Drugs (via reimbursement) ^{5,6} | |
| Annual Maximum | \$600 |
| Per Day | \$30 |

¹ all outpatient benefits are subject to the outpatient maximum ² pays in addition to standard care benefit ³ for stays in a skilled nursing facility after a hospital stay
⁴ Subject to internal limits of plan ⁵ not subject to outpatient maximum ⁶ To file a claim for reimbursement, save your receipts and remit to Planned Administrators, Inc.

DENTAL BENEFIT

| | | |
|-----------------------------------|--|------------------------|
| Waiting Period/Coinsurance | Annual Maximum Benefit \$750 | Deductible \$50 |
| 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, Bridges, Endodontics and Dentures | |

VISION BENEFIT

| | In-Network | | Out-of-Network | |
|---|--------------------------------------|--------------------------|----------------|------------|
| | You Pay | Plan Pays | You Pay | 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

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 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 Salary up to \$150 per week |
| Waiting Period/Maximum Benefit Period | 7 days, up to 26 weeks |

WEEKLY LIMITED BENEFITS PREMIUM

| | Medical | Dental | Vision | Term Life | STD |
|--------------------------|---------|---------|--------|-----------|--------|
| Employee Only | \$20.25 | \$6.17 | \$2.42 | \$0.60 | \$4.20 |
| Employee + 1 | \$41.10 | \$12.34 | \$4.92 | \$0.90 | - |
| Employee + Family | \$54.88 | \$20.36 | \$6.56 | \$1.80 | - |

LIMITED BENEFIT EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

FIXED INDEMNITY MEDICAL

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
- Declared or undeclared war
- Serving on full-time active duty in the armed forces
- The covered person's commission of a felony
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions
- Hearing examinations or hearing aids
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force
- Services provided by a member of the covered person's immediate family.

The fixed indemnity medical plan is not available to residents of Hawaii, New Hampshire or Puerto Rico.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

VISION

No benefits are payable for services or materials connected with, or charges arising from:

- Orthoptic or vision training, sub-normal vision aids, and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes, or supporting structure;
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan;
- Services provided as a result of any Worker's Compensation law;
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount);

- Services or materials provided by any other group benefit providing for vision care;
- Two pair of glasses in lieu of bifocals.

PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent, or a person who resides in your home
- Declared or undeclared war or act of war
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony
- Your participation in a riot
- If you engage in an illegal occupation
- Release of nuclear energy
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

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

TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

For Accidental Death and Dismemberment benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

Attempted suicide or intentionally self-inflicted injury; bodily or mental infirmity; disease of any kind; or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound or accidental ingestion of poisonous food substance; voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you, your spouse or domestic partner; you, your spouse's or domestic partner's child; sibling or parent; or a person who resides in your home; declared or undeclared war or act of war; your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony; your participation in a riot; if you engage in an illegal occupation; release of nuclear energy; operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; work-related injury or sickness.

Member Services:

For frequently asked questions and network information for the the Fixed Indemnity Medical Plan, please go to www.essentialstaffcare.com/FAQVSI.

PLEASE NOTE: To make changes or cancel coverage by telephone call (800) 269-7783. Your pin code for enrolling/making changes is 140 + _____ (last four digits of your SSN). Your Company has chosen to take some/all of your payroll deductions on a Pre-Tax basis. Please contact Customer Service at 1-866-798-0803 and a Representative will assist you in identifying the deductions that are taken Pre-Tax.

Essential StaffCARE Customer Service: 1-866-798-0803

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets and to add, change, or cancel coverage.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit www.paisc.com and click on "Your Plan" and enter your group number.



Frequently Asked Questions

When can I enroll in a plan?

As a part-time or full-time employee, you are able to enroll within 30 days of your hire date, or during the annual open enrollment for the plan. If you do not enroll in one of those periods, you can only enroll if you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

What is a qualifying life event?

A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Death of an immediate family member
- Loss of dependent status
- Loss of prior coverage

When can I cancel off of the plan?

As our plans are pre-tax, you are only allowed to make changes/enroll/cancel during certain times of the year. The above listed times (your first 30 days of employment, during open enrollment, or within 30 days of a qualifying life event) are the only times you are able to change/enroll/cancel.

If I fill out a form, and do not get placed on assignment right away, do I need to fill out a new form?

Your form will stay valid for 6 months. If you are placed on assignment after 6 months of the signature date, you will need to fill out a new form to enroll in the plans. If you worked for a period of time and had deductions, and then stopped working for 6 consecutive weeks, you are considered a re-hire, and would need to fill out a new form to re-enroll. If you miss less than 6 consecutive weeks, the Fixed Indemnity Insurance will continue without penalty or the need to re-enroll. After 3 missed weeks the Enhanced MEC coverage will be cancelled.

When will my deductions start and coverage begin?

Fixed Indemnity Plan – Deductions will begin about 2 weeks after we at ESSG receive the form, coverage will begin the Monday following the first deduction

Enhanced MEC Plan – Deductions will begin the first of the month after we at ESSG receive the form, coverage will begin on the first of the month following one month of deductions

When will I receive my insurance card?

Fixed Indemnity Plan – It should come about a week after your first deduction.

Enhanced MEC Plan – It should come about 10 days prior to your effective date.

Additional Fixed Indemnity Plan information:

This plan does not qualify as minimum essential coverage as defined under the Affordable Care Act (ACA). This plan is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.

The Essential StaffCARE Fixed Indemnity Medical, Prescription Drug, and Dental Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1801, 26.212, and 26.213. The Term Life, Accidental Death and Dismemberment and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200. The Vision Plan is underwritten by Companion Life Insurance Company.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.



Essential StaffCARE
ESG ESC CU(UNAC-MN) P1 v18.2



Enhanced MEC_Plan 1



Benefits Enrollment Form

New Employee

Rehire Rehire Date

Employee Information

| | | | |
|--|---|------------------------|--------------|
| Name (First and Last) | | Social Security Number | |
| Address | | City | State |
| Zip Code | | | |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced | Date of Birth | Date of Hire |
| Phone Number: | | Email Address: | |

Please Select Desired Coverage:

Employee Only - \$24.00/Week
 Employee+Spouse - \$38.00/Week
 Employee+Child(ren) - \$36.00/Week
 Family - \$63.00/Week

Dependent

| | | | | | | |
|------------|------|-----------|-------------------|------------|---|---|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
|------------|------|-----------|-------------------|------------|---|---|

Dependent

| | | | | | | |
|------------|------|-----------|-------------------|------------|---|---|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
|------------|------|-----------|-------------------|------------|---|---|

Dependent

| | | | | | | |
|------------|------|-----------|-------------------|------------|---|---|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
|------------|------|-----------|-------------------|------------|---|---|

Other coverage information including: (Aetna/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 Mar 15, 2018

EMPLOYEE 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 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 or 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

torrence perkins
torrence perkins (Mar 15, 2018)

Date Mar 15, 2018

Employer Solutions Staffing Group Health Benefits Team
 PO Box 48270
 Minneapolis, MN 55344
 Phone: 952-787-9519 Fax: 952-787-9515
 Email: Health@employersolutionsgroup.com

Fixed Indemnity Medical Benefits Plan 2

VS/ 219301-ESG-1 OFFICE USE ONLY LOCATION _____ Rehire Date ____/____/____

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

| A. REQUIRED EMPLOYEE INFORMATION | | PRINT USING BLACK or BLUE INK (Must Be Filled Out) | |
|----------------------------------|-------------------|--|--|
| Name | Social Security # | Home Phone | Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> |
| Address | | | Apt. # |
| City | State | Zip | Date of Birth / / |

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) _____ Medicare Effective Date _____

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

| C. LIMITED BENEFITS PLAN SELECTION | | Payroll Deducted Weekly Rates | | | |
|---|--|--|--|--|--|
| You MUST select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company. | | | | | |
| SELECT COVERAGE LEVEL | FIXED INDEMNITY MEDICAL ¹ | DENTAL | VISION | TERM LIFE | SHORT-TERM DISABILITY ² |
| Employee Only <input type="checkbox"/> | \$20.25 <input type="checkbox"/> | \$6.17 <input type="checkbox"/> | \$2.42 <input type="checkbox"/> | \$0.60 <input type="checkbox"/> | \$4.20 <input type="checkbox"/> |
| Employee + 1 <input type="checkbox"/> | \$41.10 <input type="checkbox"/> | \$12.34 <input type="checkbox"/> | \$4.92 <input type="checkbox"/> | \$0.90 <input type="checkbox"/> | |
| Employee + Family <input type="checkbox"/> | \$54.88 <input type="checkbox"/> | \$20.36 <input type="checkbox"/> | \$6.56 <input type="checkbox"/> | \$1.80 <input type="checkbox"/> | |
| NO to ALL Benefits <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

¹This coverage is not available to residents of NH, HI, or PR. ²STD is not available to persons who work in CA, HI, NJ, NY, or RI.
For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

| | | | | |
|------|-------------------|---------------|---|--|
| Name | Social Security # | Date of Birth | Sex | Relationship |
| | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
| Name | Social Security # | Date of Birth | Sex | Relationship |
| | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
| Name | Social Security # | Date of Birth | Sex | Relationship |
| | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
| Name | Social Security # | Date of Birth | Sex | Relationship |
| | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |

E. REQUIRED SIGNATURE **YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE**

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

DATE Mar 15, 2018 SIGNATURE torrence perkins
torrence perkins (Mar 15, 2018)

This Plan DOES NOT Alleviate the Individual Mandate Penalty

This is an Essential StaffCARE Enrollment Form.