



employer solutions staffing group.

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Smithknecht First Name Tracy Middle Initial E
 Street Address 1018 121st Lane NE Apt/Ste NA
 City/State/Zip Blaine/MN 55434 Social Security Last Four XXX-XX- 5082
 Phone Number 763-283-9872 Email Address tracysmithk@yahoo.com @
 Staffing Agency/Recruitment Partner CMG

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.

Tracy Smithknecht Tracy Smithknecht Feb 13, 2018
 Name (Print or type) Applicant's Signature Date

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

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (if applicable) _____	ESC Application _____
For ESSG Client Use				
DOH _____	ROP _____	Work Site Loc. _____	WC Code _____	

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you aren't exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$190,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____
B	Enter "1" if: <ul style="list-style-type: none"> • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F _____
(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)		
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child. 	G _____
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶	H _____
For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 		

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate ▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		OMB No. 1545-0074 2017
1 Your first name and middle initial Tracy		Last name Smithknecht		2 Your social security number 470215082
Home address (number and street or rural route) 1018 121st Lane NE		NA		3 <input checked="" type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Married, but withheld at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code Bialne/MN 55434		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5 2
6 Additional amount, if any, you want withheld from each paycheck				6 \$
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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.) ▶ Tracy Smithknecht (Feb 13, 2018)		Date ▶ Feb 13, 2018		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)			9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

- 1 Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over \$313,800 and you're married filing jointly or you're a qualifying widow(er); \$287,650 if you're head of household; \$261,500 if you're single, not head of household and not a qualifying widow(er); or \$158,900 if you're married filing separately. See Pub. 505 for details. 1 \$ _____
- 2 Enter: $\left\{ \begin{array}{l} \$12,700 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,950 \text{ if head of household} \\ \$8,350 \text{ if single or married filing separately} \end{array} \right\}$ 2 \$ _____
- 3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) 4 \$ _____
- 5 Add lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) 5 \$ _____
- 6 Enter an estimate of your 2017 nonwage income (such as dividends or interest) 6 \$ _____
- 7 Subtract line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____
- 8 Divide the amount on line 7 by \$4,050 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the *Personal Allowances Worksheet*, line H, page 1 9 _____
- 10 Add lines 8 and 9 and enter the total here. If you plan to use the *Two-Earners/Multiple Jobs Worksheet*, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the *Deductions and Adjustments Worksheet*) 1 _____
- 2 Find the number in Table 1 below that applies to the **LOWEST** paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$85,000 or less, do not enter more than "3" 2 _____
- 3 If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet. 3 _____

Note: If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 _____
- 5 Enter the number from line 1 of this worksheet 5 _____
- 6 Subtract line 5 from line 4 6 _____
- 7 Find the amount in Table 2 below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____
- 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
- 9 Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 26 if you are paid every two weeks and you complete this form on a date in January when there are 26 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are--	Enter on line 2 above	If wages from LOWEST paying job are--	Enter on line 2 above	If wages from HIGHEST paying job are--	Enter on line 7 above	If wages from HIGHEST paying job are--	Enter on line 7 above
\$0 - \$7,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$810	\$0 - \$38,000	\$810
7,001 - 14,000	1	8,001 - 16,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 22,000	2	16,001 - 28,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
22,001 - 27,000	3	28,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 70,000	5				
44,001 - 55,000	6	70,001 - 85,000	6				
55,001 - 85,000	7	85,001 - 110,000	7				
85,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 95,000	10	140,001 and over	10				
95,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

2017 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 Information	Employee's first name and initial Tracy Smithknecht	Last name	Employee's Social Security number 470215082
	Permanent address 1018 121st Lane NE		Marital status (check one box) <input checked="" type="radio"/> Single; Married, but legally separated; or Spouse is a nonresident alien <input type="radio"/> Married <input type="radio"/> Married, but withhold at higher Single rate
	City Blaine/MN	State	ZIP code 55434

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.

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

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 12738 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>Tracy Smithknecht</u>	Date Feb 13, 2018	Daytime phone 763-283-9872
--------------------------------------------------	-----------------------------	--------------------------------------

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.

Employer Information	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

What's New?

Beginning with tax year 2016, you may not have to pay Minnesota income tax on your military pension or other military retirement pay calculated under Title 10, 1401 through 1414, 1447 through 1455, and 12733. When you file your Minnesota individual income tax return, complete and file Schedule M1M, Income Additions and Subtractions, to subtract this income from your Minnesota taxable income.

If you claim this subtraction, you may not claim the credit for past military service (reported on Schedule M1C, *Other Nonrefundable Credits*) which is a credit available to individuals whose Adjusted Gross Income (AGI) is less than \$37,500.

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) Smithknecht		First Name (Given Name) Tracy		Middle Initial NA	Other Last Names Used (if any) NA	
Address (Street Number and Name) 1018 121st Lane NE			Apt. Number NA	City or Town Blaine		State MN ZIP Code 55434
Date of Birth (mm/dd/yyyy) 01/31/1990	U.S. Social Security Number 470215082 -		Employee's E-mail Address Tracysmithk@yahoo.com		Employee's Telephone Number 763-283-9872	

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):	NA
<input type="radio"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy):	NA
Some aliens may write "N/A" in the expiration date field. (See instructions)	
Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.	
1. Alien Registration Number/USCIS Number:	NA
OR	
2. Form I-94 Admission Number:	NA
OR	
3. Foreign Passport Number:	NA
Country of issuance:	NA
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee <u>Tracy Smithknecht</u> Tracy Smithknecht (Feb 13, 2018)	Today's Date (mm/dd/yyyy) Feb 13, 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



TRACY ELIZABETH SMITHKNECHT
1018 121ST LANE NE
BLAINE, MN 55434

Date of Birth 01-31-1990

Sex

F

Eyes

HZL

Class

D

Height

5-5

Weight

110

DONOR

ISSUED 01-2015

EXPIRES 01-31-2019

Tracy Smithknecht

S899119331426

UNITED STATES OF AMERICA SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA

SOCIALLY SECURE

THIS NUMBER HAS BEEN ESTABLISHED FOR

470-21-5082

TRACY ELIZABETH
SMITHKNECHT

Tracy Smith

SIGNATURE

12/16/2015

SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA SOCIAL SECURITY

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)



G59600724



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) Smithknecht	First Name (Given Name) Tracy	M.I. E	Citizenship/Immigration Status
------------------------------	-----------------------------------------------	-----------------------------------------	------------------	--------------------------------

List A
OR
List B
AND
List C
 Identity and Employment Authorization Identify Employment Authorization

Document Title	Document Title Driver's License	Document Title Social Security Card
Issuing Authority	Issuing Authority State of MN	Issuing Authority Social Security Adm
Document Number	Document Number S899119331426	Document Number 470-21-5082
Expiration Date (if any) (mm/dd/yyyy)	Expiration Date (if any) (mm/dd/yyyy) 01-31-2019	Expiration Date (if any) (mm/dd/yyyy) N/A
Document Title	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Additional information</p> </div> <div style="width: 35%; border: 1px solid black; padding: 5px;"> <p>QR Code - Sections 2 & 3 Do Not Write In This Space</p> </div> </div>	
Issuing Authority		
Document Number		
Expiration Date (if any) (mm/dd/yyyy)		
Document Title		
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 <i>[Signature]</i>	Today's Date (mm/dd/yyyy) 02/13/2018	Title of Employer or Authorized Representative Recruiter
Last Name of Employer or Authorized Representative Zepeda	First Name of Employer or Authorized Representative Chilgheam	Employer's Business or Organization Name
Employer's Business or Organization Address (Street Number and Name)	City or Town	State ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
OR	AND	
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the Instructions for more information about acceptable receipts.

Authorization

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

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

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

Printed name:	Tracy	NA	Smithknecht
	First	Middle (<input type="checkbox"/> none)	Last

Other names used: _____

Current county of residence: _____

Current and former addresses:

11/2013	current	1018 121st Lane NE	Blaine/MN	55434
from Mo/Yr	to Mo/Yr	Street	City, State & Zip	
_____	_____	_____	_____	
from Mo/Yr	to Mo/Yr	Street	City, State & Zip	
_____	_____	_____	_____	
from Mo/Yr	to Mo/Yr	Street	City, State & Zip	
_____	_____	_____	_____	

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

01/31/1990	470215082
Date of birth	Social security number
S899119331426	Tracy Elizabeth Smithknecht
Driver's license number & state	Name as it appears on license

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

Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

Signature

Feb 13, 2018

Date

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

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

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

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

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

- You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- You may limit “prescreened” offers of credit and insurance you get based on information in your credit report. Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8588.
- You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- Identity theft victims and active duty military personnel have additional rights. For more information, visit www.consumerfinance.gov/learnmore.

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

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates.	a. Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450

EMERGENCY CONTACT INFORMATION

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

Employee Name: Tracy Smithknecht

Address: 1018 121st Lane NE Blaine/MN 55434

Home Phone: 763-283-9872

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: Jaye Depew Relationship: Mother	Home Phone: 763-283-9875 Cell Phone: Work Phone:
Contact #2 Name: Relationship:	Home Phone: Cell Phone: Work Phone:

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	Tracy Smithknecht	SSN# (last 4 digits)	5082
		Effective Date	
SECTION 2 PAYROLL ELECTION			
<input checked="" type="radio"/>	Direct Deposit (Please complete Sections 3 and 5 below)		<i>Note: Direct Deposit accounts may take up to 7 days to be activated.</i>
<input 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 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 <u>Ts</u> Date <u>02/13/2018</u></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 (GLOBAL CASH 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	M.I.	Last Name	Date of Birth
Street Address (PO BOX NOT ACCEPTABLE)			Social Security#
City	State	Zip	Cell Phone (mobile)
RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)			
Payroll Debit Card Routing #	Payroll Debit Card Account #		
073972181			
<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>Tracy Smithknecht</u>		Date: _____	
Tracy Smithknecht (Feb 13, 2018)			
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:	tracysmithk@yahoo.com @		
	this information will only be used to send your paystubs electronically		
Employee's Signature: <u>Tracy Smithknecht</u>	Date: <u>Feb 13, 2018</u>		
Tracy Smithknecht (Feb 13, 2018)			



employer solutions staffing group, LLC

STATEMENT OF CONFIDENTIALITY

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

WITNESSETH:

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

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of \$10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

Tracy Smithknecht

Tracy Smithknecht (Feb 13, 2018)

Employee Signature

Employer Solutions Staffing Group LLC, Representative



employer solutions staffing group_{LLC}

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: *Tracy Smithknecht*
Tracy Smithknecht (Feb 13, 2018)

Printed Name: Tracy Smithknecht



employer solutions staffing group_{llc}

Important/Importante

LOST OR STOLEN PAYCHECKS

If a paycheck is lost (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between \$25-\$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the police report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Tracy Smithknecht

Signature/Firma: Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2013)



employer solutions staffing group.

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.



employer solutions staffing group.

- **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 18 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.



employer solutions staffing group, inc.

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)

Tracy Smithknecht

Employee's Signature:

Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

Date: Feb 13, 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 Tracy Smithknecht Social security number ► 470215082

Street address where you live 1018 121st Lane NE

City or town, state, and ZIP code Blaine/MN 55434

County _____ Telephone number 763-283-9872

If you are under age 40, enter your date of birth (month, day, year) 01/31/1990

- 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 ► Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

Date Feb 13, 2018

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

First Name: Last Name: Tracy Smithknecht	Suffix:	Street Address: 1018 121st Lane NE	City/State: Blaine/MN	Zip: 55434
SS#: 470215082	Date of Birth: 01/31/1990	Age: 28	Have you worked for this company before? Yes <input type="radio"/> No <input checked="" type="radio"/>	If yes, location:

Please complete all questions, and sign and date the form.

Yes No

1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<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 checked="" 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 checked="" type="radio"/>	<input 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 checked="" 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: Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

Date: Feb 13, 2018



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: Tracy Smithknecht Date Feb 13, 2018
Tracy Smithknecht (Feb 13, 2018)

New Hire Name: Tracy Smithknecht

Social Security Number: 470215082

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.

Employee Keeps This Form

Healthcare Notice of Exchange

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

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

The Health Benefits Team
Employer Solutions Staffing Group
952-767-9519 | health@employersolutionsgroup.com



employer solutions staffing group
Leveraging Resources in a Changing Market

Notification of Minnesota Law Requirement – Unemployment Acknowledgement

According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment.

This paragraph applies only if, at the time of beginning of employment with the staffing service, the applicant signed and was provided a copy of a separate document written in clear and concise language that informed the applicant of this paragraph and that unemployment benefits may be affected.

It is your responsibility to contact ESSG through Corporate Management Group (for instance, by calling 303-920-1425 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. Ts (Initial)

Tracy Smithknecht

Tracy Smithknecht (Feb 13, 2018)

Feb 13, 2018

Employee Signature:

Date:

Tracy Smithknecht

Employee (please print your name here)

**Telephone: 303-920-1425
12000 N. Washington Street Suite 350
Thornton, CO 80241**

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.

6. 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.

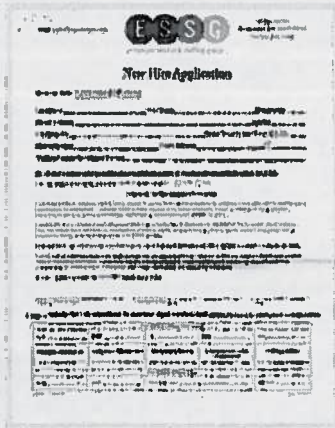
Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

Individual's Name

Feb 13, 2018

Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6








Corporate Management Group

Adobe Sign Document History

02/13/2018

Created:	02/13/2018
By:	Jamie Ready (jamie@corpmgmtgroup.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAASPeTJTh8A9qjYi0ZGjuHOolOs4PQ8bqz

"Corporate Management Group" History

-  Document created by Jamie Ready (jamie@corpmgmtgroup.com)
02/13/2018 - 8:16:35 AM MST- IP address: 68.46.20.81
-  Document emailed to Tracy Smithknecht (tracysmithk@yahoo.com) for signature
02/13/2018 - 8:16:39 AM MST
-  Document viewed by Tracy Smithknecht (tracysmithk@yahoo.com)
02/13/2018 - 8:23:43 AM MST- IP address: 97.127.50.5
-  Document e-signed by Tracy Smithknecht (tracysmithk@yahoo.com)
Signature Date: 02/13/2018 - 9:53:46 AM MST - Time Source: server- IP address: 97.127.50.5
-  Signed document emailed to Jamie Ready (jamie@corpmgmtgroup.com), Tracy Smithknecht (tracysmithk@yahoo.com) and zhil@corpmgmtgroup.com
02/13/2018 - 9:53:46 AM MST



Enhanced MEC_Plan 1



Benefits Enrollment Form New Employee Rehire Rehire Date 470-21-5082

Employee Information	
Name (First and Last) Tracy Smithknecht	Social Security Number 470-21-5082
Address 1018 121st Lane NE	City Blaine
State MN	Zip Code 55434
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Date of Birth 01/31/1990	Date of Hire 02/13/2018
Phone Number: 7632839872	Email Address: Tracysmithk@yahoo.com

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 checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input checked="" 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 checked="" type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Domestic Partner
-------------------	-------------	------------------	--------------------------	-------------------	-------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------

Dependent

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

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

EFF. DATE

EFF. DATE

EFF. DATE

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

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature

Date

EMPLOYEES DECLINING

I am DECLINING coverage

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

IF DECLINING- YOU MUST SIGN HERE

Employee Signature Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

Date 02/13/2018

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

Fixed Indemnity Medical Benefits Plan 2

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

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

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

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? 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	\$6.17	\$2.42	\$0.60	\$4.20
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
NO to ALL Benefits <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

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

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

DATE 02/13/2018 SIGNATURE Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

This Plan DOES NOT Alleviate the Individual Mandate Penalty

This is an Essential StaffCARE Enrollment Form.

Benefit Enrollment/Change Form

A. Employee Information (All information is required)			
First Name: 470-21-5082	MI:	Last Name: Smithknecht	
SSN#: 470-21-5082	Date of Hire: 1018 121st Lane NE		
Date of Birth: 01/31/1990	Gender: <input checked="" type="radio"/> M or <input type="radio"/> F	Marital Status: 02/13/2018	
Address: 7632839872	City:	State:	Zip:
Daytime Phone: ()	Home phone: ()	Email:	

B. Change of Status/Coverage			
Date of Qualifying Event:		<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Change Name
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> COBRA / Term. of Employment	<input type="checkbox"/> Drop Dependent	<input type="checkbox"/> Change Address
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Medicare	<input type="checkbox"/> Birth / Death	<input type="checkbox"/> Other
<input type="checkbox"/> Reduction in Hours	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Marriage / Divorce	

C. Medical Plan Options (If electing coverage please make a selection in both 1 & 2)					
1. Plan Election	<input checked="" type="radio"/> \$2,500 Copay Plan	<input checked="" type="radio"/> \$6,000 Copay Plan	<input checked="" type="radio"/> \$3,000 HSA Plan	<input checked="" type="radio"/> \$6,000 HSA Plan	<input checked="" type="radio"/> Decline Coverage (please complete sections E. & G.)
2. Coverage Election	<input type="checkbox"/> Employee only		<input type="checkbox"/> Employee + Spouse		<input checked="" type="checkbox"/> Employee + Children
<input type="checkbox"/> Family					

D. Dependent/Spouse Information (Must be completed for coverage of dependents)						
Name (Last, First, MI)	Relationship	Birth date	SSN	M/F	Disabled (Y/N)	Please check below to include on medical plan
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical
						<input type="checkbox"/> Medical

E. Other Insurance Coverage Information Please check one:			
<input type="checkbox"/> I have enrolled thru the state or federal Marketplace	<input type="checkbox"/> I have other insurance coverage	<input checked="" type="checkbox"/> I do not have other insurance coverage	<input checked="" type="checkbox"/> I have other insurance coverage, but intend to cancel that coverage
Policyholder's Name:		Policyholder's Date of Birth:	
Insurance Co. Name:		Policy Number:	Group Number:
Insurance Co. Address:		Names of covered individuals:	

F. Health Savings Account

Yes, I would like to set up a Health Savings Account (This option is available if you enroll in the HSA plan). Your annual deduction will be divided into equal amounts and deducted from each pay period throughout the year.

I elect to have an ANNUAL deduction of \$ TracySmith@yahoo.com (maximum of \$3,450 for employee-only coverage, or \$6,900 for all other levels of coverage) reduced from my salary before taxes to reimburse me for qualified expenses which I incur during the plan year. Maximum contribution to the HSA Plan will be reduced by company contribution. Employees who are age 55 or older can make a catch-up contribution of \$1,000 in addition to IRS maximums.

G. Enrollment Waiver (check box only if declining coverage)	
<input type="checkbox"/> I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions.	
<input type="checkbox"/> I understand by not enrolling in this plan or a Marketplace health plan as mandated by PPACA, that I may be subject to a tax penalty.	

H. Employee Authorization

I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease. I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.

To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.

Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

Employee Signature

Feb 13, 2018

Date

Signature: Tracy Smithknecht
Tracy Smithknecht (Feb 13, 2018)

Email: tracysmithk@yahoo.com