



# New Hire Application

**Personal Data-- PLEASE PRINT LEGIBLY IN INK**

Last Name William D Shaylor First Name 019-38-1329 Middle Initial 019  
 Street Address 13 Duval Road Apt/Ste 04  
 City/State/Zip Dudley Mass 01571  
 Phone Number 508-909-6017 Email Address w\_shaylor@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.

William D Shaylor William D Shaylor May 18, 2015  
William D Shaylor (May 18, 2015)  
 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 (2015)

**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 2015 expires February 16, 2016. 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 cannot claim exemption from withholding if your 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 do not apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you are not 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 2015. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b>	6017
<b>B</b>	Enter "1" if: <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b>	13 Duval
<b>C</b>	Enter "1" for your <b>spouse</b> . 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.) . . . . .	<b>C</b>	Dudley
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	Mass
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b>	01571
<b>F</b>	Enter "1" if you have at least \$2,000 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . . <b>(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)</b>	<b>F</b>	909
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$65,000 (\$100,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have two to four eligible children or <b>less</b> "2" if you have five or more eligible children.</li> <li>• If your total income will be between \$65,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child . . . . .</li> </ul>	<b>G</b>	508
<b>H</b>	Add lines A through G and enter total here. <b>(Note. This may be different from the number of exemptions you claim on your tax return.)</b> ▶	<b>H</b>	

For accuracy, complete all worksheets that apply.   

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form <b>W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <b>2015</b>	
▶ <b>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.</b>					
1 Your first name and middle initial Last name		2 Your social security number Michelle L Shaylor			
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.			
City or town, state, and ZIP code		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		1	
6 Additional amount, if any, you want withheld from each paycheck . . . . .		6		\$ 0	
7 I claim exemption from withholding for 2015, and I certify that I meet <b>both</b> of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶		7			
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶ <i>William D Shaylor</i> <small>William D Shaylor (May 18, 2015)</small>		Date ▶ May 18, 2015			
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)	



# Employment Eligibility Verification

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

USCIS  
Form I-9

OMB No. 1615-0047  
Expires 03/31/2016

▶ **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.  
**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Attestation** (Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)

Last Name (Family Name) Michelle L Shaylor		First Name (Given Name) wife		Middle Initial D	Other Names Used (if any)	
Address (Street Number and Name) 13 Duval Road			Apt. Number	City or Town Dudley	State Ma	Zip Code 01571
Date of Birth (mm/dd/yyyy) 04/17/1963	U.S. Social Security Number 0 1 9 - 3 8 - 1 3 2 9	E-mail Address w_shaylor@yahoo.com			Telephone Number 5089096017	

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

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

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

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

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

**OR**

2. Form I-94 Admission Number: \_\_\_\_\_

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

Foreign Passport Number: \_\_\_\_\_

Country of Issuance: \_\_\_\_\_

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

Signature of Employee: <u>William D Shaylor</u> <small>William D Shaylor (May 18, 2015)</small>	Date (mm/dd/yyyy): May 18, 2015
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**Preparer and/or Translator Certification** (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator:			Date (mm/dd/yyyy):		
Last Name (Family Name)			First Name (Given Name)		
Address (Street Number and Name)		City or Town	State	Zip Code	



Employer Completes Next Page



**LISTS OF ACCEPTABLE DOCUMENTS**  
**All documents must be UNEXPIRED**

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		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		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		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. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <b>a.</b> Foreign passport; and <b>b.</b> Form I-94 or Form I-94A that has the following: (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.		5. U.S. Military card or draft record		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
		6. Military dependent's ID card		5. Native American tribal document
		7. U.S. Coast Guard Merchant Mariner Card		6. U.S. Citizen ID Card (Form I-197)
		8. Native American tribal document		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		9. Driver's license issued by a Canadian government authority		8. Employment authorization document issued by the Department of Homeland Security
	<b>For persons under age 18 who are unable to present a document listed above:</b>			
	10. School record or report card			
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		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).**

**Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.**



**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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title: <u>US Passport</u>		Document Title:		Document Title:
Issuing Authority: <u>United States Department of State</u>		Issuing Authority:		Issuing Authority:
Document Number: <u>437583714</u>		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy): <u>02/01/2018</u>		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:				<div style="border: 1px solid black; padding: 5px;"> <p><b>3-D Barcode</b> Do Not Write in This Space</p> </div>
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

**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): 05/18/2015 (See instructions for exemptions.)

Signature of Employer or Authorized Representative <u>Caitlin Scholl</u>		Date (mm/dd/yyyy) <u>05/18/2015</u>	Title of Employer or Authorized Representative <u>Administrative Assistant</u>	
Last Name (Family Name) <u>Scholl</u>		First Name (Given Name) <u>Caitlin</u>		Employer's Business or Organization Name <u>EMPLOYER SOLUTIONS STAFFING GROUP LLC</u>
Employer's Business or Organization Address (Street Number and Name) <u>7301 OHMS LANE SUITE 405</u>		City or Town <u>EDINA</u>		State <u>MN</u>
				Zip Code <u>55439</u>

**Section 3. Reverification and Rehires** (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial			B. Date of Rehire (if applicable) (mm/dd/yyyy):

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:



to Caitlin Scholl

FAX 303-736-776



*William D. Shugh*

MASSACHUSETTS  
DRIVERS  
LICENSE

**SHAYLOR**  
WILLIAM

13 DUDMAN RD  
DORSET, MA 01921

SEX: M    HEIGHT: 5-00    HAIR: BRN    EYES: BRN

DOB: 04-17-1983    EXPIRES: 04-17-2020

ISSUE: 04-07-2015    LICENSE NO: S87463815

5 DOB 04-04-2015 SEX DT: M-30M2

*William D. Shugh*

**DISCLOSURE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]**

**DISCLOSURE REGARDING BACKGROUND INVESTIGATION**

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

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

**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING's website is at: [www.orangetreescreening.com](http://www.orangetreescreening.com), another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

**New York applicants or employees only:** By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

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

(Must include email address: w\_shaylor@yahoo.com)

Signature: *William D Shaylor*  
William D Shaylor (May 18, 2015) Date: May 18, 2015

**BACKGROUND INFORMATION**

Last Name: Shaylor First: William Middle: D  
Other Names/Alias: \_\_\_\_\_  
Social Security #: 019-38-1329 Date of Birth (mm/dd/yyyy)\*: 04/17/1963  
Driver's License #: s87463815 State of Driver's License: mass  
Present Address: 13 Duval Road Telephone # (Primary): 508-909-6017  
City/State/Zip: Dudley mass 01571

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

## A Summary of Your Rights Under the Fair Credit Reporting Act

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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](http://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](http://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](http://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](http://www.consumerfinance.gov/learnmore).
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

# EMERGENCY CONTACT INFORMATION

EMPLOYER SOLUTIONS STAFFING GROUP IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION
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Employee Name: William D Shaylor

Address: 13 Duval Road Dudley Mass 01571

Home Phone: 508-909-6017

<b>EMERGENCY CONTACTS</b> Please list two people (in priority order) who could be contacted in case of an emergency	
<p style="text-align: center;"><b>Contact #1</b></p> <p>Name: Michelle Shaylor</p> <p>Relationship: Spouse</p>	<p>Home Phone: 508-909-6017</p> <p>Cell Phone: 508-344-4613</p> <p>Work Phone: 508-909-6017</p>
<p style="text-align: center;"><b>Contact #2</b></p> <p>Name: Wendy Johnson</p> <p>Relationship: sister</p>	<p>Home Phone: 508-770-1999</p> <p>Cell Phone: 508-770-1999</p> <p>Work Phone: 508-770-1999</p>

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

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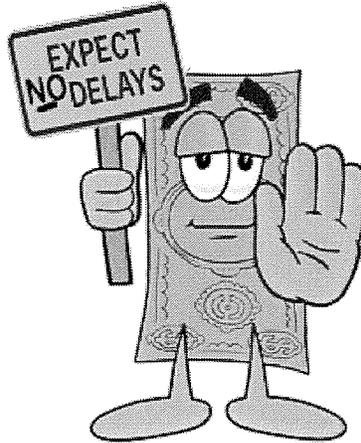
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## RECEIVE YOUR PAY WITHOUT DELAY



In order for you to continue to receive your pay each week without delay we are encouraging all employees to use direct deposit or Global Cash Card. **It is becoming more and more difficult for employees to cash checks without fees or delay due to increased security at all banks. Also, if your check is lost or stolen you will have to wait 3 days for another check.**

### GLOBAL CASH CARD

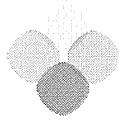
If you don't have a bank account, computer access or don't want to use direct deposit you can use **Global Cash Card** which works like a Visa.

- There are **NO FEES** for the card for your first transaction as a cash withdrawal at an ATM or if you use it like a credit card (not debit) to make individual signature purchases.
- **If you don't have access to a computer you can receive TEXT notifications for your pay check amount on pay day as well as what the current balance is. You can also receive low balance notifications set to the dollar amount that you determine on the attached form.**
- You may call Customer Service 24 hours a day, 7 days a week, 365 days a year at 888-220-4477 for balance inquiries or other questions. (Para Español, apriete dos)
- You can pay bills with the GCC (by phone/internet/in person). You can also set up your online account to make automatic payments.

Please complete the attached form and turn it in to your manager as soon as possible indicating whether you would like direct deposit or Global Cash Card. Please make sure you include an email address.

**Fill Out This Form!**





# employer solutions staffing group

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## 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 <b>William D Shaylor</b>	SSN# (last 4 digits) 1329	Effective Date May 18, 2015
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### SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below)

Payroll Debit Card (Please complete Sections 4 and 5 below)

### SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: \_\_\_\_\_

Routing# \_\_\_\_\_

Account# \_\_\_\_\_

Account Type:  Checking  Savings  Other \_\_\_\_\_

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

Initial William D Shaylor Date May 18, 2015

- To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work)
- If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

### SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.

Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)

First Name <b>William</b>	M.I. <b>D</b>	Last Name <b>Shaylor</b>	Date of Birth <b>04/17/1963</b>
Street Address (PO BOX NOT ACCEPTABLE) <b>13 Duval Road</b>			Social Security# <b>019-38-1329</b>
City <b>Dudley</b>	State <b>mass</b>	Zip <b>01571</b>	Cell Phone (mobile) <b>508-344-6923</b>

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

Payroll Debit Card Routing # <b>073972181</b>	Payroll Debit Card Account # _____
--	---------------------------------------

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

Employee's Signature: William D Shaylor Date: May 18, 2015

### SECTION 5 AUTHORIZATION

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

\*E-mail: w\_shaylor@yahoo.com @ \_\_\_\_\_

this information will only be used to send your paystubs electronically

Employee's Signature: *William D Shaylor* Date: May 18, 2015



3972 Barranca PKWY  
STE J610  
Irvine, CA 92606

## IMPORTANT

\*\*\*DO NOT DISCARD\*\*\*

## PLEASE READ

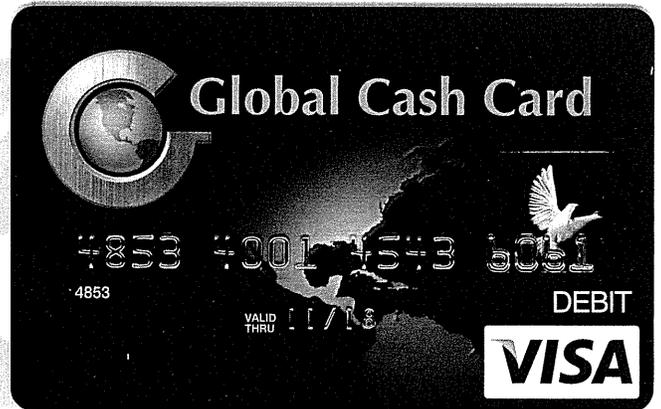


\*\*\*DO NOT DISCARD THIS CARD

William Shaylor

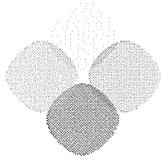
1. **Activate your card:** Online at [www.globalcashcard.com/activate](http://www.globalcashcard.com/activate) or by calling 866-929-8096.
2. **Use your card:** Sign the back of the paycard and start using it everywhere!
3. **Manage your card:** Manage your funds, your way! Go online to [www.globalcashcard.com](http://www.globalcashcard.com) and click on **User Login** to manage your paycard account online.

**Congratulations! ACTIVATE YOUR  
NEW Global Cash Card paycard!**



**Your Card. Your Money. Right Now.**

- **NO FEE purchases** - Pay retailers, restaurants, gas stations, online merchants, and more by using your paycard as a signature or credit type of purchase!
- **Get cash back** - Use your PIN for purchases and get cash back from merchants.
- **Get cash at ATMs** - Get cash at millions of ATM's worldwide.
- **Alert notifications** - Go to your online account at [www.globalcashcard.com](http://www.globalcashcard.com) to set up text or e-mail alerts.



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**STATEMENT OF CONFIDENTIALITY**

This agreement made this 18 day of May, 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and William D Shaylor 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.

William D Shaylor  
William D Shaylor (May 18, 2015)

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Employee Signature

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Employer Solutions Staffing Group LLC, Representative

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

▶ See separate instructions.

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

Your name William D Shaylor Social security number ▶ 022

Street address where you live \_\_\_\_\_

City or town, state, and ZIP code \_\_\_\_\_

County 54 Telephone number 1503

If you are under age 40, enter your date of birth (month, day, year) 1967

- 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.

**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.

*William D Shaylor*

Job applicant's signature ▶ William D Shaylor (May 18, 2015)

Date May 18, 2015

**EMPLOYER SECTION:**

<b>ESG FEIN#:</b>	<b>ESG Client Name &amp; State:</b>	
<b>Hiring Manager:</b>	<b>Position:</b>	<b>Starting Wage: \$</b>

**EMPLOYEE SECTION:**

<b>Employee Name:</b> William D Shaylor		<b>Street Address:</b> 13 Duval Road		<b>City/State:</b> Dudley, Mass	<b>Zip:</b> 01571
<b>SS#:</b> 019-38-1329	<b>Date of Birth:</b> 04-17-1963	<b>Age:</b> 52	<b>Have you worked for this company before?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>If yes, location:</b>	

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

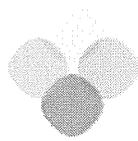
	Yes	No
<b>1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?</b> (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?</b> (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?</b> Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. <i>*If you checked yes please provide a copy of your SSI documentation.</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>4. Have you received any type of vocational rehabilitation services within the past two years?</b> If yes, please indicate which type of agency you worked with and provide their location information below: <input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program) Name of Agency: _____ Phone #: _____ City: _____ County: _____ State: _____ <i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>5. Are you a Veteran of the U.S. Military?</b> <i>*If yes, please provide a copy of your DD-214 and letter of separation.</i> (If yes, please provide information below. If no, please continue to question #6.) Dates of Service - From: ____/____/____ To: ____/____/____ Branch of Service: _____ <b>Are you entitled to or are you receiving compensation for a service-connected disability?</b> <b>Have you been unemployed at any time during the last 12 months?</b> If yes, dates of unemployment - From: ____/____/____ To: ____/____/____ <b>Did you receive unemployment compensation at any point during your unemployment?</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</b> Conviction Date: ____/____/____ Release Date: ____/____/____ Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Additional Tax Credits	
<b>IEC (Native American):</b> Are you or your spouse a member of a Native American Tribe? <i>*If you checked yes please provide a copy of your CDIB card.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>CA Residents:</b> <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?	
<b>SC Residents:</b> <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: William D Shaylor Date: May 18, 2015



## 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.

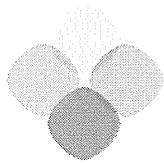
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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:** William D Shaylor  
William D Shaylor (May 18, 2018)

**Printed Name:** William D Shaylor



employer solutions staffing group<sup>LLC</sup>  
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## Important/Importante

### LOST OR STOLEN PAYCHECKS

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

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

### CHEQUES DE PAGO PERDIDOS O ROBADOS

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

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

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): William D Shaylor

Signature/Firma: William D Shaylor  
William D Shaylor (May 18, 2015)

## 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.<sup>1</sup>

**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](http://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: 7301 Ohms Lane Suite 405 Edina, MN 55439		Phone Number for Health Benefits Team: 952-767-9519			
<b>Insurance Plans Available:</b>	<b>Who is Eligible?</b>	<b>Meets Minimum Value Standard?</b>	<b>Meets Minimum Essential Coverage?</b>	<b>When is it effective?</b>	<b>Will I be penalized if I only have this plan?</b>
<b>Fixed Indemnity Plan</b>	Everyone	No	No	Available immediately – offered upon hire	Yes
<b>MEC Plan</b>	Everyone	No	Yes	Available immediately – offered upon hire	No
<b>Major Medical Plan</b>	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](mailto:health@employersolutionsgroup.com)

# Employee Keeps This Form

## NOTICE: ESSG Electronic Pay Stubs

### ATTENTION

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

1. You can view your check stub by logging into the employee portal at [www.MyPayESG.com](http://www.MyPayESG.com)

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

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

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

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

## Empleado Toma Copiar

### ATENCIÓN

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

1. Usted puede ver su talón de cheque por la tala en el portal electrónico del empleados en [www.MyPayESG.com](http://www.MyPayESG.com)

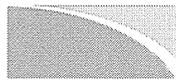
Su nombre de usuario son las cuatro primeras letras de su apellido seguido por los cuatro últimos dígitos de su número de seguro social.

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

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

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

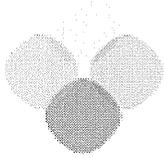
2. También puede recibir su talón de cheque por correo electrónico , al proveir su correo electronico en la **pagina 1** de este paquete  
\*\* Su talón de cheque vienen de [payroll@MyPayESG.com](mailto:payroll@MyPayESG.com), asegúrate de revisar la carpeta de spam



# Essential StaffCARE

## Limited Benefits & Self-Funded Minimum Essential Coverage (MEC) Enrollment Form

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Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**THE FIXED INDEMNITY MEDICAL PLAN IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED UNDER THE AFFORDABLE CARE ACT (ACA).**

The **MEC Wellness/Preventive Plan** is an employer-sponsored, self-funded plan that has been deemed to be in compliance with ACA rules and regulations. More information about Preventive Services may be found on the government website at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>. For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

The Fixed Indemnity Medical/Rx and Dental Rates are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.204, 26.212, and 26.213. The Term Life, Accidental Death & Dismemberment and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

BCS Insurance Company/4 Ever Life Insurance Company do not underwrite the MEC Wellness/Preventive Plan.

EMP ESC/MEC (CU) NAV\*SAD P2M v15.0

## PLAN OPTIONS

- You can choose to purchase the Fixed Indemnity Medical Plan (Option 1) or the MEC Wellness/Preventive Plan (Option 2) or both.
- Please read the following information on your plan options and fill out the Enrollment Form on the last page.

### OPTION 1 - FIXED INDEMNITY MEDICAL PLAN

#### PLAN INFORMATION

By choosing **OPTION 1** (Fixed Indemnity Medical Plan) you may still be eligible to receive a subsidy from the health insurance exchange. The fixed indemnity medical plan pays a flat amount for each covered event caused by an accident or illness. If the service costs more, you pay the difference. But if the service costs less, you keep the difference. The fixed indemnity medical plan does not satisfy the federal healthcare reform Individual Mandate.

#### PAYMENT INFORMATION

The Fixed Indemnity Medical, Dental, Term Life, and Short Term Disability Plans are payroll deducted. The premium for these products will be taken out of your paycheck.

#### TAX INFORMATION

Your Company has chosen to take some/all of your deductions for the Fixed Indemnity Medical, Dental, Term Life, and Short Term Disability Plans on a **Pre-Tax** basis. Please contact Customer Service at 1-866-798-0803 and a Representative will assist you in identifying the deductions that are taken Pre-Tax.

### OPTION 2 - MEC WELLNESS/PREVENTIVE PLAN

#### PLAN INFORMATION

Choosing **OPTION 2** (MEC Wellness/Preventive Plan) will **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. This plan **DOES NOT** cover medical services. This plan provides coverage for preventive services such as immunization and routine health screening. It does not cover conditions caused by accident or illness. This plan satisfies the federal healthcare reform Individual Mandate. **By purchasing this plan, you will not be taxed for failing to purchase insurance required by the Affordable Care Act.**

#### PAYMENT INFORMATION

The MEC Wellness/Preventive Plan will utilize a direct payment process. You will receive information in the mail with further instructions on how to set up payment. This payment option will require a credit card for payment so the premium can be automatically deducted.

# HOW TO ENROLL

## STEP 1

You **MUST** complete the Employee Form on the **last page** of this packet.

- You **MUST** complete the Employee Information Section as part of your new hire process.
- You **MUST** Accept or Decline Each Benefit.
- You **MUST** Sign and Date Even if you Decline Coverage.

## STEP 2

You **MUST** return the Enrollment Form (**last page only**) to your Branch Manager.

## STEP 3

Please keep remainder of this packet for your records.

### **Member Services:**

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

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

## AFFORDABLE CARE ACT FREQUENTLY ASKED QUESTIONS

### Can I receive a subsidy on the Exchange?

#### Enrolled into MEC Wellness/Preventive Plan:

**No**, if you enroll into the MEC Wellness/Preventive Plan you will not qualify for a subsidy at the health insurance exchange as this plan will meet the definition of Minimum Essential Coverage. Please **DO NOT** enroll into the MEC Wellness/Preventive Plan if you wish to obtain or wish to continue receiving Federally subsidized coverage from the health insurance exchange.

#### Enrolled into Fixed Indemnity Medical Plan:

**Yes**, you may receive a subsidy on the health insurance exchange (if you qualify).

### Do these plans satisfy the Individual Mandate?

#### Enrolled into MEC Wellness/Preventive Plan:

**Yes**, by enrolling into the MEC Wellness/Preventive Plan you will be meeting your Individual Mandate obligations.

#### Enrolled into Fixed Indemnity Medical Plan:

**No**, if you enroll in the Fixed Indemnity Medical Plan and **NOT** the MEC Wellness/Preventive Plan then you may be subject to the federal healthcare reform individual mandated tax penalty.

## MEC WELLNESS/PREVENTIVE PLAN FREQUENTLY ASKED QUESTIONS

### When can I enroll in the plan?

You are able to enroll in the MEC Wellness/Preventive Plan within 30 days of your hire date or during your employer's annual 30 day open enrollment period. If you do not enroll during one of these time periods, you will have to wait until the next annual open enrollment, unless you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll. In addition, you may request a special enrollment (for yourself, your spouse, and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit.

### When does coverage begin?

Coverage begins the 1st of the month following receipt of your first monthly payment.

### How can I make changes or enroll if I initially declined?

To make changes or enroll if you initially declined, contact your employer and request a change form. Changes are effective the 1st of the month following the date of the change request. You can cancel or reduce coverage at any time. Please remember that you may only enroll or add additional insured members during an open enrollment period or within 30 days of a qualifying life event.

### Does this plan cover medical services?

This plan is in compliance with ACA rules and regulations. It covers wellness and preventive services only.

### What document will I receive in addition to this enrollment packet?

In addition to this enrollment packet, you will also have access to a copy of your Summary of Benefits and Coverage (SBC), for the MEC Wellness/Preventive plan for review. You may request a copy of the SBC from your branch manager or by calling Essential StaffCARE Customer Service at 1-866-798-0803.

## **FIXED INDEMNITY MEDICAL PLAN FREQUENTLY ASKED QUESTIONS**

### **When can I enroll in the Fixed Indemnity Medical Plan?**

You are able to enroll in the Fixed Indemnity Medical Plan within 30 days of your hire date, 1st paycheck date, or your employer's annual 30 day open enrollment period. If you do not enroll during one of these time periods, you will have to wait until the next annual open enrollment, unless you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

### **When does coverage begin?**

Coverage will begin the Monday following a payroll deduction and continues as long as you have a deduction from your paycheck. Please review your check stub for deductions. If you miss a payroll deduction, to avoid a break in coverage, you may make direct payments to PAI. After six consecutive weeks without a payroll deduction or direct premium payment, coverage will be terminated and COBRA information will be sent at that time.

### **If I do not get placed on assignment right away, will I have to complete a new enrollment form?**

After six months if there has not been a deduction from your paycheck, please fill out a new enrollment form. Missing information will delay the process.

### **Can I make changes or cancel coverage?**

You may cancel or reduce coverage at any time unless your premiums are deducted pre-tax. You will only have 30 days from your hire date or first paycheck date to enroll, add additional benefits or add additional insured members. After this time frame, you will only be allowed to enroll, add benefits or add additional insured members during your annual open enrollment period or within 30 days of a qualifying life event.

*(Please refer to the "TAX INFORMATION" section on page 2 to see if deductions are Post-Tax or Pre-Tax)*

### **How can I make changes?**

To make changes or cancel coverage by telephone call (800) 269-7783. Enter your PIN CODE plus the last four digits of your Social Security number (SSN). Remember, it may take up to two or three weeks for the changes or cancellation to be reflected on your paycheck. Coverage will continue as long as you have a paycheck deduction.

**PIN CODE: 140 + \_\_\_\_\_** (last four digits of your SSN)

### **Is there coverage for contraceptives on this plan?**

Oral contraceptives are covered under the prescription benefit. Non-oral contraceptives are not covered.

### **Are maternity benefits covered?**

Yes, maternity benefits are covered the same as any other condition under this plan.

## **GENERAL FREQUENTLY ASKED QUESTIONS**

### **How do I enroll?**

Enrolling in the Essential StaffCARE plans is easy. You can enroll by completing an Essential StaffCARE enrollment application and returning it to your manager.

### **What is a qualifying life event?**

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

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

If you experience a qualifying life event, you must submit documentation of the event along with a change form requesting the change within 30 days of the event. In addition, you may request a special enrollment (for yourself, your spouse, and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit.

### **Are dependents covered?**

Yes. Eligible dependents include your spouse and your children up to age 26.

### **Is there a pre-existing clause for the Fixed Indemnity Medical Plan or the MEC Wellness/Preventive Plan?**

There are no restrictions for pre-existing conditions in these medical plans. Even if you were previously diagnosed with a condition, you can receive coverage for related services as soon as your coverage goes into effect.

## ESSENTIAL STAFFCARE NETWORK INFORMATION

### Stretch Your Benefit Dollars

This benefit plan offers you and your family savings for medical care through discounts negotiated with providers and facilities in the First Health Network. Choosing an in-network provider helps maximize benefits. When you use an in-network provider, you will automatically receive the network discount and the doctor's office will file the claim for you. If you use a doctor who is not part of the network, you will not receive the discount and you may need to file the claim yourself.

### How Do I Locate a Doctor?

Enrolled members are encouraged to visit providers in the networks listed in order to maximize their benefit dollars. To find a participating provider or verify your current medical provider is in-network, please call or visit the network websites referenced on this page.

### Prescription Drug Network

If enrolled in the Fixed Indemnity Medical Plan, you are automatically covered by the discount prescription drug program through the Caremark Pharmacy Network. Caremark has a national network with over 58,000 participating pharmacies. To find a local participating Caremark pharmacy, you can visit [www.caremark.com](http://www.caremark.com). Prescription drug benefit information can be found on the Benefits at a Glance page.

### What if I need to have a prescription filled?

For generic and brand prescriptions, the plan pays you \$20 per day up to the annual maximum, for drugs dispensed by a pharmacist. Prescription drug coverage is not provided for drugs administered during a physician office visit or hospital stay. If you choose a participating pharmacy and present your ID card, you will receive a discount off the retail price of the prescription at the time of purchase. Save your receipt to file a claim for reimbursement of the fixed dollar amount.

### Do I have to go to an in-network provider?

It is not required that you go to an in-network provider. If you choose a provider who participates in the PPO network, you receive two key advantages:

- PPO discount for all services.
- The provider will file the claim to the plan.

### Fixed Indemnity Medical Plan and MEC Wellness/Preventive Plan Network

- First Health Network  
1-800-226-5116  
[www.firsthealth.com](http://www.firsthealth.com)

### Prescription

- Caremark  
1-888-963-7290  
[www.caremark.com](http://www.caremark.com)

### Vision - (discount only)

- EyeMed Vision Care  
1-866-559-5252  
[www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)

### Dental

- DenteMax  
1-800-752-1547  
[www.dentemax.com](http://www.dentemax.com)

**Do not contact the above Networks for questions regarding your medical benefits. All medical benefit questions should be directed to the Essential StaffCARE Member Services line at 1-866-798-0803.**

### When should I expect an ID card?

ID cards will be mailed as soon as your enrollment form is received and processed. You should receive your ID card within 10 business days of your effective date.

### Member ID Cards

An ID card and confirmation of coverage letter will be mailed to your home address. If you do not receive these documents within 10 business days of your effective date, or have a change of address, please contact Essential StaffCARE Customer Service at **1-866-798-0803**. Present your ID card to the provider at the time of service. These ID cards are used for identification purposes and providers use them to verify eligibility status.

## EXCLUSIONS AND LIMITATIONS

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

### MEDICAL

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

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

#### **No benefits will be paid for:**

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

### PRESCRIPTION DRUGS

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

### DENTAL

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

## SHORT-TERM DISABILITY

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

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

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

### TERM LIFE WITH ACCIDENTAL DEATH & DISMEMBERMENT

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

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

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

**ACA Required Wellness and Preventive Benefits**

**Adults**

**The MEC Plan covers 100% of the allowed amount in network; 40% out of network**

<b>Abdominal Aortic Aneurysm</b>	One time screening for men of specified ages who have ever smoked
<b>Alcohol Misuse</b>	Screening and counseling
<b>Aspirin</b>	Use for men and women of certain ages
<b>Blood Pressure</b>	Screening for all adults
<b>Cholesterol</b>	Screening for adults of certain ages or at higher risk
<b>Colorectal Cancer</b>	Screening for adults over 50
<b>Depression</b>	Screening for adults
<b>Type 2 Diabetes</b>	Screening for adults with high blood pressure
<b>Diet</b>	Counseling for adults at higher risk for chronic disease
<b>HIV</b>	Screening for all adults at higher risk
<b>Immunization</b>	Vaccines for adults' doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella
<b>Obesity</b>	Screening and counseling for all adults
<b>Sexually Transmitted Infection (STI)</b>	Prevention counseling for adults at higher risk
<b>Tobacco Use</b>	Screening for all adults and cessation
<b>Syphilis</b>	Screening for all adults at higher risk

**Women, Including Pregnant Women**

**The MEC Plan covers 100% of the allowed amount in network; 40% out of network**

<b>Anemia</b>	Screening on a routine basis for pregnant women
<b>Bacteriuria</b>	Urinary tract or other infection screening for pregnant women
<b>BRCA</b>	Counseling about genetic testing for women at higher risk
<b>Breast Cancer Mammography</b>	Screenings every 1 to 2 years for women over 40
<b>Breast Cancer Chemoprevention</b>	Counseling for women at higher risk
<b>Breastfeeding</b>	Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
<b>Cervical Cancer</b>	Screening for sexually active women
<b>Chlamydia Infection</b>	Screening for younger women and other women at higher risk
<b>Contraception</b>	Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
<b>Domestic and Interpersonal Violence</b>	Screening and counseling for all women
<b>Folic Acid</b>	Supplements for women who may become pregnant
<b>Gestational Diabetes</b>	Screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
<b>Gonorrhea</b>	Screening for all women at higher risk
<b>Hepatitis B</b>	Screening for pregnant women at their first prenatal visit
<b>Human Immunodeficiency Virus (HIV)</b>	Screening and counseling for sexually active women
<b>Human Papillomavirus (HPV) DNA Test</b>	High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
<b>Osteoporosis</b>	Screening for women over age 60 depending on risk factors
<b>Rh Incompatibility</b>	Screening for all pregnant women and follow-up testing for women at a higher risk
<b>Tobacco Use</b>	Screening and interventions for all women, and expanded counseling for pregnant tobacco users
<b>Sexually Transmitted Infections (STI)</b>	Counseling for sexually active women
<b>Syphilis</b>	Screening for all pregnant women or other women at increased risk
<b>Well-Woman Visits</b>	To obtain recommended Preventive services for women under 65

**ACA Required Wellness and Preventive Benefits**

**Children**

The MEC Plan covers 100% of the allowed amount in network; 40% out of network

<b>Alcohol and Drug Use</b>	Assessments for adolescents
<b>Autism</b>	Screening for children at 18 and 24 months
<b>Behavioral</b>	Assessments for children of all ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years
<b>Blood Pressure</b>	Screenings for children: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 yers; 15 to 17 years
<b>Cervical Dysplasia</b>	Screening for sexually active females
<b>Congenital Hypothyroidism</b>	Screening for newborns
<b>Depression</b>	Screening for adolescents
<b>Developmental</b>	Screening for children under age 3, and surveillance throughout childhood
<b>Dyslipidemia</b>	Screening for children at higher risk of lipid disorders. Ages: 1 to 4 years; 5 to 10 years; 11 to 14 years; and 15 to 17 years
<b>Fluoride Chemoprevention</b>	Supplements for children without fluoride in their water source
<b>Gonorrhea</b>	Preventive medication for the eyes of all newborns
<b>Hearing</b>	Screening for all newborns
<b>Height, Weight, and Body Mass Index</b>	Measurements for children ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years
<b>Hematocrit or Hemoglobin</b>	Screening for children
<b>Hemoglobinopathies</b>	Or Sickle Cell screening for newborns
<b>HIV</b>	Screening for adolescents at higher risk
<b>Immunization</b>	Vaccines for children from birth to age 18-- doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae Type B, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella
<b>Iron</b>	Supplements for children ages 6 to 12 months at risk for anemia
<b>Lead</b>	Screening for children at risk of exposure
<b>Medical History</b>	For all children throughout development: Ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years
<b>Obesity</b>	Screening and counseling
<b>Oral Health</b>	Risk assessment for young children: Ages: 0 to 11 months; 1 to 4 years; 5 to 10 years
<b>Phenylketonuria (PKU)</b>	Screening for this genetic disorder in newborns
<b>Sexually Transmitted Infection (STI)</b>	Prevention counseling and screening for adolescents at higher risk
<b>Tuberculin</b>	Testing for children at higher risk of tuberculosis: Ages 0 to 11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; and 15 to 17 years
<b>Vision</b>	Screening for all children

<b>Monthly Rates</b>					
<b>Employee Only</b>	<b>\$58.87</b>	<b>Employee + 1</b>	<b>\$87.73</b>	<b>Employee + Family</b>	<b>\$186.99</b>

**YOU MUST COMPLETE THE ENROLLMENT FORM ON THE LAST PAGE**



### Fixed Indemnity Medical Benefits

Weekly Rates

Inpatient Benefits		Outpatient Benefits <sup>1</sup>	
Standard Care Maximum	\$500 per day	Annual Outpatient Maximum	\$2,000
Intensive Care Unit Maximum <sup>2</sup>	\$600 per day	Physician Office Visit	\$100 per day
Inpatient Surgery	\$3,000 per day	Diagnostic Lab	\$75 per day
Anesthesiology	\$600 per day	Diagnostic X-Ray	\$200 per day
First Hospital Admission (one per year)	\$250	Ambulance Services	\$300 per day
Skilled Nursing payable for stays in a skilled nursing facility after a hospital stay	\$100 per day	Physical, Occupational, and Speech Therapy	\$50 per day
Wellness Care		Emergency Room - Sickness	\$200 per day
Wellness Care (one per year)	\$100	Emergency Room - Accident	\$500 per day
Prescription Drug <sup>3</sup>		Outpatient Surgery	\$500 per day
Prescription Drug Annual Maximum	\$600	Anesthesiology	\$200 per day
Prescription Drug Benefits	\$20 per day		

<sup>1</sup>all outpatient benefits are subject to outpatient maximum <sup>2</sup>pays in addition to standard care benefit <sup>3</sup>not subject to outpatient maximum

<b>Employee Only</b>	<b>\$20.91</b>	<b>Employee + 1</b>	<b>\$42.44</b>	<b>Employee + Family</b>	<b>\$56.67</b>
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### Dental Benefits

Annual Maximum Benefit	\$750	Deductible	\$50		
	Waiting Period	Co-Insurance	Annual Maximum Benefit		
Coverage A	None	100%	Exams, Cleanings, Intraoral Films and Bitewings		
Coverage B	3 Months	60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures		
Coverage C	12 Months	50%	Periodontics, Crowns, Bridges, Endodontics and Dentures		
<b>Employee Only</b>	<b>\$5.99</b>	<b>Employee + 1</b>	<b>\$11.98</b>	<b>Employee + Family</b>	<b>\$19.77</b>



### Term Life Benefits

Term Life Benefits					
Employee Amount	\$10,000 (reduces to \$7,500 at 65; \$5,000 at age 70)	Child Amount (6 months to 26 years old)	\$5,000		
Spouse Amount	\$5,000 (terminates at age 70)	Infant Amount (15 days to 6 months)	\$1,000		
Accidental Death and Dismemberment Benefit					
Employee Amount	\$20,000	Child Amount (6 months to 26 years old)	\$5,000		
Spouse Amount	\$20,000	Infant Amount (15 days to 6 months)	\$2,500		
<b>Employee Only</b>	<b>\$0.60</b>	<b>Employee + 1</b>	<b>\$0.90</b>	<b>Employee + Family</b>	<b>\$1.80</b>



### Short-Term Disability

Benefit	60% of Salary up to \$150 per week	Waiting Period/Maximum Benefit Period	7 days/26 weeks
<b>Employee Only</b>	<b>\$4.20</b>		

# ENROLLMENT FORM

ESC NAV\*SAD P2M v15.0

## REQUIRED EMPLOYEE INFORMATION

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

Social Security Number 019 - 38 - 1329

Date of Birth 04 / 17 / 1963 Sex  M  F

Name William D Shaylor

Street Address 13 Duval Road

City Dudley State Mass Zip 01571

Home Phone 508 - 909 - 6017

Do you or any dependents have Medicare?

Yes  No If Yes:

Medicare Health Insurance Claim Number (HICN)  
\_\_\_\_\_

Medicare Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Names of Covered Person(s)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## REQUIRED DEPENDENT INFORMATION

Name Michelle L Shaylor

Social Security Number 022 - 54 - 1503

Date of Birth 09 / 23 / 1967 Sex  M  F

Relationship:  Spouse  Child  Domestic Partner

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F

Relationship:  Spouse  Child  Domestic Partner

## BENEFICIARY INFORMATION

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

**NAME OF BENEFICIARY**

Michelle L Shaylor

**RELATIONSHIP**

wife

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

## OPTION 1 FIXED INDEMNITY PLAN Weekly Rates

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

### FIXED INDEMNITY MEDICAL

- \$20.91 Employee Only
- \$42.44 Employee + 1
- \$56.67 Employee + Family
- NO to all Indemnity benefits.**

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

### DENTAL

- \$5.99 Employee Only
- \$11.98 Employee + 1
- \$19.77 Employee + Family
- NO**

### TERM LIFE

- YES** \$0.60 Employee Only  
\$0.90 Employee + 1
- NO** \$1.80 Employee + Family

### SHORT-TERM DISABILITY

- YES** \$4.20 Employee Only
- NO**

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

## OPTION 2 82193010-M-EMP MEC WELLNESS/PREVENTIVE PLAN Monthly Rates

- \$58.87 Employee Only
- \$87.73 Employee + 1
- \$186.99 Employee + Family
- NO to MEC Wellness/Preventive Plan**

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.

**Signature**

William D Shaylor  
WILLIAM D SHAYLOR

Date May 18, 2015 / \_\_\_\_/\_\_\_\_



FORM  
M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 1/12



Print full name William D Shaylor  
Print home address 508-909-6017

Social Security no. 019-38-1329  
City Dudley State 13 Duval Road Zip Dudley Mass 01571

Employee:

File this form or Form W-4 with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" cmg
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C. .....
3. Write the number of your qualified dependents. See Instruction D. .....
4. Add the number of exemptions which you have claimed above and write the total. 0
5. Additional withholding per pay period under agreement with employer \$ 0
  - A.  Check if you will file as head of household on your tax return.
  - B.  Check if you are blind.
  - C.  Check if spouse is blind and not subject to withholding.
  - D.  Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed \$8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date May 18, 2015 Signed William D Shaylor

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

**A. Number.** If you claim more than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income.

**If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.**

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

**B. Changes.** You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

**C. Spouse.** If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

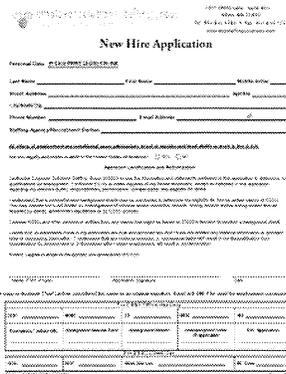
If claiming a wife or husband, write "4" in line 2. Using "4" is the withholding system adjustment for the \$4,400 exemption for a spouse.

**D. Dependent(s).** You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

**You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.**

**If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.**

IF THE ALLOWABLE MASSACHUSETTS WITHHOLDING EXEMPTIONS ARE THE SAME AS YOU ARE CLAIMING FOR U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.



# New Hire Paperwork

Adobe Document Cloud Document  
History

May 18, 2015

Created:	May 18, 2015
By:	Caitlin Scholl (Caitlin@corpmgmtgroup.com)
Status:	SIGNED
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## “New Hire Paperwork” History

-  Document created by Caitlin Scholl (Caitlin@corpmgmtgroup.com)  
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-  Document emailed to William D Shaylor (w\_shaylor@yahoo.com) for signature  
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May 18, 2015 - 6:57 PM MDT

**SENSITIVE BUT UNCLASSIFIED**

**Department of Homeland Security**  
**E-Verify**

**Report Prepared: 05/21/2015**  
**Page: 1 of 1**

**Case Verification Number: 2015141121801LK**

**Case Information:****Employee Information:**

Last Name:	Shaylor	First Name:	William
Middle Initial:	D	Other Names Used:	
Social Security Number:	*** ** 1329	Date of Birth:	04/17/1963
Citizenship Status:	A citizen of the United States	Email Address:	

**Document Information:**

List A Document:	U.S. Passport or Passport Card		
Passport or Passport Card Number:	437583716	Document Expiration Date:	02/01/2018
Alien Number:		I-94 Number:	

**Additional Information:**

Hire Date:	05/21/2015	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CSCH4411	Submitted On:	05/21/2015

**Initial Case Result:**

Case Result: Employment Authorized

**Employee Referred to SSA:**

Referred By: Referred On:

**Case Result from SSA (after SSA Tentative Nonconfirmation):**

Case Result: Response Date:

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

Last Name:	First Name:
Middle Initial:	Other Names Used:
Social Security Number:	Date of Birth:
Resubmitted By:	Resubmitted On:

**Case Result from SSA (after Resubmission):**

Case Result:

**Request Name Review:**

Comments:  
Submitted By: Submitted On:

**Case Result from DHS (after DHS Verification in Process):**

Case Result: Response Date:

**Employee Referred to DHS:**

Referred By: Referred On:

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

Case Result: Response Date:

**Photo Matching Results:**

Determination:

**Employee Referred to DHS (Additional):**

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Referred By: \_\_\_\_\_ Referred On: \_\_\_\_\_

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

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Case Result: \_\_\_\_\_ Response Date: \_\_\_\_\_

**Case Closure:**

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Closure Statement: \_\_\_\_\_  
Closed By: \_\_\_\_\_ Closed On: \_\_\_\_\_

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**SENSITIVE BUT UNCLASSIFIED**