



SENSITIVE BUT UNCLASSIFIED

**Case Verification Number: 2017318123127WJ**

Report Prepared: 11/14/2017

**Company Information**

Company ID: 47429

Company Name: Employer Solutions Staffing Group

**Employee Information**

Last Name: WILSON

First Name: LAVARO

Date of Birth: 08/09/1985

Social Security Number: \*\*\* \*\* 4808

Hire Date: 11/14/2017

Citizenship Status: A citizen of the United States

**Document Information**

List B Document: Driver's license or ID card issued by a U.S. state or outlying possession

List C Document: Social Security Card

Document Name: Driver's license

Document State: Minnesota

Driver's License or ID Card Number:

Document Expiration Date: 08/09/2021

**Case Status Information**

Current Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 11/14/2017

Case Submitted By: KRIT7027

SENSITIVE BUT UNCLASSIFIED



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

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

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

|   |  |  |                         |  |                                |  |
|---|--|--|-------------------------|--|--------------------------------|--|
| Last Name (Family Name)<br><b>Wilson</b>                  |  | First Name (Given Name)<br><b>Louvaro</b>          |                         | Middle Initial<br><b>S</b>                               | Other Last Names Used (if any) |  |
| Address (Street Number and Name)<br><b>7545 79th St S</b> |  |  | Apt. Number<br><b>2</b> | City or Town<br><b>Cottage Grove</b>                     |                                | State<br><b>MN</b>                                 |
| Date of Birth (mm/dd/yyyy)<br><b>08-09-1985</b>           |  | U.S. Social Security Number<br><b>3179-76-4808</b> |                         | Employee's E-mail Address<br><b>kingmone46@gmail.com</b> |                                | Employee's Telephone Number<br><b>612-407-8367</b> |

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

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

|  |  |
|--|--|
| <input checked="" type="checkbox"/> 1. A citizen of the United States  |  |
| <input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)  |  |
| <input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____  |  |
| <input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____<br>Some aliens may write "N/A" in the expiration date field. (See instructions)  |  |
| <p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:<br/>An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____<br/> <b>OR</b><br/>         2. Form I-94 Admission Number: _____<br/> <b>OR</b><br/>         3. Foreign Passport Number: _____</p> <p>Country of Issuance: _____</p> |  |
| <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">           QR Code - Section 1<br/>           Do Not Write in This Space         </div>  |  |

|  |   |
|--|---|
| Signature of Employee <b>J. Wilson</b> | Today's Date (mm/dd/yyyy) <b>11-14-17</b> |
|--|---|

**Preparer and/or Translator Certification (check one):**

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

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

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

Employer Completes Next Page

**MINNESOTA**  
**IDENTIFICATION CARD**  
**NOT A DRIVER'S LICENSE**

LAVARO SAMONE WILSON JR  
3450 GOLFVIEW DR APT 4216  
EAGAN, MN 55123

Date of Birth: 09-09-1985  
Sex: M Eyes: BRN Class: ID  
Height: 6-1 Weight: 240  
ISSUED: 07-2017 EXPIRES: 09-09-2021

*L. Wilson*

A001050687901

**SOCIAL SECURITY**

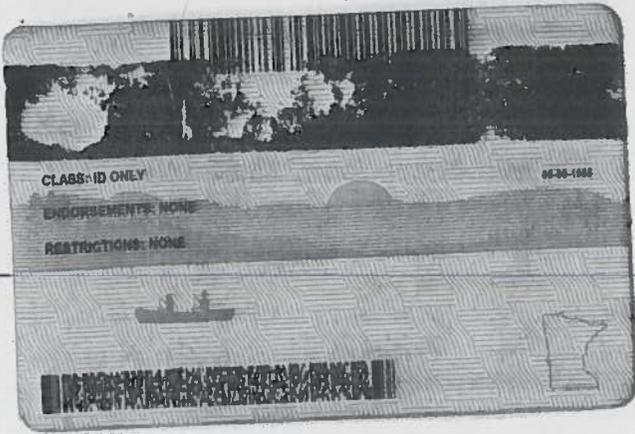
319-76-4808

THIS NUMBER HAS BEEN ESTABLISHED FOR

LAVARO SAMONE  
WILSON JR

*L. Wilson*  
SIGNATURE

USA 11/07/2012



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

If you find a card that isn't yours, please return it to:  
Social Security Administration  
P.O. Box 3008, Baltimore, MD 21290-3008

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

Social Security Administration  
Form SSA-3000 (8-2011)

 G09172671



employer solutions staffing group  
**Wage Payment Method Authorization (Minnesota)**

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 paper check.

**SECTION 1 BASIC INFORMATION**

Employee Name Lavaro Wilson SSN# (last 4 digits) 4808 Effective Date 11-14-17

**SECTION 2 PAYROLL ELECTION**

Direct Deposit (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated*

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

Paper Check (Please complete Section 5 below)

**SECTION 3 DIRECT DEPOSIT**

Update Bank Account

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

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

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

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

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

Initial \_\_\_\_\_ Date \_\_\_\_\_

- 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**

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 Lavaro M.I. S Last Name Wilson Date of Birth 08-09-1985

Street Address (PO BOX NOT ACCEPTABLE) 7545 79th St S Social Security# 319-76-4808

City Cottage Grove State MW Zip 55033 Cell Phone (mobile) 617-407-8362

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

Payroll Debit Card Routing # \_\_\_\_\_ Payroll Debit Card Account # 4853-4002-7248-1559

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: L Wilson Date: 11-14-17

**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: kingmone46@gmail.com  
 this information will only be used to send your paystubs electronically

Employee's Signature: L Wilson Date: 11-14-17



**Background Screening Report**

EZ Screen Solutions  
5994 S. Holly St. Ste. 151  
Greenwood Village, CO 80111  
Phone: 800-429-5303

FILE NUMBER 97465  
REPORT TO CMG Staffing (1353)  
12000 N Washington St. Ste. 350  
Thornton, CO 80241  
Phone: (303) 920-1425  
Fax: (303) 736-7767

REPORT DATE 11-14-2017  
ORDER DATE 11-14-2017  
TYPE CMG Staffing PKG - National Criminal

**Application Information**

APPLICANT WILSON, LAVARO SSN XXX-XX-4808 DOB 08-09-XXXX  
E-MAIL KATE@CMGJOB.COM  
ADDRESS(ES) 404 BROADWAY AVE CTRY / STATE / ZIP SAINT PAUL PARK, MN 55071

**Investigative**

**National Criminal Database Search**

RESULTS **Records Found**  
NAME SEARCHED WILSON, LAVARO SEARCH DATE 11-14-2017 10:45 AM MST  
DOB SEARCHED 08-09-XXXX SEARCH SCOPE  
JURISDICTION NATIONWIDE  
JURISDICTION(S) SEARCHED

The search you have selected is a search of our criminal database(s) and may not represent 100% coverage of all criminal records in all jurisdictions and/or sources. Coverage details available upon request.

**Offender:**

Full Name: WILSON, LAVARO SAMONE  
DOB: 1985-08-09  
Provider: Minnesota Dept of Public Safety  
State: MN  
Offense:



**Drug & Alcohol Testing Consent Form for Applicants Who Have Received a Conditional Offer of Employment – MRO**

**Acknowledgement Receipt**

I acknowledge that I have received a job offer from Corporate Management Group (CMG) conditioned upon my submitting to and passing a drug and alcohol test. I have also received, read and understand Corporate Management Group's Policy and Procedure on an at-will basis and that this policy does not alter the at-will nature of the employment relationship.

I hereby agree to submit to drug and alcohol testing under the Company's policy.

I also understand that test results and other information acquired in the drug and alcohol testing process may be disclosed to and discussed with a Medical Review Offices (MRO). I hereby consent to such test results and other information being disclosed to and discussed with an MRO.

Date: 11-14-17

L. Wilson  
Employee Signature

Lawrence Wilson  
Employee Name (Printed)

Date: 11-14-17

K Ritter  
Witness Signature

K Ritter  
Witness Name (Printed)

# TEST RESULTS RECORD

Test Reference Number MD-56101 Name of Collector \_\_\_\_\_

## COMPANY INFORMATION

Company Name Corporate Management Group Phone (81) 666-383 Fax \_\_\_\_\_  
 Address 404 Broadway Ave. City St. Paul Park State/Province MN Zip/Postal Code 55091

## DONOR INFORMATION

Employee I.D. \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Type of Identification Provided:  Driver's License  Employee Photo I.D.  Other \_\_\_\_\_  
 Reason for test:  Pre-employment  Random  Reasonable cause  Post-accident  Other \_\_\_\_\_

## CERTIFICATION

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and alcohol.

[Signature] \_\_\_\_\_ Date / Time 11-14-17  
 Donor signature

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge.

[Signature] \_\_\_\_\_ Date / Time 11-14-17 10:30am  
 Collector signature

\_\_\_\_\_  
 Laboratory signature Date / Time received \_\_\_\_\_

## TEST RESULTS

Date/Time Collected 11-14-17 10:40am  
 Time Interpreted 10:45am

NOTE: Lab personnel obtain specimen samples by puncturing the lab extraction ports on the side of device with a needle and syringe and drawing out the sample.



Cut out this panel to copy or scan results

| Drug Name       | Synb-1 | Negative                            | Positive                 | Not Tested               |
|-----------------|--------|-------------------------------------|--------------------------|--------------------------|
| Alcohol         | ALC    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Amphetamine     | AMP    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Buprenorphine   | BUP    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Benzodiazepine  | BZO    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cocaine         | COC    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EDDP            | EDDP   | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Marijuana       | THC    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Methadone       | MTD    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Methamphetamine | MET    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Opiates         | OPI    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Oxycodone       | OXY    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Phencyclidine   | PCP    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____           | _____  | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| _____           | _____  | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |

Notes / Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Acknowledgement of Receipt Antiharassment Policy**

I certify that I have received a copy of Employer Solutions Staffing Group's Antiharassment Policy. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at 952.835.1288/1.866.496.7573 with any questions I may have about this policy. I agree to comply with ESSG's policy on Antiharassment and understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am involved in any employment dispute or I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, marital, sexual orientation or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact my supervisor, manager, director or ESSG's Human Resource Department at 952.835.1288/1.866.496.7573 in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Lamaro Wilson

Employee's Signature:

J. Wilson

Date:

11-14-17

**RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT**

This is to acknowledge that I have read the Employer Solutions Staffing Group LLC Temporary Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities and obligations of my employment with the company. I understand and agree that it is my responsibility to abide by the rules, policies and standards set forth in the Handbook.

I also acknowledge that my employment with ESSG is not for a specified period of time and can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no manager or employee has the authority to enter into an employment agreement, express or implied, providing for employment other than at-will.

I also acknowledge that, except for the policy of at-will employment, ESSG reserves the right to revise, delete and add to the provisions of this Employee Handbook. All such revisions, deletions or additions must be in writing and must be signed by the CEO of the company. No oral statements or representations can change the provisions of this Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company, with or without cause or notice, at any time. No implied contract concerning any employment-related decision, term of employment or condition of employment can be established by any other statement, conduct, policy or practice.

I understand the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and ESSG concerning the duration of my employment, the circumstances under which my employment may be terminated and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings and representations concerning my employment with the company.

If I have questions regarding the content or interpretation of this Handbook, I will bring them to the attention of ESSG.

DATE 11-14-17

EMPLOYEE NAME Lavaro Wilson

PLEASE PRINT

EMPLOYEE SIGNATURE J. Wilson

ESSG REPRESENTATIVE \_\_\_\_\_



## ACKNOWLEDGMENT

The associate handbook was reviewed with me, and I have received my personal copy. I also acknowledge that I have been given the opportunity to ask questions and express concerns during my orientation. Additionally, I understand and support the following:

1. This handbook is intended as a guide and **not** an employment agreement that creates a contractual relationship, and that the employment relationship may be terminated at the will of either party at any time.
2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.
3. I agree to **notify** my ESSG Consultant **immediately** of any change in my personal data such as phone number, address, emergency notification, etc.
4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my ESSG Consultant.

Date:

11-14-17

Associate's Signature:

L. Wilson

Associate's Printed Name:

Lavaro Wilson

Orientation provided by:

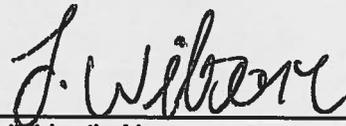
\_\_\_\_\_

**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

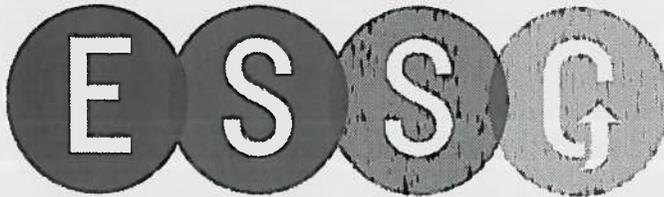


\_\_\_\_\_  
Individual's Name

11-14-17

\_\_\_\_\_  
Date

**SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6**



employer solutions staffing group<sub>llc</sub>

**Notification of Minnesota Law Requirement –  
Unemployment Acknowledgement**

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

It is your responsibility to contact ESSG (for instance, by calling 952.277.5227 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

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

L. Wilson  
Employee Signature:

11-14-17  
Date:

Lavaro Wilson  
Employee (please print your name here)

# ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v1

## A. REQUIRED EMPLOYEE INFORMATION

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

Name Lavaro Wilson  
Address 7545 79th St S

Social Security # 319-76-4808

Home Phone 612-407-8362

Sex  M  F

City Gottage Grove

State MN

Zip 55033

Apt. # 2

Date of Birth 08/07/1985

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

Yes  No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person (s):

1.

2.

3.

## C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rates

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

### SELECT COVERAGE LEVEL

Employee Only

Employee + 1

Employee + Family

NO to ALL Benefits

### FIXED INDEMNITY MEDICAL <sup>1</sup>

\$20.25

\$41.10

\$54.88

Yes  No

### DENTAL

\$6.17

\$12.34

\$20.36

Yes  No

### VISION

\$2.42

\$4.92

\$6.56

Yes  No

### TERM LIFE

\$0.60

\$0.90

\$1.80

Yes  No

### SHORT-TERM DISABILITY <sup>2</sup>

\$4.20

Yes  No

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

Name

Relationship

## D. REQUIRED DEPENDENT INFORMATION

Name

Social Security # / / Date of Birth

Sex  M  F

Relationship  Spouse  Child  Domestic Partner

Name

Social Security # / / Date of Birth

Sex  M  F

Relationship  Spouse  Child  Domestic Partner

Name

Social Security # / / Date of Birth

Sex  M  F

Relationship  Spouse  Child  Domestic Partner

Name

Social Security # / / Date of Birth

Sex  M  F

Relationship  Spouse  Child  Domestic Partner

## E. REQUIRED SIGNATURE

**YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE**

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

DATE 11/14/2017

SIGNATURE

*J. Wilson*

# Enhanced MEC Plan Plan 1

**Benefits Enrollment Form**

Employee Information  New Employee  Rehire Rehire Date

Name (First and Last) **Lavard Wilson** Social Security Number **319-76-4808**

Address **7545 79th St S** City **Cottage Grove MN** State **MIN** Zip Code **55033**

Gender  Male  Female Marital Status  Single  Married  Divorced Date of Birth **08-09-1985**

Phone Number **612-407-8362** Email Address: **kingwone46@gmail.com** Date of Hire

**Please Select Desired Coverage:**

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

**Dependent**

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

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

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

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

EFF. DATE

EFF. DATE

EFF. DATE

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

**IF ENROLLING - YOU MUST SIGN HERE**

Employee Signature

EMPLOYEES DECLINING

**I am DECLINING coverage**

Date

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

**IF DECLINING - YOU MUST SIGN HERE**

Employee Signature

*J. Wilson*

Date

11-14-17