

# FAX

**Date:** 8/9/2013**Pages including cover sheet:** 18

<b>To:</b>	IRENE RIVAL
<i>Phone</i>	
<i>Fax Number</i>	+1 (303) 736-7767

<b>From:</b>	ZBIGNIEW SOBOTA
	Microsoft
	276 Haman Rd
	INVERNESS
	IL 60067
<i>Phone</i>	+1 (866) 386-1157
<i>Fax Number</i>	+1 (866) 386-1157

**NOTE:**

This is signed New Hire Paperwork

# Form W-4 (2013)

**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 2013 expires February 17, 2014. 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 \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

**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 2013. 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>	1
<b>B</b>	Enter "1" if: { • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } . . . . .	<b>B</b>	0
<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>	0
<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>	0
<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>	0
<b>F</b>	Enter "1" if you have at least \$1,900 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . . ( <b>Note.</b> Do <b>not</b> include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	<b>F</b>	0
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have three to six eligible children or <b>less</b> "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child . . . . .	<b>G</b>	0
<b>H</b>	Add lines A through G and enter total here. ( <b>Note.</b> This may be different from the number of exemptions you claim on your tax return.) ▶	<b>H</b>	1

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 \$40,000 (\$10,000 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> ▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; text-align: center;">2013</div>
1 Your first name and middle initial <b>ZBIGNIEW</b>		Last name <b>SOBOTA</b>
Home address (number and street or rural route) <b>276 HAMAN RD</b>		2 Your social security number <b>325-76-4486</b>
City or town, state, and ZIP code <b>INVERNESS JL 60067</b>		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 <b>1</b>
6 Additional amount, if any, you want withheld from each paycheck		6 \$
7 I claim exemption from withholding for 2013, and I certify that I meet <b>both</b> of the following conditions for exemption. • 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> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶		7
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶ <b>08-08-2013</b>
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)



### Addendum to Application

**APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS**

PLEASE COMPLETE PAGES 1-4

DATE 08-08-13

Name SOBOTA ZBIGNIEW  
Last First Middle Maiden

Social Security No. 325-76-4486

Telephone 773 415 9076

If under 18, please list age \_\_\_\_\_

Referred by \_\_\_\_\_

Position applied for (1) \_\_\_\_\_  
 and salary desired (2) \_\_\_\_\_  
 (Be specific)

Days/hours available to work  
 No Pref \_\_\_\_\_ Thur \_\_\_\_\_  
 Mon \_\_\_\_\_ Fri \_\_\_\_\_  
 Tue \_\_\_\_\_ Sat \_\_\_\_\_  
 Wed \_\_\_\_\_ Sun \_\_\_\_\_

How many hours can you work weekly? \_\_\_\_\_ Can you work nights? YES

Employment desired  FULL-TIME ONLY \_\_\_ PART-TIME ONLY \_\_\_ FULL- OR PART-TIME

When available for work? \_\_\_\_\_

Do you have responsibilities or commitments that will prevent you from meeting specified work schedules?  
 No \_\_\_ Yes If so, please explain \_\_\_\_\_

Do you anticipate any absences from work on a regular basis?  
 No \_\_\_ Yes If so, please explain \_\_\_\_\_

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete mailing address)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School	<u>ZESPOL SZKOL KRAKOW</u>	<u>LACZNOSCI POLAND</u>	<u>4</u>	
College				
Bus. or Trade School				
Professional School				

HAVE YOU EVER BEEN CONVICTED OF A CRIME?  No \_\_\_ Yes

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation. \_\_\_\_\_

DO YOU HAVE A DRIVER'S LICENSE?  Yes \_\_\_ No

What is your means of transportation to work? \_\_\_\_\_

Driver's license number \_\_\_\_\_ State of issue \_\_\_\_\_

Operator \_\_\_ Commercial (CDL) \_\_\_ Chauffeur \_\_\_

Expiration date \_\_\_\_\_

Have you had any accidents during the past three years?  Yes \_\_\_ No

If so, how many? 1

Have you had any moving violations during the past three years? \_\_\_ Yes \_\_\_ No

If so, how many? \_\_\_\_\_

**OFFICE USE ONLY**

Typing \_\_\_ Yes \_\_\_ No

Personal Computer \_\_\_ Yes \_\_\_ No

10-key \_\_\_ Yes \_\_\_ No

\_\_\_\_\_ WPM

\_\_\_ PC \_\_\_ Mac

Word Processing \_\_\_ Yes \_\_\_ No

Other \_\_\_\_\_

\_\_\_\_\_ WPM

Skills \_\_\_\_\_

Please list two references other than relatives or previous employers.

Name CLARISA GERMANY

Name RICK & DAVID SWITZER

Position SUPERVISOR

Position OWNER MANAGER

Company PORTOLA PACKAGING

Company MELLOW BROTHERS PAINTING CO

Address 951 DOUGLAS  
BATAVIA

Address 1130 GREENLEAF  
WILMETTE IL 60091

Telephone (630) 546-4428

Telephone (847) 256-4476

An application form sometimes makes it difficult for an individual to adequately summarize a complete background. Use the space below to summarize any additional information necessary to describe your full qualifications for the specific position for which you are applying.

**MILITARY**

HAVE YOU EVER BEEN IN THE ARMED FORCES? \_\_\_ Yes  No

ARE YOU NOW A MEMBER OF THE NATIONAL GUARD? \_\_\_ Yes  No

Specialty \_\_\_\_\_ Date Entered \_\_\_\_\_ Discharge Date \_\_\_\_\_

**WORK EXPERIENCE**

Please list your work experience for the **past five years** beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name _____		Supervisor name <u>CLARISA GERMANY</u>	
Position <u>PRODUCTION TEAM MEMBER</u>		Employment dates	
Company <u>PORTOLA PACKAGING</u>		Pay or salary	
Address <u>951 DOUGLAS</u>		From <u>11/20/2011</u>	Start <u>10.00</u>
<u>BATAVIA</u>		To <u>05/12/2013</u>	Final <u>10.25</u>
Telephone <u>(630) 338 0037</u>		Your last job title _____	
Reason for leaving (be specific) <u>MOVE PLANT TO ARIZONA TX</u>			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.			

Name _____		Supervisor name _____	
Position <u>WORK AT PORTOLA</u>		Employment dates	
Company <u>FIRST CHOICE STAFFING</u>		Pay or salary	
Address <u>AURORA</u>		From <u>06/20/2011</u>	Start <u>9.75</u>
Telephone (____) _____		To <u>11/20/2011</u>	Final <u>10.00</u>
Reason for leaving (be specific) <u>PORTOLA HIRE ME</u>			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.			

Name _____		Supervisor name _____	
Position <u>OWNER - WORKER</u>		Employment dates	
Company <u>MASTER ZIGGY INC</u>		Pay or salary	
Address <u>276 HAMAN RD</u>		From <u>05/04/2006</u>	Start _____
<u>INVERNESS IL 60067</u>		To _____	Final _____
Telephone <u>(773) 415-9076</u>		Your last job title _____	
Reason for leaving (be specific) _____			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.			

Who were you referred by? \_\_\_\_\_

May we contact your present employer?  Yes  No

Did you complete this application yourself  Yes  No

If not, who did? \_\_\_\_\_

**PLEASE READ CAREFULLY  
APPLICATION FORM WAIVER**

In exchange for the consideration of my job application by Employer Solutions Staffing Group LLC, (hereinafter called "the Company"),

I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of the Company, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the Owner/Managing Member of the Company. Both the undersigned and the Company may end the employment relationship at any time, without specified notice or reason. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the Company permission to contact schools, all previous employers (unless otherwise indicated), references and others and hereby release the Company from any liability as a result of such contact.

I understand that, in connection with the routine processing of your employment application, the Company may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics and mode of living. Upon written request from me, the Company, will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with the Company shall be probationary for a period of ninety (90) days and further that at any time during the probationary period or thereafter, my employment relationship with the Company is terminable at will for any reason by either party.

Signature of applicant



Date:

08-08-2013



# Essential StaffCARE®

## Health Insurance Enrollment Form

### Complete the Enrollment Form to Elect or Decline Coverage

- You **MUST** Complete the Enrollment Form for the New Hire Process
- You **MUST** Elect or Decline Coverage on the Enrollment Form
- Return the Enrollment Form to your Branch Manager
- Keep the Benefit Page for Your Records and Plan Information

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



CMG

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

The Essential StaffCare Medical/Rx, Accidental Loss of Life, Limb & Sight, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.204, 26.212, and 26.213. The Term Life and Short-Term Disability Plans are underwritten by BCS Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

Form: ESC S P2D v9.1

## Frequently Asked Questions

### When does coverage go into effect?

Coverage will begin the Monday following a payroll deduction and continues as long as you have a deduction from your paycheck. Please review your pay check stub for deductions. If you miss a paycheck, 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. 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.

### When can I make changes?

Coverage may be canceled or reduced at any time, unless your employer takes premium deductions pre-tax. To make changes or cancel coverage by telephone call (800) 269-7783 within 30 days of the date of your first paycheck. You will be prompted to enter your PIN CODE plus the last four digits of your Social Security number (SSN).

**PIN CODE: 142 + \_\_\_\_ (last four digits of your 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. If you do not enroll within 30 days of your first paycheck or open enrollment date, you and your dependents will have to wait until the next open enrollment or until you have 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; Loss of insurance coverage by your spouse; Death of an immediate family member; Medicare entitlement; Employer bankruptcy; Loss of dependent status or Loss of prior coverage. 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.

### Who is eligible to enroll?

Dependents are eligible to enroll for all products, except for the short-term disability plan. Eligible dependents include an employee's spouse and unmarried/married children (natural, adopted or step-children up to age 26).

## Networks

### Medical

**Beechstreet** 1-866-907-3619

[www.beechstreet.com](http://www.beechstreet.com)

*(available except where other networks are used)*

**PHCS Network** 1-866-671-7427

[www.phcs.com](http://www.phcs.com)

*(available for residents of Arkansas and Utah)*

**Multiplan Network** 1-888-342-7427

[www.multiplan.com](http://www.multiplan.com)

*(available for residents of West Virginia)*

### Prescription

**Caremark** 1-888-963-7290

[www.caremark.com](http://www.caremark.com)

### Dental

**DenteMax** 1-800-752-1547

[www.dentemax.com](http://www.dentemax.com)

### Vision

**EyeMed Vision Care** 1-866-723-0513

[www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)

### Important Information

This is a limited benefit medical insurance plan. This is not major medical insurance. Please read this benefit packet in its entirety. This plan is only available as an employer-sponsored benefit. It cannot be purchased as an individual policy. All members may receive additional deductions and additional weeks of coverage from their date of cancellation. If you are age 65 or older or if you or your dependents are eligible for Medicare and you are enrolled in the Essential StaffCARE employee benefits program, you need to obtain an important notice regarding Medicare-part D Prescription Drug Coverage. For the Medicare-part D notice, contact your Human Resource Department.

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

**BENEFITS AT A GLANCE**

Group Number

221900-CMG

**Medical Benefits - Plan 2**

Weekly Rates

Inpatient Benefits		Outpatient Benefits	
Annual Inpatient Maximum	No Maximum	Annual Outpatient Maximum	\$1,500
Daily Standard Care Maximum	\$500 per day <sup>†</sup>	Physician Office Visit <sup>†</sup>	\$100 per visit
Daily Intensive Care Unit Maximum	\$600 per day <sup>†</sup>	Diagnostic Lab <sup>†</sup>	\$75 per testing day
Surgery (no limit on # of procedures)	\$3,000 per inpatient surgical procedure	Diagnostic X-ray <sup>†</sup>	\$200 per testing day
Anesthesiology	\$600 per inpatient surgical procedure	Ambulance Services <sup>†</sup>	\$300 per trip no limit on # of trips
Skilled Nursing (payable for stays in a skill nursing facility after a hospital stay)	\$100 per day <sup>†</sup>	Physical, Occupational, and Speech Therapy <sup>†</sup>	\$50 per visit
<b>Accidental Loss of Life, Limb &amp; Sight</b>		Emergency Room <sup>†</sup> - Sickness / Accident	\$200 / \$500 per visit
Employee Amount	\$20,000	Outpatient Surgery <sup>†</sup>	\$500 per procedure
Spouse Amount	\$20,000	Anesthesiology <sup>†</sup>	\$200 per procedure
Child Amount (6 months to 24 years old)	\$5,000	<b>Drug Card Benefits</b>	
Infant Amount (15 days to 6 months)	\$2,500	Prescription Drug Benefits <sup>†</sup> (per script)	\$10 Generic / \$30 Brand
<b>Wellness Benefit</b>			
Wellness Benefit (once per year)		\$75 lump sum payment	
<b>Employee Only</b>	<b>\$23.69</b>	<b>Employee + One</b>	<b>\$48.08</b>
		<b>Employee + Family</b>	<b>\$64.20</b>

**Dental Benefits**

Weekly Rates

	Waiting Period	Co-insurance	Annual Maximum Benefit	Deductible
Coverage A	None	80%	\$750	\$50
Coverage B	3 months	60%	Exams, Cleanings, Intraoral Films and Bitewings	
Coverage C	12 months	50%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures	
			Periodontics, Crowns, Bridges, Endodontics and Dentures	
<b>Employee Only</b>	<b>\$5.23</b>	<b>Employee + One</b>	<b>\$10.46</b>	<b>Employee + Family</b> <b>\$17.26</b>

**Vision Benefits**

Weekly Rates

	In-Network	Out-of-Network
Eye Examination for Glasses (including dilation)	Co-pay: \$10, plan pays 100%	Plan pays \$35, you pay remaining balance
Frames**	Plan pays \$110 allowance <sup>§</sup>	Plan pays \$55
Standard Plastic Lenses for Glasses*	Co-pay: \$25, plan pays 100%	Co-pay: \$0, plan pays \$25-\$55***
Standard Contact Lens Fit*	Plan pays up to \$55	You pay 100% of the price
Premium Contact Lens Fit*	Plan pays 10% off the price	You pay 100% of the price
Contact Lenses or Disposable Lenses*	Plan pays \$110 allowance <sup>§</sup>	Plan pays \$88
Contact Lenses Medically Necessary*	Plan pays 100%	Plan pays \$200
<b>Employee Only</b>	<b>\$2.35</b>	<b>Employee + One</b> <b>\$4.00</b>
		<b>Employee + Family</b> <b>\$5.64</b>

**Short-Term Disability**

Weekly Rates

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>		

**Term Life Benefits**

Weekly Rates

Employee Amount	\$10,000 Reduces to \$7,500 at 65, \$5,000 at age 70	Child Amount (6 months to 24 years old)	\$5,000
Spouse Amount	\$5,000 Terminates at age 70	Infant Amount (15 days to 6 months)	\$1,000
<b>Employee Only</b>	<b>\$0.60</b>	<b>Employee + One</b>	<b>\$0.90</b>
		<b>Employee + Family</b>	<b>\$1.80</b>

<sup>†</sup> up to annual outpatient maximum <sup>‡</sup> No limit on # of days <sup>§</sup> \$50 Monthly Maximum (no carry over)

\* Once every 12 months. \*\* Once every 24 months. \*\*\* Single Vision: \$25, Bifocal: \$40, Trifocal: \$55

§ Discount on balance above allowed amount; Frames: 20%, Conventional Contact Lenses: 15%.

### 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 AND ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT BENEFIT

**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;
- With regard to the accidental loss of life, limb or sight benefit - sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

**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.

#### 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 contact Essential StaffCARE Customer Service at 1-866-798-0803.

#### VISION

No benefits will be paid for any materials, procedures or services provided under Workers' Compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

#### PRESCRIPTION DRUGS

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

#### SHORT-TERM DISABILITY

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

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

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.

IND 221900-CMG OFFICE USE ONLY ReHire Date

**EMPLOYEE INFORMATION** (Must Be Filled Out) **ENROLLMENT FORM - PLAN 2** USE BLACK or BLUE INK ONLY

Social Security Number **325-76-4486**  
Date of Birth **06/19/1957** Sex **M**  
Name **ZBIGNIEW SOBOTA**  
Street Address **276 HAMAN RD**  
City **INVERNESS** State **FL** Zip **60067**  
Home Phone **773-415-9076**

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. \_\_\_\_\_  
4. \_\_\_\_\_

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 medical selection is a declination of coverage.

Signature *Zbigniew Sobota* Date **08/08/2013**

- You MUST enroll in the Medical Insurance Plan before adding any additional benefits.
- Your coverage level for the additional benefits will be identical to your medical plan selection.

**BENEFIT SELECTION** Weekly Rates

**MEDICAL**  
 \$23.69 Employee Only  
 \$48.08 Employee +1  
 \$64.20 Employee + Family  
 NO to all benefits.  
*If checked, stop! Go no further.*

**DENTAL**  
 YES \$5.23 Employee Only  
 NO \$10.46 Employee +1  
\$17.26 Employee + Family

**VISION**  
 YES \$2.35 Employee Only  
 NO \$4.00 Employee +1  
\$5.64 Employee + Family

**TERM LIFE**  
 YES \$0.60 Employee Only  
 NO \$0.90 Employee +1  
\$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.

**REQUIRED DEPENDENT INFORMATION**

Name **BARBARA SOBOTA**  
Social Security Number **344-76-7817**  
Date of Birth **03/19/1965** Sex **M**  
Relationship:  Spouse  Domestic Partner  Child

Name \_\_\_\_\_  
Social Security Number -  
Date of Birth //  
Sex  M  F  
Relationship:  Spouse  Domestic Partner  Child

Name \_\_\_\_\_  
Social Security Number -  
Date of Birth //  
Sex  M  F  
Relationship:  Spouse  Domestic Partner  Child

Name \_\_\_\_\_  
Social Security Number -  
Date of Birth //  
Sex  M  F  
Relationship:  Spouse  Domestic Partner  Child

**BENEFICIARY INFORMATION**

For Term Life \ Accidental Loss of Life, Limb & Sight, please write in your beneficiary information.

NAME OF BENEFICIARY \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_

Accidental Loss of Life, Limb & Sight is part of the Medical Benefit.

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

Name: ZBIGNIEW SOBOTA

Address: 276 HAMAN RD INVERNESS JL 60067

Home Phone: 773-415-9076

Person(s) to contact in case of an emergency on the job (in order of preference):

1. Name: BARBARA SOBOTA

Phone (work): \_\_\_\_\_

Phone (home): 773-802-0365

2. Name: \_\_\_\_\_

Phone (work): \_\_\_\_\_

Phone (home): \_\_\_\_\_

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

# Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen. If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck. The time that the money goes into your account on pay day varies by bank. Please allow until at least 10 am on your payday for the deposit to show.

### Please print

Check one of the following	Effective Date
<input checked="" type="checkbox"/> Start	<input type="checkbox"/> As Soon As Possible
<input type="checkbox"/> Stop	<input type="checkbox"/> Future Paydate
<input type="checkbox"/> Change	____/____/____

Social Security Number  
**325-76-44-86**

Name (Last, First Middle Initial)  
**SOBOTA ZBIGNIEW**

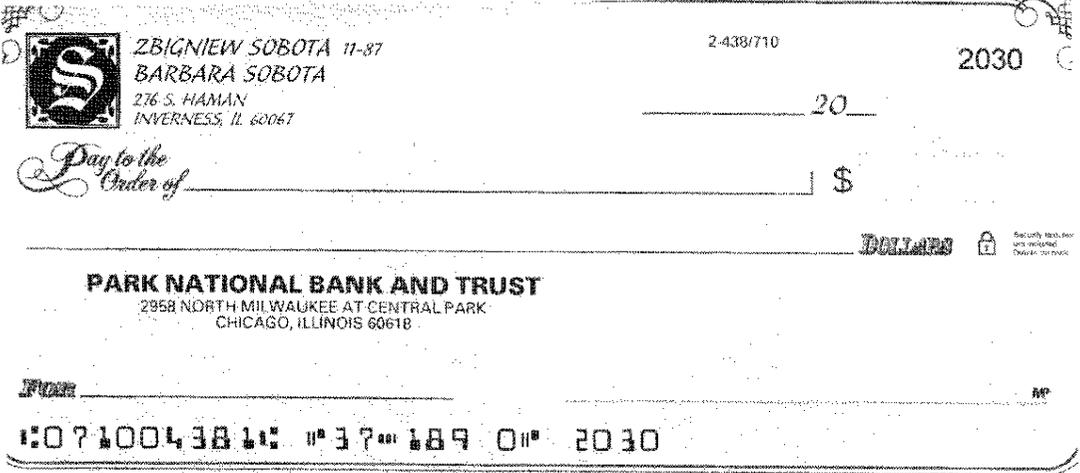
Home Address Street City State Zipcode  
**276 HAMAN RD INVERNESS IL 6006**

Date (Mo/Day/Yr) Employee Signature Daytime Phone Number  
**773-415-9076**

**SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION**

Financial Institution Name (Bank, Savings Institution, Credit Union, etc.)  
**US BANK**

Type of Account  
 Checking  
 Savings  
 Money Market Checking  
 Money Market Investment Requires Submission of FACTS Form



**PARK NATIONAL BANK AND TRUST**  
2958 NORTH MILWAUKEE AT CENTRAL PARK  
CHICAGO, ILLINOIS 60618

**usbank** Account Information

Your Park National Bank  
Acct. No. ending: **1890**

Your NEW Routing Number: **071904779**

Your NEW Account Number: **154503718905**

U.S. Bank 24 Hour Banking  
800-USBanks (800-872-2657)



**Employer Solutions Staffing Group LLC** *New Hire Application*

7301 Ohms Lane / Suite 405  
Edina, MN 55439  
T:952.835.1288 / F:952.835.4881

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

Last Name SOBOTA First Name ZBIGNIEW Middle Initial \_\_\_\_\_  
 Street Address 276 HAMAN RD  
 City/State/Zip INVERNESS JL 60067  
 Home Phone \_\_\_\_\_ Cell / Message Phone 773-415-9076  
 Company/Employer \_\_\_\_\_

**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.

ZBIGNIEW SOBOTA Name (Print or type) Z Sobota Applicant's Signature 08-08-2013 Date

**A copy or facsimile will be considered the same as an original signature.**

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	5 Day Letter (If applicable) _____	ESC Application _____



# 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) <b>SOBOTA</b>		First Name (Given Name) <b>ZBIGNIEW</b>		Middle Initial	Other Names Used (if any)	
Address (Street Number and Name) <b>276 HAMAN RD</b>		Apt. Number	City or Town <b>INVERNESS</b>		State <b>JL</b>	Zip Code <b>60067</b>
Date of Birth (mm/dd/yyyy) <b>06/19/1957</b>	U.S. Social Security Number <b>325-26-4486</b>	E-mail Address <b>ZBIGNIEW.SOBOTA@YAHOO.COM</b>			Telephone Number <b>773-415-9076</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):

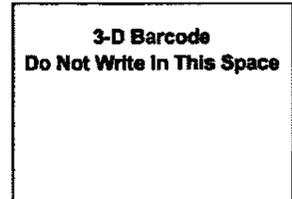
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_. Some aliens may write "N/A" 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: <i>Z Sobota</i>	Date (mm/dd/yyyy): <b>08/08/2013</b>
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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



**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:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:		<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <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): \_\_\_\_\_ (See Instructions for exemptions.)

Signature of Employer or Authorized Representative		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name (Family Name)		First Name (Given Name)	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	Zip Code

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

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
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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):
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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:
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Nationsearch.com 11160 Huron St. #201 Thornton, CO. 80234  
Phone 800.827.9550 Fax 800.827.6118

#### AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT PURPOSES

I hereby authorize Nationsearch.com, and its designated agents and representatives to conduct a review of my background through a consumer report and /or an investigative consumer report to be generated for employment purposes, promotion, reassignment or retention as an employee of \_\_\_\_\_.

I understand and am aware that the scope of the consumer report/investigative consumer report may include, but is not limited to the following areas: names and dates of previous/current employment, work experience, criminal history records, sexual offenders lists, motor vehicle records, educational records, professional license verification, credit history, civil cases, OFAC list, OIG/GSA lists and any other sanctions lists. Upon request, Nationsearch.com will supply a copy of the consumer report (completed) along with a copy of the rights under the FCRA.

I, ZBIGNIEW SOBOTA, authorize the release of these records or data pertaining to me which an individual, company, firm, corporation, or public agency may have. I authorize the full release of the information described above, without any reservation, throughout any duration of my employment at (company name) \_\_\_\_\_.

I hereby release Nationsearch.com and its agents, officials, representatives or assigned agencies, including officers, employees or related personnel both individually and collectively, from any and all liability for damages of any kind, which may at any time, result to me, my heirs, family or associates because of compliance with this authorization for release of information. I hereby certify that all information provided below and on my resume, CV or questionnaire is correct to the best of my knowledge. Any false statements provided on this form and/or on my resume, CV or application questionnaire will be considered just cause for the termination of employment at any time. This authorization and consent shall be valid in original, fax, copy or scanned form.

Please provide the following information, which is required by government agencies and other entities for identification purposes when conducting the background screening process. This information is confidential and will not be used for any other purpose.

Z Sobota \_\_\_\_\_ 08-08-2013  
Applicant Signature Date

Other Names Used: \_\_\_\_\_

Social Security Number	325-76-4486
Date of Birth: To be used for screening purposes only	06-19-1957
Drivers License number : State of Issue:	S130-9805-7174 ILLINOIS

Street Address	City	State	Zip Code
276 HAMAN RD	INVERNESS	JL	60067

