EMPLOYMENT APPLICATION

INNOVATIVE HIRING TECHNOLOGY INC.

Last Name _____ First Name _____ Middle Name _____ SS# _____

Address _____ Apt.# or P.O. Box _____ Drivers License # / State _____

City _____ State _____ Zip _____

( ) _____ Home Phone ( ) _____ Mobile Phone _____ Emergency Contact ( ) _____ Phone

Other names prior employment or education records would be shown under (i.e. Maiden Name)

Position applied for 1. _____ 2. _____ Date available: _____

How did you hear about us? _____ Referred By: _____ ❑ *Smoker ❑ *Non-Smoker

Geographic preference: _____ Workshift available: DAYS: _____ HOURS: _____

Salary desired: (Min.) $ _____ per _____ Available: ❑ Temp ❑ Perm ❑ Either ❑ Part Time ❑ Full Time

* How long have you been a local resident? _____ * Rent? _____ * Own? _____

* Spouse's Name? _____ * Spouse's Employer? _____

Have you been convicted of a crime within the past seven years? ❑ Yes ❑ No (A conviction will not necessarily preclude employment.)

If YES, list offense(s): _____

Date: _____ State: _____ Explain: _____

Have you ever been bonded? ❑ Yes ❑ No Have you ever had a fidelity bond cancelled or denied? ❑ Yes ❑ No

Have you ever been discharged by an employer? ❑ Yes ❑ No If yes, give details: _____

Education:

High School: _____ Years: ____ City: _____ Diploma: _____

College: _____ Years: ____ City: _____ Degree: _____

Other: _____ Years: ____ City: _____ Degree: _____

Most Recent Employer:

Company: _____ Type of Business: _____

Address: _____ Phone: _____

City / State / Zip _____

Dates:

Immediate Supervisor: _____ Phone / Ext. _____

Position Held: Salary From: $ _____ per _____ To: $ _____ per _____

From: _____ Mo./Yr.

Detailed Job Responsibilities: _____

To: _____ Mo./Yr.

Reason for Leaving: _____

May we contact: ❑ Yes ❑ No If No, why? _____

Previous Employer:

Company: _____ Type of Business: _____

Address: _____ Phone: _____

City / State / Zip _____

Dates:

Immediate Supervisor: _____ Phone / Ext. _____

Position Held: Salary From: $ _____ per _____ To: $ _____ per _____

From: _____ Mo./Yr.

Detailed Job Responsibilities: _____

To: _____ Mo./Yr.

Reason for Leaving: _____

May we contact: ❑ Yes ❑ No If No, why? _____

Previous Employer:

Company: _____ Type of Business: _____

Address: _____ Phone: _____

City / State / Zip _____

Dates:

Immediate Supervisor: _____ Phone / Ext. _____

Position Held: Salary From: $ _____ per _____ To: $ _____ per _____

From: _____ Mo./Yr.

Detailed Job Responsibilities: _____

To: _____ Mo./Yr.

Reason for Leaving: _____

May we contact: ❑ Yes ❑ No If No, why? _____

For Office Use Only

* Optional

Form W-4 (2019)

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

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

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, and
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	2 Your social security number

Home address (number and street or rural route)

City or town, state, and ZIP code

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note: If married filing separately, check "Married, but withhold at higher Single rate."

4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▶ ☐

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

IHT STAFFING
2105-A CROMLEY CIRCLE
MYRTLE BEACH, SC 29577

PERSONAL HEALTH HISTORY QUESTIONNAIR

Applicable state and federal laws prohibit discrimination based on disability or prior filing of claim f workers' compensation or taking medical leave to which you were entitled. This personal health histo questionnaire will be maintained in a file separate from your employment file. Any false statement misrepresentations, or concealments to secure employment are sufficient grounds for dismissal.

CHECK YES or NO if you now have, or if you are being treated now by a health care provider, OR if yc have had in the past, or have been treated in the past by a health care provider, for any of the followin Please provide the details of any "YES" answer, including the duration of the condition, dates of treatmen work restrictions or impairment level (if any), and outcome. Please use additional sheets of paper necessary to fully answer each question.

☐ YES	☐ NO	1.	Carpel Tunnel diagnosis or surgery	DETAILS:
☐ YES	☐ NO	2.	Heart Disease or Attack	DETAILS:
☐ YES	☐ NO	3.	Bone or Joint problems, ie. Knee/shoulder/wrist, etc.	DETAILS:
☐ YES	☐ NO	4.	Dizziness, fainting spells or frequent headaches	DETAILS:
☐ YES	☐ NO	5.	Depression/Nervous Disorder/Mental Illness	DETAILS:
☐ YES	☐ NO	6.	Back or neck condition/injury?	DETAILS:
☐ YES	☐ NO	7.	Have you ever had surgery?	DETAILS:
☐ YES	☐ NO	8.	Do you have any physical limitations that limit or reduce your ability to perform any work related duties?	DETAILS:
☐ YES	☐ NO	9.	Have you ever had a workers' compensation claim due to an on-the-job injury or illness?	DETAILS:
☐ YES	☐ NO	10.	Have you had any medical condition, illness, or disease that resulted in your absence from work or inability to perform the essential functions of your job for more than 7 consecutive work days?	DETAILS:

Have you ever had or been treated for any of the following conditions or diseases?

Repetitive Stress Trauma: ☐ No ☐ Yes

Back or neck problems or injury: ☐ No ☐ Yes

Knee injury: ☐ No ☐ Yes

Major illness in the past five years: ☐ No ☐ Yes

Diabetes: ☐ No ☐ Yes

Alcoholism: ☐ No ☐ Yes

Drug Addiction: ☐ No ☐ Yes

Employee Signature

Date

Print Name

Social Security Number (SSN)

Applicant Name _____

INNOVATIVE HIRING TECHNOLOGY INC.

** Please check all that apply **

Must have ACTUAL EXPERIENCE

INDUSTRIAL

- [ ] Assembly
- [ ] Buffer
- [ ] Carpentry
- [ ] Concrete Finisher
- [ ] Concrete Worker
- [ ] Construction
- [ ] Electronic Assembly
- [ ] Electronic Technician
- [ ] Forklift
- [ ] Foundry
- [ ] General Labor
- [ ] Industrial Sewer
- [ ] Inspection
- [ ] Inventory
- [ ] Landscaper
- [ ] Loading/Unloading
- [ ] Masonry
- [ ] Material Handling
- [ ] Medical Assembly
- [ ] Order Selector
- [ ] Packaging
- [ ] Painting
- [ ] Plastics
- [ ] Plating
- [ ] Plumber
- [ ] Polisher
- [ ] Sanding
- [ ] Shipping & Receiving
- [ ] Soldering
- [ ] Sorting
- [ ] Warehouse

INDUSTRIAL EQUIPMENT

- [ ] Blue Prints
- [ ] Callpers
- [ ] Hard Hat
- [ ] Micrometer
- [ ] Safety Glasses
- [ ] Steel Toed Boots
- [ ] Tools
- [ ] Work Gloves
- [ ] Work Shoes

MAINTENANCE

- [ ] Building
- [ ] Housekeeping
- [ ] Janitorial

MACHINE OPERATORS

- [ ] Boring Mill
- [ ] Brown & Sharp
- [ ] CNC
- [ ] Drill Press
- [ ] Grinder
- [ ] Hand Held Crane
- [ ] Hoist
- [ ] Injection Molding
- [ ] Lathe
- [ ] Metal Shear
- [ ] Milling
- [ ] Overhead Crane
- [ ] Printing
- [ ] Punch Press
- [ ] Set Up
- [ ] Turret Lathe

HOSPITALITY

- [ ] Banquet Server
- [ ] Bartender
- [ ] Cook
- [ ] Dishwasher
- [ ] Food Service
- [ ] Host
- [ ] Hostess
- [ ] Black Pants
- [ ] White Shirt

SKILLED POSITIONS/ TRADES

- [ ] CNC
- [ ] Electrician
- [ ] Machinist
- [ ] Machine Maintenance
- [ ] Millwright
- [ ] Tool & Die
- [ ] Welder - All
- [ ] Welder Arc
- [ ] Welder Mig
- [ ] Welder Spot
- [ ] Welder Stick
- [ ] Welder Tig

ACCOUNTING

- [ ] AS400
- [ ] MAS 90
- [ ] Peachtree
- [ ] Quickbooks
- [ ] Quicken

DRAFTING

- [ ] CAD Operator
- [ ] Drafter

SECRETARIAL

- [ ] Admin. Assistant
- [ ] Executive Secretary
- [ ] Legal Secretary
- [ ] Medical Secretary
- [ ] Receptionist
- [ ] Sales Secretary
- [ ] Switchboard Operator

OFFICE EQUIPMENT

- [ ] 10 Key
- [ ] Copy Machine
- [ ] Fax Machine
- [ ] Scanner

SHIFT

- [ ] First
- [ ] Second
- [ ] Third
- [ ] Part-Time
- [ ] Overtime
- [ ] Weekends

ACCOUNTING

- [ ] Accounting Clerk
- [ ] Accounts Payable
- [ ] Accounts Receivable
- [ ] Bank Teller
- [ ] Billing
- [ ] Bookkeeping
- [ ] Cashier
- [ ] Cost Accounting
- [ ] Credit Collections
- [ ] General Accounting
- [ ] General Ledger
- [ ] Medical Billing
- [ ] Payroll

OFFICE

- [ ] Call Center
- [ ] Customer Service
- [ ] Demonstrator
- [ ] Email
- [ ] Filing
- [ ] General Office
- [ ] Internet
- [ ] Mail Clerk
- [ ] Telemarketer

MECHANICS

- [ ] Auto Detailer
- [ ] Auto Mechanic
- [ ] Diesel Mechanic

OFFICE SKILLS

- [ ] Data Entry
- [ ] Dictaphone
- [ ] Dispatcher
- [ ] Legal Terminology
- [ ] Medical Terminology
- [ ] Shorthand
- [ ] Speed Writing
- [ ] Typing

PROFESSIONAL

- [ ] EMT
- [ ] Engineering
- [ ] Hotel Manager
- [ ] Human Resources
- [ ] Manager
- [ ] Retail
- [ ] Sales

SOFTWARE

- [ ] Access
- [ ] ACTI
- [ ] Auto Cad
- [ ] Excel
- [ ] Fax Pro
- [ ] Lotus 1-2-3
- [ ] Macintosh
- [ ] Microsoft Publisher
- [ ] Office Suite
- [ ] Outlook
- [ ] Power Point
- [ ] Photoshop
- [ ] Windows XP
- [ ] Word
- [ ] Word Perfect

TRANSPORTATION

- [ ] Car
- [ ] Public
- [ ] Ride

IF YOU ARE INTERTESTED IN GETTING PAID BY **DIRECT DEPOSIT**, YOU MUST BRING US A VOIDED CHECK OR A LETTER OF DIRECT DEPOSIT FROM YOUR BANK.

WE CAN NO LONGER ACCEPT THE ACCOUNT AND ROUTING NUMBERS HANDWRITTEN ON THE APPLICATION FORMS.

THANK YOU

IHT STAFFING

employersHR
It's what we do

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

In order to receive Automatic Deposits, please complete the following information. For new enrollees and employees changing accounts, you must attach a voided personal check; if a savings deposit, please provide the proper routing number. Print clearly using a pen

Financial Institution (Bank) Information (For Direct Deposit Accounts Only) Please verify the ABA Routing Number, with your financial institution, for your Checking Account(s) (first 9 digits on your check) and for all other accounts. The employee is responsible for the accuracy of ABA Routing Number. Please allow 14 business days before receiving your first direct deposit.

Employer Information:	Company Name IHT			Date of Hire
Employee Information:	Employee Name	Soc. Sec. #		Birth Date
	Street Address			Daytime Phone Number
	City	State	Zip Code	Home Phone Number
Check One:	☐ New Enrollment ☐ Change Institution ☐ Cancel Participation			
Financial Institution Information:	Financial Institution Name			Type of Account ☐ Checking ☐ Savings
	Street Address			Bank Phone Number
	City	State	Zip Code	Deposit Amount $_____ _____%
	Direct Deposit Routing/Transit No.	Account Number		
Financial Institution Information: (Use reverse side for additional institutions)	Financial Institution Name			Type of Account ☐ Checking ☐ Savings
	Street Address			Bank Phone Number
	City	State	Zip Code	Deposit Amount $_____ _____%
	Direct Deposit Routing/Transit No.	Account Number		

Permission to Deduct

FOR NEW ENROLLMENTS AND CHANGES, A VOIDED CHECK OR SAVINGS DEPOSIT SLIP MUST BE ATTACHED TO THIS FORM. (TO VERIFY OF ROUTING/TRANSIT NUMBERS)

I (we) hereby authorize Employers HR, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) checking and/or savings account indicated below and the Financial Institution named below to credit and/or debit the same to such account. If I become subject to any attachment, garnishment, or levies, my participation in Direct Deposit may be terminated, and I will receive a check for my pay. In the event of an employee termination, the final pay may be a physical check. In order to cancel, you MUST provide written notice to Employers HR prior to payroll run with your name, SSN, and signature with the request to cancel. Employers HR will send Direct Deposits to arrive on your check date. Employers HR assumes no responsibility for when your banking institution credits funds to your account and reserves the right to override this authorization in accordance with your work site agreement.

Employee Signature _____ Date _____

_____: PAYCARD (CHECK IF YOU WOULD LIKE A PAYCARD)

By providing the information requested above and signing below, I hereby elect and consent to receive my wages, including but not limited to off cycle age payments and wage payments upon discharge by electronic transfer of wages to a paycard.

Employee Signature: _____ Date: _____

PAYCARD NUMBER: _____

DEPOSIT AMOUNT: _____ OR ALL: _____

PRINT FULL NAME: _____

ADDRESS: _____

BIRTHDATE: _____

SS NUMBER: _____

employersHR
Its what we do

Employers HR
EMPLOYEE DATA FORM
(PLEASE FILL OUT COMPLETELY & ACCURATELY)

Company Name: _____ Location: _____

Section 1

Employee: _____ (First Name) _____ (Last Name) SS#: _____

Address: _____ Apt. _____ Telephone: (_____) _____

City: _____ County _____ State _____ Zip: _____

Hire Date with Client: _____ Hire Date with Employers HR: _____

In Case of Emergency, Please Contact:

Name: _____ Relationship: _____

Address: _____ Apt. _____ Telephone: (_____) _____

City: _____ State _____ Zip: _____

Section 2

Date of Birth: _____ Sex: ○ Male ○ Female

Please check the appropriate box below:

○ Hispanic or Latino ○ White ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ Asian
○ American Indian or Alaska Native ○ Two or more Races

Employers HR, is an Equal Opportunity Employer. The above information is used only to submit the EE0-1 Report to the Federal Government each year.
Employers HR, is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, the employer invites employees to voluntarily self-identify their race, ethnicity and gender. Submission of this information is voluntary and refusal to pro-vide it will not subject you to any adverse treatment. The information will be kept confidential and separate from personnel files. It will only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

I, the undersigned employee, in consideration of my hiring by Employers HR, (Employers HR) as an at-will leased employee of Employers HR, acknowledge and agree to the following: I have been hired as an at-will employ-ee of Employers HR which is an employee leasing company and there is no contract of employment which exists between me and the client to which I have been assigned, nor between Employers HR and me. I understand and agree that either Employers HR or I can terminate our employment relationship at any time, as I am an at-will employee. I also agree that I may be assigned to an affiliated Employers HR company and employed by such company at any time at the sole and complete discretion of Employers HR and without my consent or agreement. I also agree that while I am a leased employee of Employers HR, if Employers HR does not receive payment from client for services which I perform as a leased employee, Employers HR will still pay me the applicable minimum wage (or the legally required minimum salary or overtime pay) for any such pay period, and I agree to this method of compensation. I understand that the client to which I am assigned at all times remains obligated to pay me my regular hourly rate of pay if I am a non-exempt employee and to pay me my full salary if I am an exempt employee even if Employers HR is not paid by the client to which I am assigned. I have been informed and I agree that if my assignment with any Employers HR client to which I am assigned ends for any reason, I must report back to Employers HR within seventy-two (72) hours for possible reassignment and that unemployment benefits may be denied me if I fail to do so. In recognition of the fact that any work injuries which might be sustained by me are covered by state workers' compensation statutes, and to avoid the circumvention of such statutes which might result from suits against the customers of clients of Employers HR or against Employers HR based on the same injury or injuries, and to the extent permitted by law, I hereby waive and forever release any rights I might have to make claims or bring suit against any client or customer of Employers HR or against Employers HR for damages based upon injuries which are covered under such workers' compensation statutes. I also agree to comply with any drug testing policy, which Employers HR may adopt, and I specifically agree to post-accident drug testing in any situation where it is allowed by law. In addition, I also agree that if at any time during my employment I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, veteran status, retaliation, national origin, handicap, disability, or mar-ital status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact Employers HR's Human Resources Director at 888-796-8398 in order to obtain assistance in the resolution of such matters.

Employee Signature: _____ Date: _____

This Section Must be Completed By Your Supervisor

Supervisor's Name: _____ Hire Date: _____

Type of Hire: ○ New Hire ○ Re-Hire ○ Employers HR/Client Transition

Job Title: _____ Employee# _____ Badge#: _____

Division: _____ Department: _____ Location: _____ Region: _____

Employee: ○ Full Time ○ Part Time ○ Exempt ○ Non-Exempt

Pay Cycle: ○ Weekly ○ Bi-Weekly ○ Semi-Monthly ○ Monthly

Workers Compensation Class Code _____

Pay type & Rate:

○ Hourly Rate $_____ ○ Salary (Per Pay Cycle) $_____ ○ Commissions/Other $_____ (Ie. Auto Allowance)

Insurance Eligibility: ○ Yes ○ No Date Eligible: _____ Benefit Group: _____

This Section Completed By Employers HR

#1 Executive/Senior Level Officials & Managers #2 Professionals #3 Sales Workers #4 Clerical Workers #5 Craft Workers #6 Laborers and Helpers #7 First/Mid-Level Officials & Managers #8 Technicians #9 Administrative Support Workers #10 Operatives #11 Service Workers

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)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

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

STOP *Employer Completes Next Page* STOP

IHT STAFFING

PERMANENT & TEMPORARY SERVICES

CRIMINAL BACKGROUND AND DRUG TESTING REIMBURSEMENT

_____, I agree to have my criminal background checked for a possible position with IHT. I also agree to a drug test to be conducted.

By signing this form, applicant is agreeing to reimburse IHT for the cost of this criminal background check/drug test from their 1st paycheck in the amount of $20.00.

Applicant Signature: _____

Date: _____

IHT Coordinator: _____

Worker's Compensation Policy

All worker's compensation claims must be reported to IHT Staffing immediately for any accidents or injuries while working or while on any work site. All claims must be submitted within 8 hours of happening, whether major or minor. You must contact IHT Staffing (843-626-7970, during business hours and 843-450-3087, after hours). After reporting your injury, you must report to our office to fill out necessary paperwork. From there you will be sent to an approved Doctor's Care or Emergency Room depending on your medical needs. If an accident happens after hours or on the weekend, a report must be made and you must report to our office at 8a on the following Monday morning to complete paperwork. You must bring all medical documentation with you.

Failure to report an injury in the 8 hours could mean that your claim could be delayed. If you seek medical attention on your own, you ARE RESPONSIBLE for that medical bill.

If you have a minor injury and decide not to file a WC claim, you will need to fill out a Refusal of Treatment. This must also be done within the 8-hour period.

After each medical visit, you must bring in all documentation given to you to IHT Staffing after your visit.

I have read the Workers' Compensation Policy and understand all procedures.

_____

Date:

_____

Worker's Compensation Policy

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After each medical visit, you must bring in all documentation given to you to IHT Staffing after your visit.

I have read the Workers' Compensation Policy and understand all procedures.

_____

Date:

_____

ATTENTION ALL HOUSEKEEPING APPLICANTS and THOSE SCHEDULED FOR WEEKEND ASSIGNMENTS:

Friday, Saturday, and Sunday's are mandatory. You must show up for work on those day. If you call out ***FOR ANY REASON,*** you will be paid minimum wage.

If you are a No Call, No Show you also will be paid minimum wage. We have 24 hour, 7 days a week voicemail. You must call if you are going to be late or out. If it is before or after business hours or the weekend, you must leave a message.

By signing below, I am stating that I understand this policy.

_____

Employee Signature

_____

Date

IHT STAFFING

2105 CROMLEY CIRCLE - MYRTLE BEACH, SC 29577- O: (843-626-7970) – F: (843-626-7974)

www.ihtstaffing.com

TO:	APPLICANT
FROM:	IHT STAFFING, INC
DATE:	FEBRUARY, 2017
SUBJECT:	Homeland Security Employment Eligibility Verification & Tax Forms
	Emergency Contact and W/C Acknowledgement

Homeland Security requires that we review and verify your employment eligibility.

PLEASE CIRCLE EACH WHEN READ:

- Complete Page 1 – Employee Personal Information Section
- Complete the Employee Authorization & Acknowledgements forms
- Complete the POST HIRE Personal Health Questionnaire form
- Complete the I9 form **Note – I9 Documents- Choose 1 from A OR you may choose 1 item each from List B & C
- Provide a legible copy of your ID
- Provide a legible copy of your Social Security Card or Birth Certificate.
- Complete the 2017 FEDERAL TAX FORM (W-4)
- Complete the direct deposit information page if you have a checking account. You must include a voided check or the direct deposit form which your bank can provide. We can deposit your check for you the week that you will be paid.

WE CANNOT PROCESS YOUR PAYROLL CHECK IF WE ARE MISSING ANY OF THIS INFORMATION.

THANK YOU!!

IHT POLICIES and PROCEDURES

Please initial each line after you have read and completely understand each statement:

☐ I understand that I am expected to complete any job assignment that I accept unless the work is unsafe. If I consider the job unsafe I will call IHT immediately. A 24 hour answering service is available seven days a week for your convenience, (843) 626-7970.

☐ I understand that failure to complete a job assignment without reasonable cause will result in a pay rate of the Federal Minimum Wage for that particular assignment. This includes but is not limited to the following: quitting a position without giving a 48 hour notice to IHT Staffing, no show, no call, disorderly or improper conduct while on the job causing reason for dismissal.

☐ If for some unexpected reason such as an emergency or illness and I cannot make an assignment or if I will be arriving late I will contact IHT as soon as possible so that a replacement can be scheduled in my place. I also agree to give IHT 48 hour notice if I need time off for doctor's visits, car repairs, etc. My failure to do so will be grounds for IHT to assume that you have voluntarily quit, Non-compliance with this availability policy is regarded as voluntary quit and you may be ineligible for unemployment benefits. Also, it states onthe back of IHT's time card when signed you are agreeing to the terms and conditions. An employer maynot hire an IHT employee before said hours are completed without IHT being paid a fee.

☐ Full time is defined as 40 hours per week. Details of an assignment will be given once it is accepted by the employee.

☐ IHT has a very strict SUBSTANCE ABUSE POLICY and by signing this form I consent to submit to random drug testing. I understand that failure to comply with this agreement will be grounds for my immediate termination.

☐ IHT is not liable for drug screenings, physicals and/or credit/background checks. The employee will pay for the required pre-employment screenings upfront when applicable.

☐ Time cards are the responsibility of the employee. They can be picked up at the office or printed off the IHT website, ihtstaffing.com. I understand that IHT will not recognize or pay for any hours worked by me without a timecard signed by the client.

☐ As an employee of IHT it is my responsibility to fill out a timecard properly and make sure that it is turned in to IHT's office by 9am every Monday morning. If the timecard is faxed it is my responsibility to follow up and confirm that my timecard has been received. Pay checks are available for pick-up every Friday from7:30am-5:00pm if not direct deposited or a pay card has been issued.

☐ I understand that if I give IHT permission to mail my paycheck to the address I have provided it is my responsibility to pay $35 stop payment fee to IHT in the event I do not receive it and need a check reissued.

By signing below you are agreeing to IHT's policies and procedures.

Employee Signature:_____ Date:_____

IHT STAFFING

IHT STAFFING
2105-A CROMLEY CIRCLE
MYRTLE BEACH, SC 29577

NEW EMPLOYEE PACKET:

EMPLOYEE PERSONAL INFORMATION:

Social Security Number (SSN) _____/_____/_____

PRINT NAME EXCATLY as shown on your Social Security Card:

First Name_____

Middle Name:_____

Last Name: _____

Date of Birth_____/_____/_____

Home or Mailing Address_____

Apt/Bldg # -_____

City:_____

State_____Zip:_____

Home or Cell Phone (_____) _____

Marital Status_____

Single_____Married_____

Email Address:_____

Gender:_____Male _____Female

Emergency Contact_____Relationship_____

Phone:_____

IMPORTANT- TO ALL EMPLOYEES:

PLEASE REMEMBER TO ADHERE TO THE FOLLOWING POLICIES WHILE WORKING ON SITE FOR IHT STAFFING. FAILURE TO DO SO WILL RESULT IN RECEIVING MINIMUM WAGE AND POSSIBLE TERMINATION.

NO EATING OR DRINKING ANYWHERE WHILE AT WORK, EXCEPT IN DESIGNATED AREAS AND YOU MUST BRING YOUR OWN FOOD AND DRINK.

NO CELL PHONE USE WHILE WORKING.

NO SMOKING EXCEPT IN DESIGNATED AREAS AND ONLY AT BREAK TIMES.

NO VISITORS AT WORK.

NO DRINKING ALCOHOLIC BEVERAGES ON PREMISES

NO SLEEPING OR LOUNGING WHILE AT WORK.

DO NOT DISCUSS WAGES WITH ANY OTHER EMPLOYEES.

ALL TIMECARDS MUST BE TURNED IN BY 9AM ON MONDAY. IT IS YOUR RESPONSIBILITY TO TURN THESE IN- NOT OURS!

REMEMBER THIS POLICY:

HOSPITALITY/WEEKEND WORKERS: WEEKENDS ARE MANDATORY!!!

IF UNIFORMS ARE REQUIRED, YOU MUST WEAR THEM- THEY ARE MANDATORY.

IF UNIFORMS AND SUPPLIES ARE ISSUED AND YOU ARE NO LONGER WORKING THERE, YOU ARE REQUIRED TO TURN THEM IN TO THE OFFICE AT IHT AND YOU WILL NOT RECEIVE YOUR PAY UNTIL YOU DO.

SIGNED: _____ **DATE:** _____

EMPLOYEE ACKNOWLEDGEMENT FORM

IHT Staffing (and all affiliate companies) is firmly committed to your safety. We will do everything possible to prevent workplace accidents and are committed to providing a safe working environment for you and all employees.

You are encouraged to report any unsafe work practices or safety hazards encountered on the job. All accidents/incidents (no matter how slight) are to be reported immediately to the supervisor on duty.

A key factor in implementing this policy will be strict compliance to all applicable federal, state, local, and IHT Staffings policies and procedures. Failure to comply with these policies may result in disciplinary actions.

Additionally, IHT Staffing (and all affiliates) subscribes to these principles:

1. All accidents are preventable through implementation of effective Safety and Health Control policies and programs.
2. Safety and Health controls are a major part of our work week every day.
3. Accident prevention is good business. It minimizes human suffering, promotes better working conditions for everyone, holds IHT Staffing in higher regard with customers, and increases productivity.
4. Management is responsible for providing the safest possible workplace for Employees. Consequently, management is committed to allocating and providing the resources needed to promote and effectively implement this safety policy.
5. Employees are responsible for following safe work practices, company rules, and for preventing accidents and injuries.
6. Our safety program applies to all employees and persons affected or associated in any way by the scope of this business.

By signing this document, I confirm receipt of IHT Staffing's Employee Safety Handbook and acknowledge that I have read and understood all polices, programs, and actions as described and agree to comply with these policies.

Employee Signature **DATE**

IHT STAFFING
2105-A CROMLEY CIRCLE
MYRTLE BEACH, SC 29577

EEO IDENTIFICATION

Various agencies of the United States Government require employers to maintain information on applicant pertaining to factors such as race, sex, and type of position for which an individual applies. The informatio requested on this sheet is for compliance with certain record keeping requirements. IHT and your Worksit Employer believe all persons are entitled to equal employment opportunities and do not discriminate agains its employees or applicants for employment because of race, color, sex, religion, national origin, disability veteran status, age, marital status, or any other protected group status.

Name: _____ Date: _____ / _____ / _____

Position applied for: _____

Social Security Number (SSN): _____ Date of Birth: _____ / _____ / _____

Gender: ____ Male ____ Female

Race/Ethnic Data: (Select One Category)

☐ **White (Non-Hispanic)**
Origins of Europe, North Africa, or Middle East

☐ **Asian (Non-Hispanic)**
Origins of Far East, Southeast Asia, or the Indian subcontinent

☐ **Native Hawaiian or Other Pacific Islander**
Origins of Hawaii, Guam, Samoa, or other Pacific Islands

☐ **Black or African American (Non-Hispanic)**
Origins in any of the black Racial groups of Africa

☐ **Hispanic or Latino**
Mexican, Cuban, Puerto Rican, South or Central American, or Other Spanish culture or origin regardless of race

☐ **American Indian or Alaskan Native**
Origins of North and South America (including Central America), who maintain tribal affiliation or community attachment

☐ **Two or more races (Non-Hispanic)**
All persons who identify with more than one of the above races

Regulations issued by the U.S. Department of Labor with respect to disabled individuals, disabled veteran and Vietnam Era veterans require that federal contractors provide an opportunity for self-identification to candidates seeking employment. Such self-identification is submitted on a voluntary basis, for use one in accordance with regulations, and without subjecting the individual to adverse treatment.

Disabled/Veteran Classification(s):

☐ Special Disabled Veteran (30% or more disability)

☐ Vietnam Era Veteran

☐ Other Eligible Veteran

☐ **Disabled Individual**

To be Completed by the Worksite Employer (Client)

☐ Check here, if the employee elected not to complete this form, the Worksite Employer (Client) has completed it through visual identification as required by law.

Gore & Associates Management

Limited Benefit & Self-Funded Minimum Essential Coverage (MEC) Enrollment Guide

Complete the Enrollment Form to Elect or Decline Coverage

IMPORTANT PLAN INFORMATION: You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

1. You **MUST** complete the Enrollment Form as part of your New Hire Process.
2. Elect or decline all benefits on the Enrollment Form.
3. You **MUST** Sign and Date the bottom of the form, even if you decline coverage.
4. Return the Enrollment Form to your Branch Manager.
5. Keep the Benefits at a Glance page for your records.

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.

For Enrollees of California employer policies: In order to enroll in the Fixed Indemnity Medical Benefit, you must be enrolled in major medical coverage.

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 Essential StaffCARE Fixed Indemnity Medical, Prescription Drug, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1214, 26.212, and 26.213. The Term Life/Accidental Death and Dismemberment and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

The 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.

Voluntary Electronic Availability of Summary Health Information for MEC/Wellness Preventive Plan

Copies of the Summary of Benefits and Coverage ("SBC") and Summary Plan Description ("SPD") from Essential StaffCARE ("ESC") are available at the following link: www.essentialstaffcare.com/mec-sbc-spd

While you may have other health plans, this is the link for your specific MEC plan SPD with ESC. These important documents explain the terms and conditions of your *Health Plan, including eligi*bility, coverage amounts and exclusions along with your rights and responsibilities. At any time, you may request paper copies or revoke your consent to electronic delivery, free of charge, by calling 1-866-798-0803.

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

ESC Essential StaffCARE

VSI **2968601-AVU-1** | OFFICE USE ONLY LOCATION _____ Rehire Date __ __/__ __/__ __ __ __

ENROLLMENT FORM

ESC/MEC 4NAW P1M v20.1

A. REQUIRED EMPLOYEE INFORMATION

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

Name	Home Phone	
Social Security #	Date of Birth / /	Gender M F
Address		Apt. #
City	Zip	State

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare Benefits?
☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

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

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only	☐ **$19.98**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + Child(ren)	☐ **$33.17**	**$14.58**	**$6.54**	**$0.90**	
Employee + Spouse	☐ **$37.96**	**$10.80**	**$4.84**	**$0.90**	
Employee + Family	☐ **$50.55**	**$20.52**	**$9.20**	**$1.80**	
	☐ **NO** to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of NH, HI, or PR. [2] 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 / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82968601-M-AVU-1 **Payroll Deducted Weekly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed weekly.

☐ **$13.42** Employee Only ☐ **$15.18** Employee + Child(ren) ☐ **$16.38** Employee + Spouse ☐ **$18.66** Employee + Family

☐ **NO** to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage. I affirmatively consent to the voluntary receipt of the plan documents elections, via email or website.

DATE __ __/__ __/__ __ __ __ ▶ **SIGNATURE**

LIMITED BENEFITS SUMMARY

Policy Number **2968601-AVU-1**

FIXED INDEMNITY MEDICAL BENEFIT

For more details, please see your Summary Plan Description.

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by an accident or illness. If the covered event costs more, you pay the difference. But if the covered event costs less, you keep the difference.

Outpatient Benefits [1]		**Inpatient Benefits**	
Physician Office Visit	$100 per day	Standard Care	$300 per day
Diagnostic (Lab)	$75 per day	Intensive Care Unit Maximum [3]	$400 per day
Diagnostic (X-Ray)	$200 per day	Inpatient Surgery	$2,000 per day
Ambulance Services	$300 per day	Anesthesiology	$400 per day
Physical, Speech, or Occupational Therapy	$50 per day	Skilled Nursing [4]	$100 per day
Emergency Room Benefit - Sickness	$200 per day	First Hospital Admission (1 per year)	$250
Emergency Room Benefit - Accident [2]	$500 per day	Annual Inpatient Maximum [5]	No Limit
Outpatient Surgery	$500 per day	**Prescription Drugs (via reimbursement)** [6,7]	
Anesthesiology	$200 per day	Annual Maximum	$600
Annual Outpatient Maximum	$2,000	Generic Coinsurance	70%
Wellness Care		Brand Coinsurance	50%
Wellness Care (one per year)	$100		

[1] all outpatient benefits are subject to the outpatient maximum [2] covers treatment for off the job accidents only [3] pays in addition to standard care benefit [4] for stays in a skilled nursing facility after a hospital stay [5] Subject to internal limits of plan [6] not subject to outpatient maximum [7] To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc.

DENTAL BENEFIT

Waiting Period/Coinsurance | **Annual Maximum Benefit** $750 | **Deductible** $50

Coverage A	None / 80%	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, Endodontics, Bridges and Dentures

VISION BENEFIT [1]

	In-Network		**Out-of-Network**	
	You Pay	Plan Pays	You Pay[4]	Plan Pays
Eye Exam [2] (including dilation)	$10 Copay	100%	100%	$35
Standard Contact Lens Fit Exam (includes follow up)	Up to $55	$0	100%	$0
Premium Contact Lens Fit Exam (includes follow up)	100%, after 10% discount	$0	100%	$0
Frames (once every 24 months)	80%, after $110 allowance	20% plus $110 allowance	100%	$55
Standard Plastic Lenses (single, bifocal, trifocal) [2,3]	$25 Copay	100%	100%	$25-$55
Contact Lenses (Conventional) (materials only) [2]	85%, after $110 allowance	15% plus $110 allowance	100%	$88
Contact Lenses (Disposable) (materials only) [2]	100%, after $110 allowance	$110 allowance	100%	$88
Contact Lenses (Medically Necessary) (materials only) [2]	$0 Copay	100%	100%	$200

[1] For complete plan details, visit www.essentialstaffcare.com/vision [2] Once every 12 months [3] $15 higher in AK, CA, HI, OR, WA [4] After plan payment

TERM LIFE BENEFIT

Employee Amount	$10,000 (reduces to $7,500 at 65; $5,000 at 70)	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$5,000 (terminates at age 70)	**Infant Amount (15 days to 6 mos)**	$1,000

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D is part of the Term Life Benefit.)

Employee Amount	$20,000	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$20,000	**Infant Amount (15 days to 6 mos)**	$2,500

SHORT-TERM DISABILITY BENEFIT

Benefit Amount	60% of base pay up to $150 per week
Waiting Period/Maximum Benefit Period	7 days for injury or sickness / up to 26 weeks

OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT [1]

Policy Number **82968601-M-AVU-1**

The optional MEC Wellness/Preventive Benefit **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.

Benefit	**In-Network**	**Non-Network**
15 Preventive Services for Adults	100%	40%
22 Preventive Services for Women	100%	40%
26 Covered Preventive Services for Children	100%	40%

[1] For more information about preventive services, please visit www.healthcare.gov.

WEEKLY MEC PREMIUM	**MEC**
Employee Only	$13.42
Employee + Child(ren)	$15.18
Employee + Spouse	$16.38
Employee + Family	$18.66

WEEKLY LIMITED BENEFITS PREMIUM	**Medical**	**Dental**	**Vision**	**Term Life**	**STD**
Employee Only	$19.98	$5.40	$2.42	$0.60	$4.20
Employee + Child(ren)	$33.17	$14.58	$6.54	$0.90	-
Employee + Spouse	$37.96	$10.80	$4.84	$0.90	-
Employee + Family	$50.55	$20.52	$9.20	$1.80	-

LIMITED BENEFIT EXCLUSIONS AND LIMITATIONS

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

FIXED INDEMNITY MEDICAL

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

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

No benefits will be paid for:

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

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

DENTAL

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

VISION

No benefits will be paid for any materials, procedures or services provided under worker's 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; or
- Work-related injury or sickness.

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

TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

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

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

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

Member Services:

For frequently asked questions and network information for the Fixed Indemnity Medical Plan, visit *www.esc-enrollment.com/FAQIND*. For questions and a full list of preventive services covered by the MEC Wellness/Preventive Plan, as well as the MEC SBC, please visit *www.esc-enrollment.com/FAQMECW*. A paper copy is also available, free of charge, by calling Essential StaffCARE Customer Service 1-866-798-0803.

PLEASE NOTE: To make changes or cancel coverage by telephone call (800) 269-7783. Your pin code for enrolling/making changes is **408** + _ _ _ _ (last four digits of your SSN). Your Company has chosen to take your payroll deductions on a **Post-Tax** basis.

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

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