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. Malden 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

IHT Staffing Skill Sheet

Applicant Name: _____

PLEASE SELECT SKILLS THAT YOU HAVE EXPERIENCE IN

INDUSTRIAL
- ☐ Assembly
- ☐ Carpentry
- ☐ CNC Operator
- ☐ Construction
- ☐ Forklift
- ☐ General Labor
- ☐ HVAC
- ☐ Industrial Maint.
- ☐ Injection Molding
- ☐ Inspection
- ☐ Inventory
- ☐ Landscaper
- ☐ Loading/Unloading
- ☐ Machine Operator
- ☐ Material Handling
- ☐ Order Puller
- ☐ Packaging
- ☐ Painter
- ☐ Plumber
- ☐ Quality Control
- ☐ Security
- ☐ Seamstress/Sewer
- ☐ Stocking
- ☐ Shipping & Receiving
- ☐ Soldering
- ☐ Warehouse
- ☐ Welder

HOTEL/PROP MGMT
- ☐ Building Maint.
- ☐ Groundskeeper
- ☐ Hotel/Resort Maint.
- ☐ Housekeeping
- ☐ Laundry

MECHANICS
- ☐ Auto Detailer
- ☐ Auto Mechanic
- ☐ Diesel Mechanic

HEAVY EQUIPMENT
- ☐ Backhoe
- ☐ Bobcat
- ☐ Bulldozer
- ☐ CDL Class A
- ☐ CDL Class B
- ☐ Hazmat Endorsement
- ☐ Heavy Equip. Operator
- ☐ Non-CDL Driver

FOOD SERVICE
- ☐ Banquet Server
- ☐ Bartender
- ☐ Breakfast Cook
- ☐ Busser
- ☐ Prep Cook
- ☐ Dishwasher

SHIFT
- ☐ First
- ☐ Second
- ☐ Third
- ☐ Weekends

TRANSPORTATION
- ☐ Bike/Moped
- ☐ Car
- ☐ Public
- ☐ Ride
- ☐ Walk

OFFICE SKILLS
- ☐ Data Entry
- ☐ Dictaphone
- ☐ Dispatcher
- ☐ Filing
- ☐ Legal Terminology
- ☐ Shorthand
- ☐ Speed Writing
- ☐ Typing WPM _____

ADMIN/OFFICE
- ☐ Admin. Assistant
- ☐ Call Center
- ☐ Customer Service
- ☐ Executive Assistant
- ☐ General Office
- ☐ Human Resources
- ☐ Legal Assistant
- ☐ Mail Clerk
- ☐ Office Manager
- ☐ Paralegal
- ☐ Property Manager
- ☐ Receptionist
- ☐ Retail
- ☐ Sales
- ☐ Switchboard Operator

MEDICAL
- ☐ Insurance Verification
- ☐ Medical Assistant
- ☐ Medical Billing
- ☐ Medical Receptionist
- ☐ Medical Terminology
- ☐ Scheduler

SOFTWARE
- ☐ Access
- ☐ Email/Internet
- ☐ Excel
- ☐ Google Shared Sheets
- ☐ Iqware
- ☐ Microsoft Publisher
- ☐ Office Suites
- ☐ Outlook
- ☐ Photoshop
- ☐ Power Point
- ☐ Word
- ☐ Word Perfect

ACCOUNTING
- ☐ Accounting Clerk
- ☐ Accounts Payable
- ☐ Accounts Receivable
- ☐ AS400
- ☐ Bookkeeping
- ☐ Cashier
- ☐ Cost Accounting
- ☐ Credit Collections
- ☐ Payroll
- ☐ Peachtree
- ☐ Quickbooks

OTHER SKILLS NOT LISTED
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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

Personal Health History Questionnaire

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

Circle YES or NO if you now have, or if you are being treated now by a health care provider, OR if you have had in the past, or have been treated in the past by a health care provider, for any of the following. Please provide the details of any "YES" answer, including the duration of the condition, dates of treatment, work restrictions or impairment level (if any), and outcome. Please use additional sheets of paper if 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)

Witnessed by Date

employersHR
It's what we do

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

In order to have your paystubs emailed to you weekly from our payroll system, please provide an email address:_____

IMPORTANT: Direct Deposit will not be processed until a voided check or direct deposit form from your bank is provided to us.

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			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.

EmployeeSignature:_____Date:_____

PAYCARD NUMBER:_____

DEPOSIT AMOUNT:_____OR ALL:_____

PRINT FULL NAME:_____

ADDRESS:_____

BIRTHDATE:_____

SS NUMBER:_____

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:

_____

IHT STAFFING 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 Staffing immediately. A 24-hour answering service is available seven days a week for your convenience, 843-626-7970. All job details will be given to the employee upon acceptance of assignments.

___ I understand that failure to complete a job assignment without reasonable cause will result in a pay rate of the Federal Minimum Wage ($7.25) for that particular assignment. This includes but not limited to the following: quitting a position without giving a 48-hour notice to IHT Staffing, no call, no show, 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 Staffing as soon as possible so that a replacement can be scheduled in my place. I also agree to give IHT Staffing 48-hour notice if I need time off for a doctor's visit, car repairs, etc. My failure to do so will be grounds for IHT Staffing to assume that I have voluntarily quit. Non-compliance with this availability policy is regarded as voluntarily quit and you may be ineligible for unemployment benefits. Also, it states on the back of the IHT Staffing timecard when signed, you are agreeing to the terms and conditions. An employer may not hire an IHT Staffing employee before hours are completed without IHT Staffing being paid a fee.

____ Full-time is defined as 40 hours per week.

____ IHT Staffing has a very strict SUBSTANCE ABUSE POLICY and by signing this form I consent to submit to pre-employment (as required) and random drug testing. I understand that failure to comply with this my assignment will be grounds for my immediate termination.

____ IHT Staffing is not liable for drug screening and background checks. The employee will pay for the required pre-employment screenings upfront when applicable.

____ Timecards are the responsibility of the employee. They can be picked up at the office during business hours, printed off the IHT Staffing website (ihtstaffing.com) or found in the mailbox beside the front door. I understand that IHT Staffing will not recognize or pay for any hours worked by me WITHOUT a timecard SIGNED by the client. As an employee of IHT Staffing, it is my responsibility to fill out a timecard properly and make sure that it is turned into IHT Staffing office by 9 am every Monday morning. If the timecard is faxed, it is my responsibility to follow up and confirm that my timecard has been received. Failure to turn in a signed timecard could result in not being paid on time. Pay checks are available for pick-up every Friday from 7:30 am to 5:00 pm. IHT Staffing offers direct deposit and pay cards in addition to regular paychecks.

____ I understand that if I give IHT Staffing permission to mail my paycheck due to moving out of state to the address that I have provided on a Self-Addressed Stamped Envelope. I also understand that it is my responsibility to pay the $35 stop payment fee to IHT Staffing in the event that I do not receive my mailed check and it needs to be reissued.

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

Employee Signature: _____ Date: _____

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!

ABSOLUTELY NO GUNS, KNIVES OR OTHER WEAPONS ANYWHERE ON WORK PROPERTY- THIS INCLUDES IN VEHICLES AND ON PARKING LOTS.

REMEMBER THIS POLICY:

HOSPITALITY/WEEKEND WORKERS: WEEKENDS ARE MANDATORY!!!

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

IF UNIFORMS, KEYS 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

The Coastal Group (and all affiliated 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 The Coastal Groups policies and procedures. Failure to comply with these policies may result in disciplinary actions.

Additionally, The Coastal Group (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 The Coastal Group 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 The Coastal Group'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 Name (printed)

Employee Signature **DATE**

INT STAFFING
2105 Cromley Circle UN-A
Myrtle Beach, SC 29577

EEO IDENTIFICATION

Various agencies of the United States Government require employers to maintain information on applicants pertaining to factors such as race, sex, and type of position for which an individual applies. The information requested on this sheet is for compliance with certain record keeping requirements. Waterfront Staffing Inc believe all persons are entitled to equal employment opportunities and do not discriminate against 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:

☐ 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

☐ If the employee elected not to complete this form, the Worksite Employer has completed it through visual identification as required by law.

From the EEO job classification listed below, which one best describes the position filled?

☐ 1.1 – Executive/Senior Level Officials and Managers
☐ 1.2 – First/Mid Level Officials & Managers
☐ 2 – Professionals
☐ 3 – Technicians
☐ 4 – Sales
☐ 5 – Office and Clerical
☐ 6 – Craft Workers (skilled)
☐ 7 – Operative (semi-skilled)
☐ 8 – Laborers (unskilled)
☐ 9 – Service Workers

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

▶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

employers HR

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

Company Name: IHT Staffing Location: Myrtle Beach, SC

SECTION 1

Employee: _____ _____ SS#: _____
Address: _____ Apt.: _____ Phone: _____
City: _____ County: _____ State: _____ Zip: _____
Hire Date with Client: _____ Hire Date with Employers HR: _____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: _____ Relationship: _____
Address: _____ Apt.: _____ Phone: _____
City: _____ County: _____ 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

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 Transaction
Job Title: _____ Employees #_____ Badge #_____
Division: _____ Department_____ Location_____ Region_____
Employee: ___ Full Time ___ Part Time ___Exempt ___ Non-exempt Workers Compensation Class Code
Pay Cycle: ___ Weekly ___ Bi-Weekly ___ Semi-Monthly___ Monthly _____
Pay type and Rate: Hourly Rate $_____Salary (Per Pay Cycle) $ _____Commissions/Other $_____
Insurance Eligibility: ____ YES ___ NO Date Eligible _____ Benefit Group_____

Employers HR is an Equal Opportunity Employer. The above information is used only to submit to the EEO 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 provide 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 as an at-will leased employee, of Employer HR, acknowledge and agree to the following. I have been hired as an at will employee of Employers HR which s an employee leasing company and there is no contract of employment which exist between me and the client to which I have been assigned, not 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 non-exempt employee and to pay me my full salary if 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 with in seventy-two (72) hours for possible reassignment and that unemployment benefits may be denied to 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 or 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 marital status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact Employers HR Human Resources Direction at888-796-8398 in order to obtain assistance in the resolution of such matters.

Employee Signature: _____ Date: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
▶ Give Form W-4 to your employer.
▶ Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ Single or Married filing separately
☐ Married filing jointly or Qualifying widow(er)
☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do only one of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(a) **Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) **Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) **Extra withholding.** Enter any additional tax you want withheld each pay period . . 4(c) $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3 . . . . . 1 $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $ _____

5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4 . . . . . 5 $ _____

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

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

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

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

Print Form | Reset Form

1350

dor.sc.gov

STATE OF SOUTH CAROLINA
DEPARTMENT OF REVENUE

SOUTH CAROLINA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

SC W-4
(Rev. 10/25/21)
3527
2022

Give this form to your employer. Keep the worksheets for your records. The SCDOR may review any allowances and exemptions claimed. Your employer may be required to send a copy of this form to the SCDOR.

Part I: Employee Information

1 First name and middle initial	Last name	2 Social Security Number

Address

City State ZIP

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
If Married filing separately, check **Married, but withhold at higher Single rate.**

4 Check if **your last name is different** on your Social Security card. ☐
For a replacement card, contact the Social Security Admin at 1-800-772-1213 .

5	Total number of allowances (from the applicable worksheet on page 3)	5	
6	Additional amount, if any, to withhold from each paycheck	6	$
7	I claim exemption from withholding for 2022. Check the box for the exemption reason and write **Exempt** on line 7.		

☐ For tax year 2021, I had a right to a refund of **all** South Carolina Income Tax withheld because I had **no** tax liability, **and** for tax year 2022 I expect a refund of **all** South Carolina Income Tax withheld because I expect to have **no** tax liability.

☐ I elect to use the same state of residence for tax purposes as my military servicemember spouse. I have provided my employer with a copy of my current military ID card and a copy of my spouse's latest Leave and Earning Statement (LES). State of domicile: _____

7

Under penalty of law, I certify that this information is correct, true, and complete to the best of my knowledge.

Employee's signature (required) **Date**

Part II: Employer Information

Complete box 8 and box 10 if sending to the SCDOR. Complete box 8, box 9, and box 10 if sending to the State Directory of New Hires.

8 Employer's name and address	9 First date of employment	10 Employer identification number (EIN)

INSTRUCTIONS

Employee instructions

Complete the SC W-4 so your employer can withhold the correct South Carolina Income Tax from your pay. 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.

Determine the number of withholding allowances you should claim for withholding for 2022 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.

Consider completing a new SC W-4 each year and when your personal or financial situation changes. This keeps your withholding accurate and helps you avoid surprises when you file your South Carolina Individual Income Tax return.

For the latest information about South Carolina Withholding Tax and the SC W-4, visit **dor.sc.gov/withholding**.

Exemptions: You may claim exemption from South Carolina withholding for 2022 for one of the following reasons:

- For tax year 2021, you had a right to a refund of **all** South Carolina Income Tax withheld because you had **no** tax liability, **and** for tax year 2022 you expect a refund of **all** South Carolina Income Tax withheld because you expect to have **no** tax liability.
- Under the Servicemembers Civil Relief Act, you are claiming the same state of residence for tax purposes as your military servicemember spouse. You are only in South Carolina, or a bordering state, to be with your military spouse who is serving in the state in compliance with military orders. Provide your employer with a copy of your current military ID card and a copy of your spouse's latest Leave and Earnings Statement (LES). Your military ID card must have been issued within the last four years. The assignment location on the LES must be in South Carolina or a bordering state. Enter your spouse's state of domicile on the line provided.

If you are exempt, complete **only** line 1 through line 4 and line 7. Check the box for the reason you are claiming an exemption and write **Exempt** on line 7. Your exemption for 2022 expires February 15, 2023. If you are a military spouse and you no longer qualify for the exemption, you have 10 days to update your SC W-4 with your employer.

Filers with multiple jobs or working spouses: You will need to file an SC W-4 for each employer. If you have more than one job, or if you are married filing jointly and your spouse is also working, you may want to consider only claiming allowances on the SC W-4 for the highest earning job and/or adding additional withholding on line 6 to ensure you are having enough withheld.

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 the SC1040ES, Individual Declaration of Estimated Tax, or adding additional withholding from this job's wages on line 6. Otherwise, you may owe additional tax. Find the SC1040ES with instructions at **dor.sc.gov/forms**. The fastest, easiest way to pay Estimated Tax payments is using our free, online tax portal, **MyDORWAY**, at **dor.sc.gov/pay**. Select **Individual Income Tax Payment** to get started. Do not mail a paper copy of the SC1040ES if you pay online.

Employer instructions
Complete box 8 through box 10, as necessary. Employees do **not** complete this section.

- **New hire reporting:** You must report newly-hired employees within 20 days after the employee's first day of work. For more information, see SC Code Section 43-5-598 and 42 USC Section 653a or visit **newhire.sc.gov.**
- **Box 8:** Enter your name and address. If you are sending a copy of this form to the State Directory of New Hires, enter the address where child support agencies should send income withholding orders.
- **Box 9:** If you are sending a copy of this form to the State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If you rehired the employee after they had been separated from your service for at least 60 days, enter the rehire date.
- **Box 10:** Enter your Employer Identification Number (EIN).

All employers reporting South Carolina wages or withholdings must submit the W-2s directly to the SCDOR. Submitting the W-2s to the Social Security Administration does not meet this requirement. The fastest, easiest way to submit W-2s is using our free, online tax portal, **MyDORWAY**, at **MyDORWAY.dor.sc.gov**. Sign into your existing account or create an account to get started. Once you've logged in, select the **More** tab, then click **Upload W-2s** listed under the **Other** section.

Find the Withholding Tax Tables and the Withholding Tax Formula at **dor.sc.gov/withholding**.

Worksheet instructions
Personal Allowances Worksheet: Complete the worksheet on page 3 to determine the number of withholding allowances to claim.

- **Line C: Head of household -** Generally, you may claim the 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 a qualifying individual. For more information on filing status, refer to IRS Pub. 501 at **irs.gov**.
- **Line E: Dependents -** The total number of dependents claimed on your South Carolina return must equal the number of dependents claimed on your federal return. This includes qualifying children and qualifying relatives. Enter the total number of eligible dependents.
- **Line F: Dependents under the age of 6 -** Enter the number of dependents from line E who have **not** reached the age of six by December 31, 2022.

Enter the total from line G of this worksheet on line 5 of the SC W-4.

Deductions, Adjustments, and Additional Income Worksheet: Complete this **optional** worksheet if you plan to itemize or claim adjustments to income and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding.

- **Reduce withholding:** Complete this worksheet to determine if you are able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you reduce your withholding, your refund at the end of the year will be smaller, but your paycheck will be larger.
- **Increase withholding:** You can also use this worksheet to determine how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Enter the total from line 10 of this worksheet on line 5 of the SC W-4.

SC W-4 Worksheets

KEEP FOR YOUR RECORDS

Personal Allowances Worksheet

A	Enter 1 for yourself	**A** _____
B	Enter 1 if you will file as married filing jointly	**B** _____
C	Enter 1 if you will file as head of household	**C** _____
D	Enter 1 if: • You are single, or married filing separately, and have only one job; **or** • You are married filing jointly, have only one job, and your spouse doesn't work; **or** • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**D** _____
E	**Dependents:** Enter the number of dependents you will claim on your 2022 federal return	**E** _____
F	**Dependents under the age of 6:** Enter the number of dependents from line **E** who are under the age of 6 as of December 31, 2022	**F** _____
G	Add line A through line F	**G** _____

For accuracy, **complete all worksheets that apply.**

- **If you plan to itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If the above situation does not apply, **stop here** and enter the number from line G on line 5 of the SC W-4 on page 1.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2022 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. For more information, see IRS Pub. 505 at **irs.gov**	**1** $ _____
2	Enter the 2022 federal standard deduction amount based on your filing status	**2** $ _____
3	Subtract line 2 from line 1. If zero or less, enter 0	**3** $ _____
4	Enter an estimate of your 2022 adjustments to income and any additional standard deduction for age or blindness. For more information, see IRS Pub. 505 at **irs.gov**	**4** $ _____
5	Add line 3 and line 4	**5** $ _____
6	Enter an estimate of your 2022 nonwage income not subject to withholding (such as dividends or interest)	**6** $ _____
7	Subtract line 6 from line 5. If zero, enter 0. Enter a negative amount in **brackets**	**7** $ _____
8	Divide line 7 by $4,300. Enter a negative amount in **brackets**. Round decimals **down**	**8** _____
9	Enter the number from the **Personal Allowances Worksheet,** line G	**9** _____
10	Add line 8 and line 9. If zero or less, enter 0	**10** _____

Enter the total from line 10 on line 5 of the SC W-4 on page 1.

The Family Privacy Protection Act

Under the Family Privacy Protection Act, the collection of personal information from citizens by the SCDOR is limited to the information necessary for the SCDOR to fulfill its statutory duties. In most instances, once this information is collected by the SCDOR, it is protected by law from public disclosure. In those situations where public disclosure is not prohibited, the Family Privacy Protection Act prevents such information from being used by third parties for commercial solicitation purposes.

Social Security Privacy Act Disclosure

It is mandatory that you provide your Social Security Number on this tax form if you are an individual taxpayer. 42 U.S.C. 405(c)(2)(C)(i) permits a state to use an individual's Social Security Number as means of identification in administration of any tax. SC Regulation 117-201 mandates that any person required to make a return to the SCDOR must provide identifying numbers, as prescribed, for securing proper identification. Your Social Security Number is used for identification purposes.

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: In order to enroll in the Fixed Indemnity Medical Benefit, you and any dependent must have minimum essential coverage and 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 COVERAGE AS DEFINED IN FEDERAL HEALTH LAW.

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/coverage/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

A sample copy of the Summary of Benefits and Coverage ("SBC") from Essential StaffCARE ("ESC") is available at the following link: www.enrollment.care/info/sbcmec.

While you may have other health plans, this is the link for your MEC plan with ESC. This important document explains the terms and conditions of your Health Plan, including eligibility, 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.

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

ENROLLMENT FORM

ESC/MEC 4NAW P1M v23.1

A. REQUIRED EMPLOYEE INFORMATION

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

Name	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 reside 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 Group Term Life Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Gender M F	Relationship
Name	Social Security #	Date of Birth / /	Gender M F	Relationship
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. Note: The Patient Protection and Affordable Care Act (PPACA) individual mandate no longer imposes a penalty at the federal level; however, please check with your state for any state specific individual mandate requirements or penalties. 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

By signing below, I confirm By signing below, I confirm By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benefit plans; I've been offered self-funded ACA compliant coverage (MEC Wellness/Preventive). I understand that weekly or biweekly rates, as provided above, will be deducted based on my assignment; open enrollment is only available for a limited time; that making no benefit selection is a declination of benefit coverage and benefit coverage is only available to employees who are over the age of 18.

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 (Virtual or In-Person)	$105 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	Anesthesia	$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]	
Anesthesia	$200 per day	Annual Maximum	$600
Annual Outpatient Maximum	$2,000	Generic Coinsurance / Brand Coinsurance	70% / 50%
Wellness Care			
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

	In-Network		**Out-of-Network**	
	You Pay	Plan Pays	You Pay[3]	Plan Pays
Eye Exam[1] (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)[1,2]	$25 Copay	100%	100%	$25-$55
Contact Lenses (Conventional) (materials only)[1]	85%, after $110 allowance	15% plus $110 allowance	100%	$88
Contact Lenses (Disposable) (materials only)[1]	100%, after $110 allowance	$110 allowance	100%	$88
Contact Lenses (Medically Necessary) (materials only)[1]	$0 Copay	100%	100%	$200

[1]Once every 12 months [2]$15 higher in AK, CA, HI, OR, WA [3]After plan payment

GROUP 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 Group 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**
Preventive Services for Adults	100%	40%
Preventive Services for Women	100%	40%
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 reside in California, Hawaii, New Jersey, New York, or Rhode Island.

GROUP 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 *https://enrollment.care/info/bcs/ind.* For questions and a full list of preventive services covered by the MEC Wellness/Preventive Plan, as well as the MEC SBC, please visit *https://enrollment.care/info/bcs/mw.* 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. Use pin code **408** +____ (last four digits of your SSN) for **Limited Benefits** plans (see gray section above for benefits covered). Use pin code **648** +____ (last four digits of your SSN) for your **MEC** plan. Your Company has chosen to take some/all of 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."