STAR HR

Client Name: _____

Address: _____

_____

City State Zip

Employee Name: _____

Last Name First Name

Employee Signature: _____

Employee Email: _____

Date: _____

Welcome

This company is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, handicap, disability or marital status. We assure you that your opportunity for employment with this employer depends solely upon your qualifications. The company also accommodates individuals with handicaps, disabilities and bona fide religious beliefs.

Employee Instructions:

1. Complete this book in its entirety
2. This booklet requires signatures for successful completion and processing:
    a New Employee Certification
    b. Employment Eligibility Certification
    c. W-4 Withholding Certificate
    d. Drug Free Workplace Policy Certification
    e. Harassment Policy Certification
    f. Safety Guidelines
    g. Direct Deposit Form
    h. Policies and Procedures
    I. I-9 Disclaimer
    J. Electronic Signature Authorization

Management Instructions:

1. Verify signature on New Employee Certification page.
2. Complete the Employment Eligibility Verification and have an Authorized Representative sign Box 2.
3. Federal Withholding Certificate must be completed; verify number listed on line; verify signature.
4. Visually verify and make copies of documents used to verify employee's employment eligibility.
5. Drug Free Workplace clients must verify and witness employee's signature. Provide employees with appropriate paperwork and direct them to the appropriate facilities for testing.
6. Verify signature on Harassment Policy Certification.
7. Verify signature on Safety Guidelines
8. If employee wishes to use Direct Deposit, make sure to attach a voided check along with the signed form.

New Empoyee Certification

I affirm and certify that an offer of employment has been made to me, conditioned on the satisfactory completion of this New Hire Booklet and that all information given herein and in my interview(s) with the Company is true and correct to the best of my knowledge. I pledge to abide by all Company policies, procedures and safety rules.

I understand that if I am hired, my employment with the Company will not be for a specific term and may be terminated by me or the Company with or without notice or cause at any time. I further understand that no oral promise, Company policy, custom business proactive or other procedure (including the Company's Employee Handbook or any personnel manuals) shall constitute and employment contract or modification of the at-will employment relationship between me and the Company.

I acknowledge that as a condition of employment the Company has the right to and may require drug and alcohol testing. The testing will be at the Company's expense. I agree to submit to such testing if asked to do so.

I agree to abide by the direction and supervision of management in regards to the day-to-day operation of my duties, including but not limited to determination of my wages or salary levels, performance evaluations, scheduling, promotions, transfers and benefits.

Last Name First Name Employee Signature Date

Employee Information

(to be completed by employee)

Employee Name: _____
Last First M.I.

Address: _____
Apt. #

Phone: _____
City State Zip

Social Security Number: _____ Date of Birth: _____
mm/dd/yyyy

Drivers License Number: _____ DL Expiration Date: _____
mm/dd/yyyy

State License Held: _____

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander
☐ American Indian

Primary Contact: _____ Relationship: _____

Main Contact: _____ Mobile Phone: _____

Secondary Contact: _____ Relationship: _____

Main Phone: _____ Mobile Phone: _____

COMPANY INFORMATION

(to be completed by employer)

Company Name: _____ Job title: _____

Email Address: _____ Start Date: _____

Rate of Pay: _____ Status: _____

Division: _____ WC Code: _____

Drug-Free Workplace Policy Summ

In a commitment to safeguard the health of our employees and to provide a safe working environment, we have established a DrugFree Workplace Policy for our company. This policy is set up pursuant to the Drug-Free Workplace program requirements under applicable state laws and regulations and Department of Transportation Rule 49 CFR part 40, Procedures for Transportation Workplace Drug Testing. The contents of these drug and alcohol guidelines are presented as statements of the company's current policy and may be changed and updated by the company as required. These guidelines are not intended to create a contract between the company and any employee. Nothing in these guidelines binds the company to a specific or definite period of employment or to any specific policies, procedures, actions, rules, terms or conditions of employment. Details of this policy may be obtained from management.

Essential Parts of the Policy:

- Observance of this policy is a condition of continued employment.
- This policy prohibits the sale, possession, use, manufacturing, or distribution of drugs, drug paraphernalia or alcohol while working for or on company assigned or owned property, or while operating any vehicle, machinery, or equipment owned or leased by the company.
- It is a violation of this policy to report to work if drugs or alcohol is found to be present in your system at or above the level prescribed by application drug testing rules.
- It is a violation of this policy to report to work, return to work, or to remain at work with the odor of alcohol on your breath, regardless of whether or not you are actually intoxicated.

Testing of Employees:

- Employees may be tested when there is reasonable suspicion that the employee is using or has used drugs while performing their assigned duties.
- Employees may be required as a condition of continued employment to be drug tested if the test is conducted as part of a routine or annual fitness-for-duty medical examination.
- Employees who cause or contribute to an accident may be required to submit to a drug test. Employees, while at work, who sustain injuries requiring medical treatment beyond first aid may be drug tested.
- Employees who have been determined to have used drugs or alcohol, and are retained by the company will be subject to unannounced follow-up drug tests at least once per year for a period of up to 2 years.
- Additional testing, including random testing may also be conducted as required by applicable state or federal laws, rules or regulations or as deemed necessary by the company.

Disciplinary Action:

- The company may suspend employees without pay under this policy pending the results of a drug test or investigation.
- In the case of a first-time violation of this policy, when an employee has a positive drug or alcohol test result, (without evidence of use, sale possession, distribution, dispensation, or purchase of drugs or alcohol on company property or while on duty), the employee will be sublet to discipline up to and including discharge.
- Any employee who has a second violation of any party of this policy will be discharged.
- Any employee using, selling, purchasing, distributing, or dispensing drugs or alcohol while on duty or while on company property will be discharged.
- An employee who refuses to submit to drug screening may be denied continued employment.
- An employee who refuses to cooperate with a drug screening post accident will be subject to discipline up to and including discharge.
- An employee injured in a workplace accident who has a confirmed, positive rest result maybe be denied eligibility for medical and indemnity benefits as provided by applicable workers' compensation laws.
- An employee who is discharged from duty on the basis of a confirmed positive test will have their claim for unemployment compensation benefits opposed and possibly denied.

New Employee Certification

Employee Rights and Responsibilities:

- Each employee will be given an opportunity, both before and after drug use screening, to confidentially report to the assigned Medical Review Officer the use of prescription and/or non-prescription medication that may alter or affect the results of a test.
- Employees have the right, upon written request, to receive a copy of the drug test result.
- Employees have the right to consult the Medical Review Officer (MRO) for technical information regarding prescription and non-prescription medication. Addresses of MRO's may be obtained from management.
- An employee who is using prescription and/or non-prescription medication which may impair the employee's ability to work safely must report this medication use to their supervisor or management before starting any work related activity. This notification will be kept strictly confidential, but failure to notify your supervisor or management may result in disciplinary action.
- All information, interviews, reports, statement memoranda and drug test results, written or otherwise, received by the company as a part of this drug testing program are confidential communications. Unless authorized by state or federal laws, rules or regulations, the company will not release such information without a written consent form signed voluntarily by the person tested.
- Any employee who receives a confirmed positive drug test result has the right to challenge the result.
- An employee who elects to challenge the results of a confirmed positive test result may have the original specimen retested by another qualified laboratory. All re-testing will be at the employee's expense.
- The employee has the responsibility of notifying the drug testing laboratory of any administrative or civil action brought concerning the drug test results. The lab will maintain a sample until the case of administrative appeal is settled.
- An Employee Assistant Plan/Substance Abuse Program list is available and will be provided upon request.
- The company will provide employees with a period of training regarding substance abuse and this Drug-Free Workplace Policy.

Acknowledgment Signature:

I hereby acknowledge that I have received and read a summary of the company's Drug-Free Workplace Policy. I have had an opportunity to have this material fully explained.

I understand that this substance abuse testing program is established as a safety requirement in accordance with applicable state regulations. The program involves routine testing of urine, hair, blood, or other authorized samples to determine the presence of illegal drugs. These tests may be conducted at anytime by the company or its agent(s) to determine that the employees meet the necessary qualifications for employment and continued employment. I also understand that the Drug-Free Workplace policy and related documents are not intended to constitute a contract between the company and myself.

My signature below indicates that I have read, understood, authorize and consent to the above statement and any attached addendum and hereby voluntarily participate in the substance abuse testing program.

Employee Name (printed) Employee Signature Date

New Employee Certification

Purpose:

We are committed to maintaining a work environment free of harassment on the basis of race, creed, religion, gender, sex, national origin, age, marital status, sexual preference, or disability. We will not tolerate harassment of personnel by a supervisor, co-worker, vendor, customer or anyone else. Workplace and sexual harassment may violate one or more of the following:

- Title IV of the Civil Rights Act of 1964
- Age Discrimination Employment Act
- Americans with Disabilities Act (ADA)

Any employee who engages in sexual or other unlawful harassment violates this policy and the law and will be disciplined up to and including immediate termination.

Guidelines:

Harassment is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of their race, color, creed, religion, gender, national origin, age, marital status or disability when it:

1. has the purpose or effect of creating an intimidating, hostile, or offensive working environment
2. has the purpose or effect of unreasonably interfering with an individual's work performance; or
3. otherwise adversely affects an individual's employment opportunities.

Examples of inappropriate and prohibited harassment include, but are not limited to the following:

1. epithets, slurs, negative stereotyping, or threatening, intimidating, or hostile acts that relate to race, color, religion, gender, national origin, age, marital status, sexual preference, or disability; and,
2. written or graphic material that denigrates or shows hostility toward an individual or group because of race, color, religion, gender, national origin, age, marital status, sexual preference, or disability and that is placed on walls, bulletin boards, or elsewhere on the company's premises or circulated in the work place. This also includes acts that purport to, or are meant to be "jokes," or "pranks" but that are hostile or demeaning, such as hate mail, threats, defaced photographs, or other such conduct.

Sexual advances, request for sexual favors and any other physical, verbal, or visual conduct of sexual nature constitute sexual harassment when:

1. Submission to the conduct is an explicit or implicit term or condition of employment or continued employment;
2. Submission or rejection of the conduct is used as a basis for employment decisions affecting an employee, such as a promotion, demotion or evaluation;
3. The conduct has purpose or effect of reasonably interfering work performance or creating an intimidating, hostile or offensive work environment.

Sexual harassment may include, but is not limited to, unwelcome sexual propositions; sexual innuendo, suggestive remarks; vulgar or sexually explicit comments gestures or conduct; sexual oriented kidding, teasing or practical jokes; and physical contact, such as brushing against another's body, pinching or patting. Sexual and workplace harassment may be present when the intended target of conduct is not offended, but others reasonably find the conduct intimidating, hostile or abusive.

Safety Guidelines

These Safety Guidelines are provided for your information and education. They are intended to provide you with basic safety information that will assist you in avoiding injury while performing your daily activities.

GENERAL SAFETY GUIDELINES

1. It is important that all employees report all work related injuries to their immediate supervisor as soon as possible after they become aware of the injury.
2. Everyone should exercise extreme care and consideration in the performance of their duties to see they do not cause injury to others or create work hazards that could cause injury to others.
3. No one should try to lift or move heavy/bulky objects that could cause injury to the back or other body parts. You are requested to seek assistance.
4. Personal tools, equipment, extension cords, chemicals or electrical heaters should not be brought to work without management authorization.
5. When you become aware of a facility or equipment defect, report it to the facilities manager for proper corrective action. Failure to report faulty conditions may result in injuries.
6. Never attempt to repair electrical equipment or appliances while in service. Tag them out of service and notify proper authority to affect repair.
7. Cabinets can be very dangerous if used improperly. Opening two drawers simultaneously can cause a cabinet to crash to the floor. Whenever possible, cabinets should be bolted together in tandem, secure to the floor or wall.
8. Flammable liquids should always be stored in appropriate, closed containers. Large supplies should be stored in UL Approved cabinets or other appropriate means described by the Fire Department. Flammable liquids should never be left unattended.
9. Heavy objects should be stored on lower shelves while lighter and less dangerous items can be stored on middle and upper shelves.
10. Bookshelves, storage cabinets and other elevated storage areas should be well secured.
11. Defective furniture, worn carpet, defective chairs, loose handrails or other facility defects which could contribute to an accident should be reported to building services for proper corrective action.
12. Everyone should take time to be educated regarding emergency procedures.

PROPER LIFTING TECHNIQUES

1. Your back and neck have natural curves that should be kept flexible. Good posture maintains those curves and reduces stress on your muscles, ligaments and the shock-absorbing discs between the bones in your spine.
2. Lift mentally first, planning your route and the place you will put down the load. When the load is heavy or bulky, get help. Ask a co-worker or use equipment to ease the task (e.g., mechanical left, hand truck, cart, etc.).
3. Establish good footing as you approach the object you intend to lift. Bend your knees, not your back and get a good grip. Plan to hold the object close to your body. Tighten your stomach as you Lift. Lift smoothly with your legs, not your back.
4. Stand straight as you move the object. Don't twist your body while lifting; rather, turn your feet. Keep your balance. If you have a problem, ask for help. Be sure of your footing and pathway.

I HAVE THOROUGHLY READ AND UNDERSTAND THE SAFETY GUIDELINES. I WILL ALWAYS MAINTAIN SAFE WORK PRACTICES AS OUTLINED ABOVE AND WILL IMMEDIATELY REPORT ANY INFARCTION TO MY SUPERVISOR.

Date: _____

Signature: _____

Name: _____

STAR HR

Direct Deposit Form

We are pleased to offer you direct deposit. Now you can have your paycheck automatically deposited in your checking or savings account on payday, and you don't have to change your present banking relationship to take advantage of this service.

Here's how direct deposit works:

Once your direct deposit has been entered into our system, your account goes into pre-note status, to verify we have the correct account number set up. This typically takes 5 business days. Once verified successfully, your direct deposit becomes active.

On payday you will receive an earnings statement showing gross salary, taxes, other deductions, and net pay. Your money will already have been deposited in your account(s). The amount of the deposit will appear on your bank statement. We believe you will like the added convenience of having your net pay automatically deposited for you. Direct deposit is safe, convenient and easy.

All you need to do is:

1. Mark the box next to type of account to indicate whether your net pay will be deposited in your checking or savings account.
2. Fill in your name, the name and location of your financial institution, and today's date.
3. Attach a voided check for verification of the financial institution information. If you are unable to attach the voided check, please fill in your account number. NOTE: Be sure to sign the form!

Name: Client/Employer Name:

Phone: Email: SSN (last 4 digits):

Action Requested (Check One)

☐ Start Direct Deposit ☐ Stop Direct Deposit

☐ Change *(add/delete a bank, increase/decrease fixed amount or select a new bank account)*

Effective Date

☐ As Soon As Possible

☐ Future Pay Date

Bank Name:
Routing #: Account #: ☐ Checking ☐ Savings
Check Only One Box: ☐ Deposit any balance of net pay to this account ☐ Full deposit ☐ Fixed amount or percent $ / %

Bank Name:
Routing #: Account #: ☐ Checking ☐ Savings
Check Only One Box: ☐ Deposit any balance of net pay to this account ☐ Full deposit ☐ Fixed amount or percent $ / %

Bank Name:
Routing #: Account #: ☐ Checking ☐ Savings
Check Only One Box: ☐ Deposit any balance of net pay to this account ☐ Full deposit ☐ Fixed amount or percent $ / %

Bank Name:
Routing #: Account #: ☐ Checking ☐ Savings
Check Only One Box: ☐ Deposit any balance of net pay to this account ☐ Full deposit ☐ Fixed amount or percent $ / %

I authorize Star HR to deposit my net pay via direct deposit to my account(s) as indicated above. If funds to which I am not entitled are deposited to my account(s), I authorize Star HR to direct the financial institution(s) to return said funds.

I understand that it is my responsibility to verify that payments have been credited to my account(s) and that Star HR assumes no liability for overdrafts for any reason. I understand that in the event my financial institution(s) is/are not able to deposit any electronic transfer into my account due to any action I take, Star HR cannot issue funds to me until the funds are returned to Star HR by my financial institution(s).

I understand this authorization will override any previous authorization and will remain in effect until a) revoked by my written request; or b) immediately following my termination from employment with Star HR; or c) 120 days after my last paycheck was issued.

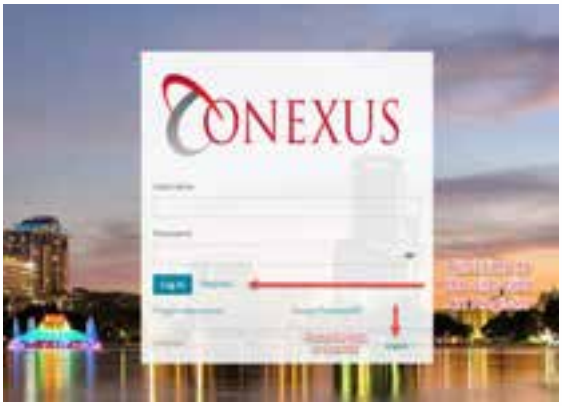
I understand I must immediately notify Star HR before I close any/all account(s) listed above while this authorization is in effect. I also understand. I will be charged for any fees incurred due to any closed or invalid accounts.

Employee Signature: ______________________ Today's Date: ______________________

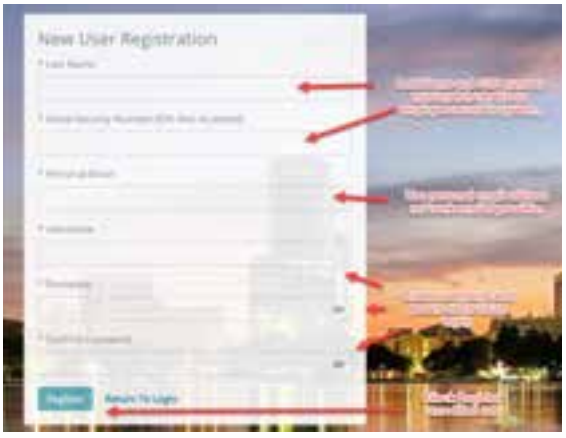
Electronic Signature Authorization & Employee Portal Registration

Star HR is pleased to be your new payroll provider. As a convenience we have auto filled your Employee New Hire Packet with the information you already have on file. Please go to http://starhro.com/resources/ to obtain a copy of the New Hire Packet and Employee Safety Manual. Both Star HR and Employee (parties) agree that the New Hire Packet and Employee Safety Manual may be electronically signed. The parties agree that the electronic signatures appearing on these documents are the same as handwritten signatures for the purposes of validity, enforceability and admissibility. If you would like a paper version of the New Hire Packet please ask your worksite supervisor. You may also go on-line and navigate to the following address https:// key-ep.prismhr.com/#/auth/login to access pay stubs and other important employee information. If we do not have your correct email address on file you will not be able to register on the employee portal.

Once there you will see the following screen and will need to click on register to enroll.



Once one the employee portal screen https://key- ep.prismhr.com/#/auth/login enter the Last Name and Social Security number that matches what is on your employee record.



You will need to have a personal email address to receive password resets and verification. Username and password must be created in next step – see parameters for password. The password must contain the following:
8 Characters in length
contain at least 1 number
contain at least uppercase letter
contain at least lowercase letter contain at least one symbol

Employee Print Name: _____

Employee Signature: _____

Date: _____

I-9 Disclaimer

ON-SITE EMPLOYER / CLIENT COMPANY
PLEASE COMPLETE & RETAIN I-9 AT
YOUR LOCATION.
STAR HR DOES NOT RECEIVE OR MAINTAIN I-9 FORMS.
PLEASE INCLUDE A COPY OF
EMPLOYEE'S VALID GOVERNMENT
ISSUED PICTURE ID WITH APPLICATION.

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

2023

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 surviving spouse
☐ 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, other details, 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) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; 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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 and you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c) . The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include other tax credits for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay each pay period , including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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.

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 2023 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:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 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 territories 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 agencies to combat terrorism.

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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Complete Top Portion Only & Sign/Date Bottom

Form **8850** (Rev. March 2016)

Department of the Treasury
Internal Revenue Service

Screening Notice and Certification Request for the Work Opportunity Credit

▶ Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

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

Your name _____ Social security number ▶ _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

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

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if any of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but not age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; or
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; or
- Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; or
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ _____ Date _____

Dear New Employee:
Your employer is participating in a federal program to initiate jobs.
In order to complete the requirements, please complete the survey below:

Signature: _____ Date: ____/____/_____ Social Security: #_____-____-_____

Print Name: _____ Date of Birth: ____/____/_____ How old are you?:_____

Have you worked for this employer before? **YES** ☐ **NO** ☐ If **Yes**, last date of employment: ____/____/_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:
(Please also complete the top and sign the bottom of the attached 8850 form. Thank you!)

1. In the **past 6 months,** have you or family member received **SNAP / Food Stamps**? **YES** ☐ **NO** ☐
   If **YES,** please give name of primary recipient & City/State: _____

2. In the **last 18 months,** have you received **TANF** (Temporary Assistance for Needy Families)? **YES** ☐ **NO** ☐
   If **YES**, please give name of primary recipient & City/State: _____

3. **Are you a VETERAN of the U.S. Armed Forces? YES** ☐ **NO** ☐ **(IF NO, Please GO to Question #4.)**
   Have you been unemployed a ***combined period of (6) months during the past year?*** **YES** ☐ **NO** ☐
   Have you been unemployed for a ***combined period of (4) weeks but less than (6) months during the past year?*** **YES** ☐ **NO** ☐
   Were you discharged or released from active duty within the past year? **YES** ☐ **NO** ☐
   Are you entitled to compensation for a service-connected disability? **YES** ☐ **NO** ☐
   Are you a member of a family that received SNAP benefits for ***at least 3 months during the past 15 months before you were hired****?* **YES** ☐ **NO** ☐
   If **YES**, please give name of primary recipient & City/State: _____

4. In the **past 60 days**, did you receive Supplemental Security Income (**SSI**) benefits? **YES** ☐ **NO** ☐

5. In the **last year**, were you convicted of a felony or released from prison after a felony conviction? **YES** ☐ **NO** ☐
   If **Yes,** enter the date of conviction: ____/____/_____ & date of release: ____/____/_____
   Was this a federal ☐ or a state ☐ conviction?

6. Are you being referred by an agency for employees with disabilities? (Must be a Vocational Rehabilitation Agency)
   YES ☐ **NO** ☐
   Are you being referred by Social Security's Ticket to Work Program for employees with disabilities?
   YES ☐ **NO** ☐
   Are you being referred by the Department of Veteran Affairs? **YES** ☐ **NO** ☐

7. **Have you received Unemployment Compensation for more than 26 consecutive weeks? YES** ☐ **NO** ☐

Starting Hourly Wage: $_____ **Start Date:** ____/____/_____

CMS is responsible for administering this program for your employer, and is an independent organization. All information disclosed by yourself, therefore, will be handled independently by your employer. The information you provide is confidential and will be used only by CMS in strict confidence with the Department of Labor to determine your eligibility for the program. Thank you for your time and effort.

Cost Management Services

STAR HR

Dear Employee,

Your company is participating in a federal program under the PATH Act to create jobs.

In order to meet the guidelines for this program, we are requesting your assistance in completing the following brief survey via telephone, web link or web link QR code. All information you provide will remain confidential, and will not impact the hiring process.

Any information you provide is confidential and will be reviewed in strict confidence with the Department of Labor to determine eligibility for the available job initiation programs.

Please select one of the following methods to complete this process-

Web Screening: https://wotc.irecruit-us.com/admin.php?wotcID=starhrwotc

Smart Phone Web Screening:

SCAN ME

Call Center #: 866-597-6917

Your time and cooperation with this effort is greatly appreciated.

Thank you!

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:89#6*<#H$$)++$8($=#$*=+#$(8$#'68++$4'()+$("#$'#O($83#'$#'68++;#'(86)'$("#$#9#'($8-$*$Z4*+)-5)'<$+)-#$#9#'(F

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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 Critical Illness coverage is underwritten by Companion Life Insurance Company.

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: https://www.enrollment.care/info/sbcmec

While you may have other health plans, this is the link for your MEC plan SPD with ESC. These important documents explain 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.

B1 2995600-BHL | OFFICE USE ONLY | LOCATION _____ | Rehire Date __ __ /__ __ /__ __ __ __

ENROLLMENT FORM

ESC/MEC CU(4EUNAW) PVM 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 select a coverage level before any benefits in Section C. Your coverage level for all the benefits in Section C will be identical. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]	CRITICAL ILLNESS
☐ Employee Only	$15.98	$5.40	$2.42	$0.60	$4.20	$2.71
☐ Employee + Child(r en)	$26.54	$14.58	$6.54	$0.90		$2.75
☐ Employee + Spouse	$30.36	$10.80	$4.84	$0.90		$4.99
☐ Employee + Family	$40.44	$20.52	$9.20	$1.80		$5.04
☐ NO to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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 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 ☐ 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

82995600-M-BHL | 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(r en) ☐ $16.38 Employee + Spouse ☐ $18.66 Employee + Family

☐ NO to MEC Wellness/Preventive

ACA

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

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) and open enrollment is only available for a limited time. I also understand 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 2995600-BHL

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)	$60 per day	Standard Care	$300 per day
Diagnostic (Lab)	$75 per day	Intensive Care Unit Maximum [3]	$400 per day
Diagnostic (X-Ray)	$150 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	$100 per day	Annual Inpatient Maximum [5]	No Limit
Emergency Room Benefit—Accident[2]	$300 per day	Wellness Care	
Outpatient Surgery	$500 per day	Wellness Care (one per year)	$75
Anesthesia	$200 per day	Prescription Drugs (via reimbursement)	[6, 7]
Annual Outpatient Maximum	$2,000	Annual Maximum	$600
		Generic Coinsurance / Brand Coinsurance	70% / 50%

[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

WEEKLY LIMITED BENEFITS PREMIUM	Medical	Dental	Vision	Term Life
Employee Only	$15.98	$5.40	$2.42	$0.60
Employee + Child(ren)	$26.54	$14.58	$6.54	$0.90
Employee + Spouse	$30.36	$10.80	$4.84	$0.90
Employee + Family	$40.44	$20.52	$9.20	$1.80

LIMITED BENEFITS SUMMARY

Policy Number 2995600-BHL

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

CRITICAL ILLNESS BENEFIT		Pre-existing Condition Limitation: 12/12	Waiting Period: 30 days
Critical Illness Insurance pays a lump sum benefit for the first ever diagnosis of a covered critical illness. Features a lump sum benefit payment to use as you see fit, and dependent coverage for spouse and/or dependent children.			
Heart Attack	100%	Employee Policy Face Amount [1]	$5,000
Invasive Cancer	100%	Spouse Amount	$3,750
Stroke	100%	Child(ren) Amount	$2,500
Carcinoma in Situ	25%		
Skin Cancer	$250		

[1]If dependent coverage is selected, coverage is payable at 75% of the Employee Policy Face Amount for a spouse and at 50% for any child(ren)

WEEKLY LIMITED BENEFITS PREMIUM	STD	Critical Illness
Employee Only	$4.20	$2.71
Employee + Child(ren)	-	$2.75
Employee + Spouse	-	$4.99
Employee + Family	-	$5.04

OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT [1]

Policy Number 82995600-M-BHL

ACA 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

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 AND ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT BENEFIT

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

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
- Declared or undeclared war
- Serving on full-time active duty in the armed forces
- The covered person's commission of a felony
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law or
- With regard to the accidental loss of life, limb or sight benefit - sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

No benefits will be paid for:

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

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

PRESCRIPTION DRUGS

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

DENTAL

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

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.

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.

GROUP TERM LIFE

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

CRITICAL ILLNESS

The Company will NOT pay the Benefit Amount for a covered condition if: i.Such covered condition is not covered under this Policy; ii.Such covered condition First Occurred while this Policy was not in force; iii.Such covered condition was diagnosed by a person who is not a Physician; iv.Such covered condition was diagnosed outside the U.S., unless the Diagnosis is confirmed in the U.S.; v. Such covered condition or surgical procedure was performed outside the U.S., unless on a U.S. military base or facility; or within another U.S. military or government building or facility; or

vi. the Insured's date of birth, Age or sex was misstated on the Application and at the correct date of birth, Age or sex the Policy would not have become effective or would have terminated.

Any Benefit Amount payment under this Policy is subject to the adjustments provided in the Policy provisions; including, but not limited to, the Time Limit for Certain Defenses, Misstatement of Age or Sex, Binding Arbitration and Grace Period provisions.

If the Insured is Age 60 or older on the Policy Effective Date, the Initial Benefit Amount will be reduced by 50 percent on the fifth anniversary of the Policy Effective Date. In all other cases, the Benefit Amount will be reduced by 50 percent when the Insured reaches Age 65. After this reduction occurs, the current benefit amount for a category is 50 percent of the benefit remaining in that category on the day prior to the reduction.

The insurance on an Insured will cease on the earliest of: i. the last day of the payroll deduction period during which the Insured ceases to be a member of a class eligible for coverage as shown in the Schedule; ii. the end of the last period for which premium payment has been made to the Company; iii. the date the Policy terminates; iv. the last day of the payroll deduction period during which the Insured is retired or pensioned; v. with respect to those Insureds working for employers with less than 20 employees on a typical work day in the preceding Calendar Year, the last day of the payroll deduction period during which the Insured attains age 70; or vi. the last day of the payroll deduction period during which the Insured

terminates employment. vii. the date on which the maximum benefit has been paid in all three categories.

The insurance on a Dependent will cease on the earliest of: i. the date the Insured's coverage terminates; ii. the end of the last period for which premium payment has been made to the Company; iii. the date the Dependent no longer meets the definition of Dependent, as defined in the Policy; or

iv. the date the Policy is modified so as to exclude Dependent coverage. v. the date on which the maximum benefit has been paid in all three categories. vi. The Company shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

The Policy, and the coverage of a Policyholder under the Policy, may be terminated as described below.

A Policyholder may terminate coverage under the Policy by giving written notice to the Company. Termination will be effective on the latter of: i. the date we receive the notice; or ii. the requested termination date.

After the first anniversary date of the Policy, the Company may terminate any or all of the insurance under the Policy, as of any premium due date, by giving written notice to the Policyholder at least 60 days prior to the termination date.

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: 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."