EMPLOYERS OVERLOAD
INNOVATIVE WORKFORCE SOLUTIONS - SINCE 1947

PAYROLL EMPLOYEE APPLICATION PROCESS

Employee Name (As listed on Social Security Card):

First Name: _____ **Middle Name:** _____ **Middle Initial:** _____

Last Name: _____ **Alias:** _____

Suffix (i.e. Jr., Sr., etc.): _____

Social Security: _____ **Date of Birth (MM/DD/YYYY):** _____

Home Address:

Apt/Building #: _____ P.O. Box: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (If different from above):

Apt/Building #: _____ P.O. Box: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers (Fill in those that apply)

Telephone #: _____

Cell ◯ Home ◯

Emergency Contacts

Name: _____

Phone Number: _____

A copy of Employers Overload's Employee Handbook is available at the County Office, along with an Employers Overload safety training for this short-term office environment assignment.

_____
Signature

_____
Date

INTERNAL OFFICE USE ☐ Criminal Record Check ☐ Driving Record Check ☐ Credit Record Check

EO Rep: _____ EO Office: _____

Company: _____ Position: _____

Company: _____ Position: _____

Company: _____ Position: _____

Company: _____ Position: _____

Company: _____ Position: _____

IDENTIFYING INFORMATION FOR CONSUMER REPORTING AGENCY

Full Legal Name: _____

(FIRST NAME) (LAST NAME) (MIDDLE NAME or INITIAL)

Have you ever used another name/nickname? ☐ YES ☐ NO Maiden Last Name, if applicable: _____

Other names used, if any, including nicknames and aliases: _____ Years Used: _____

Social Security Number: _____ Date of Birth: _____

Driver's License Number: _____ State of Issuance: _____ Expiration Date: _____

Daytime Phone Number: _____ Email Address: _____

Current Address: _____

(Street / PO Box) Apt # City State Zip County

List all other City, County and States in which you have lived (if additional space is required, please use additional paper):

City	County	State	Start Year-End Year

HAVE YOU EVER BEEN CONVICTED OF ANY FELONIES, MISDEMEANORS or VIOLATIONS? ☐ YES ☐ NO If yes, please comment below:

Description of Conviction(s): _____

Date of Conviction: _____ ☐ Felony ☐ Misdemeanor ☐ State Crime ☐ Federal Crime State of conviction: _____

Any Other Convictions: _____ Which County: _____

*Washington applicants: Answer YES only if the conviction or release from imprisonment was within the last ten (10) years or related to the functions of the position for which you are applying.

Existence of a criminal record does not automatically prevent you from employment.

BACKGROUND CHECK – ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT. I hereby authorized the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer or insurance company to furnish any and all background information requested by an outside organization acting on behalf of Employer and/or Employer itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

As an employee who may be assigned to one or multiple customers, you are acknowledging that Employers Overload (employer of record) may need to release personal information to the customer, based on business needs. This includes, but not limited to, securely providing a copy of your ID (personal identification), background and/or drug screen results, etc. to our customer (host employer) prior to the start of your employment assignment.

I certify that the information contained on this Authorization form is true and correct and that my application or employment may be terminated based on any false, omitted or fraudulent information.

SIGNATURE: _____ DATE: _____

DISCLOSURE OF CONSUMER REPORT

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employers Overload ("the Company") may obtain information about you from a third-party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by **Scout Logic Screening, 111 Barclay Blvd., Lincolnshire, IL, 60069, (800)693-2709, wwwscoutlogicscreening.com**. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

I agree that a facsimile ("fax"), electronic or photographic copy of this Disclosure shall be as valid as the original. I acknowledge receipt of this Disclosure and certify that I have read and understand this document.

_____	_____	_____
Signature	Date	(if under 18) Guardian Signature
_____	**xxx-xx-**_____	
Print Name	Last 4 SSN	

ACKNOWLEDGMENT AND AUTHORIZATION FOR CONSUMER REPORT

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by **Employers Overload** at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by **Scout Logic Screening, 111 Barclay Blvd., Lincolnshire, IL 60069, (800)693-2709, www.scoutlogicscreening.com**, and/or Employer itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

SUMMARY OF STATE RIGHTS

*Please note: You may also have the rights listed below under the FCRA.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, I understand that if I am applying for employment in New York, that I have the right to receive a copy of Article 23-A of the New York Correction Law (upon request).

Washington State applicants only: I understand that if the report is provided to an employer in the State of Washington, that I can contact the following office for more information regarding my rights under Washington state law in regard to these reports: State of Washington Attorney General, Consumer Protection Division, 800 5th Ave, Suite 2000, Seattle, WA 98104-3188. 206-464-7744p.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

California applicants only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.
- A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.
- By requesting a copy to be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. A CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person's presence.

Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

_____	_____	_____
Signature	Date	(if under 18) Guardian Signature
_____	**xxx-xx-**_____	
Print Name	Last 4 SSN	

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, DC 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, DC 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - A person has taken adverse action against you because of information in your credit report;
  - You are the victim of identify theft and place a fraud alert in your file;
  - Your file contains inaccurate information as a result of fraud;
  - You are on public assistance;
  - You are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need - usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

Identity theft victims and active duty military personnel have additional rights. For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	**Federal Trade Commission: Consumer Response Center - FCRA** Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	**Office of the Comptroller of the Currency** Compliance Management Mail Stop 6-6 Washington, DC 20219 1-800-613-6743
Federal Reserve System member banks (except national banks and federal branches/agencies of foreign banks)	**Federal Reserve Board Division of Consumer & Community Affairs** Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	**Office of Thrift Supervision** Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	**National Credit Union Administration** 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	**Federal Deposit Insurance Corporation** Consumer Response Center 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108- 2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	**Department of Transportation** Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act of 1921	**Department of Agriculture** Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051

_____
Initials

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Clear this page

2024 Form OR-W-4

Oregon Department of Revenue
19612401010000
(Rev. 08-18-23, ver. 01)

Office use only

Oregon Withholding Statement and Exemption Certificate

First name	Initial	Last name	Social Security number (SSN)	☐ Redetermination

Address	City	State	ZIP code

Note: Your eligibility to claim a certain number of allowances or an exemption from withholding may be subject to review by the Oregon Department of Revenue. Your employer may be required to send a copy of this form to the department for review.

1. **Select one:** ☐ Single ☐ Married ☐ Married, but withhold at the higher single rate.
   Note: Select "Single" if you're married but legally separated or your spouse is a non-U.S. citizen without permanent resident status.

2. **Allowances.** Total number of allowances you're claiming on line **A4, B15,** or **C5.**
   See worksheets in the instructions. If you skip the worksheets and aren't exempt, **enter 0** ..... 2.

3. **Additional amount,** if any, you want withheld from each paycheck ..... 3. .00

4. **Exemption from withholding.** I certify my wages are exempt from withholding and I meet the conditions for exemption as stated on page 2 of the instructions. Complete **both** lines below:
   • Enter your exemption code. (See instructions) ..... 4a.
   • Write "Exempt" ..... 4b.

Sign here. Under penalty of false swearing, I declare the information provided is true, correct, and complete.

Employee signature (This form isn't valid unless signed.)	Date

Employer use only.

Employer name	Federal employer identification number (FEIN)		

Employer address	City	State	ZIP code

—Submit this form to your employer—

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

2024

Step 1: Enter Personal Information

(a) First name and middle initial | Last name

Address

City or town, state, and ZIP code

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*.

(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, and when to use the estimator at *www.irs.gov/W4App*.

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). If you or your spouse have self-employment income, use this option; **or**

(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 . . . . . ☐

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)** $

select if needed

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)

Check Delivery Options

Name: _____ **SS#:** _____

Signature: _____ **Date:** _____

Please select one of three (3) payroll options below by checking the appropriate box:

- ☐ **Direct Deposit** (Attach the Direct Deposit Agreement Form)
- ☐ **Pay Card** (Attach the Kittrell Pay Card Agreement Form)
- ☐ **Live Check**

Please select one of two (2) delivery options below to receive your paycheck or pay stub:

- ☐ **I will retrieve my pay stub online through my Employers Overload online account.**
- ☐ **Please Mail my check or pay stub to the address listed below.**
  I understand that if the check is lost in the mail, Employers Overload will not reissue a check for 30 days.

Address: _____

City, State, ZIP: _____

EMPLOYERS OVERLOAD
STAFFING SERVICES SINCE 1947

Fixed Indemnity Medical Insurance Plan, Ancillary Products, and 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 Insurance 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 Summary of Benefits pages for your records.

Not available in all states. Some provisions, benefits, exclusions or limitations herein may vary by state.

The Essential StaffCARE Fixed Indemnity Medical Insurance Plan, Prescription Drug, and Short-Term Disability Plans are underwritten by Fidelity Security Life Insurance Company®, Kansas City, MO; Policy/Form Numbers: LM-162, SD-36.

THE FIXED INDEMNITY MEDICAL INSURANCE PLAN IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS COVERAGE AS DEFINED IN FEDERAL HEALTH LAW.

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 1-888-208-1998.

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

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

While you may have other health plans, this is the link for your 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 1-888-208-1998.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-888-208-1998.

ESC Essential StaffCARE

VSI **2976700-AZH** OFFICE USE ONLY LOCATION _____ Rehire Date __ __ /__ __ /__ __ __ __

BENEFIT ELECTION FORM

F-ESC/MEC 4USBYW P1M v3.0

A. REQUIRED EMPLOYEE INFORMATION

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

Name		
Phone		
Social Security Number		
Date of Birth		Gender M F NB
Address		Apt.
City	State	Zip

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare Benefits?

◯ Yes ◯ No If Yes, fill out the remainder of this section.

Medicare Health Insurance Claim Number (HICN):

Medicare Effective Date:

Name of Covered Person(s):

1.

2.

3.

C. REQUIRED DEPENDENT INFORMATION

Name		DOB
Social Security #		Gender M F NB
Relationship: ◯ Spouse ◯ Child ◯ Domestic Partner		
Name		DOB
Social Security #		Gender M F NB
Relationship: ◯ Spouse ◯ Child ◯ Domestic Partner		
Name		DOB
Social Security #		Gender M F NB
Relationship: ◯ Spouse ◯ Child ◯ Domestic Partner		

D. ENROLL IN LIMITED BENEFIT PLANS

You **MUST** select a coverage level before any benefits. Your coverage level for all the benefits will be identical.

SELECT COVERAGE LEVEL

- ◯ Employee Only
- ◯ Employee + Child(ren)
- ◯ Employee + Spouse
- ◯ Employee + Family
- ◉ **NO** to ALL Benefits

FIXED INDEMNITY MEDICAL INSURANCE PLAN[1] **Payroll Deducted Rates**

◯ **YES**
◯ **NO**

Weekly	Biweekly	
$19.98	**$39.96**	Employee Only
$33.17	**$66.34**	Employee + Child(ren)
$37.96	**$75.92**	Employee + Spouse
$50.55	**$101.10**	Employee + Family

[1] This coverage is not available to residents of **NH, HI,** or **PR**

BENEFIT BUNDLE **Payroll Deducted Rates**

Includes **Dental, Vision, Hearing** and **Term Life**. Premium amounts reflect total for all benefits. These benefits can only be selected together.

◯ **YES**
◯ **NO**

Weekly	Biweekly	
$8.51	**$17.02**	Employee Only
$21.03	**$42.06**	Employee + Child(ren)
$16.20	**$32.40**	Employee + Spouse
$30.86	**$61.72**	Employee + Family

SHORT-TERM DISABILITY (STD)* **Payroll Deducted Rates**

* STD is not available to residents of **CA, HI, NH, NJ, NY, PR** or **RI**.

◯ **YES**
◯ **NO**

Weekly	Biweekly	
$4.20	**$8.40**	Employee Only

E. BENEFICIARY INFORMATION

If you have selected the Benefit Bundle, please write in your beneficiary information for the Term Life Benefit.

Name

Relationship

F. ENROLL IN MEC WELLNESS/PREVENTIVE BENEFIT

MEC PLAN [1]

Weekly/Biweekly Payroll Deducted Rates

82976700-M-AZH

Weekly	Biweekly	
◯ **$14.38**	**$28.58**	Employee Only
◯ **$20.41**	**$40.64**	Employee + Child(ren)
◯ **$19.08**	**$37.98**	Employee + Spouse
◯ **$25.11**	**$50.04**	Employee + Family
◯ **NO to MEC Plan**		

[1] This coverage is not available to residents of **HI** or **PR**

G. 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 with a valid SSN.

DATE ▶ **SIGNATURE**

SUMMARY OF BENEFITS

Fixed Indemnity Medical Plan

Group Number: **2976700-AZH**

Your first option for medical coverage is the Fixed Indemnity Medical Plan. This 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	Per Day	Plan Year Maximum	Inpatient Benefits	Per Day	Plan Year Maximum
Physician Office visit (Virtual or in person)	$105	8 days	Hospital Admission	$250	1 day
Outpatient Surgery[1]	$500	1 day	Daily Hospital Confinement	$300	3x (unlimited days)
Anesthesia	$125	—	Intensive Care Unit Maximum[9]	$400	30 days
Diagnostic Labs[2]	$75	6 days	Skilled Nursing Facility[10]	$100	60 days (no lifetime max)
Diagnostic Tests[3]	$200	3 days	Inpatient Surgery	$2,000	1 day
Ambulance Services[4]	$300[5]/$900[6]	1 day	Anesthesia	$500	—
Emergency Room (Injuries)[7]	$500	2 days	**Wellness Care[11]**		
Emergency Room (Sickness)	$200	2 days	Persons age 1+	$100	1 day
Prescription Drugs[8]	$20	30 days	Persons under age 1	$100	4 days
Telemedicine Services*	No Cost	Unlimited			

*You will have access to a national Telemedicine program called 1.800MD. This program connects members to board certified physicians around the clock (24/7/365) via telephone or secure video. 1.800MD doctors can answer questions, give advice, and even diagnose and treat illnesses by calling 1-800-530-8666.

Short Term Disability

The Short Term Disability Benefit may provide some income in the event you are unable to work due to an injury or an off-the job accident.

Maximum Benefit Amount	60% of base pay up to $150 week/$650 per month
Waiting Period / Maximum Benefit Period	0 days for injury/7 days for sickness/Up to 6 months

MEC Wellness/Preventive Plan

Group Number: **82976700-M-AZH**

Your second option for medical coverage is the MEC Wellness/Preventive Plan. This plan provides coverage for preventive services such as immunizations and routine health screenings.

Preventive Services Benefit	In-Network	Non-Network
Preventive Services for Adults	100%	40%
Preventive Services for Women	100%	40%
Preventive Services for Children	100%	40%

PREMIUM	Fixed Indemnity Medical Weekly	Fixed Indemnity Medical Biweekly	Short Term Disability Weekly	Short Term Disability Biweekly	MEC Plan Weekly	MEC Plan Biweekly
Employee Only	$19.98	$39.96	$4.20	$8.40	$14.46	$28.92
Employee + Child(ren)	$33.17	$66.34	—		$20.49	$40.98
Employee + Spouse	$37.96	$75.92	—		$19.16	$38.32
Employee + Family	$50.55	$101.10	—		$25.19	$50.38

[1] benefits are not payable for surgical operations performed in a Physician's office [2] routine or wellness lab screens and tests are not covered [3] laboratory tests and routine wellness screens and tests not covered [4] transportation must occur within 72 hours of the accident or onset of the sickness [5] benefit is for ground/water services [6] benefit is for air services [7] treatment must be within 72 hours of the accident [8] To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc. [9] pays in addition to daily hospital confinement [10] must be under age 65 and admitted to the Skilled Nursing Facility within 14 days following a Hospital stay of at least three consecutive days [11] benefit is payable for each day an insured person has any one of the health screenings, exams, or tests listed in the policy

SUMMARY OF BENEFITS

The benefits on this page are only offered together (in a benefit bundle).
This bundle includes Dental, Vision, Hearing, and Term Life.
The premium below reflects the total amount for all benefits.

Dental

Benefits are payable for dental treatment services and supplies performed by or prescribed by a Dentist or Dental Hygienist.

Coverage	Amount	Coverage	Amount
Oral Exam [1]	$75	Fluoride (one per year, child under 19)	$100
X-Ray (one per 12 consecutive months)	$100	Sealants (one per year, child under 14)	$100
Cleaning [1]	$100	Fillings (one per 12 consecutive months)	$100

Vision

Benefits are payable for Vision Examinations performed by an Optometrist or Physician.

Coverage	Amount	Coverage	Amount
Exam (one per 12 consecutive months)	$70	Refractive Surgery (one per person per lifetime)	$500
Materials [2]	$150	Loss of Sight (one-time benefit due to injury)	$1,000

Hearing

Benefits are payable for a Hearing Examination performed by a Physician, Otolaryngologist, Otologist or Audiologist to detect and diagnose hearing loss.

Coverage	Amount	Coverage	Amount
Exam (one per 12 consecutive months)	$70	Aid (one per ear, per 24 month period)	$500

Term Life

The Term Life benefit can provide coverage to your family in the event of your passing. Don't forget to name a beneficiary in Section E on the enrollment form to receive this benefit.

Coverage	Amount	Coverage	Amount
Employee	$20,000	Dependent Child(ren) (age 6 months +)	$5,000
Spouse	$10,000	Dependent Child(ren) (age 14 days to 6 mos)	$500

PREMIUM	Benefit Bundle—Includes Dental, Vision, Hearing and Term Life (Weekly)	(Biweekly)
Employee Only	$8.51	$17.02
Employee + Child(ren)	$21.03	$42.06
Employee + Spouse	$16.20	$32.40
Employee + Family	$30.86	$61.72

[1] covered once every 6 months, twice every 12 consecutive months [2] one lump sum allowance for lenses, frames or contact lenses per 24-month period

FIXED INDEMNITY MEDICAL INSURANCE PLAN LIMITATIONS, EXCLUSIONS, AND TERMINATIONS

Limitations

Recurrent Confinements. If the Company pays benefits for a period of Confinement, and the Insured Person is readmitted within 30 days of that Confinement for the same condition, the later Confinement will be treated as a continuation of the prior Confinement. If more than 30 days have passed between periods of Confinement for the same condition or the successive Confinement is for an unrelated cause, the Company will treat the later Confinement as a new Confinement.

Exclusions

The Policy does not provide any benefits for the following:

1. suicide or any attempt of suicide, while sane or insane (in Colorado, Missouri or Montana, while sane);
2. any intentionally self-inflicted Injury or Sickness or any attempt thereat (in Colorado, Missouri or Montana, while sane);
3. rest care or rehabilitative care and treatment, except as specifically provided in the Skilled Nursing Facility Confinement benefit;
4. dependent child Pregnancy, except Complications of Pregnancy;
5. routine newborn care, except as specifically provided for in the Wellness benefit;
6. voluntary abortion, except where Medically Necessary to save the Insured Person's life;
7. participation in a Riot, insurrection, rebellion, civil commotion, civil disobedience or unlawful assembly. For purposes of this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law. This does not include a loss that occurs while acting in a lawful manner within the scope of authority;
8. committing, attempting to commit or taking part in a felony, battery, assault or engaging in an illegal occupation;
9. any Injury occurring while the Insured Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Injury took place);
10. treatment for the voluntary taking of any poison or inhalation of gas, or voluntary taking of any drug, sedative or narcotic, unless prescribed by a Physician and taken according to the prescribed dosage;
11. dental care or treatment, except:
    a. care or treatment due to an Injury to sound, natural teeth treated within 12 months of the Accident;
    b. treatment necessary due to congenital defects or birth abnormalities;
    c. excision of impacted third molars, or
    d. closed or open reduction of fractures or dislocation of the jaw;
12. sex changes;
13. the reversal of tubal ligation or the reversal of vasectomies;
14. flying or descending from any aircraft or air conveyance, except as a fare-paying passenger in any regularly scheduled commercial aircraft flying between established airports on a regularly scheduled route;
15. accidental bodily Injury occurring while serving on full-time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by the Company pro rata for any period of active duty);
16. declared or undeclared war or acts thereof;
17. injury or Sickness arising out of or in the course of any occupation for compensation, wage or profit or benefits that the Insured Person is entitled to under any Occupational Disease Law or similar law, whether or not application for such benefits have been made;
18. medical care, services or supplies provided outside of the United States of America or its territories;
19. treatment of obesity, weight reduction or dietetic control; except morbid obesity or disease etiology;
20. confinement, care or services incurred prior to the Insured Person's Effective Date or that begin after termination of coverage;
21. confinement, care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law;
22. confinement or treatment that is not Medically Necessary; or
23. any Confinement or treatment not specifically covered in the Schedule of Benefits.

BENEFIT BUNDLE PRODUCTS

General Exclusions

The Plan does not provide any benefits for treatment, services or supplies that are: caused by, related to, or required by the policyholder or another employer as a condition of employment; provided under any Worker's Compensation Law Occupational disease Law or similar legislation; furnished by any agency or program funded by federal, state or local government. This exclusion does not apply to medical assistance benefits under Title XIX of the Social Security Act (Medicaid) or where prohibited by law;; due to a loss that occurs while in the service of the Armed Forces of any country. Orders to active military service for training purposes of two months or less will not constitute service in the Armed Forces. Upon notice to the Company of entering the Armed Forces, the Company will return to the Insured Person pro-rata any premium paid, less any benefits paid, for any period during which the Insured Person is in such service; due to a loss that occurs while engaged in any act or occupation which is a felony violation of the law of the jurisdiction where the loss or cause of loss occurred; related to self-inflicted injuries while sane or insane (while sane in Colorado, Missouri, or Montana); due to participation in a riot, insurrection, rebellion, civil disobedience or unlawful assembly; due to a loss caused by declared or undeclared war or acts thereof.

In Addition to the General Exclusions:

Additional Vision and Hearing Exclusions

The plan does not provide any vision examination or vision materials benefits for treatment, services or supplies that are for othoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye or supporting structures (except for the Lasik benefit); safety eyewear; plano (non-prescription) lenses or contact lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals or lost, broken lenses, frames or contact lenses. The Hearing benefit does not provide for anyhearing benefits for treatment, services or supplies that are: for the medical and/or surgical treatment of the internal or external structures of the ear(s); any service provided by a Hearing Aid Dispenser; for hearing aid batteries, cleaning supplies or accessories; for ear protection devices or plugs; for Assistive Listening Devices; or for replacement due to loss, theft of or damage to the hearing aid.

In Addition to the General Exclusions:

Additional Vision and Hearing Exclusions
The plan does not provide any vision examination or vision materials benefits for treatment, services or supplies that are for othoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye or supporting structures (except for the Lasik benefit); safety eyewear; plano (non-prescription) lenses or contact lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals or lost, broken lenses, frames or contact lenses. The Hearing benefit does not provide for anyhearing benefits for treatment, services or supplies that are: for the medical and/or surgical treatment of the internal or external structures of the ear(s); any service provided by a Hearing Aid Dispenser; for hearing aid batteries, cleaning supplies or accessories; for ear protection devices or plugs; for Assistive Listening Devices; or for replacement due to loss, theft of or damage to the hearing aid.

SHORT-TERM DISABILITY EXCLUSIONS AND TERMINATIONS

Exclusions
Benefits will not be paid for any Disability:

1. caused by war, declared or undeclared, or acts of war;
2. while the Insured is in the military, naval or air force of any country or international organization. Any unearned premium paid by the Insured for a period not covered because of this exclusion will be returned on a pro rata basis if he or she notifies the Company.
3. the Insured intentionally inflicts on himself or herself while sane or insane (in Colorado, Missouri and Montana while sane);
4. caused by the Insured engaging in any act which is a felony violation of the law of the jurisdiction where the loss or cause of loss occurred or engaging in an illegal occupation;
5. caused by an accident that occurs while an Insured has been determined to be intoxicated:
   a. by judicial or administrative judgment or order;
   b. by evidence of an alcohol concentration in the Insured's blood, breath or urine which equals or exceeds the limits set by applicable motor vehicle laws; or
   c. by other evidence demonstrating the Insured was under the influence of any alcohol, narcotic, barbiturate or hallucinatory drug, unless the same was administered on the advice of a Physician and was taken according to the prescribed dosage; and the use of such substance was a proximate cause of the accidental bodily Injury;
6. for any period of time for which the Insured is incarcerated, whether or not the Disability commenced while incarcerated, or not;
7. caused by a Substance Abuse or Mental or Nervous Disorder, except for Alzheimer's disease and organic senile dementias;
8. caused by any Occupational disability;
9. caused by Participation in a Riot, insurrection, rebellion, civil disobedience or unlawful assembly. For this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law. This does not include a loss, which occurs while acting in a lawful manner within the scope of authority;
10. flying as a pilot, crew member or passenger in any aircraft, except as a fare-paying passenger in any regularly scheduled commercial aircraft flying between established airports on a regularly scheduled route;
11. that occurs outside of the United States or its possessions;
12. participation in a contest of speed in power driven vehicles, parachuting, parasailing, parakiting, sailgliding, bungee jumping, scuba diving, stunt driving, rock climbing, flying ultra-light aircraft, skydiving, hang gliding or any hazardous sports activity; or
13. participation in a semi-professional or professional competitive athletic competition for which the Insured receives any type of compensation.

Additional Termination of Insured's Coverage under the Short-Term Disability Policy
An Insured's coverage under the Policy automatically ends on the first of the following dates:

1. the date on which the Insured is no longer Actively at Work. However, coverage may be continued for a period not to exceed 90 days during a Policyholder-approved period of leave without pay; or
2. the next premium due date following the date the Insured requests cancellation of coverage. This request must be made to the Company in writing by the Insured.

Termination of the Insured's insurance will not prejudice any claim originating before such termination; provided the Insured continues to meet the definition of Total Disability, subject to the Maximum Benefit Period.

Member Services:

For frequently asked questions and network information for the Fixed Indemnity Medical Insurance Plan, visit *www.esc-enrollment.com/FSLIND*. For questions and a full list of preventive services covered by the MEC Wellness/Preventive Plan, as well as the MEC SBC, please visit *www.esc-enrollment.com/FSLMECW*. A paper copy is also available, free of charge, by calling Essential StaffCARE Customer Service 1-888-208-1998.

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 **Fixed Indemnity Medical Insurance 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 your payroll deductions on a **Post-Tax** basis.

Essential StaffCARE Customer Service: 1-888-208-1998

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

EMPLOYERS OVERLOAD

INNOVATIVE WORKFORCE SOLUTIONS - SINCE 1947

EMPLOYEE AUTOMOBILE AGREEMENT

This Agreement made and entered on _____ by and between EMPLOYERS OVERLOAD, hereinafter referred to as "Company", and _____, hereafter referred to as "Employee". For good and valuable considerations, the parties hereto agree that the Employee shall release and hold forever harmless the Company from and against any and all responsibility and liability for bodily injury or property damage performed for the Company by such Employee. Such employee agrees to wear a seat belt at all times and use of any mobile device will be hands free as required by law.

AUTHORIZATION FOR RELEASE OF MOTOR VEHICLE/DRIVING RECORDS

(EMPLOYMENT)

I, _____, do hereby authorize and allow an information service bureau, acting as an agent of Employers Overload, to obtain a copy of my driver's license record/abstract information, which may include personal information, to be used for verification of information and for Employment purposes, and to release my information to:

EMPLOYERS OVERLOAD
12540 SW 69TH
PORTLAND, OR 97223
503-639-1400

Driver's Full Name (Please Print): _____

Date of Birth: _____

Social Security Number: _____

Insurance Company: _____

Policy Number: _____

Signature: _____ **Date:** _____

EMPLOYERS OVERLOAD COMPANY REPRESENTATIVE:

NAME: _____ **DATE:** _____

*****Please Provide Proof of Insurance Showing Policy Limits (Declaration Page)*****