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 DISCLOSER REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT.

As an employee who may be assigned to one or multiple customers, i acknowledge 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.

Use of the Date of Birth is for identification purposes only. Employers Overload is an equal opportunity employer. Prospective employees will receive consideration without discrimination because of race, creed, color, sex, national origin, handicap or veteran status.

I certify that the information contained on the Background Release 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 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

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

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

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

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Employers Overload

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
12540 SW 69th Ave	Portland	OR	97223

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

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Clear this page

2021 Form OR-W-4

Oregon Department of Revenue
19612101010000
(Rev. 08-14-20, ver. 01)

Oregon Employee's Withholding Statement and Exemption Certificate

Office use only

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 withholding at the higher single rate.
   Note: Check the "Single" box if you're married and you're legally separated or if your spouse is a nonresident alien.

2. **Allowances.** Total number of allowances you're claiming on line **A4, B15,** or **C5.** If you meet a qualification to skip the worksheets and you 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 that 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 the corresponding exemption code. (See instructions)..... 4a.
   • Write "Exempt"..... 4b.

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

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

Employer use only.

Employer's name	Federal employer identification number (FEIN)		

Employer's address	City	State	ZIP code

—Provide 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

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)

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 three (3) delivery options below to receive your pay check 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, 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 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 Limited Benefit Medical, Prescription Drug, Vision, Dental, Hearing, Term Life, and Short-Term Disability Plans are underwritten by Fidelity Security Life Insurance Company, Kansas City, MO; Policy/Form Numbers: LM-162, LC-105, SD-36.

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 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.

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

BENEFIT ELECTION FORM

F-ESC/MEC 4USBYW P1M v2.1

A. REQUIRED EMPLOYEE INFORMATION

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

Name

Phone

Social Security Number

Date of Birth

Address

City State

Zip

Gender
☐ Male (M)
☐ Female (F)
☐ Non-binary (N)

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 N
Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner	
Name	DOB / /
Social Security #	Gender M F N
Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner	
Name	DOB / /
Social Security #	Gender M F N
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 PLAN

☐ **YES**
☐ **NO**

Weekly	Biweekly	Payroll Deducted Rates
$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

BENEFIT BUNDLE

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	Payroll Deducted Rates
$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)*

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

☐ **YES**
☐ **NO**

Weekly	Biweekly	Payroll Deducted Rates
$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

Weekly/Biweekly Rates MEC PLAN

82976700-M-AZH

☐ **$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**		

G. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Summary of Benefits and the Limitations and Exclusions for the Fixed Indemnity Limited Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage. I affirmatively consent to the voluntary receipt of the plan documents elections, via email or website. I acknowledge that Limited Benefit insurance is not major medical insurance and is not a substitute for major medical insurance. It does not qualify as minimum essential health coverage under The Patient Protection and Affordable Care Act. 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.

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

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	$14.38	$28.58
Employee + Child(ren)	$33.17	$66.34	—		$20.41	$40.64
Employee + Spouse	$37.96	$75.92	—		$19.08	$37.98
Employee + Family	$50.55	$101.10	—		$25.11	$50.04

[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

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)*****