

NEW HIRE CHECKLIST

Employee Name _____ Location _____

(Please complete the HREZ Background Consent Form and Sentry MVR Form. On the MVR form, please list the hire date as the date the form was completed. If there is no hire date on the form, the results will be delayed. Fax each of these forms to the appropriate fax number – once we receive the results on both, we will contact you with the final approval for hire. Make sure you complete a drug screen as well.)

_____ Background Consent = _____ Result
_____ MVR Consent = _____ Result
_____ Pre Employment Drug Test Consent = _____ Result

(Give New hire packet to your employee and review contents. Verify all forms below are completed and return to HR/ Payroll dept.)

_____ Application
_____ Resume
_____ New Hire Form
_____ PFW Setup Form
_____ Emergency Contact
_____ Federal W4
_____ State Form (G-4, NC-4 or VA-4, A-4) whichever applies
_____ I-9 Employment Eligibility Verification
_____ Copy of Driver's License / Social Security Card / Passport
_____ Direct Deposit OR Total Pay Form
_____ Active Employee Certificate of Agreement
_____ Handbook Acknowledgement / WC Procedure Statement
_____ Confidentiality Company Information
_____ At-Will Acknowledgement
_____ Vehicle Usage
_____ Expenses Reimbursement Acknowledgement
_____ Tool and OSHA Approved Shoe Reimbursement
_____ Dress Code Acknowledgement w/ policy
_____ Benefits Acknowledgement Form

(Give to Employee to keep and review important contents as part of the orientation process.)

_____ I-Pay Statement Instructions
_____ Employee Handbook
_____ Safety Manual
_____ Employee Benefits Summary

Employee Must return the following in 30 days to the HR Department. If not received within 30 days, benefits will be denied.

_____ Health Enrollment Form
_____ Flex Benefit Enrollment

Benefit forms given to employee _____ Date should be returned to HR _____

PRE-EMPLOYMENT DRUG TESTING CONSENT AND RELEASE FORM

I hereby consent to submit to an oral fluids drug test and/or other tests as shall be determined by Stafford in the selection process of applicants for employment, for the purpose of determining the drug content thereof.

I agree that (doctor or Lab) or a Certified Drug Testing Representative of Stafford may collect these specimens for these tests and may test them or forward them to a testing laboratory designated by Stafford for analysis.

I further agree to and hereby authorize the release of the results of said test to Stafford.

I understand that it is the current use of illegal drugs that would prohibit me from being employed at Stafford.

I further agree to hold harmless Stafford and its agents (Doctors and Laboratory name) or the Certified Drug Testing Representative of Stafford from any liability arising in whole or part, out of the collection of specimens, testing and use of the information from said testing in connection with Stafford consideration of my application of employment.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

APPLICANT

Print Name: _____ SS# _____

Signature: _____ Date: _____

Witness:

Print Name: _____

Signature: _____

Stafford Drug Testing Form OraLab

Donor's Name: _____

I.D. # _____

Collector's Name: _____

Reason for Test: Pre-Employment

 Random

 Post Accident

OraLab Expiration Date _____

<u>TEST RESULTS</u>	<u>NEGATIVE</u>	<u>FURTHER TESTING NEEDED</u>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
Morphine	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	<input type="checkbox"/>
THC	<input type="checkbox"/>	<input type="checkbox"/>

Further Testing Needed:

 Specimen sent to lab for confirmation

Signed: _____
 Donor

Date: _____

Signed: _____
 Collector

Date: _____

STAFFORD

Employment Application



Equal access to programs, services, and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of the Human Resources Department.

APPLICANT INFORMATION

Position(s) applied for		Date of Application	
Last Name	First	M.I.	
Street Address		Apartment/Unit #	
City	State	ZIP	
Primary Phone	Mobile/Beeper/Other Phone		
Date Available	Social Security No.	Desired Salary	
Are you a citizen of the United States? YES <input type="checkbox"/> NO <input type="checkbox"/> If no, are you authorized to work in the U.S.? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Have you ever worked for this company? YES <input type="checkbox"/> NO <input type="checkbox"/> If so, when?			
Type of employment desired	Full Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>	Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Educational Co-Op <input type="checkbox"/>
Are you able to meet the attendance requirements of the position?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever pled "guilty" or "no contest" to or been convicted of a crime? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, explain			
<small>ANSWERING "YES" TO THESE QUESTIONS DOES NOT CONSTITUTE AN AUTOMATIC BAR TO EMPLOYMENT. FACTORS SUCH AS OFFENSE, SERIOUSNESS AND NATURE OF THE VIOLATION, REHABILITATION AND POSITION APPLIED FOR WILL BE TAKEN INTO ACCOUNT.</small>			
Driver's license number if driving is an essential job function		State	

EDUCATION

High School Name	Location	Degree?
College Name	Location	Degree?
Other	Location	Degree?

REFERENCES

Please list three professional references.

Full Name	Title	Phone
Full Name	Title	Phone
Full Name	Title	Phone

PREVIOUS EMPLOYMENT - MOST RECENT

Company	Phone ()	
Address	Supervisor	
Job Title	Hourly Rate \$	Reason For Leaving
Job Responsibilities	From	To
May we contact your previous supervisor for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>		

PREVIOUS EMPLOYMENT – (CONTINUED)

Company		Phone ()	
Address		Supervisor	
Job Title	Hourly Rate	\$	Reason For Leaving
Job Responsibilities		From	To
May we contact your previous supervisor for a reference?		YES <input type="checkbox"/>	NO <input type="checkbox"/>

Company		Phone ()	
Address		Supervisor	
Job Title	Hourly Rate	\$	Reason For Leaving
Job Responsibilities		From	To
May we contact your previous supervisor for a reference?		YES <input type="checkbox"/>	NO <input type="checkbox"/>

SKILLS AND QUALIFICATIONS

Summarize any training, skills, licenses and/or certificates that may qualify you as being able to perform job-related functions in the position you are applying.

APPLICANT STATEMENT

I certify that all information I have provided in order to apply for and secure work with the employer is true, complete and correct.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (i) cancel further consideration of this application, or (ii) immediately discharge me from the employer's service, whenever it is discovered.

I expressly authorize, without reservation, the employer, its representative, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume' or job interview. I hereby waive any and all rights and claims I may have regarding the employer, its agents, employees or representatives, for seeking, gathering and using such information in the employment process and all other persons, corporations or organizations for furnishing such information about me.

I understand that the employer does not unlawfully discriminate in employment and no questions on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by applicable local, state or federal law.

I understand that this application remains current for only 30 days. At the conclusion of that time, if I have not heard from the employer and still wish to be considered for employment, it will be necessary to reapply and fill out a new application.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and the employer reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no supervisor or representative of the employer is authorized to make any assurances to the contract and that no implied, oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the employer's president.

I also understand that if I am hired, I will be required to provide proof of identity and legal authority to work in the United States and that federal immigration laws require me to complete an I-9 Form in this regard.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE APPLICANT STATEMENT

I certify that I have read, fully understand and accept all terms of this foregoing Applicant Statement.

Signature of Applicant _____ Date _____

STAFFORD
NEWHIRE FORM

Employee Full Name _____
(As appears on Social Security Card)

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Birth Date: _____

Home Telephone # _____

Hire Date _____ Pay Rate _____

Position _____ Location _____

WITHHOLDING:

Federal: Married _____ Single _____ Exemptions _____

State: Single _____ HD/Hshold _____ Married filing separate _____

Married filing joint: One spouse working _____

Both spouse working _____ Exemptions _____

Ethnic Origin: Hispanic or Latino _____ American Indian or Alaskan Native _____

Asian _____ Black or African American _____ White _____

Native Hawaiian or Other Pacific Islander _____ Other _____

Gender: Male _____ Female _____

Part Time _____ Full Time _____

PFW Setup Form

Please complete this information so the employee can be setup in PFW.

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone : (_____) _____

Date of Birth: _____

Social Sercuity #: _____

Hire date: _____

Employee File # (if technician): _____

Rate of Pay (if technician): _____

Job Title: _____ Dept: _____

EMERGENCY CONTACT

Name and Address of Employee _____

Spouse's Name _____

Place of Work _____ Work Phone _____

Mobile Phone _____ Home Phone _____

If Single, please name person or persons to contact in case of emergency:

Name or Names _____

Relationship _____

Place of Work _____ Work Phone _____

Mobile Phone _____ Home Phone _____

Additional Information: _____

If there are changes of employment or marital status, please let us know immediately.

Form W-4 (2010)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent	A _____
B Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit	F _____
(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	
G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children. 	G _____
H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H _____
For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2>Employee's Withholding Allowance Certificate</h2> <p>▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <h1 style="font-size: 2em;">2010</h1>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note, if married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2010, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

- 1 Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions 1 \$ _____
- 2 Enter: { \$11,400 if married filing jointly or qualifying widow(er)
\$8,400 if head of household
\$5,700 if single or married filing separately } 2 \$ _____
- 3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919) 4 \$ _____
- 5 Add lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.) 5 \$ _____
- 6 Enter an estimate of your 2010 nonwage income (such as dividends or interest) 6 \$ _____
- 7 Subtract line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____
- 8 Divide the amount on line 7 by \$3,650 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 Add lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3." 2 _____
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3 _____

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 _____
- 5 Enter the number from line 1 of this worksheet 5 _____
- 6 Subtract line 5 from line 4 6 _____
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____
- 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
- 9 Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$7,000 -	0	\$0 - \$6,000 -	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
7,001 - 10,000 -	1	6,001 - 12,000 -	1	65,001 - 120,000	910	35,001 - 90,000	910
10,001 - 16,000 -	2	12,001 - 19,000 -	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
16,001 - 22,000 -	3	19,001 - 26,000 -	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 27,000 -	4	26,001 - 35,000 -	4	330,001 and over	1,280	370,001 and over	1,280
27,001 - 35,000 -	5	35,001 - 50,000 -	5				
35,001 - 44,000 -	6	50,001 - 65,000 -	6				
44,001 - 50,000 -	7	65,001 - 80,000 -	7				
50,001 - 55,000 -	8	80,001 - 90,000 -	8				
55,001 - 65,000 -	9	90,001 - 120,000 -	9				
65,001 - 72,000 -	10	120,001 and over	10				
72,001 - 85,000 -	11						
85,001 - 105,000 -	12						
105,001 - 115,000 -	13						
115,001 - 130,000 -	14						
130,001 - and over	15						

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

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

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

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

**STATE OF GEORGIA
EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE**

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

3. MARITAL STATUS (If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

- A. Single: enter 0 or 1 []
- B. Married Filing Joint, both spouses working: enter 0 or 1 or 2 []
- C. Married Filing Joint, one spouse working: enter 0 or 1 or 2 []
- D. Married Filing Separate: enter 0 or 1 or 2 []
- E. Head of Household: enter 0 or 1 or 2 []

4. DEPENDENT ALLOWANCES []

5. ADDITIONAL ALLOWANCES []
(complete worksheet below)

6. ADDITIONAL WITHHOLDING \$ _____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES

This worksheet must be completed if Line 5 is greater than zero.

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:

Yourself: Age 65 or over Blind
 Spouse: Age 65 or over Blind Number of boxes checked _____ x 1300 = \$ _____

2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

- A. Estimated Federal Itemized Deductions \$ _____
- B. Georgia Standard Deduction (enter one):
 Single/Head of Household \$2,300
 Each Spouse \$1,500 \$ _____
- C. Subtract Line B from Line A \$ _____
- D. Allowable Deductions to Federal Adjusted Gross Income \$ _____
- E. Add the Amounts on Lines 1, 2C, and 2D \$ _____
- F. Estimate of Taxable Income not Subject to Withholding \$ _____
- G. Subtract Line F from Line E (if zero or less, stop here) \$ _____
- H. Divide the Amount on Line G by \$3,000. Enter total here and on Line 5 above _____

This is the maximum number of additional allowances you can claim. If the remainder is over \$1,500 round up.

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
 (Employer: The letter indicates the tax tables in the Employer's Tax Guide)

8. EXEMPT: Skip this line if you entered information on Lines 3 - 7. Read the instructions for Line 8 on page 2.

I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. **Check here**

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature _____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
 If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, P. O. Box 49432, Atlanta, GA 30359.

9. EMPLOYER'S NAME AND ADDRESS: _____
EMPLOYER'S FEIN: _____
EMPLOYER'S WH#: _____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

- A. Single - enter 1 if you are claiming yourself
- B. Married Filing Joint, both spouses working - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
- C. Married Filing Joint, one spouse working - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
- D. Married Filing Separate - enter 1 if you claim yourself or 2 if you claim yourself and your spouse
- E. Head of Household - enter 1 if you claim yourself but the individual(s) for whom you maintain a home does not qualify as a dependent; or 2 if you claim yourself and a qualified dependent for whom you maintain a home

Do not claim a deduction on Line 4 for a dependent used to qualify you as head of household

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number from Line H here.

Failure to complete and submit the worksheet will result in automatic denial of your claim.

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3 - 5.

Line 8: Check the box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount on Line 4 of Form 500EZ or Line 16 of Form 500 was zero, and you expect to file a Georgia tax return this year and will not have a tax liability. You can not claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund for the previous tax year does not qualify you to claim exempt.**

Do not complete Lines 3 - 7 if claiming exempt.

EXAMPLES: Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ or Line 16 of Form 500 was \$100. Your tax liability is the amount on Line 4 or Line 16; therefore, **you do not qualify** to claim exempt.

Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ or Line 16 of Form 500 was \$0 (zero) and you filed a prior year income tax return. Your tax liability is the amount on Line 4 or Line 16; therefore, **you qualify** to claim exempt.

NOTE: Effective January 1, 2003, the deduction allowed for the dependents increased from \$2,700 to \$3,000. This does not apply to the deduction allowed for you or your spouse.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

Employee's Withholding Allowance Certificate

North Carolina Department of Revenue

PURPOSE. Complete Form NC-4 so that your employer can withhold the correct amount of State income tax from your pay. **EXEMPTION FROM WITHHOLDING.** Read line 6 of the certificate below to see if you can claim exempt status. If exempt, only complete the certificate; but do not complete lines 4 and 5. No State income tax will be withheld from your pay.

BASIC INSTRUCTIONS. If you are not exempt, complete the Personal Allowances Worksheet. An additional worksheet is provided on page 2 for employees to adjust their withholding allowances based on itemized deductions, adjustments to income, or tax credits. The worksheets will help you figure the number of withholding allowances you are entitled to claim. However, you may claim fewer allowances if you wish to increase the tax withheld during the year. If your withholding allowances decrease, you must file a new NC-4 with your employer within 10 days after the change occurs except that a new NC-4 is not required until the next year in the following cases:

1. When a dependent dies during the year.
2. When an individual ceases to be a dependent during the year and the support furnished will be

the chief support for the year.

3. When an individual ceases to be head of household after maintaining the household for the major portion of the year.

HEAD OF HOUSEHOLD. Generally you may claim head of household status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. Note: "Head of Household" for State tax purposes is the same as for federal tax purposes.

QUALIFYING WIDOW(ER). You may claim qualifying widow(er) status only if your spouse died in either of the two preceding tax years and you meet the following requirements:

1. Your home is maintained as the main household of a child or stepchild for whom you can claim an exemption; and
2. You were entitled to file a joint return with your spouse in the year of your spouse's death.

Note: "Qualifying Widow(er)" for State tax purposes is the same as for federal tax purposes. Because the

standard deduction used in the tax tables for married and qualifying widow(er) is \$2,750 and you are entitled to a standard deduction of \$5,500, you may elect to claim an additional personal withholding allowance on line C below to avoid having too much tax withheld.

MARRIED AND SPOUSE DOES NOT WORK OR HAS WAGE INCOME OF LESS THAN \$3,500. The withholding tax tables are based on both spouses earning wages during the year. If your spouse does not work or will earn wages of less than \$3,500 during the year, you may elect to complete line B below to avoid having too much tax withheld.

TWO JOBS. If you have more than one job, figure the total number of allowances you are entitled to claim on all jobs using only one form NC-4. This total should be divided among all jobs. Your withholding will usually be most accurate when all allowances are claimed on the NC-4 filed for the higher paying job and zero allowances are claimed for the other.

NONWAGE INCOME. If you have a large amount of nonwage income, such as interest or dividends, you should consider making estimated tax payments using Form NC-40.

Personal Allowances Worksheet

- A. Enter "1" for yourself if no one else can claim you as a dependent A. _____
- IN ADDITION TO A. ABOVE:**
- B. Enter "1" if you are married and you expect your spouse's wages to be from \$1,000 to \$3,500.
Enter "2" if you are married and your spouse has no income or expects to earn less than \$1,000 B. _____
- C. Enter "1" if you are a qualifying widow(er) C. _____
- D. Enter the number of dependents (other than your spouse or yourself) whom you will claim on your tax return D. _____
- E. If you plan to itemize, claim adjustments to income, or have allowable tax credits and want to reduce your withholding, complete the Deductions, Adjustments, and Tax Credits Worksheet on page 2 and enter number from line 14 E. _____
- F. Add lines A through E and enter total here and on line 4 of your Employee's Withholding Allowance Certificate F. _____

..... Cut here and give this certificate to your employer. Keep the top portion for your records

North Carolina Department of Revenue

Form **NC-4**

Employee's Withholding Allowance Certificate

1 Type or print your first name and middle initial		Last name	2 Your social security number	
Home address (number and street or rural route)			3 Marital Status } <input type="checkbox"/> Single <input type="checkbox"/> Married or Qualifying Widow(er) <input type="checkbox"/> Head of Household	
City or town, state, and ZIP code				
4 Total number of allowances you are claiming (from line F above)				4
5 Additional amount, if any, you want deducted from each pay period				5
6 I claim exemption from withholding and I certify that I meet ALL of the following conditions for exemption:				<div style="border: 1px solid black; width: 100%; height: 100%; background: repeating-linear-gradient(45deg, transparent, transparent 2px, black 2px, black 4px);"></div>
<ul style="list-style-type: none"> • Last year I was entitled to a refund of ALL State income tax withheld because I had NO tax liability; AND • This year I expect a refund of ALL State income tax withheld because I expect to have NO tax liability. 				
If claiming exempt, the statement is effective for one calendar year only and a new statement must be completed and given to your employer by next February 15.				
If you meet all of the above conditions, enter the year effective and write "EXEMPT" here				
7 Are you a full-time student? (Note: Full-time students are not automatically exempt)				7
I certify, under penalties provided by law, that the withholding allowances claimed on this certificate do not exceed the amount to which I am entitled.				<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee's signature			Date , 20	
8 Employer's name and address (Employer: Complete 8 and 9 only if sending to NCDNR)			9 FEIN	

Deductions, Adjustments, and Tax Credits Worksheet

1. Additional withholding allowances may be claimed if you expect to have allowable itemized deductions exceeding the standard deduction. Enter an estimate of the total itemized deductions to be claimed on your federal tax return less the amount of any State income tax included in your federal deductions 1. _____
2. Enter

{	\$4,400 if head of household
	\$3,000 if single
	\$2,750 if married filing separately
	\$5,500 if married filing jointly or qualifying widow(er)

 2. _____
3. Subtract line 2 from line 1, enter the result here 3. _____
4. Enter an estimate of your federal adjustments to income and your State deductions from federal taxable income 4. _____
5. Add lines 3 and 4 5. _____
6. Enter an estimate of your nonwage income (such as dividends or interest) 6. _____
7. Enter an estimate of your State additions to federal taxable income (do not enter the addition for state income tax or the additions for the standard deduction and personal exemption inflation adjustment) 7. _____
8. Add lines 6 and 7 8. _____
9. Subtract line 8 from line 5 9. _____
10. Divide the amount on line 9 by \$2,500 (\$2,000 if you expect your income from all sources for the year to equal or exceed the following amounts for your filing status: \$60,000 - single; \$80,000 - head of household; \$50,000 - married or qualifying widow(er)) and enter the result here. Drop any fraction 10. _____
11. If you are entitled to tax credits, for each \$175 (\$140 if you expect your income from all sources for the year to equal or exceed the following amounts for your filing status: \$60,000 - single; \$80,000 - head of household; \$50,000 - married or qualifying widow(er)) of tax credit, enter "1" additional allowance 11. _____
12. Add lines 10 and 11 and enter total here 12. _____
13. If you completed this worksheet on the basis of married filing jointly, enter the number from line 12 that your spouse will claim 13. _____
14. Subtract line 13 from line 12 and enter the total here and on line E of the Personal Allowances Worksheet 14. _____

If you furnish an employer with an **Employee's Withholding Allowance Certificate** that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

FORM VA-4

**COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION
PERSONAL EXEMPTION WORKSHEET**
(See back for instructions)

1. If you wish to claim yourself, write "1"
2. If you are married and your spouse is not claimed on his or her own certificate, write "1"
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse).....
4. Subtotal Personal Exemptions (add lines 1 through 3).....
5. Exemptions for age
 - (a) If you will be 65 or older on January 1, write "1"
 - (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1"
6. Exemptions for blindness
 - (a) If you are legally blind, write "1"
 - (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1"
7. Subtotal exemptions for age and blindness (add lines 5 through 6).....
8. Total of Exemptions - add line 4 and line 7

 Detach here and give the certificate to your employer. Keep the top portion for your records
FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your Social Security Number	Name		
Street Address			
City	State	Zip Code	

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
 - (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet.....
 - (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet.....
 - (c) Total Exemptions - line 8 of the Personal Exemption Worksheet.....
2. Enter the amount of additional withholding requested (see instructions).....
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions (check here).....

2601064 Rev. 11/07

Signature _____ Date _____

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037.

FORM VA-4 INSTRUCTIONS

Use this form to notify your employer whether you are subject to Virginia income tax withholding and how many exemptions you are allowed to claim. You must file this form with your employer when your employment begins. If you do not file this form, your employer must withhold Virginia income tax as if you had no exemptions.

PERSONAL EXEMPTION WORKSHEET

You may not claim more personal exemptions on form VA-4 than you are allowed to claim on your income tax return unless you have received written permission to do so from the Department of Taxation.

Line 1. You may claim an exemption for yourself.

Line 2. You may claim an exemption for your spouse if he or she is not already claimed on his or her own certificate.

Line 3. Enter the number of dependents you are allowed to claim on your income tax return.

NOTE: A spouse is not a dependent.

Line 5. If you will be age 65 or over by January 1, you may claim one exemption on Line 5(a). If you claim an exemption for your spouse on Line 2, and your spouse will also be age 65 or over by January 1, you may claim an additional exemption on Line 5(b).

Line 6. If you are legally blind, you may claim an exemption on Line 6(a). If you claimed an exemption for your spouse on Line 2, and your spouse is legally blind, you may claim an exemption on Line 6(b).

FORM VA-4

Be sure to enter your social security number, name and address in the spaces provided.

Line 1. If you are subject to withholding, enter the number of exemptions from:

- (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet
- (b) Subtotal of Exemptions for Age and Blindness - line 7 of the Personal Exemption Worksheet
- (c) Total Exemptions - line 8 of the Personal Exemption Worksheet

Line 2. If you wish to have additional tax withheld, and your employer has agreed to do so, enter the amount of additional tax on this line.

Line 3. If you are not subject to Virginia withholding, check the box on this line. You are not subject to withholding if you meet any one of the conditions listed below. Form VA-4 must be filed with your employer for each calendar year for which you claim exemption from Virginia withholding.

- (a) You had no liability for Virginia income tax last year and you do not expect to have any liability for this year.
- (b) You expect your Virginia adjusted gross income to be less than the amount shown below for your filing status:

	Taxable Years 2005, 2006 and 2007	Taxable Years 2008 and 2009	Taxable Years 2010 and 2011	Taxable Years 2012 and Beyond
Single	\$7,000	\$11,250	\$11,650	\$11,950
Married	\$14,000	\$22,500	\$23,300	\$23,900
Married, filing a separate return	\$7,000	\$11,250	\$11,650	\$11,950

- (c) You live in Kentucky or the District of Columbia and commute on a daily basis to your place of employment in Virginia.
- (d) You are a domiciliary or legal resident of Maryland, Pennsylvania or West Virginia whose only Virginia source income is from salaries and wages and such salaries and wages are subject to income taxation by your state of domicile.

ALABAMA DEPARTMENT OF REVENUE
Employee's Withholding Exemption Certificate

FULL NAME _____ SOCIAL SECURITY NO. _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

If you had no Alabama income tax liability last year and you anticipate no Alabama income tax liability this year, you may claim "exempt" from Alabama withholding tax. To claim exempt status, check the block below, sign and date this form and file it with your employer. Employees claiming exempt status are not required to complete Lines 1-6.

See instructions on the back of Form A-4 before checking this box

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. If you claim no personal exemption for yourself, write the figure "0", sign and date the bottom of Form A-4 (Note: If you claim no personal exemption you cannot claim dependent exemptions on Line 4)
 2. IF YOU ARE SINGLE or MARRIED FILING SEPARATELY a \$1,500 personal exemption is allowed.
 - (a) if you are SINGLE and claim personal exemption for yourself (\$1,500) write the letter "S"
 - (b) if you are MARRIED FILING SEPARATELY and claim personal exemption for "yourself only" (\$1,500), write the letters "MS"
 3. IF YOU ARE MARRIED or SINGLE CLAIMING HEAD OF FAMILY, a \$3,000 personal exemption is allowed.
 - (a) if you are MARRIED and claim exemption for both yourself and your spouse (\$3,000), write the letter "M"
 - (b) if you are single with dependents and claim HEAD OF FAMILY exemption (\$3,000), write the letter "H"
 - (c) if you are married and wish to withhold at the higher single rate (\$1,500), write the letter "S"
 4. If during the year you will provide more than one-half of the support of persons closely related to you (other than spouse) write the number of such dependents
 5. Additional amount, if any, you want deducted each pay period:
- THIS LINE TO BE COMPLETED BY EMPLOYER:**
6. TOTAL EXEMPTIONS (Example: Employee claims "M" on Line 3 and "1" on Line 4. Employer should use column headed M-1 in the Withholding Tables.)

DATE _____ SIGNED _____

CHANGES IN EXEMPTIONS

You may file a new certificate at any time if the number of your exemptions **INCREASES**.

You must file a new certificate within 10 days if the number of exemptions previously claimed by you **DECREASES** for any of the following reasons:

- (a) Your spouse for whom you have been claiming exemption is divorced, legally separated, or claims her or his own exemption on a separate certificate.
- (b) The support of a dependent for whom you claimed exemption is taken over by someone else and you no longer expect to furnish more than half of this dependent's support for the year.

OTHER DECREASES in exemption, such as the death of a spouse or dependent, do not affect your withholding until the next year, but require the filing of a new certificate by December 1 of the year in which this occurs.

Any correspondence concerning this form should be sent to the Alabama Department of Revenue, Individual and Corporate Tax Division, Withholding Tax Section, P.O. Box 327480, Montgomery, AL 36132-7480 or telephone (334) 242-1300 (fax (334) 242-0112).

EXCLUSION FROM WITHHOLDING TAX (EXEMPT STATUS)

This exemption applies only to those individuals who filed an Alabama income tax return for the previous year and who had no tax liability on that return.

"No tax liability last year" means that your previous year's Alabama tax return indi-

cated no tax liability for that taxable year. Therefore, if you had Alabama income tax withheld or paid estimated tax, all of this tax must have been refunded to you. If any portion of the tax paid last year was not refunded, you will not qualify for this exemption from Alabama withholding tax. For example, if your employer withheld \$450 from your Alabama wages during the year and after filing your tax return for that year you received a \$425 refund, you would not be eligible for exempt status.

DEPENDENTS

To qualify as your dependent (line 4 on other side), a person must receive more than one-half of his or her support from you for the year and must be related to you as follows:

- Your son or daughter (including legally adopted children), grandchild, stepson, stepdaughter, son-in-law, or daughter-in-law;
- Your father, mother, grandparent, stepfather, stepmother, father-in-law, or mother-in-law;
- Your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law, or sister-in-law;
- Your uncle, aunt, nephew, or niece (but only if related by blood).

PENALTIES

Penalties are imposed for willfully supplying false information. If an employee is believed to have claimed too many exemptions, this information should be reported to the Alabama Department of Revenue, Withholding Tax Section.

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature	Date (month/day/year)
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Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
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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	Date (month/day/year)
--	-----------------------

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

**Documents that Establish
Employment Authorization**

OR

AND

1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form	4. Voter's registration card	
	5. U.S. Military card or draft record	
	6. Military dependent's ID card	5. Native American tribal document
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	6. U.S. Citizen ID Card (Form I-197)
	9. Driver's license issued by a Canadian government authority	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	For persons under age 18 who are unable to present a document listed above:	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS (ACH CREDITS)

COMPANY NAME: **Stafford Development Company**

I (we) hereby authorize Stafford Development Company, hereinafter called COMPANY, to initiate credit entries to my (our)

(select one) Checking Account

Savings Account

indicated below at the depository names below, hereinafter called DEPOSITORY, to credit the same to such account.

DEPOSITORY
NAME: _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

ROUTING NO: _____ ACCOUNT NO: _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) _____
(PLEASE PRINT)

DATE: _____ SIGNED: _____

DATE: _____ SIGNED: _____

Attach copy of voided check. (Deposit ticket not accepted)

ACTIVE EMPLOYEE CERTIFICATION OF AGREEMENT

I do certify that I have received and read Stafford Equipment's Substance Abuse and Testing Policy and have had the Worker's Compensation Drug-Free Workplace certification program (O.C.G.A. 34-9-410) explained to me. I understand that if my performance indicates it is necessary, or in the case of random testing, I will submit to a substance abuse test. I also understand that failure to comply with a substance abuse test request or a positive result may lead to termination of employment and denial of unemployment benefits. I understand that failure to submit to a substance abuse test or a positive test result may affect my right to obtain worker's compensation benefits. I further agree to and hereby authorize the release of the results of said tests to the company. Nothing in this consent form is to be construed as a contract between the parties.

Name (please print): _____

Signature: _____

Acknowledgment of Receipt of Employee Handbook

I have received a copy of Stafford Equipment Employee Handbook, and I understand that the contents of the Handbook are presented for my information only. While Stafford Equipment believes wholeheartedly in the plans, policies, procedures, and benefits described in the Handbook, it is not a contract for such or a guarantee of employment.

I accept responsibility for familiarizing myself with the information contained in this handbook and will seek verification or clarification of its terms or guidance where necessary.

I understand that, because of the broad range of subjects included, and because the number of changes that will be required, Stafford Equipment reserves the right to modify, revoke, suspend, terminate, or revise the information included as necessary. I further understand that the Employee Handbook contains language giving Stafford Equipment that right. The description of any benefit's included in this document are not totally inclusive, and I realize that the formal, benefits' description is contained elsewhere.

I further understand that my employment with Stafford Equipment is for no definite period of time, and nothing in the Employee Handbook in any way creates an expressed or implied contract of employment; but, rather it provides a brief description of benefits offered by the Company and an overview of its policies and rules. I understand that the Employee Handbook and the policies, rules, and benefits to which it refers may be amended, modified, or discontinued, at any time, by Stafford Equipment in its discretion.

I further understand that in consideration of my continued employment, I agree to conform to these policies and rules, and that either I or the company can terminate my employment at-will at any time with or without cause, and without notice.

Signature

Name (Please Print)

Date

Acknowledgement of Understanding Worker's Comp Reporting Procedures

Safety is a very important part of your job. Each employee is expected to obey all safety rules and to exercise caution in all work activities. All employees are covered by Worker's Compensation Insurance, as required by law. Employees *must immediately* report any unsafe condition to the appropriate supervisor. Employees who violate safety standards, who cause hazardous or dangerous situations, or who fail to report or, where appropriate, remedy situations; will be subject to disciplinary action up to and including termination of employment. **Falling to "immediately" report an "on the job" injury or incident to your supervisor will jeopardize any claims for benefits. Your claims can be denied. All employees will undergo drug testing following an incident or near miss.**

I understand this policy and agree to report all injuries or incidents immediately to my supervisor.

Signature

Name (Please Print)

Date

Confidentiality of Company Information

All employees are asked to sign the following statement at the time of employment. "As an employee of Stafford Equipment, I will not at any time disclose or use, either during or subsequent to my employment, and information, knowledge or data which I receive or develop during my employment which is considered proprietary by Stafford Equipment or which relates to the trade secrets of Stafford Equipment. Such information, knowledge or data may consist of the following which is by example only: processes, know-how, designs, drawings, diagrams, formulas, test data, accounting or financial data, pricing, salary data, marketing data, business plans and strategies, negotiations and contracts, research, customer or vendor lists, inventions, and discoveries.

I further agree that upon termination of my employment with Stafford Equipment, I shall promptly return any and all documents containing the above information, knowledge or data, relating thereto, to Stafford Equipment. This agreement shall be binding upon my successors, heirs, assigns, and personal representatives and shall be for the benefit of the successors and assigns of Stafford Equipment. In the event that a dispute arises concerning this agreement and a lawsuit is filed, the prevailing party shall be entitled to reasonable attorney's fees and costs.

I understand that my continued employment with Stafford Equipment is contingent upon my compliance with this agreement."

Signature

Name (Please Print)

Date

At-Will Acknowledgement Form

I, _____, acknowledge that my employment with Stafford is an "at-will" relationship that has no specific duration. This means that I can resign my employment at any time, with or without reason or advance notice, and that Stafford has the right to terminate my employment at any time, with or without reason or advance notice.

I also acknowledge that no officer, supervisor, or employee of Stafford, other than the Chief Executive Officer, has the authority to promise or agree to any substantive terms or conditions of employment different from those stated in the written guidelines and policies contained in the Employee Handbook I received from Stafford. I also understand that any different employment agreement or arrangement entered into by the Chief Executive Officer must be clearly stated in writing and signed by this individual.

Furthermore, I acknowledge that the Employee Handbook I received from Stafford is neither a contract of employment nor a legal document and nothing in the handbook creates an expressed or implied contract of employment. I understand that I should consult my supervisor or a representative of the Human Resource Department if I have any questions that are not answered in this handbook.

Employee Signature: _____ Date: _____

**STAFFORD
Vehicle Usage Policy**

Management has adopted the following policy regarding use of Company owned vehicles:

For business reasons, certain employees have been designated to drive a company owned vehicle to and from their residence. This shall be the only authorized personal use of the vehicle. Individuals driving company vehicles may have occasions where an incidental stop is necessary between business stops. Such use shall not be considered to be in violation of this policy.

The company requires that no personal items other than incidentals be stored in or on the company vehicle. The vehicle is to be locked each night with work articles stored either in the lock box or trunk when vehicle is not in use.

ASSIGNMENT AND CONVEYANCE OF IMPROVEMENTS:

In consideration of my being granted the business use of a company vehicle and for other good and valuable consideration the receipt and sufficiency of which are hereby acknowledged, I do hereby agree as follows:

If I should make changes, additions, or improvements to a company vehicle at my expense, such changes, additions, and improvements are hereby assigned, sold, and conveyed by me to the company. By signing this form I confirm my agreement to assign, sell, and convey any such changes, additions, and improvements to STAFFORD. I understand and agree that should I leave employment with the Company, voluntarily or involuntarily, for any reason or no reason, that I will have to immediately relinquish the Company vehicle and all improvements, changes, and additions I have made thereto to the Company, irrespective of how long such improvements, changes, and additions may have been installed on the vehicle.

I further agree that should I damage the company vehicle in an attempt to remove such changes, additions or improvements, that I will be responsible for such damage, in ADDITION to the value of the item (purchased by me, but assigned, sold, and conveyed to the Company/ STAFFORD by this agreement), and I agree the total amount of same could be withheld by the Company from my final paycheck.

I have read the above vehicle usage policy, assignment, and conveyance and I understand and agree to all its terms and conditions without reservation.

Employee Signature

Print Employee Name

Date

EMPLOYEE INCURRED EXPENSES AND REIMBURSEMENT

To ensure that all proper business-related expenses incurred by employees are reimbursed, the following procedure has been established:

1. All business-related expenditures must be accompanied by a receipt or evidence of expenditure to receive reimbursement.

Business charge cards are provided as a convenience to the employee. Business charge accounts should not be used for personal items.

Without exception, expenses charged on a business charge account and not supported by receipts or evidence will be charged back to the employee and deducted via a payroll deduction. Failure to follow guidelines for business charge cards will result in termination of the card.

2. All items purchased or charged by the employee are to be itemized on the approved company expense report. All portions of the report must be filled out or marked "N/A" (not applicable), and the necessity and purpose of the expenditure must be explained in sufficient detail.
3. Expense reports must be signed and dated by the employee and initialed by the manager showing approval. Reports are due in the accounting department by the 5th of the month following the month the expense was incurred in. You expect timely reimbursement and we expect the expenses to be filed timely.

Reimbursement will be made within 14 days of filing a timely expense report. Checks will only be cut once a month for reimbursement.

4. Any expense report older than 60 days will be not be reimbursed.

Agreed to this ____ day of _____

Signed: _____

Stafford Development Company and Affiliates
Policy – Corporate Credit Card

1. Issuance of Card and credit limits must be approved in writing by an officer of Stafford Development Company.
2. Each cardholder is responsible and accountable for the proper use of the Corporate Credit Card, including the timely submission of necessary statements, receipts, reports, and other documentation to assure the Corporation's ability to make prompt credit card payments. Receipts must be turned in accounting department three days prior to end of the month.
3. The cardholder is responsible for all transactions made with the card. The cardholder shall retain itemized receipts and any other information related to a card transaction and forward them to Accounts Payable along with a completed Business Expense Report as documentation for all charges made, and such documentation shall comply in form and substance with the applicable corporate policies related to expense reports.
4. Though the Accounting staff will be happy to assist you, it is the responsibility of the cardholder to attempt to resolve any disputes with a vendor. If resolution is not possible, the cardholder should report the problem to the appropriate Accounting staff within 30 days of the original transaction.
5. As with any credit card, the Corporate Card must be signed by the named cardholder. Only the named cardholder should use the card.
6. The cardholder is responsible for reporting the loss or theft of her/his card immediately to the Accounting staff.
7. The card is for business purposes only. Personal charges should not be charged on the card. Should personal expenses be placed on the card they should specifically be identified on the expense report and reimbursed immediately. By agreeing to this policy, you also give the company authority to withhold any un-reimbursed personal expenses from your pay.
8. Non-adherence to any policies or procedures will result in revocation of individual cardholder privileges.

Agreed to this ____ day of _____

Signed: _____

Dress Code Acknowledgement

I have received and read a copy of the new dress code policy and agree to abide by the policy guidelines as a condition of my employment at Stafford Development and its subsidiaries. I acknowledge that I fully understand this policy and agree to consult the Human Resources Department if any questions arise.

Employee Signature _____

Employee Printed Name _____

Date _____

Dress Code:

Our Company's objective in establishing a business casual dress code is to allow our employees to work comfortably in the workplace. Yet, we still need to project a professional image for our customers, potential employees and community visitors. Business casual dress is the standard for this dress code.

Because all casual clothing is not suitable for the office, these guidelines will help you determine what is appropriate to wear to work. Clothing that works well for the beach, yard work, dance clubs, exercise sessions, cookouts and sports contests is not appropriate for a professional appearance at work.

Clothing that reveals too much cleavage, your back, chest, feet, stomach or your under garments is not appropriate for a place of business, even in a business casual setting.

Clothing should be pressed and never wrinkled. All seams must be finished. Clothing that is unacceptable: anything with sports team, university or fashion brand names, and also clothing with words, terms or pictures that may be offensive to other employees. However, clothing with the company logo is encouraged.

Employees who are required to wear uniforms should follow the guidelines already established by the Company. This includes ensuring these items fit appropriately, are clean, pressed, and free of holes or tears.

Effective immediately, we will no longer have dress down days. You will no longer be allowed to wear jeans or denim on Fridays or any other work day.

Guide to Business Casual Dressing for Work

This is a general overview of appropriate and inappropriate business casual attire. Neither list is all-inclusive and is subject to change at any time.

No dress code can cover all contingencies, so employees must exercise a certain amount of judgment and common sense in their choice of clothing for work. If uncertain about acceptable, professional business casual attire, please ask your Human Resources Director.

Slacks, Plants and Suit Pants

Acceptable: Slacks similar to Dockers and other makers of cotton or synthetic material pants; wool pants, dressy Capri's, culottes and nice looking dress synthetic pants.

Not acceptable: Jeans, sweatpants, exercise pants, warm-up or jogging suits, Bermuda shorts, "short shorts", shorts of any type on men and women, bib overalls, leggings, cargo pants and any spandex or other form-fitting pants such as those worn biking.

Skirts, Dresses and Skirted Suits

Acceptable: Casual dresses and skirts that are at or below the knee. Dress and skirt length should be at a length at which you can sit comfortably in public.

Not acceptable: Short skirts, “micro –minis,” skorts, beach dresses and spaghetti-strap dresses.

Shirts, Tops, Blouses and Jackets

Acceptable: Casual shirts, dress shirts, sweaters, tops, golf-type shirts and turtlenecks. Most suit jackets or sport jackets are also acceptable attire for the office, if they don't violate the previous listed guidelines.

Not acceptable: Tank tops, midriff tops, see-through tops, shirts with potentially offensive words, terms, logos, pictures, cartoons or slogan; halter or tube tops, tops with bare shoulders unless worn under blouse or jacket; t-shirts for men, oversized or “grunge” clothing, spaghetti strap tops, sweatshirts and t-shirts unless worn under another blouse, shirt jacket or dress.

Shoes and Footwear

Acceptable: Conservative loafers, men's dress shoes, boots, dress flats, dress heels, dress sandals with heel and leather deck-type shoes. Not wearing stockings in warm weather is acceptable.

Not acceptable: Absence of socks on men; flashy athletic or exercise shoes, sandals for men, tennis shoes, sneakers or any casual shoes similar to tennis shoe soles, crocs, flip flops, thong slippers, flat sandals and slippers.

Jewelry, Makeup, Perfume and Cologne

Jewelry should be worn in good taste, with no body piercing except ears. Jewelry on feet and ankles should not be visible. No extreme hair or makeup is allowed. Remember, some employees are allergic to the chemicals in perfumes, cologne, lotions and make-up, so wear these substances with restraint. If these items become a problem for a co-worker, you will be asked to eliminate wearing these items. Tattoos should be covered at all times.

Hats and Head Covering

Hats are not appropriate in the office.

Conclusion

Every possible type of apparel cannot be detailed within these lists. Everyone is subject to review for appropriate dress whether or not the item is listed herein. Additionally, in cases of medical need, special individual circumstances or other accommodation required by law, exceptions can be made. If any employee believes he/she is unable to follow the dress code policy for such a reason, please contact Human Resources. A doctor's excuse may be required. Complaints about a potential violation should be made to Human Resources. In the event that a dress code violation exists, one or more of the following disciplinary actions may be pursued: a formal oral warning, a written warning to include requiring the employee to return home to change clothes, suspension from work and termination. All of these violations will be documented in the employee file.

Again, Stafford's dress code is business casual Monday through Friday. Blue Jeans are no longer allowed in the workplace. Please use appropriate judgment when selecting your work attire.

Grooming

It is the policy of Stafford Development and its subsidiaries not to allow facial hair other than a neatly trimmed and groomed mustache that stays on or above the lip line, unless the employee is unable to comply with this policy due to medical, ethnic or religious reasons. Make sure your hair is freshly cut in a nice, neat manner. Protruding nasal and ear hair is prohibited. When wearing a skirt or dress, please shave your legs.

An employee that requests an exception to this rule must provide the necessary documentation (i.e., doctor's note, religious documentation, etc). If an exception is granted, all facial hair must be neatly trimmed and groomed and shall not exceed a length of more than 2 inches.

We are pleased to announce ADP iPayStatements, a new benefit for all associates. Through ADP, our payroll provider, we are able to offer to you your earnings statements and W-2 forms 24 hours a day, 7 days a week. In addition, you can make changes to your W-4. Simply type in your changes, print the form, sign it and forward the completed form to the Payroll Department for processing.

How to Register on ADP iPayStatements

1. Go to <https://paystatements.adp.com>
2. Click on "Register Now"
3. Enter the **Self Service Registration Pass Code** which is: **StaffDev-adpnet**
4. Select iPayStatements as the self-service product.
5. From your most recent pay statement, enter the following information:
 - Company Code
 - File Number
 - Social Security Number
 - Pay Date or Advice Date
 - Check/Voucher or Advice Number

You will then be prompted to complete a registration process during which you must answer a few security questions and select a password. Your password must contain between 8 to 20 characters and at least one alpha and one numeric character. You will be assigned a system generated User ID. The security questions will be used to verify your identity if you ever forget your user ID or password.

Upon completing the registration process, you may access your pay statements at <https://paystatements.adp.com>.

Once you have logged into iPayStatements, there are some options listed under "Things You Can Do". One option is to "Go Paperless". Choosing this option will allow you to receive your statements online only. The payroll department will no longer provide you with a paper copy of your statement. You will be notified by email when your current pay statement is ready to be viewed.

We hope you enjoy this new feature. We appreciate the opportunity to provide you with this exciting new way of viewing your pay information.

Thank you,

Payroll/Human Resources Department



Employee Benefits Summary

Stafford Group Insurance to Include:

- **Two Major Medical Health Plans:**
- **Basic Plan**
 - *Deductible*
(\$1,500 per covered person)
(\$6,000 per covered person Out of Pocket)
- **Enhanced Plan**
 - *Deductible*
(\$500 per covered person)
(\$2,500 per covered person Out of Pocket)
 - *Member Incentive Reserve (MI)*
(Applies after calendar year deductible. Remaining 2009 balance will be matched \$1 for every \$5 remaining. If no balance remaining no new amount will be added until 2010 and it will be based on matched at that time based on the amount of out of pocket you have not used - \$1 for every \$5 remaining)
 - *Requires participation on Annual Assessment, Compliance with Disease Management Program if required*
- **Dental Insurance**
(\$50 Deduct / \$1000 Maximum) Deductible applies to class B and C services
- **Prescription Drug Coverage with \$10, \$25, and 50% copay by tier**

Total Cost (Biweekly) includes all of the above:

Basic Plan

Single: \$ 80.00
 Employee +1 : \$160.00
 Family: \$204.00

Enhanced Plan

Single: \$73.00
 Employee +1 : \$146.00
 Family: \$170.00

Surcharge - \$1,300.00 annually (applies if spouse takes our ins. and other coverage is available)

Stafford Flexible Spending Account (\$5,000 Maximum)

- *Medical Expense Spending Account*
 - *Dependent Care Spending Account*
- (Premiums for Group Insurance and Flexible Spending are deducted each payroll, on a Pre-tax/Basis)*

Prepaid Legal & Identity Theft – Monthly Cost – IDT - \$12.95, Legal \$15.95

Voluntary Benefits Available:

- *Allstate Universal and Group Life Insurance*
- *Allstate Accident Insurance*
- *Allstate Cancer Insurance*

After completion of 90 days of service, an Eligible Employee will be entitled to the following benefit assuming all requirements are met: (Quarterly Enrollment)

401K Retirement Plan

- *Emp. Contributes between 3-15%, Discretionary Empr Match – 25% of EmpContribution*

ENROLLMENT FORM

COMPANY/EMPLOYER NAME					DIVISION/LOCATION						
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)					SOCIAL SECURITY NUMBER						
ADDRESS: STREET			CITY		STATE		ZIP		PHONE NUMBER		
MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> FLEXIBLE BENEFITS <input type="checkbox"/>	ORIGINAL DATE OF COVERAGE		DATE HIRED FULL TIME		DATE OF BIRTH		SEX				
	MO DAY YEAR		MO DAY YEAR		MO DAY YEAR		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	STATUS <input type="checkbox"/> NEW EMPLOYEE <input type="checkbox"/> REHIRED EMPLOYEE	<input type="checkbox"/> SPECIAL ENROLLEE <input type="checkbox"/> LATE ENROLLEE	<input type="checkbox"/> OPEN ENROLLMENT								
ELIGIBLE FOR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER COVERAGE: POLICY# NAME OF INSURANCE:		Coverage: <input type="checkbox"/> Self <input type="checkbox"/> Family		EFFECTIVE DATE:					
<small>TO BE COVERED, ALL DEPENDENTS MUST BE LISTED BELOW. DEPENDENTS NOT NAMED ARE NOT COVERED. DEPENDENTS ARE NOT ELIGIBLE FOR COVERAGE NOT ELECTED BY THE EMPLOYEE. INDICATE ANY DEPENDENT CHILD IN A SCHOOL BEYOND HIGH SCHOOL OR WHO IS HANDICAPPED. NOTE: COMPLETE DENTAL BLOCK ONLY IF DENTAL IS PROVIDED IN THE PLAN. COMPLETE "ORIGINAL DATE OF COVERAGE" ONLY FOR INDIVIDUALS CURRENTLY COVERED UNDER THE EMPLOYER'S MEDICAL PLAN. PLAN IS BEING REPLACED.</small>											
SPOUSE		<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL	DATE OF BIRTH		SEX		SPOUSE SS#				
			MO DAY YEAR		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE						
IS SPOUSE EMPLOYED? IF YES, WHERE?		<input type="checkbox"/> YES <input type="checkbox"/> NO		DOES SPOUSE HAVE GROUP COVERAGE AVAILABLE THROUGH EMPLOYER?		<input type="checkbox"/> YES <input type="checkbox"/> NO		IS SPOUSE COVERED UNDER SUCH PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>			
DEPENDENT CHILD		<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL	DATE OF BIRTH		SEX		CHILD SS#				
			MO DAY YEAR		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE						
BEYOND HIGH SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO		HANDICAPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT CHILD COVERED UNDER ANY OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO							
IF YES, INDICATE NAME OF COVERED PERSON AND PLAN:											
DEPENDENT CHILD		<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL	DATE OF BIRTH		SEX		CHILD SS#				
			MO DAY YEAR		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE						
BEYOND HIGH SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO		HANDICAPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT CHILD COVERED UNDER ANY OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO							
IF YES, INDICATE NAME OF COVERED PERSON AND PLAN:											
LIFE INSURANCE BENEFICIARY:					RELATIONSHIP:						
<p>I hereby apply for self-funded and/or insurance coverage. The beneficiary designation supersedes all previous designations. I agree the copy of my signature or copy of this form may be accepted as my signature. I authorize necessary deductions from my salary, account or dues for any contributions required. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my family's health, to give to the insurer, including the reinsurers, such information. A photographic copy of this authorization shall be as valid as the original. I agree that, to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the insurance of any coverage by any underwriter or carrier. Subject to the approval of this application, the coverage applied for shall become effective in accordance with the terms of the plan document. I understand that coverage, once offered and declined, may be elected at a later date (1) with respect to health coverage, (a) under the plan document's Special Enrollment Rules or (b) if the plan document provides for Open Enrollment or Late Enrollment (A Late Enrollee is subject to a post-coverage waiting period of eighteen (18) months for pre-existing condition), or (2) with respect to Life Insurance, subject to approval by the carrier upon the submission of a health questionnaire. I understand that I must meet all eligibility requirements before coverage can become effective. I understand that any falsification will result in denial or cancellation of coverage so that the result is no coverage was ever in effect and any claims paid will be reimbursed by me. By my signature below, I acknowledge that all information was entered above prior to my signing this Enrollment Form.</p>											
I ACKNOWLEDGE RECEIPT OF THE SUMMARY PLAN DESCRIPTION INCLUDING MY INITIAL COBRA NOTICE OF RIGHTS AND OBLIGATIONS FOR MYSELF AND MY COVERED DEPENDENT(S) (IF ANY)					I HAVE ATTACHED A CERTIFICATE(S) OF CREDITABLE COVERAGE FOR MYSELF AND/OR MY ELIGIBLE DEPENDENT(S) FOR DETERMINATION OF ANY CREDIT TOWARD THE PLANS POST-COVERAGE WAITING PERIOD FOR PRE-EXISTING CONDITIONS.						
SIGNATURE OF EMPLOYEE _____					DATE SIGNED _____						
SPECIAL ENROLLMENT RULES											
FOR INDIVIDUALS LOSING OTHER COVERAGE - IF YOU ARE DECLINING ENROLLMENT FOR YOURSELF OR YOUR DEPENDENTS (INCLUDING YOUR SPOUSE) BECAUSE OF OTHER HEALTH COVERAGE, YOU MAY IN THE FUTURE BE ABLE TO ENROLL YOURSELF OR YOUR DEPENDENTS IN THIS PLAN, PROVIDED YOU REQUEST ENROLLMENT WITHIN 30 DAYS AFTER YOUR OTHER COVERAGE ENDS. EACH OF THE CONDITIONS SET FORTH IN THE SPECIAL ENROLLMENT PERIODS SECTION OF THE SUMMARY PLAN DESCRIPTION MUST BE MET. FOR NEWLY ACQUIRED DEPENDENTS - IF YOU HAVE A NEW DEPENDENT AS A RESULT OF MARRIAGE, BIRTH, ADOPTION, PLACEMENT FOR ADOPTION OR OBTAINING CUSTODY OF A FOSTER CHILD, YOU MAY BE ABLE TO ENROLL YOURSELF AND YOUR DEPENDENTS, PROVIDED THAT YOU REQUEST ENROLLMENT WITHIN 30 DAYS AFTER THE MARRIAGE, BIRTH, ADOPTION, PLACEMENT FOR ADOPTION OR OBTAINING CUSTODY OF THE FOSTER CHILD.											
I DECLINE ENROLLMENT FOR:											
<input type="checkbox"/> MYSELF (I HAVE NO ELIGIBLE DEPENDENTS)											
<input type="checkbox"/> MYSELF AND MY ELIGIBLE DEPENDENTS											
<input type="checkbox"/> MY ELIGIBLE DEPENDENTS											
THE REASON THAT I AM DECLINING ENROLLMENT IS:											
<input type="checkbox"/> HAS OTHER COVERAGE UNDER A GROUP HEALTH PLAN OR HAVE HEALTH INSURANCE COVERAGE (AS INDICATED IN THE 'OTHER HEALTH COVERAGE' SECTION.											
<input type="checkbox"/> OTHER - (PLEASE EXPLAIN) _____											
SIGNATURE OF EMPLOYEE: _____					DATE: _____						

Health/Dependent Care Flexible Spending Account Enrollment Form

This form is designed to be completed by using your computer and tabbing through the designated fields. If completing a printed copy by hand, please use black or blue ink, print clearly and only in the spaces provided.

Social Security Number - -

First Name M.I. Last Name

Address

City State

Zip Code Day Phone

Email

*Need help deciding how much to elect or how much you will save using a Flexible Spending Account?
VISIT OUR WEBSITE at www.flexdirect.adp.com*

I have reviewed the terms of my employer's Plan and I understand that I may elect coverage under either or both of the accounts below, subject to the terms of the Plan, for the Plan Year _____.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT	CONTRIBUTION PER PAY PERIOD	NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR	=	YOUR ANNUAL ELECTION AMOUNT
	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	X <input type="text"/> <input type="text"/>		= <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
CANNOT EXCEED \$5,000 PER HOUSEHOLD				

HEALTH CARE FLEXIBLE SPENDING ACCOUNT	CONTRIBUTION PER PAY PERIOD	NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR	=	YOUR ANNUAL ELECTION AMOUNT
	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	X <input type="text"/> <input type="text"/>		= <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

I elect to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's plan. Any salary deductions that have not been used for expenses incurred in the Current Plan Year noted above will be forfeited.

If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

Employee Signature Date

Employer Section: ADP FSA Client ID Employee ADP Company Code Effective Date of Employee Election