Employee Documentation Checklist

Name: _____ Hire Date: _____

START:

___ Application for Employment
___ Consent form to do background check
___ Picture of License & Social Security Card
___ Driver's Abstract Inquiry Authorization

VETTING:

___ Google search employees and city name *(don't have to include results in file)*
___ Talk to former employers if manager
___ Background Check PUT IN FILE!
___ Driver's Abstract PUT IN FILE!

AFTER OFFER:

___ Early Employment Drug Test Results PUT IN FILE
___ Physical (Human Performance) PUT IN FILE

LEGAL:

___ 30 Day Trial Employment Agreement
___ SPT Handbook Acknowledgement *(one copy to employee and one copy in the file)*
___ SPT Confidentiality Agreement *(one copy to employee and one copy in the file)*
___ Road Test Certification (if applicable)
___ DOT Med Card copy
    ___ Long form
___ Form I-9 Employment Eligibility Verification
___ Form W-4
___ NYS IT-2104 or employed state's equivalent (if applicable)
___ Emergency Contact Form
___Safety and Sexual Harassment Document
___ Wage theft document signed *(one copy to employee and one copy in the file)*
___ St Pauly sign lunch policy *(one copy to employee and one copy in the file)*

BENEFITS:

___ Give employee benefits page *(one copy to employee and one copy in the file)*
___ ***Log 60 day medical coverage offering on calendar
___ Filled out Health Insurance Form or waiver.
___ Filled out Retirement Plan
___Offered Dental / eye.
___Explain: Your raise will be based on how well you do.
___Life insurance offered

DIF – Document in File

DOCS: (COPIES TO EMPLOYEE AND In FILE!)

___ Attendance policy signed
___ No Shopping document signed *(one copy to employee and one copy in the file)*
___ Drug free document signed *(one copy to employee and one copy in the file)*
___ Cyber security document signed
___ Direct deposit info, if needed

AFTER:

___ Add birthday to calendar
___ Add benefit offering time to calendar
___ Setup employee LENS / DMV monitoring in respective state
___ Set proper permissions on payroll system (Geofencing, etc.)
___ Add retroactive vacation time to payroll system
___ Add to random drug testing
___ Properly program Fleetmatics fob, give it to employee, and explain how it works.
___ Payroll to Joey
___ Safety certification completed (East) Date:_____
___ Given uniform
___ Employee company email account

Email _____

Password _____

Training: ***(If not applicable, mark N/A)***

___ Review Duties, Responsibilities and Driving Safely document
___ Review Driver or Manager Manual
___ Watch training videos
___ Introduced to the team
___ Drive with a Trainer
___ Explain how the company works – how funding works to the non-profit organizations
___ Explain the importance of clean sheds
___ Explain what "sorted clothes" means
___ Explain the importance of cleaning up all garbage around and inside the shed
___ Explain how future raises work – criteria for raises

Hiring Manager Name and Signature_____ Date _____

DIF – Document in File

(Applicant Name) (Date)

St. Pauly Textile, Inc.

Application for Employment

Accessibility: If you need help completing this form please contact our main number: 585-924-7941.
St. Pauly Textile, Inc. is committed to equal opportunity for all, without regard to race, religion, color, national origin, citizenship, sex, sexual orientation, gender identity, age, veteran status, disability, genetic information, or any other protected characteristic.

St. Pauly Textile, Inc. will make reasonable accommodations for known physical or mental limitations of otherwise qualified employees and applicants with disabilities unless the accommodation would impose an undue hardship on the operation of our business.

APPLICANT INFORMATION

Full Name: _____
(Last) (First) (M.I.)

Address: _____
(Street Address)

_____
(Apartment/Unit Number)

_____
(City) (State) (Zip Code)

Phone: _____ Email: _____

Position applied for: _____

Type of employment desired: _____ Full-Time _____ Part-Time

Have you ever applied or worked for this company before _____ Yes _____ No

If yes, when? _____

Are you at-least 18 years of age? _____ Yes _____ No
Please do not list your age or birth date anywhere on this application.

Are you legally authorized to work in the United States _____ Yes _____ No

Do you have a reliable means of travel to work _____ Yes _____ No

(Applicant Name) (Date)

St. Pauly Textile, Inc.

EDUCATION, CERTIFICATIONS AND SKILLS

EDUCATION	Name and location of school	No. of yrs. Attended	Degree Received	Subjects studied/Major
High School				
College or University				
Trade, Business or Correspondence School				

Please list any additional professional certifications, memberships to professional associations and/or other skills you believe are worthwhile to this position:

(Applicant Name) (Date)

St. Pauly Textile, Inc.

WORK HISTORY

Please list your previous three employers here in descending order (most current first).
If you have additional employment history please include on an additional form.

Employer Name _____

Address: _____ Phone: _____

Position Held: _____ From: _____ To: _____

Supervisor's Name: _____

Reason for Leaving: _____

Employer Name _____

Address: _____ Phone: _____

Position Held: _____ From: _____ To: _____

Supervisor's Name: _____

Reason for Leaving: _____

Employer Name _____

Address: _____ Phone: _____

Position Held: _____ From: _____ To: _____

Supervisor's Name: _____

Reason for Leaving: _____

(Applicant Name) (Date)

St. Pauly Textile, Inc.

PROFESSIONAL REFERENCES

Please provide up to three professional references. A professional reference is a person that can attest to your professional development, qualifications, successes, and speak to your ability to perform the duties of this position satisfactorily. They may be a previous employer, supervisor, co-worker, teacher, professor, affiliate of a professional association, or other.
Please do not list personal family members, friends or acquaintances.

1._____
(Name) (Title) (Phone/Email)

Years Known _____

Please describe your relationship with this person – current or former – and why you chose them as a reference.

2._____
(Name) (Title) (Phone/Email)

Years Known _____

Please describe your relationship with this person – current or former – and why you chose them as a reference.

3._____
(Name) (Title) (Phone/Email)

Years Known _____

Please describe your relationship with this person – current or former – and why you chose them as a reference.

(Applicant Name) (Date)

St. Pauly Textile, Inc.

APPLICATION DISCLAIMER AND ACKNOWLEDGMENT

I, _____ (please print name) certify that the information contained in this application is correct to the best of my knowledge. I understand that to falsify information is grounds for refusing to hire me, or for discharge should I be hired.

I hereby authorize any of the persons or organizations listed in my application to give all information concerning my previous employment, education, or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application, and release all such parties from all liability that may result from furnishing such information to you.

I understand that if I am selected to continue in the hiring process I will be asked to participate in a formal background check including review of driver's abstract during a later part of the interview process. I understand that the driver's abstract will be supplied at my expense, of which will be reimbursed if I am hired.

I authorize St. Pauly Textile, Inc. and/or St. Pauly Textile East, Inc. ("Company") to request and receive such information. In consideration for my employment and my being considered for employment by your company, I agree to adhere to the rules and regulations of the company and hereby acknowledge that these rules and regulations may be changed by your company at any time, at the company's sole option and without any prior notice.

In addition, I acknowledge that my employment may be terminated, and any offer of employment, if such is made, may be withdrawn, with or without prior notice, at any time, at the option of either the company or me. I understand that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to assure or make some other personnel move, either prior to commencement of employment or after I have become employed, or to assure any benefits or terms and conditions of employment, or to make any agreement, that is contrary to the foregoing.

I hereby acknowledge that that this application will remain active for no more than 90 days and retained for no longer than one year from the date it was signed.

_____ _____

(Applicant Signature) (Date)

Authorization for Background Check

Pursuant to the federal Fair Credit Reporting Act, I hereby authorize St. Pauly Textile, Inc. and its designated agents and representatives to conduct a comprehensive review of my background through a consumer report and/or an investigative consumer report to be generated for employment, promotion, reassignment or retention as an employee. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: verification of Social Security number; current and previous residences; employment history, including all personnel files; education; references; credit history and reports; criminal history, including records from any criminal justice agency in any or all federal, state or county jurisdictions; birth records; motor vehicle records, including traffic citations and registration; and any other public records.

I, _____ (Please Print Name), authorize the complete release of these records or data pertaining to me that an individual, company, firm, corporation or public agency may have. I hereby authorize and request any present or former employer, school, police department, financial institution or other persons having personal knowledge of me to furnish [Company Name] or its designated agents with any and all information in their possession regarding me in connection with an application of employment. I am authorizing that a photocopy of this authorization be accepted with the same authority as the original.

I understand that, pursuant to the federal Fair Credit Reporting Act, if any adverse action is to be taken based upon the consumer report, a copy of the report and a summary of the consumer's rights will be provided to me.

_____ _____

Signature Date

U.S. DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SAFETY PROGRAM
INQUIRY TO STATE AGENCY FOR
DRIVER'S RECORD
391.23

_____
(Driver's Name)

_____
(Driver's Operator's Lic. No.)

_____
(Driver's Social Sec. No.)

Dear _____,

The above listed individual has made application with us for employment as a driver. Applicant has indicated that the above numbered operator's license or permit has been issued by your State to applicant and it is in good standing.

In accordance with Section 391.23(a)(1) and (b) of the Federal Motor Carrier Safety Regulations, we are required to make inquiry into the driving record during the preceding 3 years of every State in which an applicant-driver has held a motor vehicle operator's license or permit during those 3 years.

Therefore, please certify to us what the individual's driving record is for the preceding 3 years, or certify that no record exists if that be the case.

In the event that this inquiry does not satisfy your requirements for making such inquiries, please send us such forms of yours as are necessary for us to complete our inquiry into the driving record of this individual.

Respectfully yours,

_____
Signature of individual making inquiry

Joseph R. Howlett
(printed) Name of person making inquiry

Vice President
Title of person making inquiry

St. Pauly Textile, Inc.
Motor Carrier Name

1067 Gateway Drive	Farmington	NY	14425
Street Address	City	State	Zip

St. Pauly Textile, Inc.

Trial Employment Period Agreement

This letter is to certify that _____ is starting at St. Pauly Textile, Inc. on _____ and will be on a 30 day trial period which ends on _____. At the completion of this trial period will be a performance review to determine eligibility for full time employment. St. Pauly Textile, Inc. or _____ may voluntarily end employment at any time during the trial period or post trial period performance review process.

_____
Name

_____
Operations Manager

1067 Gateway Drive · Farmington, NY 14425 · 585-924-7941 · www.StPaulyTextile.com

St. Pauly Employee Handbook Acknowledgment of Receipt

I, _____, acknowledge that I have been provided the opportunity to review the contents of the St. Pauly Employee Handbook (Version 7).

Signature:_____ Date:_____

CONFIDENTIALITY AGREEMENT

1. *EMPLOYEE'S ACKNOWLEDGEMENTS AND COVENANTS*

(a) *Confidential Material and Information.* In performing duties for Employer, Employee regularly will be exposed to and work with Employer's Confidential Material and Information concerning the Business to which Employee devotes Employee's business time, attention and energies for Employer. Employee acknowledges that such Confidential Material and Information are critical to Employer's success and that Employer has invested substantial time and money in developing Employer's Confidential Material and Information. While Employee is employed by Employer, and after such employment ends for any reason, Employee will not reproduce, publish, disclose, use, reveal, show, or otherwise communicate to any person or entity any Confidential Material and Information of Employer unless specifically assigned or directed by Employer to do so. The covenant in this Subparagraph (a) applies for as long as the Confidential Material and Information is not generally known to the public or others who are not restricted from using or disclosing it.

(b) *Non-Solicitation of Employees.* While Employee is employed by Employer, and for twenty-four (24) months after such employment ends, for any reason, Employee, acting either directly or indirectly, or through any other person, firm or corporation, will not induce or attempt to induce or influence any employee of Employer to terminate employment with Employer.

(c) *Restrictive Covenant.* Employee recognizes that unauthorized use or disclosure of Confidential Material and Information by Employee would harm Employer. Employee further recognizes that Employer has a legitimate interest in preventing its employees from exploiting the customer relationships developed at Employer's expense and in its name. Thus, while Employee is employed by Employer, and for twenty-four (24) months after such employment ends, for any reason, Employee agrees and promises not to perform directly or indirectly any managerial or professional function for any person, company or business entity in competition with Employer's Business in which Employee either worked for Employer at any time during Employee's last twenty-four (24) months of employment with Employer or regularly received Confidential Material and Information at any time during Employee's last twelve (12) months of employment with Employer.

In addition, while Employee is employed by Employer and for twenty-four (24) months after such employment ends, for any reason, Employee will not, directly or indirectly: (i) have an ownership interest greater than two percent (2%) of the outstanding stock in any company or entity in competition with Employer in Industries; or (ii) call on, solicit or communicate with any of Employer's customers or prospects for the purpose of obtaining any Industries business, other than for the benefit of Employer. As used in this Agreement, "customer" means a business entity (including representatives of such business entity) to which Employer provided Industries goods or services at any time in the

prior twenty-four (24) months, and "prospect" means a business entity (including representatives of such business entity) to which, at any time in the previous twenty-four (24) months, Employer made a proposal, or was actively considering making a proposal, for providing Industries good or services.

(d) *Return of Confidential Material and Information.* Employee agrees that whenever Employee's employment with Employer ends for any reason, all documents and other items containing or referring to Employer's Confidential Material and Information in Employee's possession or under Employee's control will be delivered by Employee to Employer immediately, with no request being required.

(e) *Irreparable Harm.* Employee acknowledges and agrees that a breach of any covenant in this Section will cause Employer irreparable injury and damage for which Employer may have no adequate remedy.

(f) Employer may apply to any court of competent jurisdiction for a temporary restraining order, preliminary injunction or other injunctive relief to enforce Employee's compliance with the obligations, acknowledgements and covenants in this Section 1. Employer may also include as part of such injunction action any claims for injunctive relief under any applicable law arising from the same facts or circumstances as any threatened or actual violation of Employee's obligations, acknowledgements and covenants in this Section 1.

(g) *Costs.* Employer shall recover from Employee, and Employee shall pay, the reasonable costs and attorneys fees Employer incurs in enforcing compliance with Employee's obligations, acknowledgements and covenants in this Section 1 or in remedying Employee's violation of those obligations, acknowledgements and covenants.

(h) *Additional Acknowledgements.* Employee, having carefully considered the nature and extent of the restrictions upon Employee and the rights and remedies conferred upon Employer by this Section 1, hereby acknowledges and agrees that the terms of this Section are a material inducement for Employer to enter into this Agreement, are reasonable in time and scope to only prevent unfair competition and to protect Employer's Confidential Material and Information, do not prevent Employee's fair use of Employee's general skill and experience, and are appropriate and reasonably necessary to protect Employer's legitimate business interests.

2. *RETURN OF EMPLOYER PROPERTY.*

Employee further agrees that whenever Employee's employment with Employer ends for any reason, Employee shall deliver to Employer immediately without request, all property belonging to Employer, including, but not limited to, computer equipment, software, credit cards, keys and access cards.

3. *APPLICABLE LAW.*

THIS AGREEMENT WILL BE INTERPRETED, GOVERNED AND ENFORCED ACCORDING TO THE LAWS OF THE STATE OF NEW YORK.

4. *MODIFICATION AND SEPARABILITY.*

If any portion of this Agreement is held to be invalid or unenforceable in any respect, Employee and Employer agree that such invalid or unenforceable part may be severed or modified to permit the Agreement to be enforced to the maximum extent permitted under law, with the remaining portions unaffected by the invalidity or unenforceability of any part of this Agreement.

5. *COMPLETE AGREEMENT.*

ASIDE FROM THE AMOUNTS OF EMPLOYEE'S COMPENSATION AND EMPLOYEE'S ENTITLEMENT TO BENEFITS, THIS AGREEMENT CONTAINS THE ENTIRE AGREEMENT BETWEEN EMPLOYER AND EMPLOYEE REGARDING SUBJECTS ADDRESSED HEREIN, AND THE PARTIES CAN AMEND OR MODIFY THIS AGREEMENT ONLY BY A SUBSEQUENTLY-EXECUTED WRITTEN AGREEMENT SIGNED BY BOTH PARTIES.

Employee:

_____

(Print Name)

Employer:

ST. PAULY TEXTILE CORP.

By: _____

(Print Name)

Title: _____

CERTIFICATE OF DRIVER'S ROAD TEST

Instructions: If the road test is successfully completed, the person who gave it shall complete a certificate of the driver's road test. The original or copy of the certificate shall be retained in the employing motor carrier's driver qualification file of the person examined and a copy given to the person who was examined. (49 CFR 391.31(e)(f)(g))

CERTIFICATION OF ROAD TEST

Driver's Name _____

Social Security Number _____

Operator's or Chauffeur's License Number _____

State _____

Type of Power Unit Box Truck (24')

Type of Trailer(s) n/a

If passenger carrier, type of bus n/a

This is to certify that the above-named driver was given a road test under my supervision on _____, 20___, consisting of approximately _____ miles of driving.

It is my considered opionion that this driver possesses sufficient driving shill to operate safely the type of commercial motor vehicle listed above.

_____
(Signature of Examiner)

Manager
(Title)

St. Pauly Textile, Inc. 1067 Gateway Drive Farmington, NY 14425
(Organization and Address of Examiner)

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
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. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		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 report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet exp red and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tr bal document		
		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:**		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **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 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employer 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		Additional Information		OR Code - Sections 2 & 3 Do Not Write In This Space
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

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	
Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

Form W-4 (2019)

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

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. You may claim exemption from withholding for 2019 if both of the following apply.

- For 2018 you had a right to a refund of all federal income tax withheld because you had no tax liability, and
- For 2019 you expect a refund of all federal income tax withheld because you expect to have no tax liability.

If you're exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at *www.irs.gov/W4App* to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---------- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. ----------

Form **W-4** Department of the Treasury Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ Whether you're 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.

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2019, and I certify that I meet both of the following conditions for exemption. • 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
(This form is not valid unless you sign it.) ▶ Date ▶

8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers***.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

IT-2104

New York State • New York City • Yonkers

2019

First name and middle initial	Last name	Your social security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐ Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	Note: If married but legally separated, mark an *X* in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Complete the worksheet on page 3 before making any entries.

1 Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 20)*	1	
2 Total number of allowances for New York City *(from line 35)*	2	

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3 New York State amount	3	
4 New York City amount	4	
5 Yonkers amount	5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an *X* in box A and/or box B to indicate why you are sending a copy of this form to New York State *(see instructions)*:

A Employee claimed more than 14 exemption allowances for NYS ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see instr.)*: ☐

Are dependent health insurance benefits available for this employee? .... Yes ☐ No ☐

If Yes, enter the date the employee qualifies *(mm-dd-yyyy)*: ☐

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)*	Employer identification number

Instructions

Changes effective for 2019

Form IT-2104 has been revised for tax year 2019. Additional allowances are allowed for covered employees of employers who elected to pay the employer compensation expense tax and for employees who made contributions to a New York Charitable Gifts Trust Fund during 2018. The worksheet on page 3 and the charts beginning on page 4, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2019 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn $107,650 or more during the tax year.
- The total income of you and your spouse has increased to $107,650 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.

Department of Revenue Services
State of Connecticut
(Rev. 12/18)

Form CT-W4

Employee's Withholding Certificate

Complete this form in blue or black ink only.

Effective January 1, 2019

Employee Instructions

- Read instructions on Page 2 before completing this form.
- Select the filing status you expect to report on your Connecticut income tax return. See instructions.
- Choose the statement that best describes your gross income.
- Enter the *Withholding Code* on Line 1 below.

Married Filing Jointly	Withholding Code
Our expected combined annual gross income is less than or equal to $24,000 or I am claiming exemption under the Military Spouses Residency Relief Act (MSRRA)* and no withholding is necessary.	E
My spouse is employed and our expected combined annual gross income is greater than $24,000 and less than or equal to $100,500. See *Certain Married Individuals*, Page 2.	A
My spouse is not employed and our expected combined annual gross income is greater than $24,000.	C
My spouse is employed and our expected combined annual gross income is greater than $100,500.	D
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income	D
Qualifying Widow(er) With Dependent Child	**Withholding Code**
My expected annual gross income is less than or equal to $24,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	E
My expected annual gross income is greater than $24,000.	C
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

Married Filing Separately	Withholding Code
My expected annual gross income is less than or equal to $12,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	E
My expected annual gross income is greater than $12,000.	A
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D
Single	**Withholding Code**
My expected annual gross income is less than or equal to $15,000 and no withholding is necessary.	E
My expected annual gross income is greater than $15,000.	F
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D
Head of Household	**Withholding Code**
My expected annual gross income is less than or equal to $19,000 and no withholding is necessary.	E
My expected annual gross income is greater than $19,000.	B
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

* If you are claiming the Military Spouses Residency Relief Act (MSRRA) exemption, see instructions on Page 2.

Employees: See *Employee General Instructions* on Page 2. Sign and return Form CT-W4 to your employer. Keep a copy for your records.

1. Withholding Code. Enter *Withholding Code* letter chosen from above ..... 1. _____
2. Additional withholding amount per pay period: If any, see instructions. ..... 2 $_____
3. Reduced withholding amount per pay period: If any, see instructions. ..... 3 $_____

☐ Check if you are claiming the MSRRA exemption and enter state of legal residence/domicile. _____

First name	MI	Last name	Social Security Number
Home address (number and street, apartment number, suite number, PO Box)			
City/town	State	ZIP code	

Declaration: I declare under penalty of law that I have examined this certificate and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for reporting false information is a fine of not more than $5,000, imprisonment for not more than five years, or both

Employee's signature	Date

Employers: See *Employer Instructions* on Page 2.

Is this a new or rehired employee? ☐ No ☐ Yes Enter date hired _____ mm/dd/yyyy

Employer's business name			Federal Employer Identification Number
Employer's business address			
City/town	State	ZIP code	
Contact person			Telephone number ( )

Employee General Instructions

Form CT-W4, *Employee's Withholding Certificate*, provides your employer with the necessary information to withhold the correct amount of Connecticut income tax from your wages to ensure that you will not be underwithheld or overwithheld.

You are required to pay Connecticut income tax as income is earned or received during the year. You should complete a new Form CT-W4 at least once a year or if your tax situation changes.

If your circumstances change, such as you receive a bonus or your filing status changes, you must furnish your employer with a new Form CT-W4 within ten days of the change.

Gross Income

For Form CT-W4 purposes, *gross income* means all income from all sources, whether received in the form of money, goods, property, or services, not exempt from federal income tax, and includes any additions to income from *Schedule 1* of **Form CT-1040** *Connecticut Resident Income Tax Return* or **Form CT-1040NR/PY**, *Connecticut Nonresident and Part-Year Resident Return*.

Filing Status

Generally, the filing status you expect to report on your Connecticut income tax return is the same as the filing status you expect to report on your federal income tax return. However, special rules apply to married individuals who file a joint federal return but have a different residency status. Nonresidents and part-year residents should see the instructions to Form CT-1040NR/PY.

Check Your Withholding

You may be underwithheld if any of the following apply:

- You have more than one job;
- You qualify under *Certain Married Individuals*; or
- You have substantial nonwage income

If you are underwithheld, you should consider adjusting your withholding or making estimated payments using **Form CT-1040ES**, *Estimated Connecticut Income Tax Payment Coupon for Individuals*. You may also select *Withholding Code* "D" to elect the highest level of withholding.

If you owe $1,000 or more, after subtracting from your Connecticut income tax the amount withheld from your income for the prior taxable year, and any PE Tax Credit, you may be subject to interest on the underpayment at the rate of 1% per month or fraction of a month.

To help determine if your withholding is correct, see **Informational Publication 2019(7)**, *Is My Connecticut Withholding Correct?*

Certain Married Individuals

If you are a married individual filing jointly and you and your spouse both select Withholding Code "A," you may have too much or too little Connecticut income tax withheld from your pay. This is because the phase-out of the personal exemption and credit is based on your combined incomes. The withholding tables cannot reflect your exact withholding requirement without considering the income of your spouse.

To minimize this problem, and determine if you need to adjust your withholding using Line 2 or Line 3, see IP 2019(7).

Nonresident Employees Working Partly Within and Partly Outside of Connecticut

If you work partly within and partly outside of Connecticut for the same employer, you should also complete **Form CT-W4NA**, *Employee's Withholding or Exemption Certificate - Nonresident Apportionment*, and provide it to your employer. The information on Form CT-W4NA and Form CT-W4 will help your employer determine how much to withhold from your wages for services performed within Connecticut. To obtain Form CT-W4NA, visit the Department of Revenue Services (DRS) website at **portal.ct.gov/DRS** or request the form from your employer. Any nonresident who expects to have no Connecticut income tax liability should choose *Withholding Code* "E."

Armed Forces Personnel and Veterans

If you are a Connecticut resident, your armed forces pay is subject to Connecticut income tax withholding unless you qualify as a nonresident for Connecticut income tax purposes. If you qualify as a nonresident, you may request that no Connecticut income tax be withheld from your armed forces pay by entering *Withholding Code* "E" on Line 1.

Military Spouses Residency Relief Act (MSRRA)

If you are claiming an exemption from Connecticut income tax under the MSRRA, you must provide your employer with a copy of your military spouse's Leave and Earnings Statement (LES) and a copy of your military dependent ID card.

See **Informational Publication 2018(15)**, *Connecticut Income Tax Information for Armed Forces Personnel and Veterans*.

Employer Instructions

For any employee who does not complete Form CT-W4, you are required to withhold at the highest marginal rate of 6.99% without allowance for exemption. You are required to keep Form CT-W4 in your files for each employee. See **Informational Publication 2019(1)**, *Connecticut Employer's Tax Guide, Circular CT*, for complete instructions.

Report Certain Employees Claiming Exemption From Withholding to DRS

Employers are required to file copies of Form CT-W4 with DRS for certain employees claiming "E" (no withholding is necessary). See IP 2019(1). Mail copies of Forms CT-W4 meeting the conditions listed in IP 2019(1) under *Reporting Certain Employees to:*

Department of Revenue Services
PO Box 2931
Hartford CT 06104-2931

Report New and Rehired Employees to the Department of Labor

New employees are workers not previously employed by your business, or workers rehired after having been separated from your business for more than sixty consecutive days.

Employers with offices in Connecticut or transacting business in Connecticut are required to report new hires to the Department of Labor (DOL) within 20 days of the date of hire.

New hires can be reported by:

- Using the Connecticut New Hire Reporting website at www.ctnewhires.com;
- Faxing copies of completed Forms CT-W4 to **800-816-1108**, or
- Mailing copies of completed Forms CT-W4 to:

  Connecticut Department of Labor
  Office of Research, CT-W4
  200 Folly Brook Blvd
  Wethersfield CT 06109

For more information on DOL requirements or for alternative reporting options, visit the DOL website at **www.ctdol.state.ct.us** or call DOL at 860-263-6310.

For More Information

Call DRS during business hours, Monday through Friday

- **800-382-9463** (Connecticut calls outside the Greater Hartford calling area only); or
- **860-297-5962** (from anywhere).

TTY, TDD, and Text Telephone users only may transmit inquiries anytime by calling 860-297-4911.

Forms and Publications

Visit the DRS website at **portal.ct.gov/DRS** to download and print Connecticut tax forms and publications.

Notice to Employee

1. For state purposes, an individual may claim only natural dependency exemptions. This includes the taxpayer, spouse and each dependent. Dependents are the same as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year for which the taxpayer would have been permitted to claim had the taxpayer filed such a return.

2. 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*** because:
   (a) Your spouse for whom you have been claiming exemption is divorced or 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.
   (c) You find that a dependent for whom you claimed exemption must be dropped for federal purposes.

   The death of a spouse or a dependent does not affect your withholding until the next year but requires the filing of a new certificate. If possible, file a new certificate by Dec. 1st of the year in which the death occurs.

   For further information, consult the Ohio Department of Taxation, Personal and School District Income Tax Division, or your employer.

3. If you expect to owe more Ohio income tax than will be withheld, you may claim a smaller number of exemptions, or under an agreement with your employer, you may have an additional amount withheld each pay period.

4. A married couple with both spouses working and filing a joint return will, in many cases, be required to file an individual estimated income tax form IT 1040ES even though Ohio income tax is being withheld from their wages. This result may occur because the tax on their combined income will be greater than the sum of the taxes withheld from the husband's wages and the wife's wages. This requirement to file an individual estimated income tax form IT 1040ES may also apply to an individual who has two jobs, both of which are subject to withholding. In lieu of filing the individual estimated income tax form IT 1040ES the individual may provide for additional withholding with his employer by using line 5.

please detach here

Ohio | Department of Taxation

Employee's Withholding Exemption Certificate

T 4
Rev. 5/07

Print full name _____ Social Security number _____

Home address and ZIP code _____

Public school district of residence _____ School district no. _____
(See *The Finder* at tax.ohio.gov.)

1. Personal exemption for yourself, enter "1" if claimed ..... _____
2. If married, personal exemption for your spouse if not separately claimed (enter "1" if claimed) ..... _____
3. Exemptions for dependents ..... _____
4. Add the exemptions that you have claimed above and enter total ..... _____
5. Additional withholding per pay period under agreement with employer ..... $ _____

Under the penalties of perjury, I certify that the number of exemptions claimed on this certificate does not exceed the number to which I am entitled.

Signature _____ Date _____

EMERGENCY CONTACT FORM

In case of an emergency please list anyone you would like us to contact, and with whom you will allow us to share information about your location, situation, and logistical requirements.

Employee Name: _____

Address: _____

Phone: _____

First Contact:

Name: _____

Relationship to Employee: _____

Address: _____

_____

Phone Number: _____ **Cell Phone:** _____

Second Contact:

Name: _____

Relationship to Employee: _____

Address: _____

_____

Phone Number: _____ **Cell Phone:** _____

St. Pauly Textile, Inc.

St. Pauly Textile, Inc. Annual Safety & Sexual Harassment Training

I, _____ have completed my annual safety & sexual harassment training provided by St. Pauly Textile, Inc. By signing this, I certify that I understand the training, will abide by the guidelines set forth, will act in an appropriate and respectful manner, and will report any sexual harassment that I experience or witness to the appropriate manager.

_____

Employee Name

_____

Employee Signature

_____

Date

_____

Trainer Name

_____

Trainer Signature

1067 Gateway Drive · Farmington, NY 14425 · 585-924-7941 · www.StPaulyTextile.com

NEW YORK STATE OF OPPORTUNITY

Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name:

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

Mailing Address:

Phone:

2. Notice given:

☐ At hiring

☐ Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay:

$ _____ per hour

4. Allowances taken:

☐ None

☐ Tips _____ per hour

☐ Meals _____ per meal

☐ Lodging _____

☐ Other _____

5. Regular payday: _____

6. Pay is:

☐ Weekly

☐ Bi-weekly

☐ Other

7. Overtime Pay Rate:

$ _____ per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

8. Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:

☐ I have been given this pay notice in English because it is my primary language.

☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

St. Pauly Textile, Inc.

St. Pauly Textile Lunch Policy

Section 162 of the NYS Labor Law

1. Every person employed in or in connection with a factory shall be allowed at least sixty minutes for the noonday meal.

2. Every person employed in or in connection with a mercantile or other establishment or occupation coming under the provisions of this chapter shall be allowed at least thirty minutes for the noonday meal, except as in this chapter otherwise provided. The noonday meal period is recognized as extending from eleven o'clock in the morning to two o'clock in the afternoon. An employee who works a shift of more than six hours, which extends over the noonday meal period, is entitled to at least thirty minutes off within that period for the meal period.

3. Every person employed for a period or shift starting before eleven o'clock in the morning and continuing later than seven o'clock in the evening shall be allowed an additional meal period of at least twenty minutes between five and seven o'clock in the evening.

4. Every person employed for a period or shift of more than six hours starting between the hours of one o'clock in the afternoon and six o'clock in the morning, shall be allowed at least sixty minutes for a meal period when employed in or in connection with a factory, and forty-five minutes for a meal period when employed in or in connection with a mercantile or other establishment or occupation coming under the provision of this chapter, at a time midway between the beginning and end of such employment.

5. The commissioner may permit a shorter time to be fixed for meal periods than hereinbefore provided. The permit therefore shall be in writing and shall be kept conspicuously posted in the main entrance of the establishment. Such permit may be revoked at any time.

All St. Pauly Textile, Inc employees are supposed to take a 30 minute lunch break daily. All team members are to record that time. Time taken for the lunch is not paid.

_____

Employee Signature

_____

Printed Name

_____

Date

St. Pauly Textile, Inc.

St. Pauly Textile East, Inc. Full Time Employee Benefits Package

Raises: Raise reviews shall occur yearly. Also, *raises may occur when taking on more responsibility.*

Raises will be based upon the following factors

- -Commitment to safety
- -Attendance
- -Positive attitude
- -Look of sheds
- -Team Work

Vacation policy: After one year you will have earned one week of paid vacation per year. After three years, you will have earned two weeks of paid vacation per year.

Sick Days: All employees are allowed two sick days per year beginning after one year of employment.

Medical Benefits: Employees are eligible for partially subsidized medical benefits at 60 days. Our company covers half of the cost of a single plan and part of the family plan. We reimburse 50% of the deductible

Retirement Plan: We provide a SIMPLE IRA retirement plan, with a 3% match eligible at 60 days

_____

Employee Name

_____

Employee Signature

_____

Date

Excellus
LIVE FEARLESS

FOR INTERNAL USE ONLY	
HIOS ID#	78124NY1000169-00
EC	SNH5

Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply to you. Additional instructions are included.

- This application cannot be processed without this information and signatures

Section 1: Employer Group & Benefit Information - To be completed by the Group Administrator

Employer Name

Association/Chamber Name (if applicable)

Group Administrator's Signature (required) Date

Employee Number

Department Number

Medical Information

Medical Group Number (8 digits)

Medical Subgroup Number (4 digits)

Medical Class Number (4 digits)

____/____/____
Medical Effective Date

If enrolling in a Medical plan, who do you need coverage for?

☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

Dental Information

Dental Group Number

Dental Subgroup Number

Dental Class or Package Number

____/____/____
Dental Effective Date

If enrolling in a Dental plan, who do you need coverage for?

☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

Subscriber Status: ☐New Hire ■Rehire ■Open Enrollment ☐Retired ☐COBRA

Medical Plan Selection

SimplyBlue Plus Bronze 4

Dental Plan Selection

■Dental Blue Classic (DI) ☐Dental Blue Options (DJ)
■Dental Other (DE)

Section 2: Subscriber's Information

Last Name

First Name

Middle Initial

Title (e.g., Jr, Sr, III, etc.)

Street Address

City

State

Zip Code

Phone

Birthdate ____/____/____
Gender: ☐Male ☐Female

Social Security # **

Date of Hire/Rehire: ____/____/____

Retire Date: ____/____/____

Marital Status: ■Single ■Married ☐Legally Separated
☐Divorced Marital Status Event Date: ____/____/____

Subscriber's Medicare Number (if applicable)

____/____/____
Part A Effective Date

____/____/____
Part B Effective Date

■Age 65+ ■Disability
■End Stage Renal *

FOR INTERNAL USE ONLY

Section 3: Please indicate the reason for this enrollment or change - To be completed by the Group Administrator

Special Enrollment Opportunity:

☐Change in employment status ☐A move in or out of the service area **Date of Event** ___ /___ /_____
☐Involuntary loss of coverage ☐Former dependent regains eligibility
☐Medicare Eligible ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other _____

Termination of Coverage: See Section 4

☐Canceled - Effective Date: ____ /____ /_____
☐Change to new employer that does not offer insurance ☐Remove Dependent
☐Loss of eligibility through employer ☐Discontinuation of employer coverage
☐Dependent reaches maximum age of coverage ☐Death

☐**COBRA Election**- Effective Date: ____ /____ /_____

Please indicate reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse
☐Disability ☐Dependent Reached Max Age ☐ Other: _____

Demographic Change:

☐Address Change ☐Subscriber Name Change ☐Marital Status Change: ☐Married ☐Divorced
☐Birthdate Change ☐Dependent Name Change ☐Phone Number Change

Section 4: If canceling coverage, who are you canceling coverage for?

☐Subscriber - ☐Medical Cancellation Date ___ /___ /_____ ☐Dental Cancellation Date ___ /___ /_____

☐Dependent(s) - ☐Medical Cancellation Date ___ /___ /_____ ☐Dental Cancellation Date ___ /___ /_____
(List each dependent)

Spouse/DP_____ **Dependent 2**_____ **Dependent 3** _____ **Dependent 4** _____

Why are you canceling coverage?

■Subscriber's request ■Divorce ■Deceased ■Coverage through spouse/domestic partner
■Left Employment ■Loss of eligibility through employer ■Other _____
■Medicare/Medicaid or other coverage ■Discontinuation of employer coverage

Section 5: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child (Separate application form required)
☐Other_____

Last Name (if different) _____ First Name _____ MI ____ Social Security # ** _____

Gender: ☐Male ☐Female Birthdate ___ /___ /_____

Is dependent a full time student over age 19? ☐Yes ☐No
If yes, please provide name of college/university _____ Expected Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ■Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ /___ / Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ■Other_____

Last Name (if different) _____ First Name _____ MI ____ Social Security # ** _____

Gender: ☐Male ☐Female Birthdate ___ /___ /_____

Is dependent a full time student over age 19? ☐Yes ☐No
If yes, please provide name of college/university _____ Expected Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ■Disability ■End Stage Renal *

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_____

Last Name (If different) _____ First Name _____ MI ____ Socia Security # ** _____

Gender: ☐Male ☐Female Birthdate ___ /___ /_____

Is dependent a full time student over age 19? ☐Yes ☐No Expected Graduation Date: ___ /___ /____

If yes, please provide name of college/university _____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____

Medicare Number (if applicable)

Note: Use an additional application if more than four people need coverage.

Section 6: Other coverage information (Required) You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? ☐Yes ☐No

If yes, what type of coverage? ☐Medical ☐Dental

What is the effective date of the other coverage? ☐Medical: ____ /____ /_____ ☐Dental: ____ /____ /_____

What is the name of the other carrier? _____

Are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage end? ____ /____ /_____

Policyholder's name _____ ID# _____

Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

Section 7: Release – You must sign and date this form to be eligible for health insurance.

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ **Date** _____

Please return to P.O. Box 21146 Eagan, MN 55121
If you have questions, please contact your Group Administrator.
Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application

Section 1: Employer Group & Benefit Information
This section should be completed by a Group Administrator. Medical and/or dental group information must be populated. Select who you want to cover on your medical and/or dental plan(s) and indicate the subscriber's status. Select the dental plan your employer offers. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information
This section should be completed by the Subscriber.
**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Section 3: Please indicate the reason for this enrollment or change
Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you must also check coverage type and persons to be covered, and complete the Dependent Information section.

You may be required to provide documentation of certain events.

Section 4: If canceling coverage, who are you canceling coverage for?
If you are canceling coverage, select who you are canceling coverage for and enter the date the coverage is to be canceled. List each applicable dependent to be canceled. Then select your reason for canceling.

Section 5: Information about who you would like coverage for
Please include information about all the people who you would like coverage for.
Use an additional application if more than four people need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.
Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Section 6: Other coverage information (Required)
Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release
Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Excellus BCBS: SimplyBlue Plus Bronze 4

A nonprofit independent licensee of the BlueCross BlueShield Association

Coverage Period: 01/01/2019 - 12/31/2019

Coverage for: Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at www.excellusbcbs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $6,550 Individual/ $13,100 Family; Out-of-Network: $7,500 Individual/ $15,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $6,550 Individual/$13,100 Family; Out-of-Network: $7,500 Individual/ $15,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Costs for premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	No Charge	None
	Specialist visit	No Charge	No Charge	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per contract year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No Charge Blood Work: No Charge	X-Ray: No Charge Blood Work: No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.excellusbcbs.com	Tier 1 (Generic drugs)	No Charge	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription) Preauthorization required. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	No Charge	Not Covered	
	Tier 3 (Non-preferred brand drugs)	No Charge	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	No Charge	No Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge	None
	Inpatient services	No Charge	No Charge	

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge	No Charge	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	No Charge	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	No Charge	No Charge	None
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	40 Visits per contract year limit
	Rehabilitation services	No Charge	No Charge	60 Visits per condition per plan year limit
	Habilitation services	No Charge	No Charge	60 Visits per condition per plan year limit
	Skilled nursing care	No Charge	No Charge	200 Days per contract year limit
	Durable medical equipment	No Charge	No Charge	
	Hospice services	No Charge	No Charge	210 Days per year limit Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	1 Exam per plan year
	Children's glasses	No Charge	No Charge	1 Pair per plan year
	Children's dental check-up	No Charge	No Charge	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$6,550
Coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,550
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,610**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$6,550
Coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$6,550
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$6,610**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$6,550
Coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,930
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,930**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Excellus 165 Court Street
Rochester, NY 14647

ExcellusBCBS.com

Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Health Plan (Product) Effective Date: _____ Average number of hours working weekly _____

I understand that I am eligible to participate in my employer's group health insurance coverage and that my employer is contributing the following amount to the health plan(s) premium:

Product Name: _____

Monthly Contribution Dollar Amount:

Single $_____ Family $_____ Other (amount & tier) $_____ $_____

Product Name: _____

Monthly Contribution Dollar Amount:

Single $_____ Family $_____ Other (amount & tier) $_____ $_____

Please Check All That Apply:

[ ] I waive my employer's group **health** insurance coverage for myself and my dependents (if any).

[ ] I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).

Reason for Waiving Coverage - Please Check One:

[ ] Covered through spouse's employer [ ] Covered through a parent's employer

[ ] Under 65 Retiree covered by previous employer's insurance program

[ ] Other Please specify: _____

Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage

- At the time of my employer's open enrollment.

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete.

Employee Signature: _____ Date:_____

Simple IRA Instructions

Simple IRA Application:

1) Fill out Section 1 (Information about you)
2) Fill out Section 4 (Beneficiary Information)
3) Fill out Section 6 (Spousal Consent Signature) if applicable
4) Fill out Section 7 (Signature and Date)

Direct Account Form:

1) Fill out Section 2 (Primary Account Holder)
2) Fill out Section 4 (Suitability)
3) Fill out Section 5 (Additional Account Holders) if applicable
4) Fill out Section 7 (Account Agreement and Signature)
    a. Initial in 2 Spots
    b. Print, Sign and Date

A copy of your driver's license is required with all applications

JW COLE FINANCIAL

DIRECT ACCOUNT FORM

REP CODE: RBJ

☑ New Account
☐ Account Update
☐ Account Transfer

1. ACCOUNT SETUP

No. of Account Holders: 1 (Owners, Trustees, Custodians, Authorized Individuals, etc.)

Non-Qualified Accounts

☐ Individual

Transfer on Death:
☐ TOD – Individual
☐ TOD – Joint Tenants with Rights of Survivorship
☐ TOD – Joint Tenants in Entirety

Joint:
☐ Tenants with Rights of Survivorship
☐ Tenants in Common
☐ Tenants in Entirety
☐ Community Property

Custodial:
☐ UGMA
☐ UTMA
☐ 529 Plan

Estate:
☐ Administrator
☐ Executor
☐ Personal Representative
☐ Foreign

Qualified Accounts

☐ Traditional IRA
☐ Roth IRA
☐ Rollover IRA
☐ SEP
☑ SIMPLE
☐ IRA Beneficiary Distribution Account
☐ Roth IRA Beneficiary Distribution Acct.
☐ 401(k) Plan
☐ 403(b)/457 Plan
☐ Pension Plan

Entity Accounts

Trust:
☐ Under Agreement
☐ Under Will

Corporation:
☐ C Corporation
☐ S Corporation
☐ Partnership
☐ Unincorporated Association

Limited Liability Company
☐ C Corporation
☐ S Corporation

Other: American Funds Simple IRA

2. PRIMARY ACCOUNT HOLDER

Personal Information

For Tenants in Common, indicate this holder's share: ____%

FULL LEGAL NAME (First, Middle, Last)

DATE OF BIRTH (mm/dd/yyyy)

COUNTRY OF CITIZENSHIP

DAY PHONE

EVENING PHONE

SOCIAL SECURITY NO. / TAXPAYOR ID NO.

E-MAIL

TYPE OF GOVERNMENT-ISSUED ID

ID NUMBER

☐ SINGLE/DIVORCED/WIDOWED
☐ MARRIED

NO. OF DEPENDENTS: ____

STATE/COUNTRY OF ID ISSUANCE

ID EXPIRATION DATE

LEGAL ADDRESS (No P.O. Boxes):

ADDRESS LINE 1

ADDRESS LINE 2

CITY STATE ZIP/POSTAL CODE

COUNTRY

MAILING ADDRESS: ☐ Same as Legal Address

ADDRESS LINE 1

ADDRESS LINE 2

CITY STATE ZIP/POSTAL CODE

COUNTRY

PRIMARY ACCOUNT HOLDER *(continued)*

Employment Status: ☑ Employed ☐ Not Employed ☐ Retired

IF RETIRED OR NOT EMPLOYED PROVIDE SOURCE OF INCOME

OCCUPATION

St. POauly's Textile
EMPLOYER NAME

Farmington NY 14425
CITY STATE ZIP/POSTAL CODE

☐ I am a control person or affiliate or an immediate family/household member of a control person or affiliate of the a publicly traded Company under SEC Rule 144 (this would include, but is not limited to, a director, 10% shareholder, policy-maker officer, and members of the board of directors).

COMPANY NAME COMPANY SYMBOL/CUSIP

☐ I am affiliated with or employed by, a stock exchange, or a member firm of an exchange or Financial Industry Regulatory Authority (FINRA), or a municipal securities dealer If yes, provide name of Member Firm.

MEMBER FIRM NAME

☐ I am a senior foreign political figure or a family member or close relative of a senior foreign political figure.

3. ENTITY ACCOUNT INFORMATION

ENTITY NAME

TAXPAYOR ID NO.

LEGAL ADDRESS *(No P O Boxes)*

ADDRESS LINE 1

ADDRESS LINE 2

CITY STATE ZIP/POSTAL CODE

COUNTRY

COUNTRY OF ORGANIZATION DATE OF INCEPTION *(Required for Trusts)*

ENTITY ID DOCUMENT *(Trust Document, Corporate Resolution, etc)*

MAILING ADDRESS: ☐ *Same as Legal Address*

ADDRESS LINE 1

ADDRESS LINE 2

CITY STATE ZIP/POSTAL CODE

COUNTRY

4. SUITABILITY

Financial Position

Do not include primary residence, personal possessions, household goods, primary vehicles, or non-appraised collectibles in Estimated Net Worth. All values should be joint for married couples. Special expenses include planned, one-time capital expenditures such as a new car, home improvements, education expenses, etc.

Estimated Net Worth: $_____

Annual Household Income: $_____

Investable / Liquid Assets: $_____

Annual Household Expenses: $_____

Federal Tax Bracket

☐ 10% - 15% ☐ 33% - 35%

☐ 25% - 28% ☐ over 35%

Special Expenses

☐ None known at this time

☐ 0 - 2 years $_____

☐ 3 5 years $_____

☐ 6 - 10 years $_____

Description._____

Account Funding Source *(Check all that apply)*

☐ Asset appreciation ☐ Legal/insurance settlement

☐ Business revenue ☐ Sale of assets

☐ Inheritance ☐ Saving from earnings

☐ Transfer ☐ Other: _____

Investment Profile

Please rank your Investment Purpose(s) and Investment Objective(s) for this account in order of importance (#1 being the highest). Please limit the number of choices for each to three (i.e. do not number each and every available purpose or objective).

Investment Purpose:

- ___ Save for education
- 1 Save for retirement
- ___ Save for short-term goal(s)
- ___ Generate income
- ___ Accumulate wealth
- ___ Preserve wealth
- ___ Market speculation
- ___ Other: _____

Risk Tolerance *(select one)*:

- ☐ Conservative
- ☐ Moderately Conservative
- ☐ Moderate
- ☐ Moderately Aggressive
- ☐ Aggressive
- ☐ Combination *(please specify)*: _____

Investment Objectives:

- ___ Preservation of capital
- ___ Income
- ___ Capital appreciation
- ___ Speculation
- ___ Trading profits
- ___ Growth and Income
- ___ Other: _____

Investment Time Horizon *(select one)*:

- ☐ Short (Under 5 years)
- ☐ Intermediate (5- 10 years)
- ☐ Long (Over 10 years)
- ☐ Combination - *(please specify)*: _____

Investment Product Knowledge

Check either None, Limited, Good, or Extensive, based on your knowledge of the following:

	None	Limited	Good	Extensive
CD's	☐	☐	☐	☐
Bonds	☐	☐	☐	☐
Stocks	☐	☐	☐	☐
Options	☐	☐	☐	☐
ETF's	☐	☐	☐	☐
Mutual Funds	☐	☐	☐	☐
Fixed Annuities	☐	☐	☐	☐
Indexed Annuities	☐	☐	☐	☐
Variable Annuities	☐	☐	☐	☐
Fixed Life Insurance	☐	☐	☐	☐
Variable Life Insurance	☐	☐	☐	☐
Alternative Investments (REIT's, BDC's, O I & Gas, Royalties, Limited Partnerships)	☐	☐	☐	☐

Investments/Assets Held Away

Provide total value of investments/assets held away from J.W. Cole Financial and approximate dollar amounts for each category. Please include IRA/ROTH IRA funds under the investment types they are held in.

Checking/Savings	$_____	Fixed Annuities	$_____
Certificates of Deposit	$_____	Indexed Annuities	$_____
Money Markets	$_____	Variable Annuities	$_____
Stocks/ETFs	$_____	Cash Value of Life Insurance	$_____
Mutual Funds	$_____	401(k) or other pension	$_____
Other (specify)	$_____		

Total dollar amount of Investment/Assets Held Away $ _____

5. ADDITIONAL ACCOUNT HOLDERS

Use this section to provide personal information on any additional individuals associated with this account (such as a joint owner, authorized individual, custodian, administrator, additional trustee, additional partner, participant, or 529 Plan Beneficiary).

For Tenants in Common indicate this holder's share:_____%

Personal Information

FULL LEGAL NAME (First, Middle, Last)

DATE OF BIRTH (mm/dd/yyyy) COUNTRY OF CITIZENSHIP

DAY PHONE EVENING PHONE

SOCIAL SECURITY NO. / TAXPAYOR ID NO.

E-MAIL

TYPE OF GOVERNMENT-ISSUED ID ID NUMBER

☐ SINGLE/DIVORCED/WIDOWED NO. OF DEPENDENTS:_____
☐ MARRIED

STATE/COUNTRY OF ID ISSUANCE ID EXPIRATION DATE

LEGAL ADDRESS (No P.O. Boxes):

ADDRESS LINE 1

ADDRESS LINE 2

CITY STATE ZIP/POSTAL CODE

COUNTRY

MAILING ADDRESS: ☐ *Same as Legal Address*

ADDRESS LINE 1

ADDRESS LINE 2

CITY STATE ZIP/POSTAL CODE

COUNTRY

Employer Information and Affiliations

Employment Status: ☐ Employed ☐ Not Employed ☐ Retired

IF RETIRED OR NOT EMPLOYED, PROVIDE INCOME SOURCE

OCCUPATION

EMPLOYER NAME

CITY STATE ZIP/POSTAL CODE

☐ Check this box if you are a control person or affiliate or an immediate family/household member of a control person or affiliate of a publicly traded Company under SEC Rule 144 (this would include, but is not limited to, a director, 10% shareholder, policy-maker officer, and members of the board of directors). If yes, provide name of company.

COMPANY NAME COMPANY SYMBOL/CUSIP

☐ Check this box if you are affiliated with, or employed by, a stock exchange, or a member firm of an exchange or Financial Industry Regulatory Authority (FINRA), or a municipal securities dealer. If yes, provide name of Member Firm

MEMBER FIRM NAME

☐ I am a senior foreign political figure, or a family member or close relative of a senior foreign political figure.

6. Customer Account Pre-Dispute Arbitration Agreement

This agreement contains a pre-dispute arbitration clause. By signing an arbitration agreement, the parties agree as follows:

(A) All parties to this agreement are giving up the right to sue each other in court, including the right to a trial by jury, except as provided by the rules of the arbitration forum in which a claim is filed.

(B) Arbitration awards are generally final and binding; a party's ability to have a court reverse or modify an arbitration award is very limited.

(C) The ability of the parties to obtain documents, witness statements and other discovery is generally more limited in arbitration than in court proceedings.

(D) The arbitrators do not have to explain the reason(s) for their award unless, in an eligible case, a joint request for an explained decision has been submitted by all parties to the panel at least 20 days prior to the first scheduled hearing date.

(E) The panel of arbitrators will typically include a minority of arbitrators who were or are affiliated with the securities industry.

(F) The rules of some arbitration forums may impose time limits for bringing a claim in arbitration. In some cases, a claim that is ineligible for arbitration may be brought in court.

(G) The rules of the arbitration forum in which the claim is filed, and any amendments thereto, shall be incorporated into this agreement

All controversies that may arise between us (including, but not limited to controversies concerning any account, order or transaction, or the continuation, performance, interpretation or breach of this or any other agreement between us, whether entered into or arising before, on or after the date this account is opened) shall be determined by arbitration in accordance with the rules then prevailing of the Financial Industry Regulatory Authority (FINRA) as I may designate. If I do not notify you in writing of my designation within five (5) days after I receive from you a written demand for arbitration, then I authorize you to make such designation on my behalf. I understand that judgment upon any arbitration award may be entered in any court of competent jurisdiction.

No person shall bring a putative or certified class action to arbitration, nor seek to enforce any Pre-Dispute Arbitration Agreement against any person who has initiated in court a putative class action, or who is a member of a putative class action who has not opted out of the class with respect to any claims encompassed by the putative class action until: (i) the class certification is denied; or (ii) the class is decertified; or (iii) the customer is excluded from the class by the court. Such forbearance to enforce an agreement to arbitrate shall not constitute a waiver of any rights under this agreement except to the extent stated herein.

7. Account Agreement and Signature

*Each account holder must initial both statements below

c _____ _____ I have received a copy of J.W. Cole Financial's Privacy Policy and the Business Continuity Plan. I understand the content of each document and have had my questions answered by my J.W. Cole Financial Representative

b _____ _____ I have received all related prospectus(s) for each individual investment that I have chosen, which describes risk factors, fees and surrender charges that may apply. In addition, I understand that all investments bound by this agreement are subject to market fluctuation, investment risk and possible loss of principal.

Account Agreement

I have received J.W. Cole's Customer Identification Program notice and understand that to help the government fight the funding of terrorism and money laundering activities, federal law requires J.W. Cole to obtain, verify, and record information that identifies each person who opens an account.

I have verified the account information within and request J.W. Cole Financial to open the Account in the name(s) set forth below. I understand that the requested account contains a Pre-Dispute Arbitration Agreement stated above. I have read and understand the terms and conditions that will govern my account and agree to be bound by them as currently in effect and as amended from time to time.

ACCOUNT HOLDER NAME (PRINT)	CO-ACCOUNT HOLDER NAME (PRINT)
ACCOUNT HOLDER SIGNATURE DATE	CO-ACCOUNT HOLDER SIGNATURE DATE
Robert Barley, Jr. FINANCIAL ADVISOR NAME (PRINT)	REGISTERED PRINCIPAL NAME (PRINT)
FINANCIAL ADVISOR SIGNATURE DATE	REGISTERED PRINCIPAL SIGNATURE DATE

AMERICAN FUNDS®
from Capital Group

SIMPLE IRA Application

To be completed by employer

St, Pauly's Textile — Name of company
Joseph Howlett — Employer contact
( ) Ext. — Daytime phone

Company address — City — State — ZIP

Check A or B.

A. ☐ New plan (must be accompanied by a copy of the employer's completed and signed *SIMPLE IRA Adoption Agreement*)

B. ☒ Existing plan (provide Plan ID for reference) _____

To be completed by employee

1 Information about you

***Important:** This section must be completed, and the application must be signed in Section 7 before an account can be established*
Please type or print clearly.

SSN of SIMPLE IRA owner — Date of birth (mm/dd/yyyy) — ( ) Ext. Daytime phone

First name — MI — Last — Country of citizenship of SIMPLE IRA owner

Residence address (physical address required — no P.O. boxes) — City — State — ZIP

Email address*

Mailing address (if different from residence address) — City — State — ZIP

* Your privacy is important to us. For information on our privacy policies, visit www.americanfunds.com.

Please mail or fax this form to the appropriate service center.

Indiana Service Center
American Funds Service Company
P.O. Box 6164
Indianapolis, IN 46206 6164
Overnight mail address
12711 N Meridian St
Carmel, IN 46032 9181
Fax (888) 421-4371

Virginia Service Center
American Funds Service Company
P.O. Box 2560
Norfolk, VA 23501-2560
Overnight mail address
5300 Robin Hood Rd.
Norfolk, VA 23513-2430
Fax (888) 421-4371

If you have questions or require more information, contact your financial advisor or call American Funds Service Company at (800) 421-4225.

02/20

AMERICAN FUNDS®
From Capital Group

SIMPLE IRA Application

2 Financial advisor

This section must be filled out completely by a financial advisor.

We authorize American Funds Service Company (AFS) to act as our agent for this account and agree to notify AFS of purchases made under a Statement of Intention or Rights of Accumulation.

Name(s) of advisor(s)	Advisor/team ID number	Branch number	Daytime phone
Robert Barley, Jr.	RBJ		(585) 427-0650 Ext.

Branch address	City	State	ZIP
3445 Winton Place Suite 117	Rochester	NY	14623

Name of broker-dealer firm (as it appears on the Selling Group Agreement)	Signature of person authorized to sign for the broker-dealer
JW Cole Financial	X

3 Investment instructions

For a quick guide to fund names, numbers, minimums and share class restrictions, go to www.americanfunds.com/fundguide. If you do not select a share class, this investment will be placed in Class A shares.

A. Select a share class: ☐ Class A **OR** ☒ Class C (Certain Class C share funds have restrictions.)

B. Provide investment instructions:

☐ Invest my contribution(s) in the American Funds Target Date Retirement Series.® For a list of target date funds, go to www.americanfunds.com/fundguide.

American Funds _____ Target Date Retirement Fund
Year

OR

☒ Invest my contribution as instructed below.

Fund name or number	Percentage* (whole percentages only)
American Balanced	100 %
	%
	%
	%
	%
	%
Total	100 %

*The percentage you elect must equal the minimum of $25 per fund for payroll deduction plans.

Notes:
- To make changes to your fund selections and/or percentage allocations in the future, please notify your employer.
- To rebalance funds or set up an automatic exchange plan, visit our website at www.americanfunds.com.
- To add bank information for future redemption requests, include a completed *Add/Update Bank Information* form.
- The $10 setup fee will be deducted from your account.

AMERICAN FUNDS®
The Capital Group

SIMPLE IRA Application

4 Beneficiary designation

All stated percentages must be whole percentages (e.g., 33%, not 33.3%). If the percentages do not add up to 100%, each beneficiary's share will be based proportionately on the stated percentages. When a percentage is not indicated, the beneficiaries' shares will be divided equally.

Select A for the Custodial Agreement default. For other beneficiary designation options, select B. If no option is selected, the Custodial Agreement default will apply.

A. ☐ **I elect the Custodial Agreement default:** According to the terms of the Custodial Agreement, your default beneficiary will be your spouse. In the event you have no spouse, your beneficiary(ies) will be your children equally. If any child does not survive you, the deceased child's share will go to his or her children (your grandchildren) or, if none, the surviving children equally. If no children or grandchildren survive you, your beneficiary will be your estate.

- **Proceed to Section 5.**

OR

B. ☒ **I designate the following beneficiary(ies):** Your spouse may need to sign in Section 6. If you wish to customize your designation or need more space, attach a separate page.

Primary Beneficiary(ies): If any designated Primary Beneficiary(ies) dies before I do, that beneficiary's share will be divided proportionately among the surviving Primary Beneficiaries.

1. _____ Name (print) ☐ Spouse ☐ Nonspouse ☐ Trust ☐ Other _____ Date of birth (mm/dd/yyyy) _____%

_____ Address _____ City _____ State _____ ZIP _____ SSN

2. _____ Name (print) ☐ Spouse ☐ Nonspouse ☐ Trust ☐ Other _____ Date of birth (mm/dd/yyyy) _____%

_____ Address _____ City _____ State _____ ZIP _____ SSN

Contingent Beneficiary(ies): (*To designate a Contingent Beneficiary, a Primary Beneficiary must be named.*) If no Primary Beneficiary survives me, pay my benefits to the following Contingent Beneficiary(ies). If any designated Contingent Beneficiary(ies) dies before I do, that beneficiary's share will be divided proportionately among the surviving Contingent Beneficiaries.

1. _____ Name (print) ☐ Spouse ☐ Nonspouse ☐ Trust ☐ Other _____ Date of birth (mm/dd/yyyy) _____%

_____ Address _____ City _____ State _____ ZIP _____ SSN

2. _____ Name (print) ☐ Spouse ☐ Nonspouse ☐ Trust ☐ Other _____ Date of birth (mm/dd/yyyy) _____%

_____ Address _____ City _____ State _____ ZIP _____ SSN

5 Decline telephone and website exchange and/or redemption privileges (optional)

Telephone and website exchange and redemption privileges will automatically be enabled on your account unless you decline below. To decline these privileges, read the individual statements and check the applicable box(es).

Note: If either option is declined, no one associated with this account, including your financial advisor, will be able to request exchanges or redemptions by telephone or via the website. Requests would need to be submitted in writing.

Exchanges: I DO NOT want the option of using the telephone and website exchange privilege. ☐

Redemptions: I DO NOT want the option of using the telephone and website redemption privilege. ☐

6 Spousal consent to beneficiary designation — if required

If you are married to the IRA owner and he or she designated a Primary Beneficiary(ies) other than you, please consult your financial advisor about the state-law and tax-law implications of this beneficiary designation, including the need for your consent.

I am the spouse of the IRA owner named in Section 1, and I expressly consent to the beneficiary(ies) in Section 4 or attached.

Name of spouse of IRA owner (print) _____ X _____ Signature of spouse of IRA owner _____ Date ___/___/___ (mm/dd/yyyy)

7 Your signature

I hereby establish an American Funds SIMPLE IRA, appoint Capital Bank and Trust Company℠ (CB&T) as Custodian and acknowledge that I have received, read and agree to the *SIMPLE IRA Custodial Agreement*.

I have read and agree to the terms of the current prospectus(es) of the funds selected in the investment instructions section and consent to the $10 setup fee and the annual custodial fee (currently $10). I understand that any dividends and capital gains will be reinvested for all my fund selections.

I agree to the conditions of the telephone and website exchange/redemption authorization unless I checked the box(es) in Section 5 and agree to indemnify and hold harmless CB&T; any of its affiliates or mutual funds managed by such affiliates; and each of their respective directors; officers; employees; and agents for any loss, expense or cost arising from such instructions once the telephone and website exchange and redemption privileges have been established.

I certify, under penalty of perjury, that my Social Security number in this application is correct. I authorize the registered representative assigned to my account to have access to my account and to act on my behalf with respect to my account. I designate the beneficiary(ies) specified in this application and certify that, if I am married and have not named my spouse as Primary Beneficiary, I have consulted my advisor about the need for spousal consent.

I understand that to comply with federal regulations, information provided on this application will be used to verify my identity. For example, my identity may be verified through the use of a database maintained by a third party. If CB&T is unable to verify my identity, I understand it may need to take action, possibly including closing my account and redeeming the shares at the current market price, and that such action may have tax consequences, including a tax penalty.

Should this application be signed electronically, I acknowledge and agree that CB&T has provided prior approval for the electronic signature and that such electronic signature is valid evidence of my consent to be legally bound by this application and such subsequent terms as may govern this application. The electronically stored copy of this application is considered to be the true, complete, valid, authentic and enforceable record of the application, admissible in judicial or administrative proceedings to the same extent as if the documents and records were originally generated and maintained in printed form. I agree not to contest the admissibility or enforceability of the electronically stored copy of this application.

X _____ Signature of SIMPLE IRA owner _____ Date ___/___/___ (mm/dd/yyyy)

For fax and mailing instructions, see the maps on page 3.

Solstice Enrollment/Change Form

Solstice
P.O. Box 19199
Plantation, FL 33318
Office 1.877.760.2247
Fax 954.370.1701

Effective Date (MM/DD/YYYY)

	/		/	

PLEASE MARK APPROPRIATE BOX

☐ New enrollment ☐ Change of plan ☐ Change of name ☐ Waive
☐ Change of address ☐ Change of dependents ☐ Reinstate Terminated employment

Group, Association, or Employer Name

Group Number

NOTE : PLEASE COMPLETE ALL INFORMATION

SOCIAL SECURITY #	NAME (Last, First, Middle Initial)	DATE OF BIRTH (MM/DD/YYYY)
- -		/ /

ADDRESS / CITY / STATE / ZIP

DATE EMPLOYED (MM/DD/YYYY)	TELEPHONE NUMBER	GENDER	EMAIL ADDRESS
/ /	( ) -	☐ Male ☐ Female	

SELECT YOUR PLAN (Refer to your Schedule of Benefits for plan details)
☐ Dental ☐ Vision ☐ Other (If multiple plan options have been offered, please write in plan selection below)

FAMILY INFORMATION

RELATIONSHIP	NAME (Include last name if different)	SOCIAL SECURITY #	SEX	DATE OF BIRTH (MM/DD/YYYY)	(CHECK ONE)
SPOUSE		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel

Please submit proof of handicapped status for over age dependents. I hereby apply for benefits for which I am eligible as either an employee or association member. If contributions or fees are required, I authorize my employer to deduct such fees from my salary.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I have read and accept the provisions printed above	SIGNATURE	DATE
		/ /

Solstice Health Insurance Company is a licensed Accident and Health Insurance Company under New York Insurance Law Section 1113(a)(3)
SHI-ENR-01-01-NY0914

Solstice

Prepared For St Pauly Textile East

	11025		11029		11015	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Preventive & Diagnostic	100%	100%	100%	100%	100%	100%
Basic Restorative	80%	80%	80%	80%	90%	80%
Specialty Services	80%	80%	80%	80%	90%	80%
Major Restorative	50%	50%	50%	50%	60%	50%
Orthodontia	N/C	N/C	N/C	N/C	N/C	N/C
Annual Maximum	$1,000	$1,000	$1,500	$1,500	$1,500	$1,500
P&D Waiver Saver	Not Included		Not Included		Not Included	
Individual Deductible	$50	$50	$50	$50	$50	$50
Deductible Type	Annual		Annual		Annual	
Orthodontia Lifetime Maximum	N/C	N/C	N/C	N/C	N/C	N/C
Reimbursement Method	MAC	MAC	MAC	MAC	MAC	MAC
Pediatric EHB Rider	Not Included		Not Included		Not Included	
Cleaning Allowance (Prophylaxis)	2 Cleanings		2 Cleanings		2 Cleanings	
Solstice BenefitsBooster	Included		Included		Included	
Implant Coverage	Not Covered		Not Covered		Not Covered	

Proposed Rates Effective 12-1-2018

		11025	11029	11015
2-Tier	Employee Only	$30.33	$35.23	$37.25
	Employee + Family	$85.48	$99.30	$104.98
3-Tier	Employee Only	$30.33	$35.23	$37.25
	Employee + 1	$60.66	$70.47	$74.50
	Employee + 2+	$88.24	$102.50	$108.37
4-Tier	Employee Only	$30.33	$35.23	$37.25
	Employee + Spouse	$60.66	$70.47	$74.50
	Employee + Child(ren)	$68.93	$80.08	$84.66
	Employee + Family	$96.51	$112.11	$118.53

*

Rate Assumptions and Caveats

- *Rates are valid for groups sitused in the 146 3 digit ZIP area. At least 80% of participating employees must reside within or around the ZIP area.*
- *Voluntary rate type requires a minimum of 35% group participation*
- *Participation requirements will be based on 30 benefit eligible employees*
- *Rates assume the Group's SIC Code to be 8399*
- *Rates are only valid on a takeover basis for groups with existing dental coverage.*
- *Solstice reserves the right to adjust the quoted rates should the Group's member to sub ratio exceed 3.0*
- *Rates are valid until the listed effective date and assume a 12 month contract period*
- *Rates include a 10.00% commission load.*
- *Plans including Orthodontia coverage require a minimum of 10 subscriber enrollment applications*
- *The following apply for groups with less than 15 subscribers:*
  - *An ACH/EFT Authorization Form must be completed and automatic ACH/EFT must be the method of payment to avoid an additional service fees*
  - *A NYS45 Form or equivalent employer's quarterly report form must be provided for groups with less than 15 subscribers.*

Solstice Vision Plan IC 4

In-Network Benefits		Plan Design Options
Frequency – Once Every:		**IC 4**
		Designer
Eye Examination inclusive of Dilation (when professionally indicated)		12 Months
Spectacle Lenses		12 Months
Frame		24 months
Contact Lens Evaluation, Fitting & Follow-Up Care		12 Months
Contact Lenses (in lieu of eyeglasses)		12 Months
Copayments		
Eye Examination		$10
Spectacle Lenses		$25
Contact Lens Evaluation, Fitting & Follow-Up Care		$25
Eyeglass Benefit - Frame	Average Retail Value	
Non-Collection Frame Allowance (Retail):	Up to $150	Up to $130 Plus a 20% discount on any overage [1]
Davis Vision Frame Collection[2] (in lieu of Allowance):		
Fashion level	Up to $125	Included
Designer level	Up to $175	Included
Premier level	Up to $225	$25 copayment
Eyeglass Benefit - Spectacle Lenses	Average Retail Value	Member Charges
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	$60-$120	Included
Tinting of Plastic Lenses	$20	Included
Scratch-Resistant Coating	$25-$40	Included
Polycarbonate Lenses (Children [3]/ Adults)	$60-$75	$0 or $30
Ultraviolet Coating	$25-$30	$12
Anti-Reflective (AR) Coating (Standard/Premium/Ultra)	$50-$125	$35 / $48 / $60
Progressive Lenses (Standard / Premium / Ultra[4])	$150-$300	$50 / $90 / $140
Intermediate Vision Lenses	$150-$175	$30
High-Index Lenses	$90-$150	$55
Polarized Lenses	$95-$110	$75
Plastic Photosensitive Lenses	$95-$150	$65
Scratch Protection Plan: Single Vision | Multifocal Lenses		$20|$40
Contact Lens Benefit (in lieu of eyeglasses)		
Non-Collection Contact Lenses: Materials Allowance		Up to $130 Plus a 15% discount on any overage[1]
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Included
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		Up to $60 with an additional 15% discount off any overage
Collection Contact Lenses [2] (in lieu of Allowance): Materials		
- Disposable		4 boxes / multi-packs
- Planned Replacement: up to		2 boxes / multi-packs
- Evaluation, Fitting & Follow-up Care		Included
Medically Necessary Contact Lenses (with prior approval)		
- Materials, Evaluation, Fitting & Follow-Up Care		Included

Out-of-Network Reimbursement Schedule: up to

Eye Examination: $40	Single Vision Lenses: $40	Trifocal Lenses: $80	Elective Contact Lenses $1[illegible]
Frame: $50	Bifocal/Progressive Lenses: $60	Lenticular Lenses: $100	Medically Necessary CL $2[illegible]

Rates for New York Groups

	Voluntary	Employer Paid
Employee Only	$6.92	$5.88
Employee + Spouse	$12.10	$10.29
Employee + Child(ren)	$15.01	$12.76
Employe + Family	$19.02	$16.17

[1] Additional discounts not applicable at Walmart or Sam's Club locations
[2] Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals
[3] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/ 6.00 diopters or greater.
[4] Category includes digital free-form progressive lenses.

One-year eyeglass breakage warranty included

Pre-Enrollment Summary for: St. Pauly Textile, Inc.

Thank you for considering Allstate Benefits for your Supplemental Benefit needs. St. Pauly Textile, Inc. has made this opportunity possible to enable you to add important benefits that can protect you and your family from the financial hardships that often arise from the unexpected events that happen in our lives.

These benefits:

- Are available through the convenience of payroll deduction
- Are paid in addition to any other benefits you may have and are paid directly to you
- Can be designed for Individuals, Spouses and Children
- Are portable...meaning you can keep them even if you change jobs
- Qualify for pre-tax deductions where allowed, thereby reducing your taxable income
- ***Are available with Contingent Guaranteed Issue (CGI) and asks only three questions for life and health coverage's.***
    - Are you actively at work 20+ hours a week?
    - Have you been diagnosed with aids or any aids related illness?
    - In the last 6 months, have you been hospitalized, disabled or had outpatient surgery?

Voluntary Benefit Plan Summaries

Life Insurance

- ✓ **Term Life options up to $150,000**
- ✓ **Coverage for Spouse and Children available**
- ✓ **Policies customized for your needs**
- ✓ **Optional riders to enhance coverage include LTC (UL) Children's Term and more**
- ✓ **Sample Rate for 20 yr Term Policy- Age 40 – non-smoker - $6.00/week prem.= $60,826 Death Benefit**

Accident Insurance

- ✓ **Cash benefits for ON or OFF Job injuries...24/7**
- ✓ **Benefits paid for Hospitalization, ER, Medical Expenses, Specific Injury Benefits, Accidental Death and Dismemberment Benefits, CT Scan and MRI, Surgery, Blood, Surgery, Prosthesis, Physical Therapy, Burns, Skin Grafts and more**
- ✓ **Sample Rate for "Basic Plan"...Individual- $2.40/week...Family- $6.30/week**

Please refer to the specific product brochures for a complete description of the benefits, limitations and exclusions

All Products underwritten by: Allstate Life Insurance Company of New York. This flyer is incomplete without brochure AWD7091NY-2, AWD12580NY-1, AWD7795NY-1, AWD8585NY-3, AWD12662NY-1, AWD6889NY-3 and ABJ17444-WCNY which provide complete descriptions of the benefits, limitations and exclusions

Allstate
You're in good hands

Employee Interest Form

Please complete the following so that we may provide you with information regarding some of the most talked about voluntary insurance programs in the industry today! ***Whether you have a high deductible or a traditional health insurance plan, these benefits may help with the copays and your deductible!***

☐ **Allstate Accident Insurance –** Emergency treatment, follow-up treatment, initial hospitalization, hospital confinement, accidental death, physical therapy plus...much more

☐ **Allstate Life Insurance –** Enables you to tailor coverage for your individual needs and help provide financial security for your family members. Coverage is also extended to your spouse and dependent children.

All plans are available to you with the convenience of payroll deductions

Employee Name_____ **Phone**_____

☐ Please contact me to set up a time to meet
☐ I am not interested

St. Pauly Textile, Inc.

Attendance Policy

1) Overview

All Employees at St. Pauly Textile Inc. are expected to be present for work, on time, every day. Regular attendance and punctuality are important to keep your team and St. Pauly Textile Inc. operating efficiently. Arriving late, being tardy, or absent causes disruptions and negatively impacts the company. St. Pauly Textile Inc. utilizes a point system that is detailed below.

2) Attendance Infractions

a) Absent with calls: 1 Point
b) Absent, no call: 2 Points
c) Tardy: ½ Point
d) Early departure: ½ Point
e) Failure to clock-in or clock-out consistently over a week: ½ Point.

Employees are given a 5 minute grace period to clock-in on the scheduled start time. Employees cannot clock-in more than 15 minutes before their scheduled start time.

If there is a problem clocking-in or clocking-out employees should inform management immediately for a resolution.

All attendance infractions expire 6 months after the date the infraction took place.

A sick or vacation day will be used in place of an absent with a call. A sick or vacation day will not be used for an absence without a call.

You will be considered absent with no call if you have not called in at least 30 minutes before your shift begins. Calling in ahead of time gives the team time to adapt if you are going to be absent.

3) Disciplinary Action for Attendance Infractions

a) 3 Points: Verbal warning

St. Pauly Textile, Inc.

b) 4 Points: Written warning
c) 5 Points: Meeting with manager and 1-3 day suspension
d) 6 Points: Employee is subject to termination

If an employee is absent from work for three or more days, evidence for excusing the absence, such as a doctor's note, must be provided.

If an employee is a no call or no show for three or more consecutive days it will be considered job abandonment, or termination without notice.

Employees may request exceptions for work absences from management. These must be approved on a case by case basis.

4) Excused Absences

a) Funerals
b) Jury Duty
c) Military Duty
d) Bereavement
e) Childbirth
f) FMLA absences
g) ADA absences
h) Medical Appointment
i) Unavoidable Emergencies

Documentation must be provided for all of the above to provide reason for absence within 48 hours.

5) Good Attendance Benefits

An extra vacation day will be rewarded for every 6 consecutive months an employee works without an attendance infraction.

_____

Signature

St. Pauly Textile, Inc.

No Shopping Policy

St. Pauly Employee,

It is against company policy for team members to take donated items unless the items were going to be thrown away. IF a team member does want to take a item, they need to ask a manager before taking it. **Stealing from the company may lead to disciplinary action or termination.**

Es contra la política de la empresa para los miembros del equipo para tomar artículos donados a menos que los artículos iban a ser desechados. Si un miembro del equipo no quieren tomar un tema, tienen que pedir a un administrador antes de tomarlo. **Robar a la empresa puede dar lugar a una acción disciplinaria o terminación.**

_____

Employee Signature

_____

Printed Name

_____

Date

1067 Gateway Drive · Farmington, NY 14425 · 585-924-7941 · www.StPaulyTextile.com

St. Pauly Textile, Inc.

Drug Free Workplace

I, _____ understand that St. Pauly Textile, Inc. has a drug free workplace. I also understand that St. Pauly periodically has random drug testing. If I test positive for drug use, I may lose my job immediately.

_____
Employee Name

_____
Employee Signature

_____
Date

St. Pauly Textile, Inc.

St. Pauly Textile Cyber Security Policy

Our company cyber security policy outlines our guidelines and provisions for preserving the security of our data and technology infrastructure.

This policy applies to all our employees, contractors and anyone who has permanent or temporary access to our systems and hardware. Remote employees must follow all data encryption, protection standards and settings, and ensure their private network is secure.

Confidential Data

Confidential data is secret and valuable. All employees are obliged to protect this data. Confidential data includes, but is not limited to:

- Financial information
- Data of employees, customers, partners, and vendors
- Customer lists (existing and prospective)

Protect Personal and Company Devices

When employees use their digital devices to access company emails or accounts, they introduce a potential security risk to company data. Employees should keep both their personal and company-issued computer, tablet and/or cell phone secure. Ways to secure devices include, but are not limited to:

- Keeping all devices password protected
- Installing antivirus software
- Ensuring devices are not exposed or left unattended
- Installing security updates of browsers and systems as they become available
- Log into company accounts and systems using secure and private networks

Keep Emails Safe

Emails often host scams and malicious software. To avoid virus infection or data theft, we instruct employees to:

- Avoid opening attachments and clicking on links when the content is not adequately explained
- Be suspicious of clickbait titles (ie. Offering prizes, advice, etc.)
- Check email and names of people you receive messages from to ensure they are legitimate
- Look for inconsistencies or give-aways (ie. Grammar mistakes, capital letter, excessive number of exclamation marks, etc.)

If an employee isn't sure that an email is safe, they should delete it without opening.

St. Pauly Textile, Inc.

St. Pauly Textile Cyber Security Policy

Manage Passwords Properly

Password leaks are dangerous since they can compromise the entire company infrastructure. Not only should passwords be secure so they won't be easily hacked, they should also remain secret. For this reason, we advise our employees to:

- Choose passwords that are strong and avoid information that can be easily guessed
- Remember passwords instead of writing them down. If employees need to write their passwords down, they are obliged to keep the paper or digital document confidential and destroy it when their work is done
- Exchange credentials only when absolutely necessary. Do not send passwords to people you do not know or trust
- Change passwords regularly

Additional Measures

To reduce the likelihood of security breaches, we also instruct our employees to:

- Turn off their screens and lock their devices when leaving their desks
- Report stolen or damaged equipment as soon as possible
- Change all account passwords at once when a device is stolen
- Report a perceived threat or possible security weakness in company systems
- Refrain from downloading suspicious, unauthorized or illegal software on company equipment
- Avoid accessing suspicious websites

I have read and understand the guidelines above. I will follow all guidelines and implement any changes that are necessary to be compliant with these guidelines.

_____ _____

Name Date