Impact Labor, LLC

New Hire Employee Checklist

Employee Name _____

Employee # _____

Date of Hire _____

- ☐ ID's
- ☐ PAN
- ☐ W-4
- ☐ State Specific Forms
- ☐ I-9
- ☐ Paycard
- ☐ Payroll Deduction For Uniforms
- ☐ Direct Deposit
- ☐ Background Check
- ☐ Kronos Proxy Card
- ☐ Pay Policy
- ☐ Employee Application
- ☐ Affirmative Action
- ☐ Handbook Acknowledgment
- ☐ Health Insurance Coverage Forms

New Hire File Audit Completed By: _____ Hiring Manager (Please Print)

Contact (Cell): _____

Date: _____

Impact Labor, LLC

Personal Action Notice (PAN)

Social Security # _____

Employee ID _____

Accounting Code _____

First Day Worked _____

☐ New Hire ☐ Position Change

☐ Rehire ☐ Data Change

☐ Transfer

☐ Other _____

Personal Information (Required)		
Last Name:	First Name:	MI:
Mailing Address:	Apt/Lot #:	
City:	State:	Zip:
Phone Number:	Date of Birth:	

Pay Information	
Primary Kronos Job: _____	Proxy Card Number: _____
Choose **ONE** Option Below:	
Option 1: ☐ Straight Hourly: $ _____	**Option 2:** ☐ Hourly + Bonus

Transfer
To _____ From_____ Effective Date: ____/____/____

Filled Out By (Please Print): _____

Signature: _____ Date: _____

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

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, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6 Additional amount, if any, you want withheld from each paycheck	**6** $	
7 I claim exemption from withholding for 2017, 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 lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)
Impact Labor, LLC 7980 N Brother Blvd Memphis, TN 38133		27-0919057

Deductions and Adjustments Worksheet

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

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

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

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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

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

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

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

Form G-4 (Rev. 7/14)

1511004011

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS

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

A. Single: Enter 0 or 1.....[ ]

B. Married Filing Joint, both spouses working:
Enter 0 or 1 .....[ ]

C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 .....[ ]

D. Married Filing Separate:
Enter 0 or 1 .....[ ]

E. Head of Household:
Enter 0 or 1 .....[ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
   Yourself: ☐ Age 65 or over ☐ Blind
   Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300.....$_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

A. Federal Estimated Itemized Deductions..... $_____

B. Georgia Standard Deduction (enter one): Single/Head of Household $2,300
Each Spouse $1,500 $_____

C. Subtract Line B from Line A.....$_____

D. Allowable Deductions to Federal Adjusted Gross Income .....$_____

E. Add the Amounts on Lines 1, 2C, and 2D .....$_____

F. Estimate of Taxable Income not Subject to Withholding .....$_____

G. Subtract Line F from Line E (if zero or less, stop here).....$_____

H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above ..... _____

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

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

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**

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

b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is _____. My spouse's (servicemember) state of residence is _____. The states of residence must be the same to be exempt. **Check here** ☐

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

Employee's Signature_____ Date _____

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

9. EMPLOYER'S NAME AND ADDRESS: **EMPLOYER'S FEIN:**_____

EMPLOYER'S WH#:_____

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

INSTRUCTIONS FOR COMPLETING FORM G-4

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

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

A. Single – enter 1 if your are claiming yourself
B. Married Filing Joint, both spouses working – enter 1 if you claim yourself
C. Married Filing Joint, one spouse working – enter 1 if your claim yourself or 2 if you claim yourself and your spouse
D. Married Filing Separate – enter 1 if you claim yourself
E. Head of Household – enter 1 if you claim yourself

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

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number on Line H here.
Failure to complete and submit the worksheet will result in automatic denial on your claim.

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

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

Line 8:

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

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

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

b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:

1. The servicemember is present in Georgia in compliance with military orders;
2. The spouse is in Georgia solely to be with the servicemember;
3. The spouse maintains domicile in another state; and
4. The domicile of the spouse is the same as the domicile of the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 for 2010 and any year thereafter, the employer should not report any of the wages as Georgia wages on the W-2.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Worksheet for calculating additional allowances. Enter the information as requested by each line. For Line 2D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

Do not complete Lines 3-7 if claiming exempt.

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

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

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

Employer Completes Next Page


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

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

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

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

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Impact Labor LLC

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
7980 N Brother Blvd	Memphis	TN	38133

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

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 expired 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
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		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		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.

Employee ID Number

TransCard Prepaid MasterCard Enrollment Form

I hereby authorize Impact Labor, LLC to deposit my payroll into a TransCard Prepaid Master Card account and to credit or debit my account as necessary to place the correct net payroll amount into my account. I further authorize TransCard to debit or credit my account for transactions initiated by Impact Labor, LLC. Your initial card will be provided free of charge. Any replacement cards will be deducted from your paycheck in the amount of $10.00 per card.

To Be Completed by Employee

Name		
Street Address		Apt #
City	State	Zip
Social Security Number		Date of Birth

I hereby acknowledge receipt of the below mentioned TransCard Prepaid MasterCard for payroll disbursement, Cardholder Agreement and Disclosure, and instructions.

Employee Signature	Date

To Be Completed by Employer

Card Number Issued (please print clearly; must have 16 digits)	Date

Employee ID Number

PAYROLL DEDUCTION AUTHORIZATION AGREEMENT FOR UNIFORMS (t-shirts)

I, _____, at _____,
Print Name Accounting Code or Location

authorize Impact Labor, LLC to deduct the cost of my uniforms (t-shirts)

from my paycheck.

These deductions are being withheld for the following reason: required uniforms.

t-shirt(s) _____x $5.00 = _____.
Number of shirts Total withheld

Important Please circle size - Small Medium Large XL 2XL 3XL

By signing this Payroll Deduction Authorization Agreement, I authorize Impact Labor, LLC to withhold out of my regular earnings the amount specified above for the reason stated above. Once the deduction has been taken from your pay, the shirts will be shipped to your work location and handed out to you by your manager.

_____ _____
Employee Signature Date

Employee ID Number

Authorization Agreement for Direct Deposit of Payroll

I hereby authorize Impact Labor, LLC to initiate Direct Deposit of my payroll and to credit or debit my account as necessary to place the correct net payroll amount into my account as indicated below. I further authorize the depository named on this form to debit or credit to my account the transactions initiated by Impact Labor, LLC.
This authority is to remain in full force and effect until Impact Labor, LLC has received written notification from me of its termination an in such manner as to afford Impact Labor, LLC a reasonable opportunity to act upon it.

Printed Name_____

Social Security Number_____

Signature_____ Date_____

THIS AUTHORIZATION IS NOT VALID UNLESS ACCOMPANIED BY ONE OF THE FOLLOWING:

1) A VOIDED CHECK FROM YOUR CHECKING ACCOUNT.

2) DIRECT DEPOSIT ENROLLMENT FORM FROM THE ACCOUNT YOU CHOOSE TO RECEIVE THE DIRECT DEPOSIT.

PHOTOCOPIES OF A CHECK OR DEPOSIT TICKETS ARE NOT ACCEPTABLE.

Please staple the voided check or attach the direct deposit form from your bank account (where you want your wages to be deposited) to this form below the line and return it to:

Impact Labor, LLC
7980 N. Brother Blvd.
Memphis, TN 38133

(STAPLE THE VOIDED CHECK HERE)

Employee ID Number

NOTICE REGARDING BACKGROUND INVESTIGATION
[IMPORTANT – PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGEMENT]

Impact Labor, LLC ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report obtained with regards to applicants for employment is an investigation into your education and/or employment history conducted by Data Facts, PO Box 4276, Cordova, TN 38088, Phone: 800-264-4110, Fax: 901-685-7351 or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now, and if you are hired, throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

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

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

California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law.

Name_____
Please Print

Social Security Number_____DOB**_____

Current Address_____

City_____/State_____/Zip_____

Drivers License Number_____State_____

Signature_____Date_____

**Date of Birth is being requested in order to obtain accurate retrieval of records.

Employee ID Number

TO: All Impact Labor, LLC Associates
FROM: Impact Labor, LLC Management
RE: Kronos Proxy Card Acknowledgement
DATE: January 10, 2013

In the course of your employment with Impact Labor, LLC, you will be provided a proximity (Proxy) card to be used for the automated recording of time and attendance. With the assignment of this card come expectations; including, but not limited to the following:

1. I understand and acknowledge that I am responsible for using my assigned card for the daily entry of time and activities into the automated system. I understand and acknowledge that I am to clock in prior to performing any work or work-related duties. I understand and acknowledge that I am not to perform any work or work-related duties after I have clocked out. I have been advised that Impact Labor, LLC does NOT allow me to work while not clocked in for work.
2. I understand and acknowledge that I am responsible for the entry of time and activities only for myself and at NO TIME am I authorized to enter time or activities for another person.
3. The first Proxy card will be provided to me; if lost, I am responsible for the $10.00 cost for the replacement of the card.
4. On terminating my employment with Impact Labor, LLC I agree to return my assigned Proxy card. If not returned, I authorize Impact Labor, LLC to deduct the $10.00 cost of the card from my final pay.

By signing this document, I acknowledge my understanding of its content and agree to the terms outlined above. Thank you for choosing Impact Labor, LLC as your employer; we are committed to your well-being and look forward to a strong future together.

_____ _____

Associate (Sign) Date

CONFIDENTIAL

7980 N. Brother Blvd
Memphis, TN 38133
Phone/901.377.5298 Fax/901.377.9307
www.impact-logistics.com

Impact Labor, LLC

Employee ID Number

TO: All Impact Labor, LLC Associates
FROM: Impact Corporate
RE: Pay Policy
DATE: January 10, 2013

As many of you are aware, over the past few months we have been reviewing and updating our Employee Handbook to ensure that we properly communicate with each person employed with Impact Labor, LLC. In so doing, we are also updating our Pay Stubs which you receive weekly to include an hourly wage and bonus based on performance. I want to make you aware that each pay period you will be receiving two documents: an Earnings Statement and a Pay Stub.

The Earnings Statement will identify your gross wages, deductions and withholdings, such as state and federal taxes and your net wages earned.

The Pay Stub identifies in detail your work completed for the pay period and associated pay. Specifically it identifies the following:

1. The name and address of the employer.
2. The pay date and pay period.
3. Hourly rates of pay earned.
4. Total pay for each hourly activity completed.
5. Total pay for regular overtime hours worked.
6. Bonus pay calculation.
7. Overtime calculation on Bonus pay.
8. A detailed breakdown of each container loaded/unloaded.
9. Total earnings for the pay period.
10. Employee information.

If you should have any questions, please do not hesitate to contact your Supervisor or Director, who will address any questions that may arise. I want to thank you for your hard work and commitment to Impact Labor, LLC; you are very much appreciated and we look forward to a strong future together.

_____ _____

Associate (Sign) Date

CONFIDENTIAL

7980 N. Brother Blvd
Memphis, TN 38133
Phone/901.377.5298 Fax/901.377.9307
www.impact-logistics.com

Impact Labor, LLC

impact

An Equal Opportunity Employer

Application for Employment

Please provide complete information to all requests.

Date Application Completed:_____ Location Applied For: _____

Last Name	**First Name**	**Middle Name**	**Social Security Number**
Street address			**Phone Number** ( )
City, State, Zip			
Emergency Contact:	**Do you understand the requirements of the Position you have applied for?** Yes ☐ No ☐ **Can you perform the physical requirements with or without reasonable accommodation?** Yes ☐ No ☐ **Will you work Overtime if needed?** Yes ☐ No☐		
Emergency Phone Number: ( )			
Position Applied For:	**Pay Expected:**		

Only those U.S. Citizens or Aliens who have a legal right to work in the United States are eligible for employment. Can you, upon employment, provide documentation verifying your legal right to work in the United States and your identity? Yes ☐ No ☐

Name & Location of Schools Attended	**Graduated (Yes/No)**	**Type of Degree Awarded**	**Major Area of Study**
High School			
College			
Other			

If you did not graduate from High School, circle the last year of school you completed.

5 6 7 8 9 10 11

List any other education, certifications, or trade skills that you have which relate to this job.

_____

_____

Are you 18 years of age or older? Yes ☐ No ☐

A record of conviction does not necessarily disqualify you from employment consideration. Have you ever been convicted of a felony or misdemeanor, other than traffic violations? Yes ☐ No ☐ If yes, list only convictions and dates: _____

_____

Employment History

Please provide accurate, complete full-time and part-time employment history for your last four positions. Start with your most recent employer.

#1 Co. Name	Telephone ( )
Address	Employed From to
Supervisor's Name	Starting Pay Ending Pay
Your Title	Reason for Leaving

#2 Co. Name	Telephone ( )
Address	Employed From to
Supervisor's Name	Starting Pay Ending Pay
Your Title	Reason for Leaving

#3 Co. Name	Telephone ( )
Address	Employed From to
Supervisor's Name	Starting Pay Ending Pay
Your Title	Reason for Leaving

#4 Co. Name	Telephone ( )
Address	Employed From to
Supervisor's Name	Starting Pay Ending Pay
Your Title	Reason for Leaving

IMPORTANT-READ CAREFULLY BEFORE SIGNING

I certify that the information provided in this Application for Employment is true, correct and complete. If employed, any misstatement or omission of material fact on this application will result in my immediate dismissal. I understand and agree that the fact that Impact Labor, LLC has or has not made an investigation or the fact that I performed my work satisfactorily for any period of time prior to this termination, shall not constitute a waiver, abandonment or bar of the right of Impact Labor, LLC to take such disciplinary action. I authorize all persons, schools, companies, corporations, credit bureaus, government agencies, or any other party to release information concerning my background which may include, but is not limited to, criminal, credit, driver's records, so long as not prohibited by law and the requests are job related.

I further agree to submit to alcohol and /or drug screening tests, if requested of me, at any time prior to (only drug screens will be administered pre-employment), or during my employment in accordance with applicable law, and I further understand and consent to the results of said tests being communicated to Impact Labor, LLC and to my worksite employer. I further understand that no one, other than the President of Impact Labor, LLC in writing, has the authority to enter into an employment agreement with me that differs from that which is outlined here, and that if I should become employed by Impact Labor, LLC that the employment relationship is "at will" and can be terminated by either party without cause.

I further understand that this application for employment will remain "active" for thirty (30) days from today's date. If I still desire a position with Impact Labor, LLC, it will be my responsibility to fill out a new application and file it with Impact Labor, LLC after that period expires.

Signature of Applicant_____ Date_____

Affirmative Action

Voluntary Information

It is the policy of this organization to provide equal employment opportunity to all qualified applicants for employment without regard to race, color, religion, national origin, sex, age, veteran status or disability. Various agencies of the government require employers to invite applicants to identify themselves as indicated below.

COMPLETION OF THIS FORM IS VOLUNTARY AND IN NO WAY AFFECTS THE DECISION REGARDING YOUR APPLICATION FOR EMPLOYMENT. THIS FORM IS CONFIDENTIAL AND WILL BE MAINTAINED SEPARATELY FROM YOUR APPLICATION FORM. YOU COOPERATION IS APPRECIATED.

Please Print

Referral Source

☐ Walk In ☐ Government Employment Agency ☐ Private Employment Agency

☐ Employee ☐ Relative ☐ School

☐ Advertisement-Source_____ ☐ Other_____

Name of Person who referred you (if applicable) _____

Name:_____ Date:_____

Address:_____

Telephone Number:_____

Position Applied For: (List Only One)_____

☐ Male ☐ Female

Please Check One of the Following Equal Employment Opportunity Identification Groups:

☐ White (Not of Hispanic Origin)
☐ Hispanic
☐ American Indian/Alaskan Native
☐ Black (Not of Hispanic Origin)
☐ Asian or Pacific Islander

For Administrative Use Only

Position(s) Applied For ☐ Available ☐ Not Available

Other Positions Considered For _____

Hired ☐ Yes ☐ No

Position Hired For _____ Date of Hire ____/___/_____

From the EEO Job Classification Listed Below, Which One Best Describes the Position Filled?

☐ Officials & Managers ☐ Sales Workers ☐ Operatives (Semi-Skilled)

☐ Professionals ☐ Office & Clerical ☐ Laborers (Unskilled)

☐ Technicians ☐ Craft Workers (Skilled) ☐ Service Workers

Completed By: _____ Date: ___/___/_____

Employee ID Number

HANDBOOK ACKNOWLEDGMENT FORM

I acknowledge that a copy of this Handbook was made available to me at the local Impact office and through Impact's intranet site: http://www.impact-logistics.com/gaemployeehandbook.pdf

I understand that I am responsible for knowing and adhering to the policies set forth in the Handbook during my employment with Impact. I understand that the policies contained in the Handbook are not intended to create any contractual rights or obligations, with the exception of Impact's at---will employment and arbitration policies. I further understand that Impact reserves the right to amend, interpret, modify, or withdraw any portion of this Handbook at any time. I understand and agree that if the terms of this Acknowledgment are inconsistent with any policy or practice of Impact now or in the future, the terms of this Acknowledgment shall control.

I further understand and agree that my relationship with Impact is "at will," which means that my employment is for no definite period and may be terminated by me or by Impact at any time and for any reason with or without cause or advance notice. I also understand that Impact may demote or discipline me or alter the terms of my employment at any time at its discretion, with or without cause or advance notice. I understand that no policy, statement, conduct, or action on the part of Impact or any company personnel may alter or waive the at---will nature of my employment at any time or under any circumstances. I understand that in the absence of a writing signed by me and by the President or Chief Operating Officer, which expressly provides for employment for a specified term, no policy, practice, procedure, statement, or action of or any individual at may alter, modify, or waive the at---will nature of employment with in any way or at any time.

I further understand that in the event of a dispute arising between Impact and me regarding my employment or termination from employment, such dispute will be resolved in accordance with the arbitration provisions set forth in the separate Mutual Agreement to Arbitrate Claims, and without a jury trial in the event I pursue litigation. I further understand that both Impact and I expressly waive any constitutional or statutory right Impact or I may possess to have employment---related disputes decided in a court of law or equity before a jury.

Finally, I agree that this Acknowledgment contains a full and complete statement of the agreements and understandings that it recites, and I agree that this Acknowledgment supersedes all previous agreements, whether written or oral, express or implied, relating to the subjects covered in this Acknowledgment.

_____ _____

Employee Signature Date

EMPLOYEE COPY

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Ashley Yarbro @ (901) 377-5298.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

EMPLOYEE COPY

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Impact Labor, LLC		4. Employer Identification Number (EIN) 27-0919057
5. Employer address 7980 N Brother Blvd		6. Employer phone number (901) 377-5298
7. City Memphis	8. State TN	9. ZIP code 38133
10. Who can we contact about employee health coverage at this job? Ashley Yarbro		
11. Phone number (if different from above) (901) 377-5298	12. Email address ayarbro@impact-logistics.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    FULL-TIME ACTIVE EMPLOYEES
    (WORKING AT LEAST 130 HOURS PER MONTH FOR 3 CONSECUTIVE MONTHS.)
    Note: There is a 90 day waiting period before health insurance coverage can begin
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

EMPLOYEE COPY

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COPY

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Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

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You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Ashley Yarbro @ (901) 377-5298.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

I have received a copy of this notice.

Employee Signature: _____ Date: _____

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

EMPLOYER COPY

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7. City Memphis	8. State TN	9. ZIP code 38133
10. Who can we contact about employee health coverage at this job? Ashley Yarbro		
11. Phone number (if different from above) (901) 377-5298	12. Email address ayarbro@impact-logistics.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    FULL-TIME ACTIVE EMPLOYEES
    (WORKING AT LEAST 130 HOURS PER MONTH FOR 3 CONSECUTIVE MONTHS.)
    Note: There is a 90 day waiting period before health insurance coverage can begin
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

I have received a copy of this notice.

Employee Signature: _____ Date: _____

EMPLOYER COPY

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

I have received a copy of this notice.

Employee Signature: _____ Date: _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)