7 W. 45th Street, Suite 1701 New York, NY 10036
(212) 683-2300 office
(800) 490-8017
www.networkesc.com

Employment Onboarding Package - 2024

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ Desired Salary: **$** _____

Position Applied for: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address:

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: ______________________ Relationship: ______________

Company: ______________________ Phone: ______________

Address: ______________________

Full Name: ______________________ Relationship: ______________

Company: ______________________ Phone: ______________

Address: ______________________

Previous Employment

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary:**$** ______________ Ending Salary:**$** ______________

Responsibilities: ______________________

From: ______________ To: ______________ Reason for Leaving: ______________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary:**$** ______________ Ending Salary:**$** ______________

Responsibilities: ______________________

From: ______________ To: ______________ Reason for Leaving: ______________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary:**$** ______________ Ending Salary:**$** ______________

Responsibilities: ______________________

From: ______________ To: ______________ Reason for Leaving: ______________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

NETWORK TEMPS, INC.
Employee Direct Deposit Enrollment Form

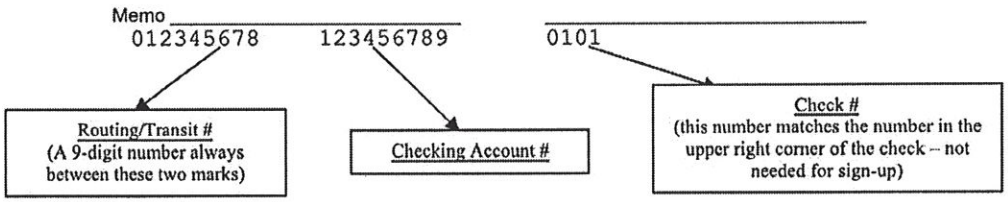
Payroll Manager – Please complete this section and send a copy to ADP for enrollment. (Please print.)

Company Code: _____ Company Name: _____ Employee File Number: _____

Payroll Mg. Name: _____ Payroll Mgr. Signature: _____

To enroll in Full Service Direct Deposit, simply fill out this form and give it to your payroll manager. Attach a voided check for each checking account – not a deposit slip. If depositing to a savings account ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you get paid correctly.

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.



Important! Please read and sign before completing and submitting.

I hereby authorize my employer (hereinafter "Company") to deposit any amounts owed to me by initiating credit entries to my accounts at the financial institutions (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Company to my accounts. In the event that Company deposits funds erroneously into my account, I authorize Company to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such time and in such manner as to afford Company and Bank reasonable opportunity to act on it.

Employee Name: _____ Social Security #: _____

Employee Signature: _____ Date: _____

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form. Make sure to indicate what kind of account, along with amount to be deposited if less than your total net paycheck.

1. Bank Name/City/State: _____

   Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

   Checking Savings Other I wish to deposit: $ _____ or Entire Net Amount

2. Bank Name/City/State: _____

   Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

   Checking Savings Other I wish to deposit: $ _____ or Entire Net Amount

3. Bank Name/City/State: _____

   Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

   Checking Savings Other I wish to deposit: $ _____ or Entire Net Amount

Attention Payroll Manager:
Employee must keep each original employee enrollment form on file as long as the employee is using FSDD, and for two years thereafter.

EMPLOYEE CONDUCT

Network Temps, Inc. believes in the highest standards of conduct. As an integral member of the Network Temps. Inc. team, you are expected to accept certain responsibility, adhere to acceptable business principles in matters of conduct and exhibit a high degree of personal integrity at all times.

Listed below are most, but not all, of the rules and regulations of Network Temps, Inc. Types of behavior and conduct that Network Temps, Inc. considers inappropriate and which could lead to corrective action/disciplinary action, up to and including termination of employment include:

1. Falsifying employment or other Network Temps, Inc. business records
2. Violating the anti-discrimination and/or anti-harassment policy
3. Establishing a pattern of excessive absenteeism orchard illness
4. Engaging in unauthorized use of supplies for personal purposes
5. Reporting to work intoxicated or under the influence of non-prescribed drugs
6. Illegally manufacture, use, possession, sale or distribution of drugs or alcohol in the workplace
7. Fighting or using obscene, abusive, or threatening language or gestures
8. Theft or inappropriate removal or possession of property from co-workers
9. Possession of dangerous or unauthorized material s, such *as* explosives or firearms, on Network Temps, Inc. premises or while on Network Temps, Inc. client premises
10. Disregarding safety. Health or security regulations
11. Engaging in insubordination or other d disrespectful conduct
12. Displaying boisterous or disruptive activity in the workplace
13. Negligence or improper conduct leading to damage of employer owned tenant owned property
14. Unsatisfactory performance or behavior
15. Violation of any personnel policies established by Network ESC a Division of Network Temps, Inc.

If your performance, work habits, overall attitude, conduct, or demeanor becomes unsatisfactory as determined by Network Temps. Inc. (In its sole discretion), based on violations either of the above or any other Network Temps, Inc policies. Rules or regulations, you will be subject to disciplinary action, up to and including termination. All employees are reminded that notwithstanding the above, they are employed "at will" and may be terminated without cause or notice at any time.

CONFIDENTIALITY

The protection of confidential business information is vital to the interests and success of Network Temps, Inc. Such confidential information includes, but is not limited to: compensation data, customer lists and related information, financial information, marketing strategies, or business proposals. Any employee who misappropriates for his or her own use or discloses confidential information to other persons, organizations or entities, will be subject to disciplinary action (up to and including immediate termination) and legal action, regard less if the disclosure of the confidential information provides a benefit to the employee.

Confidential information may be exchanged among company employees on a need to know basis in connection with regular business duties. Any employee who is not certain whether someone is authorized to receive certain confidential information, that employee should immediately consult with Joe Giambo to discuss the matter before any such disclosure is made.

Date: _____

Employee:_____

EQUAL EMPLOYMENT OPPORTUNITY

Network Temps, Inc. adheres to the principles of Equal Employment Opportunity in accordance with federal, state, and local laws regarding discrimination in employment to all qualified individuals.

Network Temps, Inc. provides equal. Employment opportunities regardless of race, color, creed, national origin, ancestry, religion, sex, age, disability, marital status, citizenship, sexual orientation, military status, and any other legally protected status.

This equal opportunity policy applies in all phases of employment at Network Temps, Inc. including but not limited to, recruiting, hiring, and training. Promotion, demotion, discipline, rate of pay or other compensation and benefits, transfer, lay-offs and termination.

ANTI-HARASSMENT / DISCRIMINITATION POLICY

Network Temps, Inc. is committed to providing a work environment free of unlawful harassment and discrimination. Network Temps, Inc.'s policy prohibits harassment and discrimination based on all legally protected status. Any such harassment or discrimination is unlawful. In keeping this commitment, Network Temps. Inc., will not tolerate harassment or discrimination of any employee by anyone, including, but not limited to, supervisors, management, co- workers. and tenants. Vendors, clients or customers.

COMPLAINT PROCEDURES FOR HARASSMENT / DISCRIMINATION CLAIMS

Anyone who feels that he or she has been subjected to unlawful harassment or discrimination (sexual or
otherwise) should immediately provide a complaint, preferably written to Joseph Giambo or any supervisor if you feel more comfortable doing so. All complaints should provide details of the incident or incidents, including dates
of occurrences, names of the individual(s) involved and names
of any witness(s).

Every report of perceived harassment and discrimination will be promptly and thoroughly investigated and reviewed by, Joseph Giambo, CEO.

Any employee who has been determined by Network Temps Inc. as having engaged in harassing and/or discriminatory conduct may be held personally liable for his or her actions. For employees who make false and/or malicious accused ions or who otherwise abuse this policy, there will be repercussions, up to and including termination which will not constitute retaliation.

MEMO: Policies and Procedures

Job Assignments: On the first day of your assignment, please check in with your Recruiter. It is your responsibility to notify us if you are going to be late or unable to report to work. Please give us as much advance notice as possible. For your convenience, please call our office and leave a message.

All employees are required to have a phone or access to one. Your appearance must be neat and you must be ready to work. Regular and prompt attendance is an essential function of every job with Network Temps, Inc. Payroll is processed every Friday for hours worked the prior week.

Timesheets: Timesheets are the responsibility of the employees. Please fax your approved timesheet to 800-490-8017 or email to staff@networkesc.com. Timesheets are due Monday at 12:00 pm. If you are unable to provide your timesheet by this time, please contact Elvin Molina, Payroll Coordinator at 212-683-2300.

Overtime: All work performed in excess of 40 hours per week will be paid at time and half your regular hourly y rate. You are to work overtime only if the client requests and approves such work. Temporary staff working with the HHC are not allowed to work over 40 hours per pay period.

Vacation: Temporary employees do not receive vacation or paid days off. However, the temporary employee is allowed to take the time off, *without pay*, if he/she is ill or has other personal circumstances that require the time off.

Conversion to Full-Time by Client: If a company you are assigned to wants to hire you, please notify Network Temps, Inc., the company/client may screen you before an offer is made. Conversion to full-time employment. is not guaranteed by Network ESC, Inc. or the company/client.

Medical and Annual Physicals: All temporary employees working with healthcare clients are required to complete a full medical examination before they are onboarded and once every year. The initial cost for the exam can range from $195.00 to $550.00. Network ESC will cover the initial cost, however when the assignment begins Network ESC will deduct $30.00 towards the balance every week until the balance is completely paid. You may also choose to use your own personal physician.

If you are injured on the job while employed for Network Temps, Inc. You must notify Network Temps, Inc. office immediately. You must also notify your on-site supervisor at the job site where you are working. Be prepared when notifying the supervisor to give details of the accident, exact time and place, and a list of witnesses. This information must also be provided to Network Temps, Inc. within 24 hours. In the event of an accident where medical care is necessary, we will follow instructions on your Emergency Contact form on file.

Signature: _____

Name: _____

Date: _____

DISCLOSURE AND CONSENT FOR PROCUREMENT OF A CONSUMER AND INVESTIGATIVE CONSUMER REPORT AND RELEASE AUTHORIZATION

I understand that regarding my application for employment and/or ongoing employment an investigative consumer report will be requested from time to time. This investigative consumer report may contain information as to my character, general reputation. This investigative consumer report may include, but is not limited to: a criminal background history, verification of current and previous employment, verification of educational credentials, professional reference verification, credit report, and motor vehicle report. The investigative consumer report will be requested from PointHR Inc. (www.pointhr.com), a third-party pre-employment background investigation company.

I understand that according to the Fair Credit Reporting Act, prior to taking an adverse action based, in whole or in part, on the information contained in the consumer report, a copy of the consumer report as well as a written summary of my rights under the Fair Credit Reporting Act will be provided to me. Upon written request, within a reasonable period of time after my receipt of this disclosure, a complete and accurate disclosure of the nature and scope this investigative consumer report will be made to me. This disclosure shall be made inwriting no later than five days after the date on which the request for such disclosure was received or such report was first requested, whichever is later.

The information requested will be used in compliance with the Fair Credit Reporting Act, the Federal Americans with Disabilities Act (ADA) and/or any other applicable federal or state laws. Furthermore: I understand that if I am denied employment because of information contained in whole or in part, in my consumer report I have the right to be notified and given the name and address of the agency or source that provided the information.

I hereby authorize, without any reservation, any law enforcement agency, school, employer, reference; information service bureau, institution, or insurance company contacted by PointHR, Inc. or its agents, to furnish the information described in Section I.

I understand that a FAX or photographic copy of this release shall be valid as the original.

I hereby release the agents and employers and all other persons, agencies, and entities providing information or reports about me from any and all liability arising out of the request for or release of any of the above-mentioned information or reports.

I have read and understand this Disclosure and Consent form. By my signature below, I consent to the release of a consumer and/or investigative consumer report, as defined above, in conjunction with my application for employment or ongoing employment.

I understand that my consent will apply throughout my employment, to the extent permitted by law

Signed_____

Printed Name_____

Date_____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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 with no other entries on the form; 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 territories 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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

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

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

Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Commuter Benefits Participation Form

Under NYC's Commuter Benefits Law, certain employers must offer commuter benefits to existing full-time employees beginning January 1, 2016 or four weeks after an employee begins full-time work, whichever is later. For more information, please call 311 or visit nyc.gov/commuterbenefits to read Frequently Asked Questions about the Commuter Benefits Law.

Note to Employees:
Your employer is required by law to offer you a commuter benefits program; however, your participation is voluntary. You may decline to enroll in the program, or you may cancel your participation at any time. You may also choose to enroll in the program at a later date.

EMPLOYER INFORMATION	
Employer Name	
Address	
City/State/ZIP Code	
Phone Number	
EMPLOYEE INFORMATION	
Name (First/Middle/Last)	
Address	
City/State/ZIP Code	
Phone Number	
Email Address	
Date of Hire	

I, _____, (*Employee's printed name*) ☐ **Accept** ☐ **Decline** my employer's offer to use pre-tax income to pay for qualified transportation benefits to the extent permitted under federal law.

_____ _____
Employee's Signature Date

If you have questions about your employer's obligations under NYC's Commuter Benefits Law or to report non-compliance, please contact the Department of Consumer Affairs (DCA) at nyc.gov/commuterbenefits, email commuterbenefits@dca.nyc.gov, or contact 311 (212-NEW-YORK outside NYC).

Updated 1/2016

Network Temps, Inc.

DBA Network ESC

7 West 45th Street- Suite 1701

NY, NY 10018

212-683-2300

December 31, 2023

Dear Valued Employees,

Our current health benefits, Oscar Bronze Plan will be renewed as of January 01, 2024.

All Employees are eligible after ninety days of continuous employment.

Your contribution will be 8.39% of your annual income for an individual. If you are interested to add your spouse and or child/children, you will have to pay the additional costs.

Please be aware that the deductible is $7,300.00 which means you will have to pay the first $7,300.00.

After your deductible the plan pays for covered services.

Attached is the description of the benefits from our carrier, Oscar. If you wish to enroll, please complete the application. if you are not interested, please complete the waiver and indicate the reason for refusing coverage.

Feel free to contact me with any questions.

Below are the current monthly rates:

Single-$787.06

Couple-$1,574.14

Parent with Child/Children-$1,338.01

Family-$2,243.14

Thank You

Maltie Pooran

CFO

oscar

New York 2023 Employee

Enrollment Application/Change Request

Instructions: With the exception of Section A, You (the employee) must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Please complete this form in blue or black ink and submit to your employer when complete.

Section A: Information provided by your employer (to be completed by employer)

Employer name	Employer group ID (ex: BIZ12345678)
X	X

Employee's work address		
City X	State	ZIP code

Employee's status (check all options that apply):
X

☐ Active ☐ Union ☐ Non-union
☐ Hourly ☐ Salary ☐ Other (please explain):

Employee's class	Date of hire (mm/dd/yyyy)	Hours worked per week

Section B: Application type

Application type

☐ New application ☐ Change benefits plan ☐ Information update (name, address, etc.)
☐ Add/remove a dependent ☐ Termination

Application reason

☐ Open enrollment ☐ New hire ☐ Rehire
☐ COBRA ☐ New York State Continuation ☐ Qualifying Life Event
☐ Other (please explain):

If you selected COBRA or New York State Continuation as the application reason above, please select one of the following qualifying life events:

- ☐ Left employment
- ☐ Death
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status
- ☐ Medicare entitlement
- ☐ Reduction in hours

Continuation qualifying event date (mm/dd/yyyy):

If you selected Qualifying Life Event as the application reason above, please select one of the following applicable qualifying life events:

- ☐ Loss of coverage*
- ☐ Marriage
- ☐ Birth
- ☐ Adoption*
- ☐ Court-ordered dependent addition*
- ☐ Moved to service area*

Other qualifying event date (mm/dd/yyyy):

* indicates that appropriate documentation must be submitted along with this form to be eligible for coverage.

Section C: Member information

Instructions: The below information must be completed for the subscriber and any additional family members to be covered. An eligible dependent may be your spouse, domestic partner (if this option is chosen by your employer), your children, your spouse's children or your domestic partner's children (if applicable). *Please attach a copy of the form below to account for more than two children.*

Coverage of a child dependent will continue to the end of the calendar month in which the child turns age 26 unless:

- He or she qualifies as a disabled person (if you have a disabled dependent, please call us at (855) 672-2784 to request a disabled dependent form).
- Your employer has chosen extended dependent coverage for adult dependents through age 29 and your dependent qualifies.
- Your dependent qualifies for and enrolls in the Young Adult Option, which extends coverage for young adults through age 29.

	Employee	Spouse	Child	Child 2
Full name				
Social security number	☐ Not available	☐ Not available	☐ Not available	☐ Not available
Check all that apply:		☐ Domestic partner ☐ Employee of this business	☐ Disabled ☐ Young adult ☐ Employee of this business	☐ Disabled ☐ Young adult ☐ Employee of this business
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)				

For the section below, if all members share the same details - only fill out the first column. However, if there are differences or if a dependent is enrolling as a Young Adult, please fill out the other respective columns.

Address line 1				
Address line 2 (optional)				
City x				
State				
ZIP code x				
County				
Phone (xxx) xxx - xxxx				
Email				

On the day your coverage begins, if you or any of your family members will be eligible or covered by Medicare or other coverage fill out the section below.

Eligible for Medicare	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:

Medicare coverage (check appropriate box and list effective date and Medicare ID number)	☐ Part A: ☐ Part B: ☐ Part C: ☐ Part D: ID number:	☐ Part A: ☐ Part B: ☐ Part C: ☐ Part D: ID number:	☐ Part A: ☐ Part B: ☐ Part C: ☐ Part D: ID number:	☐ Part A: ☐ Part B: ☐ Part C: ☐ Part D: ID number:
Other health coverage (check appropriate box and list coverage dates, carrier name and Policy number)	☐ Individual ☐ Group Start date: End date: Carrier name: Policy number:	☐ Individual ☐ Group Start date: End date: Carrier name: Policy number:	☐ Individual ☐ Group Start date: End date: Carrier name: Policy number:	☐ Individual ☐ Group Start date: End date: Carrier name: Policy number:

Section D: Choose your plan

Only a selection of these plans have been selected as options by your employer - check with them for details.

All plans below include pediatric dental coverage.

- ☐ Circle Platinum $0 Option 1
- ☐ Circle Platinum $0 Option 2
- ☐ Circle Gold $0
- ☐ Circle Gold $1000
- ☐ Circle Gold $1250
- ☐ Circle Gold $2000
- ☐ Circle Silver $0
- ☐ Circle Silver $3000
- ☐ Circle Silver $3250 HSA
- ☐ Circle Silver $5000
- ☐ Circle Bronze $4500
- ☐ Circle Bronze $5400 HSA
- ☐ Circle Bronze $7300

Section E: Terms, conditions, and authorizations

Please read this section carefully before signing the application

Eligible Employee means:
An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer, who meets the definition of "employee" under New York State and Federal laws, and approved by Oscar as of the effective date. Employment must be verifiable from state or federal wage tax reports;

An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days;

Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or

An employee, who is eligible for continued coverage under New York State or Federal laws.

Eligible Dependent means:
Your spouse, or child age 26 or younger, including a newborn, natural child, or a child placed with You for adoption, a stepchild or any other child for whom You have legal guardianship or court ordered custody. The age limit for coverage of a child is (1) age 26 unless the Employer has chosen extended dependent coverage and the dependent qualifies, or (2) You or the dependent have purchased a rider to extend coverage for young adults through age 29 and Your dependent is eligible. Coverage for children will end on the last day of the month in which the children reach age 26, or age 30 if applicable.

An unmarried child (at any age during initial or continued enrollment), who is incapable of self-sustaining employment because of mental retardation, mental illness, developmental disability, or physical incapacity that began prior to the child reaching the age limit for coverage. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if You provide proof of handicap and dependence at the time of enrollment. You may be asked to provide a physician's certification (HAC 506) of the dependent's condition.

W-9 Certification:
As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

In signing this, I represent that:
I am an Eligible Employee (as defined above), and I am requesting coverage for myself and all Eligible Dependents (as defined above) listed and authorize my Employer to deduct any required contributions for this insurance from my earnings.

I understand all benefits are subject to conditions stated in the Group Contract and coverage documents.

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

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.

Applicant signature	Sign here	Date (mm/dd/yyyy)
X.....		

oscar

Employee Waiver Form

You, the employee, must complete this waiver (if eligible but declining or waiving coverage). You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your waiver. Please complete this form in blue or black ink, and submit this to your employer when complete.

Employer name x	Employer group number (if available) x

Section B: Employee information

Employee first name x	M.I. x	Last name x	
Social Security Number x	Gender ☐ Male ☐ Female		Date of birth (mm/dd/yyyy)
Phone number x		Email address	

Section C: Waiver / declining coverage

Reason(s) for declining coverage (please check all that apply):

- ☐ Covered by a spouse's / domestic partner's coverage
- ☐ Covered by a parent's / guardian's group coverage
- ☐ Enrolled in individual insurance
- ☐ Enrolled in another carrier's group plan sponsored by this employer
- ☐ Enrolled in Medicare, Medicaid, or Veterans Affairs coverage
- ☐ I elect not to have coverage
- ☐ Other reasons (please explain):

Carrier

Policy number

If you chose Medicare / Medicaid / Veterans Affairs as your reason for declining coverage, please specify one below:

☐ Medicare ☐ Medicaid ☐ Veterans Affair coverage

Policy number

Section D: General agreement

Please read this section carefully, and please sign only if declining coverage:

I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. By waiving group medical coverage (unless employee and/or dependents have group medical coverage elsewhere) I acknowledge that my dependents and I may have to wait until the next open enrollment to be enrolled in this group's medical plan unless I qualify for special open enrollment.

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.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Oscar at (844) 567-2272.

Applicant signature Sign here	Printed name	Date (mm/dd/yyyy)

TRANSITCHEK® COMMUTER
Employee Enrollment Form

TransitChek® is an IRS-approved commuter benefits program that lets you save money by paying for your commute by transit or eligible vanpools with tax-free dollars (see limits below). You are eligible to use up to the IRS allowable amount, tax-free.

To enroll and begin saving, follow the step-by-step instructions below.

Return this form to your company's TransitChek Program administrator by: _____

1 SELECT TRANSPORTATION

How do you commute to work? Check all that apply.

- ☐ Bus
- ☐ Subway
- ☐ Commuter Rail / Light Rail
- ☐ VanPool/UberPool
- ☐ Ferry
- ☐ Other (please specify) _____

2 CALCULATE MONTHLY COMMUTING COST

How much are you currently paying for your monthly transit commute?

$ _____ / month

3 DETERMINE MONTHLY PRE-TAX DEDUCTION AMOUNT

How much of your pay would you like to set aside as a pre-tax payroll deduction towards your commute each month? Please note, there is an IRS monthly limit of $270.

$ _____ / month

4 PRODUCT SELECTION CHART

Use the ***TransitChek Product Selection Chart*** to the right to choose the product(s) you would like to use for your benefit. Please note that if you choose more than one product or select multiple denominations of a single product, the total value of all selections cannot exceed the IRS limit of $270/month.

5 RETURN COMPLETED FORM

Return this completed form to your TransitChek Program administrator. TransitChek products will be distributed to you at work and will be ready to use. You may not return or get a refund once your benefit products have been distributed.

Employee name: _____

Date: _____

TRANSITCHEK® by WageWorks

ALL REGIONS

TransitChek Prepaid Visa® Card (Not Returnable/Refundable)

The TransitChek Card can be used to purchase your transit tickets and passes everywhere Visa debit cards are accepted that exclusively sells transit fare media. You can also add funds from a personal credit or debit card for transit passes that exceed the stated value of the Card. To add funds, go to: **www.tccard.transitchek.com**.

Quantity	Cost/Item		Quantity	Cost/Item	
_____	x $_____	= $_____	_____	x $_____	= $_____
_____	x $_____	= $_____	_____	x $_____	= $_____
_____	x $_____	= $_____	_____	x $_____	= $_____

Minimum amount $21, Maximum amount $270.00

TransitChek® Voucher (Not Returnable/Refundable)

Not accepted at MTA NYC Transit subway station booths, Metro-North Railroad, Long Island Rail Road.

TransitChek Vouchers can be used to purchase your transit tickets and passes. They are accepted by most commuter rail, subway, bus, ferry, and ticket-by-mail programs throughout the country.

Quantity	Cost/Item		Quantity	Cost/Item	
_____	x $15	= $_____	_____	x $50	= $_____
_____	x $25	= $_____	_____	x $55	= $_____
_____	x $30	= $_____	_____	x $75	= $_____
_____	x $35	= $_____	_____	x $100	= $_____
_____	x $45	= $_____			

NEW YORK COMMUTERS ONLY

TransitChek® MetroCard®

The TransitChek MetroCard can be used on MTA-NYC Transit subway, local and express buses and other MetroCard-equipped services throughout New York City.

Pay-Per-Ride Cards	Quantity	Cost/Item	
$33.00 (12 trips)	_____	x $33.00	= $_____
$44.00 (16 trips)	_____	x $44.00	= $_____
$55.00 (20 trips)	_____	x $55.00	= $_____
$66.00 (24 trips)	_____	x $66.00	= $_____
Unlimited Ride Cards			
7–Day Unlimited	_____	x $33.00	= $_____
7–Day Express Bus Plus	_____	x $62.00	= $_____
30–Day Unlimited	_____	x $127.00	= $_____

Access-A-Ride

Access-A-Ride provides door-to-door transportation for eligible commuters with disabilities within the five boroughs of New York City.

Quantity	Cost/Item	
_____	x $2.75	= $_____

Mail&Ride

Mail&Ride is a program offered by Metro-North Railroad and Long Island Rail Road where you can receive your rail tickets at home instead of purchasing them at a station window or vending machine.

Long Island Rail Road Account # _____ $_____

Metro-North Railroad Account # _____ $_____

Name on Account (First) _____ (Last) _____

TOTAL OF ALL PRODUCTS SELECTED (Cannot exceed $270/month)

$ _____ / month