

\*\* MANAGER MUST FILL OUT; NOT JOB APPLICANT \*\*

EMPLOYEE NEW HIRE FORM

Hotel Name/Address	
State of Employment	
Employee First Name	
Employee Last Name	
Address 1	
Address 2	
Part Time or Full Time	
Gender	
Employee Phone Number	
Employee Email Address	
Social Security #	
Marriage Status	
Dependents	
Date of Birth	
Rate of Pay	
Hire Date	
Department	
Position	
Health Insurance Selection	<input type="checkbox"/> UHC HRA Base Plan <input type="checkbox"/> UHC HRA Buy Up Plan <input type="checkbox"/> CWI Minimum Essential Plan <input type="checkbox"/> CWI Minimum Indemnity Plan <input type="checkbox"/> UHC Dental <input type="checkbox"/> UHC Vision
Health Insurance Copay per Pay Period	

\*\* Submit this form along with following documents to - apinvoicing@googlegroups.com. Failure to do so will result in payroll not being processed by the office. **Please make sure all is legible.**

<b>Documents to include</b>	<p>* Completed Job Application</p> <p>* Completed W4 Tax Deduction Document (Make sure signed/dated and box 5 filled out)</p> <p>* Completed I9 Immigration Document (Make sure signed/dated, page 1 and 2 filled out)</p> <p>* Copy of documents from - 1 Item from List A or List B (e.g. State drivers license) 1 Item from List C (e.g. SSN number)</p> <p>- All documents must be legible!!</p> <p>* Completed Direct Deposit form <b>with email address</b></p> <p>* Must be accompanied with <u>typed</u> bank letter or voided check with employee name on it that matches payroll name.</p>
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<b>EMPLOYEE NEW HIRE NOTIFICATION</b>	
(To be handed to Associate at hire <u>and</u> submitted with new hire packet)	
<b>Employee First Name</b>	
<b>Employee Last Name</b>	
<b>Hotel Name</b>	
<b>Hotel Address</b>	
<b>Department Hired In</b>	
<b>Job Title</b>	
<b>Name of Direct Supervisor</b>	
<b>Job Start Date</b>	Date - _____ Start of Shift Time - _____
<b>Pay Rate</b>	\$_____ per hour
<b>Pay Frequency</b>	<input type="checkbox"/> Weekly <input type="checkbox"/> BiWeekly
<b>Payment Method</b>	<input type="checkbox"/> Check <input type="checkbox"/> Direct Deposit
<b>1st Pay Date</b>	
<b>Office Contact Information</b>	Should an employee need to contact an asset manager overseeing the property's management staff, they can be reached at - Ph - 908.444.8139 Fax - 732.579.0142 Email - njbackoffice@email.com

## **AT WILL EMPLOYMENT**

Your employment relationship with the Hotel is ‘At-Will’ which means that it is a voluntary one which may be terminated by either the Hotel or yourself, with or without cause, and with or without notice, at any time. Nothing in these policies shall be interpreted to be in conflict with or to eliminate or modify in any way the ‘employment-at-will’ status of Hotel associates.

## **EQUAL EMPLOYMENT OPPORTUNITY**

Your employer (the “Hotel”) provides equal employment opportunities to all employees and applicants for employment without regard to race, color, religion, sex, sexual orientation, national origin, age, disability, genetic predisposition, military or veteran status in accordance with applicable federal, state or local laws. This policy applies to all terms and conditions of employment, including but not limited to, hiring, placement, promotion, termination, transfer, leaves of absence, compensation, and training.

## **SEXUAL AND OTHER UNLAWFUL HARRASMENT**

We are committed to providing a work environment that is free from sexual discrimination and sexual harassment in any form, as well as unlawful harassment based upon any other protected characteristic. In keeping with that commitment, we have established procedures by which allegations of sexual or other unlawful harassment may be reported, investigated and resolved. Each manager and associate has the responsibility to maintain a workplace free of sexual and other unlawful harassment. This duty includes ensuring that associates do not endure insulting, degrading or exploitative sexual treatment.

Sexual harassment is a form of associate misconduct which interferes with work productivity and wrongfully deprives associates of the opportunity to work in an environment free from unsolicited and unwelcome sexual advances, requests for sexual favors and other such verbal or physical conduct. Sexual harassment has many different definitions and it is not the intent of this policy to limit the definition of sexual harassment, but rather to give associates as much guidance as possible concerning what activities may constitute sexual harassment.

Prohibited conduct includes, but is not limited to, unwelcome sexual advances, requests for sexual favors and other similar verbal or physical contact of a sexual nature where:

- Submission to such conduct is either an explicit or implicit condition of employment;
- Submission to or rejection of such conduct is used as a basis for making an employment-related decision;
- The conduct unreasonably interferes with an individual’s work performance; or
- The conduct creates a hostile, intimidating or offensive work environment.

Sexual harassment may be male to female, female to male, female to female or male to male. Similarly, other unlawful harassment may be committed by and between individuals who share the same protected characteristics, such as race, age or national origin. Actions which may result in charges of sexual harassment include, but are not limited to, the following:

- Unwelcome physical contact, including touching on any part of the body, kissing, hugging or standing so close as to brush up against another person;

- Requests for sexual favors either directly or indirectly;
- Requiring explicit or implicit sexual conduct as a condition of employment, a condition of obtaining a raise, a condition of obtaining new duties or any type of advancement in the workplace; or
- Requiring an associate to perform certain duties or responsibilities simply because of his or her gender or other protected characteristic.

Other behavior that may seem innocent or acceptable to some people can constitute sexual harassment to others. Prohibited behaviors include, but are not limited to:

- unwelcome sexual flirtations, advances, jokes or propositions;
- unwelcome comments about an individual's body or personal life;
- openly discussing intimate details of one's own personal life;
- sexually degrading words to describe an individual; or
- displays in the workplace of objects, pictures, cartoons or writings, which might be perceived as sexually suggestive.

Unwelcome conduct such as degrading jokes, foul language direct to or at a person, racial slurs, comments, cartoons or writing based upon any other protected characteristic is similarly prohibited.

All associates are required to report any incidents of sexual or other unlawful harassment of which they have knowledge. Similarly, if you ever feel aggrieved because of sexual harassment, you have an obligation to communicate the problem immediately and should report such concerns to your manager, and/or the offending associate directly. If this is not an acceptable option, you should report your concern directly to the administrative office confidentially. In all cases in which a manager or another member of management is notified first, the administrative office should be notified immediately. Management has an obligation to report any suspected violations of this policy to the asset manager. A manager who is aware of a violation, even if the associate is outside the manager's immediate area of supervision, but doesn't report it, will be held accountable for his or her inaction. The asset manager shall conduct a prompt investigation of the allegations to obtain the facts from any and all parties or witnesses.

While we will attempt to maintain the confidentiality of the information received, it will not always be possible to do so. Should the facts support the allegations made, we will remedy the situation and, if appropriate under the circumstances, take disciplinary action up to and including termination.

## **WORKPLACE VIOLENCE PREVENTION POLICY**

The Hotel strives to maintain a productive work environment free of violence and the threat of violence. We are committed to the safety of our associates, vendors, customers and visitors.

The Hotel does not tolerate any type of workplace violence committed by or against associates. Any threats or acts of violence against an associate, vendor customer, visitor or property will not be tolerated. Any associate who threatens violence or acts in a violent manner while on Hotel premises, or during working hours will be subject to disciplinary action, up to and including termination. Where appropriate, the Hotel will report violent incidents to local law enforcement authorities.

A violent act, or threat of violence, is defined as any direct or indirect action or behavior that could be interpreted, in light of known facts, circumstances and information, by a reasonable person, as indicating the potential for or intent to harm, endanger or inflict pain or injury on any person or property.

Examples of prohibited conduct include but are not limited to:

- Physical assault, threat to assault or stalking an associate or customer;
- Possessing or threatening with a weapon on hotel premises;
- Intentionally damaging property of the Hotel or personal property of another;
- Aggressive or hostile behavior that creates a reasonable fear of injury to another person;
- Harassing or intimidating statements, phone calls, voice mails, or e-mail messages, or those which are unwanted or deemed offensive by the receiver, including cursing and/or name calling;
- Racial or cultural epithets or other derogatory remarks associated with hate crime threats.
- Conduct that threatens, intimidates or coerces another associate, customer, vendor or business associate
- Use of hotel resources to threaten, stalk or harass anyone at the workplace or outside of the workplace.

The Hotel treats threats coming from an abusive personal relationship as it does other forms of violence and associates should promptly inform their immediate supervisor or General Manager of any protective or restraining order that they have obtained that lists the workplace as a protected area.

Any associate who feels threatened or is subjected to violent conduct or who witnesses threatening or violent conduct at the workplace should report the incident to his or her supervisor or any member of management immediately. In addition, associates should report all suspicious individuals or activities as soon as possible.

Associates who are not comfortable reporting incidents at the property level may contact the administrative office at (908) 444-8139 or via email at [njbackoffice@lakecrest.com](mailto:njbackoffice@lakecrest.com). A representative will promptly and thoroughly investigate all reports of threats or actual violence as well as suspicious individuals and activities at the workplace.

The Hotel will not retaliate against associates making good-faith reports of violence, threats or suspicious individuals or activities.

Anyone determined to be responsible for threats of or actual violence or other conduct that is in violation of this policy will be subject to disciplinary action, up to and including termination.

In order to maintain workplace safety and the integrity of its investigation, the Hotel may suspend associates suspected of workplace violence or threats of violence, either with or without pay, pending investigation.

The Hotel strictly forbids any employee to possess, concealed, or otherwise, any weapon on their person while on the Hotel premises, including but not limited to fire arms. The Hotel also forbids brandishing firearms in the parking lot (other than for lawful self-defense) and prohibiting threats or threatening behavior of any type.

## **SURVEILLANCE**

For safety, visual and audio recording devices are installed throughout the property and the footage is recorded.

## **PAY, PAY PERIOD AND PAY DAY**

Associates are paid biweekly (every other week) for their hours worked during the preceding pay period.

- A pay period consists of two consecutive pay weeks, at 7 days per week.

For employees who have elected direct deposit as payment method, a pay stub will not be issued at the Hotel. Contact your General Manager for electronic access to your pay stub through a payroll portal. For employees who do not select direct deposit, a check and pay stub will be made available for you, customarily on Friday by 1PM local time. Employee pay checks will not be released to anyone other than you, except with your written permission (required for every instance), and submitted to your General Manager.

Non-exempt associates will be paid for all work in excess of 40 hours a week at hourly rate plus ½ hourly wages, in accordance with Federal and State laws.

- Overtime must be approved by your manager before it is performed.
- Personal Time Off will not be counted towards hours worked for overtime calculations.

Failure to work scheduled overtime or overtime worked without prior authorization from the supervisor may result in disciplinary action, up to and including possible termination of employment.

## **FRATERNIZING WITH GUESTS AND DATING AT THE WORK PLACE**

Contact with guests, other than in the normal course of day-to-day operations of the hotel is not permitted at any time. Unauthorized presence at guest functions, or unauthorized presence anywhere on the hotel premises, including guest rooms, may be considered a violation of Hotel policy and disciplinary action may result.

Supervisors and associates under their supervision are strongly discouraged from forming romantic or sexual relationships. Such relationships can create the impression of impropriety in terms and conditions of employment and can interfere with productivity and the overall work environment.

If you are unsure of the appropriateness of an interaction with another associate of the Hotel, contact any member of management or the administrative office for guidance.

If you are encouraged or pressured to become involved with a customer or associate in a way that makes you feel uncomfortable, you should also notify management immediately.

## **CONTACT WITH MEDIA**

In the event that you are contacted by any member of the media or any outside party regarding hotel business or incident, occurring on or off property, kindly refer such inquiries to your General Manager.

## **REMOVAL OF ITEMS OFF HOTEL PREMISES**

No items other than an associate's own personal property may be removed from Hotel premises without authorization. Permission must be obtained from your General Manager in order to remove any item from the hotel premises. (An example of such is a small article of minimal value that the guest did not take with him/her). The hotel has the right of inspection and retention of any such items suspected to being removed from the premises. At no time is food of any type or form, full or partial, containers of alcoholic beverages to be removed from the Hotel.

## **ACCESS TO HOTEL FACILITIES AND SOLICITATION POLICY**

The hotel and its facilities are for the use and enjoyment of the hotel guests. Associates are to leave the building and premises immediately after their scheduled shifts. Returning to the hotel after scheduled hours for any reason is not permitted without previous approval from the General Manager.

Only associates, guests, visitors, vendors and suppliers doing business with the Hotel or its affiliates are permitted at any time on the Hotel's premises. Persons other than associates of the Hotel may never engage in solicitation, distribution or postings of written or printed materials of any nature at any time in or on the Hotel's premises.

Employees are prohibited from engaging in solicitation or distribution of any kind during working time, in any working areas, including guest rooms, guest dining areas, parking lot or areas within the Hotel where guests congregate (lobby, lounge, etc.).

For the purpose of this policy, "working time" includes the working time of both the associate doing the solicitation or distribution and the associate to whom it is directed, but does not include break, lunch or other duty-free periods of time.

Off-duty associates are not permitted access to the interior of the Hotel's premises except where they are attending a Hotel event, or to conduct business with the Hotel's management or administrative office that cannot be conducted during the associate's regular work shift. Unless explicitly approved by the asset manager, associates are not permitted to stay on property.

## **ELECTRONIC MAIL**

Electronic mail may be provided to facilitate the business of the Hotel. It is to be used for business purposes only. The electronic mail and other information systems are not to be used in a way that may be disruptive, offensive to others, or harmful to morale.

Specifically, it is against Hotel policy to display or transmit sexually explicit messages, or cartoons. Therefore, any such transmission or use of e-mail that contain ethnic slurs, racial epithets, or anything else that may be construed as harassment or offensive to others based on their race, national origin, sex, sexual orientation, age, disability, religious, or political beliefs is strictly prohibited and could result in appropriate disciplinary action up to and including termination.

Destroying or deleting e-mail messages which are considered business records is strictly prohibited. The Hotel reserves the right to monitor all electronic mail retention and take appropriate management action, if necessary, including disciplinary action, for violations of this policy up to and including termination.

The Hotel reserves the right to take immediate action, up to and including termination, regarding activities (1) that create security and/or safety issues for the Hotel, associates, vendors, network or computer resources, or (2) that expend Hotel resources on content the Hotel in its sole discretion determines lacks legitimate business content/purpose, (3) other activities as determined by Hotel as inappropriate, or (4) violation of any federal or state regulations.

## **HAZARD COMMUNICATION PLAN**

The Hotel values employee safety and gives it the utmost priority. A Hazard Communication Plan is located in the Hotel, which each employee is required to review prior to start of their first shift of work. Please ask your General Manager where it is located.

# Paid Time Off and Holiday Policy

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The Company offers PTO to ‘regular full-time and part-time associates’ only. Temporary/seasonal associates do not earn PTO. Eligible associates begin to accrue PTO immediately, at hire and accrual is rate is only based on regular hours worked. This PTO can be used for any reason that the associate deems appropriate, with advance notice and management approval, and is paid at the rate of pay when PTO is paid out. All PTO earned during each calendar year will be paid out on the last payroll of the calendar year. If associates choose, they may elect to carry over no more than 5 hours of PTO can be carried over into the following year. The rate of accrual and maximum PTO hours that an associate may accrue during a given calendar year will vary with the associate’s length of service and hours worked.

YEAR OF EMPLOYMENT	PTO ACCRUAL RATE NON-EXEMPT/HOURLY ASSOCIATES (PER PAID HOUR)	ACCRUED PTO PER ANNIVERSARY YEAR (ASSUMING 2080 HOURS WORKED PER YR)
1 - 3	0.019	5 days (40 hours)
4 - 8	0.027	7 days (56 hours)
9 +	0.038	10 days (80 hours)

Notes:

- PTO is granted as a benefit and in order to be paid for this benefit, the day(s) must be taken off.
- Upon termination of employment, associate is not be entitled for payment of any unused PTO, regardless of when it was earned or reason for termination.
- All requests for days off/PTO must be in submitted in advance in writing and approved by your manager.
- Associates can not borrow from their PTO and will accrue PTO when working at the rates specified in the table above.
- PTO is paid at the pay rate at time of payment.

The Company pays associates for six holidays, in addition to accrued PTO. Full time employees are paid for 8 hours, at regular pay. Part time employees, classified as working less than 30 hours a week will be paid for 4 hours.

- New Year's Day (January 1)
- Memorial Day
- Independence Day (July 4)
- Labor Day
- Thanksgiving Day
- Christmas Day (December 25)

*The above policy supersedes any previously communicated policies, including any previously issued employee handbooks.*

# **ACKNOWLEDGEMENT OF RECEIPT**

In consideration of my employment, I agree to conform to the rules and regulations of the Hotel. I understand my employment and compensation can be terminated, with or without cause, with or without notice, at any time and at the option of either the Hotel or myself. I understand that no representative of the Hotel has any authority to enter into any agreement of employment for any specific period of time or to make any agreement contrary to this paragraph. I further understand that if, during the course of my employment, I acquire confidential or proprietary information about the Company or any division thereof, and its clients, that this information is to be handled in strict confidence and will not be disclosed to or discussed with outsiders during the term of my employment or any time thereafter. I also understand that should I have any questions or concerns, at any point during my employment, I may speak to my direct supervisor, or if necessary, contact the administrative office at (908) 444-8139 or via email at njbackoffice@lakecrest.com.

Note - while every attempt has been made to create these policies consistent with federal and state law, if an inconsistency arises, the policy(ies) will be enforced consistent with the applicable law.

My signature below certifies that I have read and understood the above information as well as the remainder of the contents asked of me to review. Further, my signature below certifies that I have located the Hotel's Hazard Communication Plan and I have reviewed it. I understand that if I have any questions, at any point during my employment, I should go to my direct supervisor, or the General Manager immediately.

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**ASSOCIATE NAME**

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**ASSOCIATE SIGNATURE**

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**DATE**

**THIS ACKNOWLEDGMENT MUST BE RETURNED  
WITHIN YOUR FIRST FIVE (5) DAYS OF  
EMPLOYMENT.**

TO BE RETAINED IN YOUR PERSONNEL FILE



# Employment Eligibility Verification

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

USCIS

Form I-9

OMB No.1615-0047

Expires 05/31/2027

**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
<b>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.</b>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): <input type="checkbox"/> 1. A citizen of the United States <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.) <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) <input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any) _____		
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)			Additional Information		
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)					
<input type="checkbox"/> 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.

## 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: <ul style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ul>
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: <ul style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:               <ul style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ul> </li> </ul>		5. U.S. Military card or draft record	5. U.S. Citizen ID Card (Form I-197)
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		6. Military dependent's ID card	6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card	7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document	For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="http://uscis.gov/i-9-central">uscis.gov/i-9-central</a> .
		9. Driver's license issued by a Canadian government authority	The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b> , document, not a List C document.
		<b>For persons under age 18 who are unable to present a document listed above:</b>	
		10. School record or report card	
		11. Clinic, doctor, or hospital record	
		12. Day-care or nursery school record	

### Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

<ul style="list-style-type: none"> <li>Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	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.
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\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



# 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 05/31/2027

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**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 ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial (if any)
Address ( <i>Street Number and Name</i> )	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 ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial (if any)
Address ( <i>Street Number and Name</i> )	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 ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial (if any)
Address ( <i>Street Number and Name</i> )	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 ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial (if any)
Address ( <i>Street Number and Name</i> )	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 05/31/2027

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**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 ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date (mm/dd/yyyy)	Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	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 ( <i>if any</i> )	Expiration Date ( <i>if any</i> ) (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 ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date (mm/dd/yyyy)	Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	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 ( <i>if any</i> )	Expiration Date ( <i>if any</i> ) (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 ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date (mm/dd/yyyy)	Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	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 ( <i>if any</i> )	Expiration Date ( <i>if any</i> ) (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.

**Employee's Withholding Certificate**

OMB No. 1545-0074

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.

2025

<b>Step 1: Enter Personal Information</b>	(a) First name and middle initial	Last name	(b) Social security number
	Address		
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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.)		

**TIP:** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

**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, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

<b>Step 2: Multiple Jobs or Spouse Works</b>	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 <b>only one</b> of the following.  (a) Use the estimator at <a href="http://www.irs.gov/W4App">www.irs.gov/W4App</a> for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; <b>or</b>  (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; <b>or</b>  (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 . . . . . <input type="checkbox"/>
--	---

**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.)

<b>Step 3: Claim Dependent and Other Credits</b>	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 . . . . . <b>3</b> \$ _____
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . . <b>4(a)</b> \$ _____  (b) <b>Deductions.</b> 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 . . . . . <b>4(b)</b> \$ _____  (c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . . <b>4(c)</b> \$ _____

<b>Step 5: Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	<b>Employee's signature</b> (This form is not valid unless you sign it.)		<b>Date</b>
<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### 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](http://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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

**Your privacy.** Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

**TIP:** Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

**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 these taxes through withholding from your wages, use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to figure the amount to have withheld.

**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. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, 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 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 2025 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; or, you can use the online withholding estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

- 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 2025 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: { • \$30,000 if you're married filing jointly or a qualifying surviving spouse  
• \$22,500 if you're head of household  
• \$15,000 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.





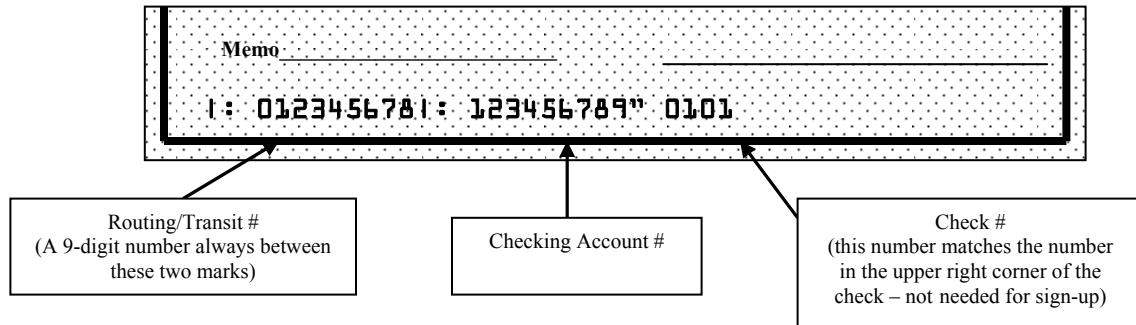
# Employee Direct Deposit Enrollment Form

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

Company Code: \_\_\_\_\_ Company Name: \_\_\_\_\_ Employee File Number: \_\_\_\_\_  
Payroll Mgr. Name: \_\_\_\_\_ Payroll Mgr. Signature: \_\_\_\_\_

To enroll in Full Service Direct Deposit, simply fill out this form and give 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 are 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 ADP to deposit any amounts owed me, as instructed by my employer, by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by ADP to my account. In the event that ADP deposits funds erroneously into my account, I authorize ADP 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 ADP and Bank have received written notice from me of its termination in such time and in such manner as to afford ADP and Bank reasonable opportunity to act on it.

Employee Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Email: \_\_\_\_\_

## **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:**

Employers must keep each original employee enrollment form on file as long as the employee is using FSDD, and for two years thereafter.



# HUMAN TRAFFICKING

What you need to know. How you can help.

*Speak up for those who cannot speak for themselves,  
For the rights of all who are destitute.*

*Speak up and judge fairly:  
Defend the rights of the poor and needy.  
Proverbs 31:8-9*

**Over 20 million  
slaves exist in our  
world today.**

Nearly 200,000 people live enslaved right now in the US.

300 children are sold in Atlanta every month.

300,000 children worldwide are currently trafficked as child soldiers.

Attorneys from the US Department of Justice have prosecuted slave-trade activity in 91 cities across American and in nearly every state.

## HOT SPOTS WHERE SLAVES ARE FOUND

Housecleaning services

Garment factories

Landscape and gardening businesses

Hotels (housekeeping)

Domestic (home) workers

Nail salons

Large-scale agricultural labor

Zones known for prostitution

Construction sites

Strip clubs/massage parlors

Casinos

Domestic violence cases

## ENVIRONMENTAL SIGNS OF POSSIBLE TRAFFICKING:

Locks on the outside of a door (as opposed to inside)

Bars on windows

People sleeping and working in the same location, and in cramped, overcrowded conditions

Sparse living conditions, generally a mattress on the floor

**HUMAN TRAFFICKING HOTLINE 888-3737-888 (888-373-7888)**

**Find out more at [www.kimberlyrae.com](http://www.kimberlyrae.com)**

\*Information taken from The Slave Across the Street, [www.TraffickFree.com](http://www.TraffickFree.com), No Longer a Slumdog, [www.gfa.org](http://www.gfa.org), Not For Sale, [www.notforsalecampaign.org](http://www.notforsalecampaign.org), and Women At Risk International, [www.warinternational.org](http://www.warinternational.org).

# DO YOUR PART

TO KEEP IT BETTER AT WORK

By using the Confidential Associate Hotline

We rely on our associates to protect the assets and reputation of our company. If you have knowledge of:

**THEFT, HARRASSMENT, ABUSE,  
DANGEROUS, SUSPICIOUS OR  
QUESTIONABLE PRACTICES**

Send an e-mail to:

**feedback@lakecrest.com**

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**ALL REPORTS WILL BE CONFIDENTIAL AND TAKEN SERIOUSLY**

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When reporting, please remember to:

Identify the name of the hotel where the incident occurred

Explain details of the Incident to include:

- Date(s)
- Time(s)
- Name(s) of involved person(s)
- A clear, detailed account of the event

*Our 'No Retaliation' policy strictly prohibits any adverse action taken on employees who, in good faith, file a report.*

## SIGNS A PERSON MIGHT BE A VICTIM OF HUMAN TRAFFICKING:

Bruises, abrasions around the wrists, ankles or neck  
Sudden change in behavior, sudden drop in grades  
New set of friends, particularly older ones who are unfriendly and distant to adults  
New cell phone, expensive jewelry, or other items you know their family could not afford  
Frequent, unexplained absences from school or dropping out of activities they used to enjoy  
Out in public without identification or money  
Makes reference to frequent travel to other cities, but doesn't know specifics about the location  
Is inappropriately dressed based on the weather conditions or surroundings  
Shows signs of drug addiction  
Makes reference to sexual situations that are beyond age-specific norm  
Has a boyfriend who is noticeably older

## WAYS TO GET INVOLVED:

### Learn:

First Responder Video:

<http://www.dhs.gov/files/programs/human-trafficking-awareness-training-first-responders.shtm>

As many as 30% of human trafficking victims will have an encounter with healthcare professionals during the time they are being trafficked.

### Act:

#### **WOMEN AT RISK INTERNATIONAL**, [www.warinternational.org](http://www.warinternational.org)

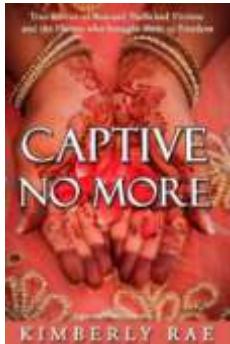
Rescues women and children all over the world, including America. Sells jewelry made by at-risk or rescued women—a great way to bring awareness to your church or home is to host a jewelry party. WAR Int. even send a presentation DVD so you don't even need a speaker!

#### **Truckers Against Trafficking**, [www.truckersagainsttrafficking.org](http://www.truckersagainsttrafficking.org)

Watch videos, get materials, find out about training sessions for truckers

#### **INTERNATIONAL JUSTICE MISSION**, [www.ijm.org](http://www.ijm.org)

Rescues victims of violence, sexual exploitation, slavery and oppression.



# **Prohibition of Weapons on Hotel Premises**

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The Company strictly forbids any employee to possess, concealed, or otherwise, any weapon on their person while on the Hotel premises. This includes but is not limited to fire arms, knives, etc and regardless of whether an Employee possesses any governmental licenses and/or approvals. The Company also forbids brandishing firearms in the parking lot (other than for lawful self-defense) and prohibiting threats or threatening behavior of any type. Violation of this policy may lead to disciplinary action, up to and including termination of employment.

*Effective On - July 10, 2017*



Plan Year: January 1, 2025 – December 31, 2025

Effective Date: \_\_\_\_\_

Deadline to Submit: \_\_\_\_\_

Property Name: \_\_\_\_\_

**Reason for Request** (check one of the following) New Hire – Date of Hire: \_\_\_\_\_  Open Enrollment  Qualifying Event – If so, state event & date: \_\_\_\_\_**Personal Information**

Employee's Name (Last, First, MI)	Social Security #	Birth Date	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Employee's Address	City	State	Zip
Phone Number	Email Address		

**Coverage Elections** (deductions below are Bi-Weekly)**Medical: United Healthcare**

<b>HRA \$6K Plan</b>					
<input type="checkbox"/> Employee Only	\$59.91	<input type="checkbox"/> Employee + Spouse	\$319.29	<input type="checkbox"/> Employee + Child(ren)	\$264.10
<b>HRA \$4K Plan</b>					
<input type="checkbox"/> Employee Only	\$136.84	<input type="checkbox"/> Employee + Spouse	\$396.21	<input type="checkbox"/> Employee + Child(ren)	\$341.02
<b>HRA \$2K Plan</b>					
<input type="checkbox"/> Employee Only	\$213.76	<input type="checkbox"/> Employee + Spouse	\$473.13	<input type="checkbox"/> Employee + Child(ren)	\$417.95
<input type="checkbox"/> I Decline Medical Coverage					

**Limited Medical: ACI Benefits****Minimum Essential Coverage Plan**

<input type="checkbox"/> Employee Only	\$7.77	<input type="checkbox"/> Employee + Spouse	\$17.55	<input type="checkbox"/> Employee + Child(ren)	\$19.03	<input type="checkbox"/> Employee + Family	\$27.61
<b>Indemnity Plan (Does not meet individual ACA mandate)</b>							
<input type="checkbox"/> Employee Only	\$19.61	<input type="checkbox"/> Employee + Spouse	\$37.24	<input type="checkbox"/> Employee + Child(ren)	\$31.45	<input type="checkbox"/> Employee + Family	\$49.12
<b>Minimum Essential Coverage + Indemnity</b>							
<input type="checkbox"/> Employee Only	\$27.37	<input type="checkbox"/> Employee + Spouse	\$54.79	<input type="checkbox"/> Employee + Child(ren)	\$50.48	<input type="checkbox"/> Employee + Family	\$76.74
<input type="checkbox"/> I Decline Medical Coverage							

**Dental: United Healthcare**

<b>Dental PPO</b>							
<input type="checkbox"/> Employee Only	\$13.45	<input type="checkbox"/> Employee + Spouse	\$27.44	<input type="checkbox"/> Employee + Child(ren)	\$31.13	<input type="checkbox"/> Employee + Family	\$45.63

 I Decline Dental Coverage**Vision: United Healthcare**

<input type="checkbox"/> Employee Only	\$3.04	<input type="checkbox"/> Employee + Spouse	\$5.59	<input type="checkbox"/> Employee + Child(ren)	\$5.86	<input type="checkbox"/> Employee + Family	\$8.78
<input type="checkbox"/> I Decline Vision Coverage							

## Dependent Information

**This Section Must Be Completed for All Dependent Coverages**

Provide the following information for each individual that should be insured for any of the above elections and list mailing address for any dependent that is different from the employee's as noted on the previous page.

Check Appropriate Box	Coverage Selection	Last Name, First, MI. Ø Only add mailing address if different from Employee Ø If spouse last name differs from the Employee, proof of marriage is required (i.e., marriage license)	Gender M      F	Date of Birth	SSN (required)
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Spouse	<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Child	<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Child	<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Child	<input type="checkbox"/> <input type="checkbox"/>		

Have you included stepchildren as dependents?  Yes  No If "yes", indicate names: \_\_\_\_\_

Are they dependent on you for support and maintenance?  Yes  No

I affirm that all dependents listed meet the IRS Section 152 definition of "dependent" so that premiums can be paid with pre-tax dollars, if applicable:  Yes  No

## Premium Only IRS Code Section 125

I understand that if my required contribution to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

I understand that:

- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the plan year unless I have changes in family status (some examples of possible qualifying events include: marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of spouse, change in my spouse's employment status from full-time to part-time or from part-time to full-time, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, etc.). Notification of change must be within 30 days of the qualifying event. Qualifying events are defined in the plan's Summary Plan Description.
- I may be able to make a change to my elections if I, or my dependents, lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP. Notification of change must be within 60 days of this qualifying event.
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.
- I hereby authorize my employer to reduce my cash compensation by the amount(s) indicated for each pay period during the plan year following the date on which this agreement is signed.
- I understand that my election may impact my future Social Security benefits.
- If I do not file a new Agreement to Participate and a new Salary Reduction Agreement with the Plan Administrator before the start of each new plan year, my current elections will be continued (to the extent available) until I change my elections, and my salary will be reduced accordingly by my Employer.

**For Coverages Offered UnitedHealthcare:** I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependent(s) may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy.

ENROLLMENT  
WAIVER:

If I have waived any of the above insurance coverages, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and the insurance carrier reserves the right to reject my request.

Coverage summaries provided herein are intended as an outline of coverage only. Participants will receive a certificate of coverage. In the event of any discrepancy between this brochure and the certificate of coverage, the terms of the certificate of coverage will control.

	Enrollment Signature of Employee	Date
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## Waiver of Group Health Benefits

Associate Name

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Job Title

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Associate Number (ID, Social Security, etc.)

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For the plan year effective **January 1, 2025** I am waiving coverage in the insurance plans offered by Baywood Hotels/Lakecrest Partners (UnitedHealthcare & ACIBenefits) for:

- Myself
- Spouse/Domestic Partner
- Dependents(s):

If selecting Dependent(s), please list their name(s):

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I am waiving coverage due to:

- My preference not to have coverage
- Coverage under my spouse's/domestic partner's plan
- Other coverage

This other coverage is:

- Employer-sponsored Group Plan
- Individual policy
- Medicare
- COBRA
- TRICARE
- Medicaid

**Special Enrollment Notice and Certification – Please review and sign below if you wish to waive coverage**

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Associate Signature

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Date

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Año: Enero 1, 2025 – Diciembre 31, 2025

Dia Efectivo: \_\_\_\_\_

Fecha límite para enviar: \_\_\_\_\_

Nombre de la Propiedad: \_\_\_\_\_

### Razon de la solicitud (Marque una de las siguientes)

Empleado Nuevo     Inscripcion Abierta     Evento de Calificacion – Sies asi, Estado y dia del evento:\_\_\_\_\_

### Informacion Personal

Nombre	Seguro Social #	Dia de Nacimiento	Genero M <input type="checkbox"/> F <input type="checkbox"/>
Direccion	Ciudad	Estado	Codigo Postal
Telefono	Email		

### Eleccion de Cobertura (deducciones mostradas abajo son cada 2 semanas)

#### Médico: United Healthcare

##### HRA \$6K Plan

Empleado Solo \$59.91     Empleado + Esposo \$319.29     Empleado + Niño (s) \$264.10     Empleado + Familia \$390.25

##### HRA \$4K Plan

Empleado Solo \$136.84     Empleado + Esposo \$396.21     Empleado + Niño (s) \$341.02     Empleado + Familia \$467.17

##### HRA \$2K Plan

Empleado Solo \$213.76     Empleado + Esposo \$473.13     Empleado + Niño (s) \$417.95     Empleado + Familia \$544.09

Yo rechazo cobertura medica

#### Médico limitado: ACI Benefits

##### Minimum Essential Coverage Plan

Empleado Solo \$7.77     Empleado + Esposo \$17.55     Empleado + Niño (s) \$19.03     Empleado + Familia \$27.61

##### Indemnity Plan (Does not meet individual ACA mandate)

Empleado Solo \$19.61     Empleado + Esposo \$37.24     Empleado + Niño (s) \$31.45     Empleado + Familia \$49.12

##### Minimum Essential Coverage + Indemnity

Empleado Solo \$27.37     Empleado + Esposo \$54.79     Empleado + Niño (s) \$50.48     Empleado + Familia \$76.74

Yo rechazo cobertura medica

#### Dental: United Healthcare

##### Dental PPO

Empleado Solo \$13.45     Empleado + Esposo \$27.44     Empleado + Niño (s) \$31.13     Empleado + Familia \$45.63

Yo rechazo cobertura dental

#### Vision: United Healthcare

Empleado Solo \$3.04     Empleado + Esposo \$5.59     Empleado + Niño (s) \$5.86     Empleado + Familia \$8.78

Yo rechazo cobertura vision

## Información Dependiente

**Esta sección debe completarse para todas las coberturas dependientes**

Provide the following information for each individual that should be insured for any of the above elections and list mailing address for any dependent that is different from the employee's as noted on the previous page.

Marque la Casilla apropiada	Cobertura Seleccionada	Apellido, Primer Nombre, Inicial Ø Only add mailing address if different from Employee Ø If spouse last name differs from the Employee, proof of marriage is required (i.e., marriage license)	Genero M      F	Fecha de Nacimiento	Seguro Social (required)
<input type="checkbox"/> Inscribirse <input type="checkbox"/> Cancelar <input type="checkbox"/> Cambio	<input type="checkbox"/> Medico <input type="checkbox"/> Dental <input type="checkbox"/> Visión	Conyuge	<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Inscribirse <input type="checkbox"/> Cancelar <input type="checkbox"/> Cambio	<input type="checkbox"/> Medico <input type="checkbox"/> Dental <input type="checkbox"/> Visión	Hijo	<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Inscribirse <input type="checkbox"/> Cancelar <input type="checkbox"/> Cambio	<input type="checkbox"/> Medico <input type="checkbox"/> Dental <input type="checkbox"/> Visión	Hijo	<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Inscribirse <input type="checkbox"/> Cancelar <input type="checkbox"/> Cambio	<input type="checkbox"/> Medico <input type="checkbox"/> Dental <input type="checkbox"/> Visión	Hijo	<input type="checkbox"/> <input type="checkbox"/>		

Have you included stepchildren as dependents?  Yes  No If "yes", indicate names: \_\_\_\_\_

Are they dependent on you for support and maintenance?  Yes  No

I affirm that all dependents listed meet the IRS Section 152 definition of "dependent" so that premiums can be paid with pre-tax dollars, if applicable:  Yes  No

## Sólo Premium IRS sección Código 125

Entiendo que si mi contribución requerida para pagar las primas para los beneficios elegidos se aumentan o disminuyen, mientras que este acuerdo se mantiene vigente, mi compensación se ajustará automáticamente para reflejar ese aumento o disminución.

### Yo entiendo que:

- No puedo cambiar o revocar cualquiera de mis elecciones de este acuerdo como reducción de la compensación en cualquier momento durante el año del plan a menos que tenga cambios en la situación familiar (algunos ejemplos de posibles eventos de calificación son: el matrimonio, el divorcio, la muerte de un cónyuge o hijo, nacimiento o adopción de un hijo, terminación o inicio del empleo del cónyuge, el cambio en la situación laboral de mi cónyuge de tiempo completo a tiempo parcial o de tiempo parcial a tiempo completo, un cambio sustancial en la cobertura de salud de mi familia debido a un cambio en la cobertura de salud patrocinado por el empleador de mi cónyuge, etc.). Notificación de cambio debe ser dentro de los 30 días del evento calificador. Clasificación eventos se definen en el plan de descripción resumida del plan.
- Puede que sea capaz de realizar un cambio en mis elecciones si yo o mis dependientes, perdieramos la elegibilidad para la cobertura de Medicaid o de la Infancia Programa de Seguro de Salud (CHIP) o ser elegible para un subsidio de asistencia para las primas bajo Medicaid o CHIP. Notificación de cambio debe ser dentro de los 60 días de ocurrir este evento.
- Antes del primer día de cada año del plan se les ofrecerá la oportunidad de cambiar las opciones de beneficios para el siguiente año.
- Por la presente autorizo a mi empleador para reducir mi compensación en efectivo por la cantidad (s) indicado para cada período de pago durante el año del plan después de la fecha en que se firme este acuerdo.
- Entiendo que mi elección puede afectar mis futuros beneficios de Seguro Social.
- Si no presento un nuevo acuerdo para participar y un nuevo acuerdo de reducción de salario con el Administrador del Plan antes del comienzo de cada nuevo año, se continuará con mis actuales elecciones (en la medida disponible) hasta que cambie mis elecciones, y mi salario se reducirá en consecuencia por mi empleador

**Para coberturas ofrecidas por UnitedHealthcare:** Entiendo que el pago de la prima no garantiza mi elegibilidad para la cobertura. Entiendo y acepto que debo satisfacer todo el trabajo activo y / o requisitos activas de empleo que se refieren a la política para ser elegible para la cobertura. Entiendo y acepto que la cobertura de seguro de vida para mi dependiente elegible (s) se puede retrasar si están confinados (en casa, en un hospital, o en cualquier otra institución o instalación) o desactivado en el seguro de la fecha, de otro modo comenzará, de conformidad con los términos de la póliza

ENROLLMENT  
WAIVER:

If I have waived any of the above insurance coverages, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and the insurance carrier reserves the right to reject my request.

**Coverage summaries provided herein are intended as an outline of coverage only. Participants will receive a certificate of coverage. In the event of any discrepancy between this brochure and the certificate of coverage, the terms of the certificate of coverage will control.**

X	Firma de inscripción del empleado	Fecha
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# Renuncia a los beneficios médicos grupales

Nombre del empleado

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Puesto

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Número del empleado (Identificación, Seguro Social, etc.)

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Para el año del plan en vigencia a partir de **01 de enero 2025** estoy renunciando a la cobertura de los planes de seguros ofrecidos por Baywood Hoteles/Lakecrest Partners (UnitedHealthcare y ACIBenefits) para:

- Mí
- Cónyuge/Concubino
- Dependiente(s):

Si selecciona Dependiente(s), escriba sus nombres:

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Renuncio a la cobertura por el siguiente motivo:

- Prefiero no tener cobertura
- Tengo cobertura en virtud del plan de mi cónyuge/concubino
- Tengo otra cobertura

La otra cobertura tiene las siguientes características:

- Plan grupal patrocinado por el empleador
- Póliza individual
- Medicare
- COBRA
- TRICARE
- Medicaid

**Aviso de inscripción especial y certificación.** Revise y firme a continuación si desea renunciar a la cobertura

Al firmar a continuación, certifico que se me ha dado la oportunidad de solicitar cobertura para mí y mis dependientes elegibles, si corresponde. Rechazo la inscripción como se indica arriba. Entiendo que, si rechazo la inscripción para mí o mis dependientes elegibles (incluido mi cónyuge) porque tengo otro seguro médico o cobertura de plan médico grupal, podría inscribirme e inscribir a mis dependientes elegibles en este plan si yo o mis dependientes elegibles perdiéramos la elegibilidad para esa otra cobertura (o si el empleador dejara de realizar aportes a dicha cobertura para mí o para mis dependientes elegibles).

Entiendo que debo solicitar la inscripción, a más tardar, 30 días después de la fecha en que finalice la otra cobertura de plan médico (o después de que el empleador deje de realizar aportes a la otra cobertura). Si no lo hago en ese tiempo, no podré inscribirme hasta el próximo período de inscripción abierta anual de mi empleador.

Además, entiendo que si tengo un nuevo dependiente elegible en virtud de un matrimonio, un nacimiento, una adopción o una entrega en adopción, podría inscribirme e inscribir a mis dependientes elegibles. Sin embargo, debo solicitar la inscripción en un plazo de 30 días después del matrimonio, del nacimiento, de la adopción o de la entrega en adopción.

Entiendo que para poder solicitar una inscripción especial u obtener más información debo comunicarme con el administrador de mi grupo.

Firma del empleado

Fecha