Drug Screen Results Form

Specimen ID Number _____

Collection Test Date _____

Company Information: *(information about the company doing the testing)*

Company GEAR, LLC

Address 3356 REGAL DRIVE Suite A

City ALCOA State TN Postal Code 37701

Collector's Name _____ Phone 865-724-2215

Specimen's Temperature: (90 - 100° F) In Range ☐ Other _____ Fax 865-724-1671

Donor Information: *(information about the person being tested)*

Donor's Name _____

ID or SSN last 4 SSN Only _____

Identification Type _____ Expiration _____

Notes _____

Certification Information: *(Must be signed by both Donor and Collector)*

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and/or alcohol.

_____ _____

Donor's Signature *Date*

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

_____ _____

Collector's Signature *Date*

Initial Screen Results: *(All "Confirm" or non-negative results must be confirmed using GC/MS)*

Drug Name	Device	Negative	Confirm	Not Tested
Cocaine	COC	☐	☐	☐
Marijuana	THC	☐	☐	☐
Opiates/Morphine	OPI/MOP	☐	☐	☐
Amphetamines	AMP	☐	☐	☐
Methamphetamines	mAMP	☐	☐	☐
Phencyclidine	PCP	☐	☐	☐
Benzodiazepines	BZO	☐	☐	☐
Barbiturates	BAR	☐	☐	☐
Methadone	MTD	☐	☐	☐
Tricyclic Antidepressants	TCA	☐	☐	☐
Oxycodone	OXY	☐	☐	☐
Propoxyphene	PPX	☐	☐	☐
Methylenedioxymethamphetamines	MDMA	☐	☐	☐
Buprenorphine	BUP	☐	☐	☐
Cotinine	COT	☐	☐	☐
ALCOHOL SCREEN	ALC	☐		

Level _____

Adulteration Panel Results
(See color chart and package Insert for interpretation)

☐ OX/PCC	Oxidants/PCC In Range / Other _____	☐
☐ S.G.	Specific Gravity In Range / Other _____	☐
☐ PH	pH In Range / Other _____	☐
☐ NIT	Nitrate In Range / Other _____	☐
☐ GLUT	Glutaraldehyde In Range / Other _____	☐
☐ CRE	Creatine In Range / Other _____	☐

Last Name _____

First Name _____

Rev-0213

GEAR Contractor Lockdown Sheet

Contractor Name: _____

Contractors Phone: _____

Contractors Position: _____

Company Assigned To: _____

Company Contact Name/Phone: _____

Worksite Address: _____

Start Date: _____

Start Time: _____

Starting Pay: _____

Recruiters Name/Phone: _____

State of Birth / Weight & Height: _____

Special Instructions: _____

_____

_____

GEAR Representative

Name: _____

Signature: _____

Date: _____

Contractor

Name: _____

Signature: _____

Date: _____

GEAR Employment Application

Name: _____ Date: _____

Address: _____

Phone: _____ Position Applying For: _____

Required Pay Rate: _____ Date Available for Hire: _____

Are you currently employed? Y☐ N☐ Have you ever been employed by GEAR? Y☐ N☐

Do you have reliable transportation? Y☐ N☐

Are you willing to submit to a drug screen? Y☐ N☐

Are you willing to submit to a background check? Y☐ N☐

Are you eligible to work in the United States? Y☐ N☐

Are you at least 18 years old or older? Y☐ N☐

Do you have two forms of Identification? Y☐ N☐

Are you willing to relocate or travel? Y☐ N☐

Do you have a hard hat, steel toe boots, and safety glasses? Y☐ N☐

Do you have all required hand tools to do your trade? Y☐ N☐

Do you have a banking account or pay card? Y☐ N☐

Do you have any certifications? Y☐ N☐ Please list: _____

_____

Do you have anything scheduled that would cause you to miss work? Y☐ N☐ _____

_____

GEAR Global Employment And Recruiting LLC

Please list your last Four Employers

Company Name: _____

Position: _____

Duties: _____

Reference Name: _____ Reference Phone: _____

Company Name: _____

Position: _____

Duties: _____

Reference Name: _____ Reference Phone: _____

Company Name: _____

Position: _____

Duties: _____

Reference Name: _____ Reference Phone: _____

Company Name: _____

Position: _____

Duties: _____

Reference Name: _____ Reference Phone: _____

GEAR
Global Employment And Recruiting
LLC

3356 Regal Drive Suite A
Alcoa, TN 37701
Office: 865.724.2215
Fax: 865.724.1671

Employee Agreement

Under the terms of this agreement, I become an employee of GEAR, LLC, and GEAR, LLC would become my administrative employer of record. GEAR, LLC will also be responsible for administration of unemployment, worker's compensation, and other employee benefits. GEAR, LLC also assumes responsibility for the payment of wages to the employees. I understand that I may contact GEAR, LLC with any issues/concerns regarding my employment.

I understand and agree that, if hired, my employment is for no definite period and, regardless of the date of payment of my wages or salary; I may be terminated at any time without prior notice.

I understand that as the Employee, I will not accept employment directly or indirectly by the Client to which Employee is assigned for a period of one hundred eighty (180) days following the completion of assignment to said Client and/or assignment to the work of said Client performed on Employer's premises or in the field without the written consent of Employer. In the event of an actual or threatened breach of this paragraph, Employer shall be entitled to an injunction restraining the Employee from accepting such employment. Nothing herein stated shall be construed as prohibiting Employer from pursuing any other remedies available to the Employer for such breach or threatened breach, including the recovery of damages from Employee. The Employee is required to give the Employer notice of any solicitation or offer for employment by a competitor or the Client (related to the assignment) within 48 hours of the offer or solicitation. Employee further agrees to advise any person or business entity of the existence of this provision at the time of solicitation or offer.

I certify that the facts herein submitted are true and complete to the best of my knowledge and understand that, if employed; falsified statements may be grounds for dismissal.

_____ _____

Applicant Signature Date

Notice of Unemployment

Any employee will be presumed to have voluntary left employment without good cause if the employee does not contact GEAR, LLC upon completion of an assignment or a layoff. Failure to contact GEAR, LLC may cause unemployment benefits to be denied. Employee must contact GEAR, LLC office within 2 business days.

_____ _____

Applicant Signature Date

GEAR
Global Employment And Recruiting LLC

3356 Regal Drive Suite A
Alcoa, TN 37701
Office: 865.724.2215
Fax: 865.724.1671

EMPLOYEE INFORMATION SHEET

To Be Completed By Employer

Position_____ Client_____ Supervisor_____

Employment Status_____ Hire Date_____ Starting Pay_____

Employee:

Please complete this Employee Information Sheet. It will supply us the information we need for our payroll and benefit programs. Please be advised that this information will be used and kept confidential in accordance with the applicable laws and regulations. This information will not be used as the basis for any adverse employment decision. **You are responsible for updating this information is there are any changes during your employment.**

Personal Data

Please Print

Name_____ Today's Date_____
Last First Middle

E-mail_____ SSN_____

Present Address_____ City_____ State_____ Zip_____

How long at present location_____ Home Phone _____ Cellular/Other Phone_____

Previous Address_____ City_____ State_____ Zip_____

List any family or friends working for us_____

In Case of Emergency Information

1 Name_____ Phone (Day)_____

Address_____ Phone (Night) _____

City_____ State_____ ZIP_____ Relationship_____

2 Name_____ Phone (Day)_____

Address_____ Phone (Night) _____

City_____ State_____ ZIP_____ Relationship_____

3 Name_____ Phone (Day)_____

Address_____ Phone (Night) _____

City_____ State_____ ZIP_____ Relationship_____

HIPPA privacy act code – employee's mother's maiden name:

GEAR
Global Employment And Recruiting LLC

3356 Regal Drive Suite A
Alcoa, TN 37701
Office: 865.724.2215
Fax: 865.724.1671

AUTHORIZATION FOR AUTOMATED DIRECT DEPOSITS

COMPANY NAME **GEAR, LLC**

COMPANY ID NUMBER

I (we) hereby authorize GEAR, LLC , hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit and adjustments for any credit entries in error to my (our) Checking _____ Savings _____ account (check one) indicated below and the depository bank named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

1. PRIMARY ACCOUNT – DEPOSITORY

Name _____ Branch _____
City _____ State _____ Zip _____
Transit / ABA No. _____ Account No. _____

2. SECONDARY ACCOUNT – DEPOSITORY

Name _____ Branch _____
City _____ State _____ Zip _____
Transit / ABA No. _____ Account No. _____
* Amount deposited into this account _____

* **Required if using secondary account.**

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

Name _____ ID Number _____
Signature _____ Date _____

Please attach a voided check or deposit ticket if checking account is selected.

For Company Use Only

Date Received _____

Processed By _____

Client Name: _____
Client Contact: _____
Client Email: _____

Client Account Number: _____
Client Phone Number: _____

DISCLOSURE OF PROCUREMENT OF CONSUMER REPORT AND/OR INVESTIGATIVE CONSUMER REPORT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

PLEASE BE ADVISED that GEAR - Global Employment and Recruiting ("the End User") may obtain a Consumer Report about you in order to evaluate your eligibility **for employment purposes**. It may be an Investigative Consumer Report, which may include information about your character, general reputation, personal characteristics, and mode of living. You have the right to request disclosure of the nature and scope of the report, which may involve personal interviews with sources such as your neighbors, friends, associates, or others.

These reports may include credit information, credit history, employment history and reference checks, criminal and civil history information, motor vehicle records and moving violation reports ("driving records"), sex offender status reports, education verification, professional licensure verification, and other items.

THE UNDERSIGNED HEREBY ACKNOWLEDGES THAT HE/SHE HAS READ THE FOREGOING DISCLOSURE.

_____ _____

APPLICANT'S SIGNATURE DATE

_____

PRINT NAME

MULTIPLE PARTY AUTHORIZATION

I HEREBY AUTHORIZE GEAR - Global Employment and Recruiting (the "End User") to obtain "consumer reports" and/or "investigative consumer reports" at any time after receipt of this Authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any person or entity, law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information to ESS, 2500 Southlake Park, Birmingham, AL 35244, toll free 866.859.0143, www.es2.com, or its subcontractor or another outside organization acting on behalf of ESS. The term "background information" includes, but is not limited to, employment history, reference checks, criminal and civil history information, motor vehicle records, moving violation reports, sex offender status information, credit reports, education verification, professional licensure verification, drug testing, information related to my Social Security number, and information concerning workers' compensation claims. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

I FURTHER AUTHORIZE the disclosure of my reports to Click here to enter text. or other customers of the End User, at which I may be eligible to be staffed or otherwise to perform services.

I acknowledge receipt of the Disclosure Of Procurement Of Consumer Report And/Or Investigative Consumer Report. I understand I can view ESS's Privacy Policy on its website, www.es2.com. You have the right to request from the End User a written summary of the rights of a consumer prepared pursuant to the Fair Credit Reporting Act, 15 U.S.C. § 1681g(c).

_____ _____

Signature of Employee or Prospective Employee Date

APPLICANT INFORMATION: TO BE COMPLETED BY APPLICANT: PLEASE USE BLACK INK

The following is for identification purposes only to perform the background check and will not be used for any other purpose.

Print: Last Name		First Name		Middle Initial
Date of Birth	Social Security Number		Driver's License Number	State
Current Address:		City	State	Zip Code
Previous Address (Past 7 Years):		City	State	Zip Code
Previous Address (Past 7 Years):		City	State	Zip Code
Alias Names (Other names I have been known by):				
Degree Obtained	Year Graduated	Name of School		City and State of School
Last Name Used at Time of Graduation				

Searches to be Ordered

Para informacion en espanol, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20522.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - A person has taken adverse action against you because of information in your credit report;
  - You are the victim of identity theft and place a fraud alert in your file;
  - Your file contains inaccurate information as a result of a fraud;
  - You are on public assistance;
  - You are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above:	
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, SE Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street S.W. Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

Employment Eligibility Verification

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

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

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

(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
		Recruiter

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		GEAR Recruiting, LLC

	City or Town	State	ZIP Code
3356 Regal Drive	Alcoa	TN	37701

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

STATE OF TENNESSEE
NEW HIRE REPORTING

Effective October 1, 1997, all Tennessee employers are required to report certain information about employees who have been newly hired, rehired, or have returned to work. Employers must either (1) complete this form, or (2) submit a copy of the employee's IRS W-4 form, (3) other form with required information at a minimum, or (4) submit the information by Internet, magnetic tape or diskette. This form may be reproduced as necessary. **Reports made on this form must be within 20 calendar days of hire or if you wish to help the Department of Labor and Workforce Development, within 5 days of date of hire.**

TO ENSURE ACCURACY, PLEASE PRINT (or TYPE) NEATLY IN UPPER-CASE LETTERS AND NUMBERS, USING A DARK, BALL-POINT PEN

REQUIRED INFORMATION: — *EMPLOYEE DATA*

Social Security Number: ___ – __ – ____

Name: *First* _____ *M.I.* _____

Last _____

Home Address: (Do not use Employer Address, Do not leave blank) _____

_____

City _____ *State* ____ *Zip Code* _____ – ____

Employee Date of Hire: __ – __ – ____

EMPLOYER DATA

Federal EIN: 27 – 0810349

Employer Name: GEAR, LLC

Address: 3356 REGAL DR

_____

City ALCOA *State* TN *Zip Code* 37701 – ____

ADDITIONAL INFORMATION:

Store or Outlet Number: _____

Gender (M/F): ____ **Employee State of Hire:** ____ **Date of Birth:** __ – __ – ____

Earned Income Tax Credit Available? (Y/N): ____
(if unknown, leave blank)

Employee Left Your Employment? (Y/N): ____
(Has this employee left your employment before you filed this report?)

Does your company offer Medical Insurance? (Y/N): Y

Corporate or Payroll Address: (if different from business address) _____

_____

City _____ *State* ____ *Zip Code* _____ – ____

REPORTS WILL NOT BE PROCESSED WITHOUT MANDATORY INFORMATION

Send Reports To:

Tennessee New Hire Reporting Program
P.O. Box 17367
Nashville, Tennessee 37217
Fax: (877) 505-4761

Form W-4 (2017)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

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

For accuracy, complete all worksheets that apply.

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)
GEAR, LLC 3356 REGAL DRIVE ALCOA, TN 37701		27-0810349

Deductions and Adjustments Worksheet

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

1 Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $

2 Enter: { $12,700 if married filing jointly or qualifying widow(er) / $9,350 if head of household / $6,350 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2017 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

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

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

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

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

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

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

Table 2

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

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

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

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

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

GEAR
Global Employment And Recruiting LLC

3356 Regal Drive Suite A
Alcoa, TN 37701
Office: 865.724.2215
Fax: 865.724.1671

AUTHORIZATION TO MAKE DEDUCTION FROM PAYCHECK

I authorize and give my consent to GEAR, LLC to make any applicable deductions from my paycheck if I voluntarily leave my employment within the first 2 weeks of being placed with a GEAR, LLC client.

These deductions include the cost of pre-employment screening services such as drug tests, background checks, physicals, etc., which were ordered by the employer, to reimburse GEAR, LLC for these costs. In addition, the cost of any PPE provided by GEAR, LLC to employee not returned to GEAR, LLC will be deducted from employee's paycheck.

I UNDERSTAND THAT THE AMOUNT OF THESE DEDUCTIONS TAKEN FROM MY PAYCHECK WILL BE DETERMINED IN ACCORDANCE WITH THE FAIR LABOR STANDARDS ACT AND ANY APPLICABLE STATE LAW.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS CONSENT FORM. I AGREE TO ABIDE BY ITS TERMS, AS EVIDENCED BY MY SIGNATURE BELOW.

Employee:_____ **Date:**_____
Signature

Employee:_____
Print Name

3356 Regal Drive Suite A
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Fax: 865.724.1671

Cell Phone Use Policy

The purpose of this policy is to outline the acceptable use of cellular phones ("cell phones") and other communication devices, including, but not limited to Blackberries, mobile phones, iPhones, text pagers, two-way radios and other wireless devises at Gear LLC client sites. These rules are in place to protect workers and the Company. Inappropriate use of communication devices endangers workers by distracting them and may interfere with their proper and safe use of equipment and machinery. The devises themselves and any headphones or wireless ear pieces may get tangles in machinery or interfere with proper use of PPE (Personal Protective Equipment). Lastly, when workers are at work, they're expected to be doing their jobs, not engaging in personal conversations, checking personal email, playing games or sending text messages.

1. **Who This Policy Applies to**

This policy applies to workers, contractors, consultants, temporary workers and other workers at the Company.

2. **Prohibited Uses**

While in the workplace during work hours, workers are expected to focus on work. Thus, workers may not use any communication device in the workplace while they are working. Use of communication devices while on the job site is always prohibited. Prohibited uses includes, but is not limited to use of communication devices to:

- Engage in conversations
- Play games
- Surfing the internet
- Checking email
- Sending text messages

3. **Permitted uses**

Workers are permitted to use communication devices while they are not working, provided that the use of devices is confined to breaks and lunch.

4. **Violations of the Policy**

Workers who violate this policy will be subject to disciplinary measures up to and including dismissal.

I have read and will abide by the terms of this policy regarding the use of communication devices at work.

Name (printed) _____

Signature _____ Date _____

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AUTHORIZATION AND CONSENT FOR DRUG AND ALCOHOL SCREEN

I give full permission and authorization to have GEAR, LLC, and/or their medical physician, send a specimen of my urine and/or blood to a laboratory for screening using N.I.D.A standards for the presence of illegal drugs, alcohol, or prescription medication taken without a prescription.

I will hold all parties involved harmless, meaning I will not send or hold them responsible for and alleged harm to me or interfering with my obtaining a job or continuing employment as a result of not submitting to the tests or as a result of the determination of the testing. This Includes, but is not limited to, any possible clerical or laboratory errors made.

I understand this is a legal binding document, which is binding because GEAR, LLC is both sending me for the examination and paying for the examination. I fully understand the wording of this document.

Should an accident occur while on assignment, I understand a drug and or alcohol screen will be required immediately. I consent and authorize my participation in random drug testing, and agree to hold all parties involved harmless in the event any test may show a positive result. My refusal to submit to the drug and or alcohol testing requested will be grounds for immediate termination.

Should the test results be negative, GEAR, LLC agrees to pay all lab fees.

Should the test results be negative and one or more of the following occurs, I agree to pay the lab fees:

- I leave the assignment before the 90-day term unless other agreements are made
- I am released from an assignment for cause
- Retesting is required because of diluted specimen
- I fail to report to the assignment as agreed

In the event the lab results are positive, I agree to pay lab fees Incurred.

I _____, hereby understand that as a condition of my employment, I may be subject to drug/alcohol testing for the following reasons:

*Pre-Employment *For Cause or Suspicion *Post-Hire *Random *Post-Accident *Promotion and/or Job Transition

My signature below indicates that I acknowledge the following: Should a drug/alcohol test be requested or is appropriate under the above drug/alcohol screen authorization and consent, and if I fail or refuse to submit the required blood or urine sample for the authorized screen, such failure or refusal, whatever reason, will be grounds for termination.

_____ _____

Applicant Signature Date

GEAR
Global Employment And Recruiting LLC

3356 Regal Drive Suite A
Alcoa, TN 37701
Office: 865.724.2215
Fax: 865.724.1671

EMPLOYEE ACKNOWLEDGEMENT OF WHAT TO DO IN THE EVENT OF A WORK INJURY

I,_____

(Print Employee's Name)

Acknowledge and understand that I must report any workers compensation injury immediately to my work place supervisor within 24 hours.

In an emergency, I understand that I should seek immediate medical treatment as soon as possible. I should then contact my supervisor and/or GEAR, LLC for further medical treatment and claim direction.

As stated on the LB-0922 Tennessee Worker's Compensation Insurance Notice; if you are injured on the job; notify your supervisor immediately, he then will contact GEAR, LLC, for claim reporting and continued medical treatment to where you will select a treating physician from a panel provided by GEAR, LLC

I acknowledge that the required LB-0922 Tennessee Worker's Compensation Insurance Notice is posted for my use in the case of a Workers Compensation injury.

_____ _____

Employee Signature **Date**

_____ _____

Supervisor Signature **Date**

All employees are required to sign this acknowledgement. It should then become a part of the employee's permanent file.

GEAR
Global Employment And Recruiting
LLC

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Alcoa, TN 37701
Office: 865.724.2215
Fax: 865.724.1671

RELEASE OF MEDICAL INFORMATION

I,_____authorize GEAR, LLC to request and obtain all records regarding any industrial and/or occupational disease involving myself and GEAR, LLC This is to Include, but is not limited to, doctor's reports, nurse's notes, follow-up reports, medical bills, test results, etc.

A facsimile or photo static copy of this authorization shall be considered as effective and valid as the original. The release shall be in effect until specifically rescinded by me in writing.

_____ _____

Applicant Signature **Date**

GEAR
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LLC

3356 Regal Drive Suite A
Alcoa, TN 37701
Office: 865.724.2215
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January 16, 2017

Dear GEAR Employee,

Open Enrollment for GEAR's health insurance benefit plan starts today and ends on January 26, 2017 for the 2017 plan year which starts on February 1, 2017. Open Enrollment is an opportunity for you to make changes in your coverage if you already have insurance through GEAR, or to start coverage for the 2017 plan year if you do not already have coverage through GEAR.

Enclosed is an **Employee Benefits Enrollment Guide** which describes the coverage and monthly cost to employees, an enrollment form and a payroll deduction form.

We are pleased to announce a decrease in the cost employees for the standard coverage (Option 2 in the Benefit Guide) which continues to be offered through Blue Cross/Blue Shield of Tennessee's Network S. Additionally, we have added Option 1 which includes a Prescription Drug card at an additional cost. Please review the Benefit Guide carefully and let us know if you have questions.

Whether you wish to enroll in our health insurance program or not, you must return the enclosed Employee Enrollment form to us by January 26, 2017.

If you do wish to continue your coverage, make changes to coverage, or enroll in the health insurance program for the 2017 plan year , you will also need to return a **payroll deduction form to us authorizing us to deduct weekly (monthly amount x 12 divided by 52) premiums from your pay.**

Regards,

Matt Blankenship

EMPLOYEE PAYROLL DEDUCTION AUTHORIZATION FORM

Employee Name: _____ SSN: _____

Employee #: _____ Hire Date: _____ Deduction Effective Date: _____

WEEKLY DEDUCTION (PRE-TAX) FOR MEDICAL or MEDICAL/ PRESCRIPTION DRUG COVERAGE

(Please check the box beside the coverage in which you wish to enroll)

Weekly Payroll Deductions	Option 1 (with Prescription Card)	Option 2 (no Prescription Card)
☐ EMPLOYEE ONLY:	☐ $52.78/week	☐ $ 32.33/week
☐ EMPLOYEE + SPOUSE	☐ $120.18/week	☐ $ 81.23/week
☐ EMPLOYEE + CHILD(REN)	☐ $102.50/week	☐ $ 69.22/week
☐ FAMILY	☐ $175.62/week	☐ $122.78/week

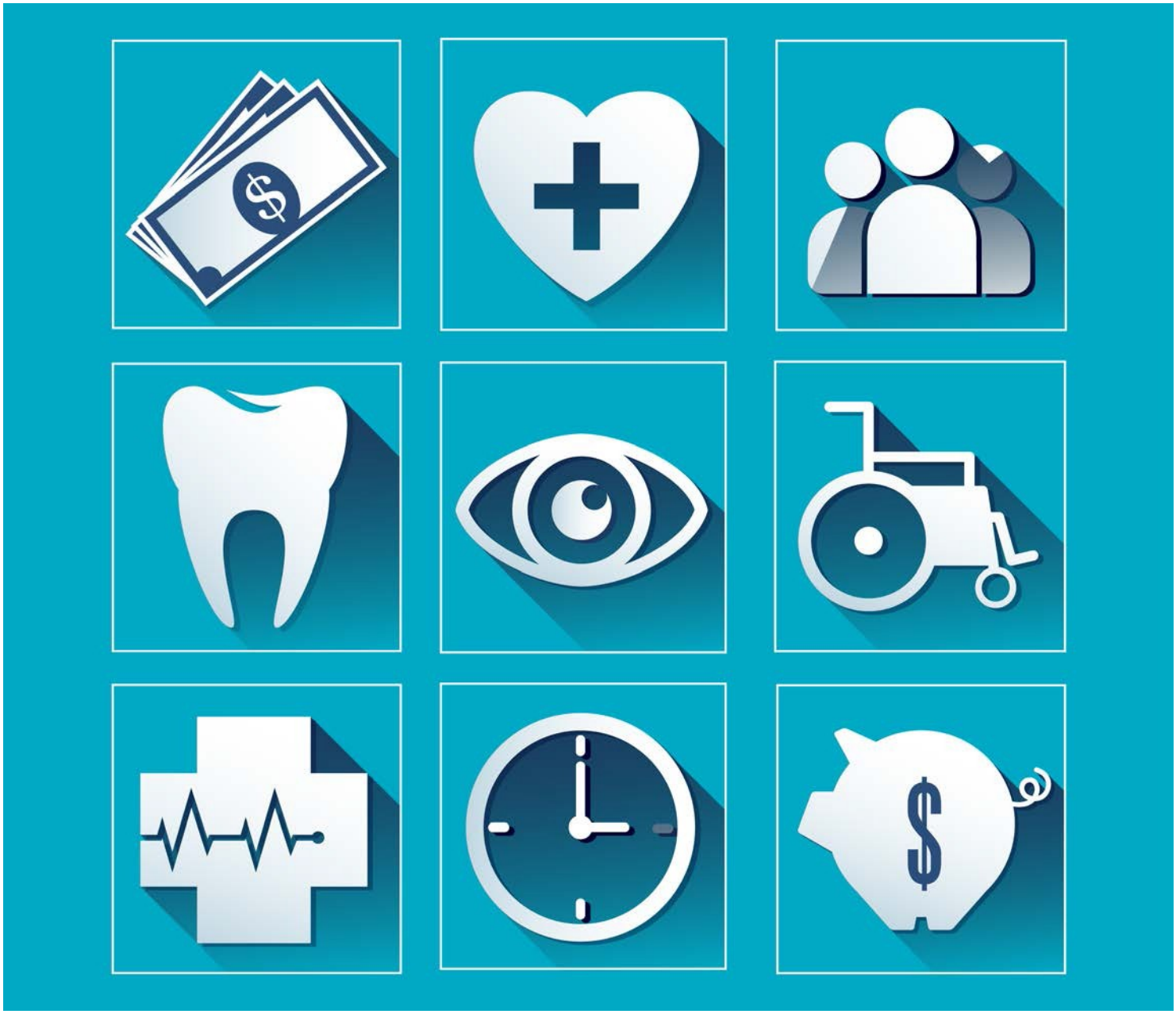
I acknowledge that the medical insurance premium for which I am enrolling will be deducted from my gross pay each week.

In the event a new Employee Payroll Deduction Authorization Form is not executed on or before the next year-end, this form shall be deemed to continue in force for the next succeeding year. I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a qualifying event/change in status as outlined in the Benefit Guide. Should my election change during the course of the plan year, I authorize my employer to deduct the new corresponding amount from my pay.

Employee Signature: _____ Date:_____

Employee Benefits Enrollment Guide

Plan Year: F e b r u a r y 1, 2018 – January 31, 2019



BlueCross BlueShield of Tennessee

Medical and Prescription Drugs

Gear, LLC, provides medical coverage through BlueCross BlueShield of Tennessee for employees and their dependent(s). GEAR employees may choose between two plan options illustrated below:

Plan Features	*Option 1/Network S*	*Option 2/Network S*
Annual Calendar Year Deductible	$5,000 – Individual $10,000 – Family	$5,000 – Individual $10,000 – Family
Coinsurance – In Network	70%	70%
Annual Out-of-Pocket	$6,850 – Individual $ 13,700 – Family	$6,850 – Individual $ 13,700 – Family
Office Visits	70% after Deductible	70% after Deductible
Emergency Room Services	70% after Deductible	70% after Deductible
Inpatient Hospital Expenses	70% after Deductible	70% after Deductible
Outpatient Hospital Expenses	70% after Deductible	70% after Deductible
Surgical Expenses	70% after Deductible	70% after Deductible
Urgent Care	70% after Deductible	70% after Deductible
Preventive Care	100%, No Deductible or Copay	100%, No Deductible or Copay
Wellness Benefit	100%, No Deductible or Copay	100%, No Deductible or Copay
Prescription Contraceptives	100%, No Deductible or Copay	100%, No Deductible or Copay
Prescription Drugs	$10/$35/$50 Self-Admin Specialty $100	70% after Deductible
Out of Network – Deductible	$10,000 - Individual $20,000 - Family	$10,000 - Individual $20,000 – Family
Out of Network – Out-of-Pocket	$20,550 - Individual $41,100 - Family	$20,550 - Individual $41,100 – Family
Out of Network – Coinsurance	50%	50%

Monthly Payroll Deductions	Option 1	Option 2
Employee	$228.70 ($52.78 weekly)	$140.10 ($32.33 weekly)
Employee + Spouse	$520.78 ($120.18 weekly)	$352.00 ($81.23 weekly)
Employee + Child(ren)	$444.17 ($102.50 weekly)	$299.95 ($69.22 weekly)
Family	$761.02 ($175.62 weekly)	$532.05 ($122.78 weekly)

Please verify that your provider is in network:
https://bcbst.vitalschoice.com/#/?geo_location=37203&network_id=39&ci=DFT

Who do I contact?

Questions?	Contact
Medical Benefits	**Blue Cross Blue Shield of Tennessee** **(800) 565-9140** **www.bcbst.com**

Insurance Questions?

Who is Eligible and When?

You are considered an eligible employee if you are a regular full-time employee scheduled to work at least 30 hours per week. Full-Time employees are eligible for benefits after 30 days of employment with **Gear, LLC.**

Eligible Dependents are listed below

1. Spouse, including Same-Sex Spouse**
2. Children (birth to age 26)
3. Dependent, who receives at least 51% of financial support from you as the employee.
4. Disabled Dependent, who is physically or mentally disabled, regardless of age

**Couple must have been married in a state where these marriages are legal.

When do my benefits start?

At open enrollment, benefits will become effective February 1st. If you are a new hire, they are effective 30 days after your date of hire.

When can I see the doctor?

If you are a new enrollee, you may make an appointment any time after your effective date. Please make sure that you have your Employee ID number and Group number with BCBST before making an appointment.

When will I receive my ID card?

You will receive ID Cards from BCBST at your home address within two weeks once your paperwork has been submitted.

Please check your ID Cards to make sure names are spelled correctly.

Qualifying Event/Change in Status

A qualifying event or life event is the only time that you may change your elections or add dependents to your plan. These qualifying events are:

- **Marriage/Divorce**
- **Birth, Adoption or placement for adoption of eligible child**
- **Death of your covered spouse or covered child**
- **Change in you or your spouse's work status that affects benefits eligibility**
- **Becoming eligible for Medicare or Medicaid during the plan year**

Any other election changes or canceling of coverage cannot be completed until the Annual Open Enrollment period.

2018 ANNUAL NOTICES

HIPAA - Summary Notice of Privacy Practices

The use and disclosure of Protected Health Information is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). This notice describes how information about you may be used and disclosed, and how you can get access to this information with regard to your benefits. We keep the health and financial information of our current and former members private, as required by law. This notice explains your rights and our legal duties and privacy practices.

MEDICARE PART D - Notice of Creditable Coverage

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires group health plans that provide prescription drug coverage to disclose to individuals eligible for Medicare Part D whether their coverage is "creditable," i.e., whether it is at least actuarially equivalent to the Medicare Part D coverage. Medicare Part D notices of creditable or non-creditable coverage must be provided to Medicare-eligible individuals prior to November 15 of each year.

NEWBORN NOTICES

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. *It is the employee's responsibility to notify the Human Resources Department of pregnancy so they can be provided their statement of rights under the Newborn's and Mother's Health Protection Act.*

SPECIAL ENROLLMENT NOTICE

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 30 days after your or your dependent's 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 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Mark Grayson at 865-724-2102.

WHCRA - Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator, Mark Grayson, at 865-724-2102 for more information.

WHCRA - Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

- BCBS PPO: Single Deductible $5,000/Family Deductible $10,000 with 80% Coinsurance.

If you would like more information on WHCRA benefits, call your plan administrator, Mark Grayson, at 865-724-2102 for more information.

of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402-0001
bcbst.com
- CONFIDENTIAL -

EMPLOYEE ENROLLMENT / WAIVER

PLEASE USE BLUE OR BLACK INK ONLY
IF YOU ARE DECLINING COVERAGE, PLEASE GO TO BACK OF FORM.

Plan Use Only
Rec:_____

EEW-15

Section 1 – Group / Employer Information – This form cannot be processed without this information

GROUP NO. | SUBGROUP NO. | DEPARTMENT NO. | GROUP NAME

COVERAGE EFFECTIVE DATE: Medical __/__/____ Dental __/__/____ Vision __/__/____ FSA __/__/____

NEW ENROLLMENT (CHECK IF APPLICABLE):

❑ New Hire ❑ Open Enrollment ❑ Rehire

❑ Part-time change to Full-time

Full-time Date of Hire: __/__/____ Hrs Wkd/Wk ____

Part-time / Rehire Date: __/__/____

QUALIFYING EVENT:

❑ Loss of Other Medical Cvg ❑ Loss of Other Dental Cvg

❑ Loss of Other Vision Cvg ❑ Marriage ❑ New Dependent Child

❑ Court Order ❑ Other (FSA Only) ❑ Continuation Coverage Period Expired

EVENT DATE: __/__/____

❑ **COBRA OR** ❑ **STATE CONTINUATION:**

❑ Termination of Employment (Voluntary or Involuntary) ❑ Employee Eligible for Medicare

❑ Reduction in Hours ❑ Dependent Child No Longer Eligible

❑ Divorce/Legal Separation ❑ Death of Employee

EVENT DATE: __/__/____

Section 2 - Employee/Member Information – Employee Must Complete In Full

ELECT: Medical Option: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other _____ ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren)

ELECT: Dental Option: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other _____ ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren)

ELECT: Vision Option: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Other _____ ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren)

ELECT: FSA: ❑ Health Care: $ _____.__ Annual Pledge Amount*

❑ Dependent Care: $ _____.__ Annual Pledge Amount*

If your Group does not offer a debit card with FSA, should BCBST automatically pay Health Care FSA funds when medical claims are processed? ❑ **YES** ❑ **NO**

OTHER INSURANCE
If you or listed dependents will be covered by other medical/Medicare or dental insurance when this plan goes into effect, indicate which coverage.
❑ Medical/Medicare ❑ Dental

HICN _____

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | JR., SR., ETC. | SSN/TIN** | DATE OF BIRTH __/__/____ | Male ❑ Female ❑

ADDRESS

❑ **SPANISH IS MY PRIMARY HOUSEHOLD LANGUAGE**

CITY (Please do not abbreviate) | STATE | ZIP | EMAIL ADDRESS***

PAID CLASSIFICATION
❑ Hourly ❑ Salary ❑ Retiree ❑ Surviving Spouse

JOB CLASSIFICATION
❑ Management ❑ Non-Management ❑ Exec/Officer/Owner

JOB TITLE | PAYROLL NO.

Section 3 – Acknowledgement - Signature and Date MUST BE COMPLETED

Employee should notify BlueCross BlueShield of Tennessee if any dependent's address is different from the employee's address. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage. I understand, and agree, that I am applying for coverage and: 1) that any contract which may be issued to me will be subject to all the terms and conditions of the Group Agreement; 2) that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee any and all medical records pertaining to any person covered by the contract; 3) that I am responsible for any fee for these records; and 4) that Health and Dependent Care Flexible Spending Accounts (FSAs) are on a pre-tax basis and they cannot be changed prior to the end of the plan year unless a change in status event occurs as defined in the Summary Plan Description and I will forfeit any amount remaining in the account after all eligible expenses are submitted for reimbursement should I over estimate my annual needs.

Employee's Signature: X _____ Date: __/__/____ Phone: ___-___-____

**Annual maximum applies. See your Benefits Administrator if you have questions.* ***To comply with Federal regulations we must have SSN/TIN.* ****By providing your email address, you are agreeing to receive all communications (presently available or that become available during the term of your policy) related to this policy, the benefits considered under this policy, your relationship with BCBST, etc., in electronic form from BCBST or its subsidiaries.*

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

GROUP NO. | EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME

EEW-15

Section 4 - Dependent Information - Please provide all information for each person to be covered. Consult employer guidelines for dependent eligibility.

SPOUSE LAST NAME | SPOUSE FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SSN/TIN**

(1) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SSN/TIN**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (specify) ❑ Physically Handicapped ❑ Full-time Student Over 19

(2) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SSN/TIN**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (specify) ❑ Physically Handicapped ❑ Full-time Student Over 19

(3) DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | DATE OF BIRTH | Male ❑ Female ❑ | SSN/TIN**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (specify) ❑ Physically Handicapped ❑ Full-time Student Over 19

Section 5 – Ancillary Insurance Information ***(NOTE: Products are offered by USAble Life or other carriers which are independent and solely responsible. These are NOT BlueCross BlueShield products.)***

ELECT (Mark all that apply): ❑ Basic Life/ADD ❑ Dependent Life ❑ STD ❑ LTD ❑ Supplemental Life/ADD Life Class | Annual Salary $ .00

BASIC LIFE INSURANCE AMT $ .00 OR TIMES SALARY

SUPPLEMENTAL LIFE/ADD AMT $ .00 OR TIMES SALARY

BENEFICIARY	RELATIONSHIP	PERCENTAGE	BENEFICIARY	RELATIONSHIP	PERCENTAGE
1			3		
2			4		

Section 6 – Waiver of Coverage - Complete this section to waive coverage, however, your Employer may require an additional, separate waiver form.

DECLINE COVERAGE – I understand that I have been offered, and have declined, coverage sponsored by my employer.

Medical ❑ Dental ❑ Vision ❑ Basic Life/ADD ❑ Dependent Life ❑ STD ❑ LTD ❑ Supplemental Life/ADD ❑

Reason for declining (Mark all that apply):

❑ Other group medical coverage ❑ Other group dental coverage
❑ Other group vision coverage ❑ I have TennCare
❑ Other

GROUP NO. | GROUP NAME

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | EMPLOYEE DATE OF BIRTH

WAIVER SIGNATURE (Note: Signature also required in Section 3 when electing any coverage) X | **DATE**

Special Enrollment Period for Medical, Dental and Vision: An Employee or eligible dependent who did not apply for coverage within thirty-one (31) days of first becoming eligible for coverage under this Plan may enroll if: 1) he or she had other health care coverage at the time coverage under this plan was previously offered; and 2) he or she stated, in writing, at the time coverage under this Plan was previously offered, that such other coverage was the reason for declining coverage under this Plan; and 3) such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and 4) he or she applies for coverage under this Plan and the administrator receives the change form within thirty-one (31) days after the loss of other coverage. The Employee also may enroll at the next Open Enrollment Period.

GEAR
Global Employment And Recruiting
LLC

3356 Regal Drive Suite A
Alcoa, TN 37701
Office: 865.724.2215
Fax: 865.724.1671

PAYCHECK INTRANET LOGIN ACCESS FOR GEAR EMPLOYEES

1. **Go to the Massey Group website**

   a. http://payroll.masseygroup.ws/

2. **Locate this area on the page and click Pay Info**

   Webmail Submit a Ticket Pay Info Time App

   Phone Directory

3. **You will be prompted to create a login by using your Employee ID and last 4 digits of your SSN. (Screen should look like this)**

5. Massey Group Payroll Login

   User name

   Password

   Log in

   Sign up/Forgot Your Username or Password?

Please note your Employee ID will not be created until after you begin work. Please contact your Recruiter for your Employee ID.

3356 Regal Drive Suite A
Alcoa, TN 37701
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Fax: 865.724.1671
www.gearrecruiting.com

Client Assigned To: _____

Employee Name: _____

Start Week's (Monday) Date _____

Supervisor's Signature: _____

		MON	TUES	WED	THURS	FRI	SAT	SUN	TOTAL HOURS
Date (mm/dd)									
Mandatory Supervisor's Daily Initials									
Hours									
Total									

Email completed timecards to payroll@gearrecruiting.com or Fax to 865-724-1671

Supervisors: Please save a copy of the completed timecard for your record each week.

Worker's Comp Injury Statement

Employee certifies no accident or injury was sustained while working on the assignment unless so noted in the comment section.

Comments _____

Employee Signature _____

PLEASE NOTE: All time cards must be signed by assigned Client Site Supervisor and turned into GEAR payroll for APPROVAL BY FRIDAY AT 5:00 P.M.

TIMECARDS MUST BE FAXED OR EMAILED TO GEAR BY 10:00 A.M. (EASTERN) MONDAY MORNING.

Timecards that fail to have Client Site Supervisor's signature will be considered invalid and not approved for payroll.

In the event employment is terminated either voluntary or involuntary employee is responsible for gaining the site supervisor's signature for timecard approval.

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Supervisor's Signature: _____

		MON	TUES	WED	THURS	FRI	SAT	SUN	TOTAL HOURS
Date (mm/dd)									
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		MON	TUES	WED	THURS	FRI	SAT	SUN	TOTAL HOURS
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