THIS FORM IS FOR OFFICE USE ONLY!

New Employee File Checklist

Employees please fill out name and Last Four of SSN and continue on to the rest of the packet.
A Lingo representative will fill out the rest of this form.

Employee Name: _____ Last Four of SSN: _____

General Forms	Authorized Employee Initials
Lingo Staffing Application	_____
I-9 Form	_____
Copy of D.L or I.D	_____
Copy of Birth Certificate	_____
Copy of S.S Card	_____
Form W-4 Rev.	_____
Form VA-4 or Applicable State	_____
Direct Deposit Form	_____
Background Consent and Release Form	_____
Drug Screen Results	_____
Employee Policy Manual Acknowledgment	_____
Misc. Form: _____	_____

Authorized Employee Signature: _____ Date: _____

Form W-4 (2017)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

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

For accuracy, **complete all worksheets that apply.**

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
2017

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

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

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q Form **W-4** (2017)

FORM VA-4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION
PERSONAL EXEMPTION WORKSHEET

(See back for instructions)

1. If you wish to claim yourself, write "1" ..... _____
2. If you are married and your spouse is not claimed on his or her own certificate, write "1" ..... _____
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse) ..... _____
4. Subtotal Personal Exemptions (add lines 1 through 3) ..... _____
5. Exemptions for age
   (a) If you will be 65 or older on January 1, write "1" ..... _____
   (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1" ..... _____
6. Exemptions for blindness
   (a) If you are legally blind, write "1" ..... _____
   (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" ..... _____
7. Subtotal exemptions for age and blindness (add lines 5 through 6) ..... _____
8. Total of Exemptions - add line 4 and line 7 ..... _____

Detach here and give the certificate to your employer. Keep the top portion for your records

FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your Social Security Number	Name	
Street Address		
City	State	Zip Code

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
   (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet ..... _____
   (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet ..... _____
   (c) Total Exemptions - line 8 of the Personal Exemption Worksheet ..... _____
2. Enter the amount of additional withholding requested (see instructions) ..... _____
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions ..... (check here) ☐
4. I certify that I am not subject to Virginia withholding. I meet the conditions set forth Under the Service member Civil Relief Act, as amended by the Military Spouses Residency Relief Act ..... (check here) ☐

Signature _____ Date _____

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037. Note: Employers may establish a system to electronically receive Forms VA-4 from employees, provided the system meets Internal Revenue Service requirements as specified in § 31.3402(f)(5)-1(c) of the Treasury Regulations (26 CFR).

2801084 Rev. 08/11

Lingo Staffing, Inc.
DIRECT DEPOSIT OF PAYROLL AUTHORIZATION AGREEMENT

Employee Name: _____ **Last 4 of SS#:** _____

While working for Lingo Staffing you have two choices to get paid:

1) Have your check Direct Deposited into your own Checking or Savings Account.
2) Have your check Direct Deposited into a Lingo Staffing issued Global Cash Card Account.

Do to the fact that our employees work on a variety of sights we **DO NOT ISSUE OR MAIL LIVE CHECKS.** By having your checks Direct Deposited you will never have to worry about standing in line to cash your check or have to deal with lost or stolen checks or funds.

Please Choose one of the following by initialing the appropriate line:

I want my check Direct Deposited into the Lingo Global Cash Card Account: _____
(You will be issued an ATM card and account # on your first day of work and receive a Debit Visa within two weeks)

Account #: _____ Routing ABA#: 073972181 Bank Name: META Bank
Bank Address: 5501 S. Broadband Lane Sioux Falls, SD 57108

I want my check Direct Deposited into my own Checking or Savings Account: _____
(A deposit slip cannot be used.)

Checking: _____ **(Must include voided check or letter from bank)**
Savings: _____ **(Must include letter from bank)**

_____ _____
ACCOUNT NUMBER **TRANSIT/ROUTING NUMBER**

_____ _____ _____
BANK NAME **CITY** **STATE**

I hereby authorize *Lingo Staffing, Inc.*, to initiate credit entries or such adjusting entries, either debit or credit which are necessary for corrections, to my Checking and/or Savings account indicated below and the financial institution named below to credit (or debit) the same to such account(s).

This authority is to remain in full force and effect until Lingo Staffing has received written notification from me of its termination in such time and in such manner as to afford Lingo Staffing a reasonable opportunity to act on it.

_____ _____
SIGNATURE **DATE**

***Please note this Process may take up to 2 weeks and will not delay or hold back your paycheck.**

Lingo Staffing, Inc.

BACKGROUND CHECK
CONSENT AND RELEASE FORM

In connection with my application for employment (including contract for services), I understand that investigative background inquiries are to be made concerning myself including consumer reports, investigative consumer reports, criminal, driving and other reports. These reports may include information as to my character, credit worthiness, general reputation, personal characteristics, mode of living, work habits, performance, and experience along with reasons for termination of past employment from previous employers. I have a right to request disclosure of the nature and scope of the report, which involves personal interviews with sources such as neighbors, friends, or associates.

It is the policy of Lingo Staffing that all employees submit to a background check before they begin employment. It is our policy that we background check 100 percent of our employees on an annual basis. Please read the statement below. By signing you are stating that you agree and will adhere to this policy.

I freely and voluntarily agree to submit to a Lingo Staffing, Inc. approved background check as part of my application for employment. I understand that either refusal to submit to the background check will disqualify me from further consideration. Furthermore I understand that my criminal history may disqualify me from employment.

I agree to let Lingo Staffing share the results of my background check with an employer if needed.

I have read this form in full and understand and agree with the above statements and conditions of employment.

I authorize, without reservation, any party or agency contacted by this employer or its agent to furnish the above mentioned information:

First Name: _____ **Middle:** _____ **Last:** _____

DOB:** _____ **Social Security Number:** _____/_____/_____

Current Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Drivers License Number: _____ **State:** _____

Applicant's Signature: _____

Prospective Employer: _____

Lingo Staffing, Inc.

EMPLOYMENT/POST ACCIDENT DRUG TESTING CONSENT AND RELEASE FORM

It is the policy of Lingo Staffing that all employees submit to a drug test before they begin employment. It is our policy that we drug test 100 percent of our employees on an annual basis. Also, we drug test 50 percent of our employees randomly throughout each calendar year. Please read the statement below. By signing you are stating that you agree and will adhere to this policy.

I freely and voluntarily agree to submit to a Lingo Staffing Inc, Inc. approved drug test as part of my application for employment. I understand that either refusal to submit to the drug screen or a positive test result will disqualify me from further consideration.

I further understand that upon commencement of employment with the company, I may be required to submit to drug testing in accordance with Lingo Staffing's Drug Free Workplace policy. I understand that refusal to submit to the approved Lingo Staffing's drug test or failure to meet the minimum standards set for the screen may result in the immediate suspension or discharge.

In the event that the drug testing lab would change the results to positive after my employment commences, I understand that I will be immediately discharged.

I agree to let Lingo Staffing share the results of my drug screen with an employer if needed.

Included in this form, is consent for post accident drug screening. Failure to comply with a request for screening for Lingo Staffing is grounds for immediately discharge. By declining to take the Post Accident Drug Test your Workers Compensation benefits may be denied.

I have read this form in full and understand and agree with the above statements and conditions of employment.

Applicant Printed Name	Last Four of Social Security Number
Applicant Signature	Date

REMEMBER, IF YOU ARE INJURED <u>ON THE JOB</u> AND DO NOT REPORT IT IMMEDIATELY, YOUR STATE'S WORKERS' COMPENSATION MAY NOT COVER THE ACCIDENT.

ACKNOWLEDGEMENT OF EMPLOYEE HANDBOOK

Employee's Name _____
(Type or print)

This is to acknowledge that I have been provided with an opportunity to fully review the Lingo Staffing Employee Handbook, which outlines the policies, and practices of Lingo Staffing (the Company), referred to herein as the "Company." I further acknowledge that I understand that the Employee Handbook is always available for me to review on the Lingo Staffing webpage, as well as a hardcopy of the handbook that is available in each branch office. I agree that I will promptly read and familiarize myself with the information contained in this Handbook. I understand I must comply with its contents.

I understand that the policies and procedures in this Handbook are not intended to be contractual commitments or to create a contract of employment, but are merely descriptions of recommended procedures to be followed and policies necessary for the safe and efficient operation of the business. I further understand that with the exception of its policy of at-will employment and those policies compelled by law, the Company reserves the sole right to revoke, change or supplement its policies and guidelines at any time without notice. No policy is intended as a guarantee that benefits or rights will continue.

I understand and agree that my employment is at will, which means that either I or the Company may end the relationship at any time, for any legal reason, with or without cause, with or without notice. No one except the President of the Company can enter into an agreement for employment for a specified period of time, or make any agreement contrary to this policy of at-will employment. Any such agreement must be in writing, and must be signed by both the President and by me.

My signature below further signifies that I have carefully read this Acknowledgement of Receipt. I agree to observe the policies set forth in the Handbook.

_____
Employee's Printed Name

_____
Employee's Signature

_____
Date

Note to the employee: The original of this form will go into your personnel file and you will receive a copy upon request.

REPORTING ON-THE-JOB INJURIES AND HAZARDOUS WORKING CONDITIONS

Employee's Name _____
(Type or print)

I understand and agree as follows:

1. Employees who are involved in a work-related accident or who sustain a work-related injury or illness must inform their supervisor immediately. No matter how minor the accident, injury, or illness may appear, I agree that I shall report it immediately. _____ (Initials)

2. Failure to report an on-the-job accident or injury, as soon as reasonably practical, will result in disciplinary action up to, and including, termination of my employment. ____ (Initials)

3. Employees who violate safety standards, who cause hazardous or dangerous situations, or who fail to report or, where appropriate, remedy such situations, may be subject to disciplinary action. _____ (Initials)

4. Failure to report any potentially hazardous or unsafe condition shall be grounds for disciplinary action, up to and including termination of my employment. _____ (Initials)

My signature below signifies that I have carefully read the forgoing and I agree to observe the policies set forth.

_____ _____
Employee's Signature Date

ACKNOWLEDGEMENT OF NON-DISCRIMINATION AND ANTI-HARASSMENT POLICY

Employee's Name _____
(Type or print)

I understand and agree as follows:

1. Lingo Staffing, Inc. does not discriminate in employment opportunities or practices on the basis of sex, gender, race, color, religion, national origin, creed, citizenship status, ancestry, age, sexual orientation, marital status, pregnancy, cancer-related medical condition, mental and physical disability (actual or perceived), veteran status or any other characteristic protected by applicable law or local ordinance. I will fully comply with this policy. _____ (Initials)

2. Lingo Staffing, Inc. is committed to complying fully with the federal Americans with Disabilities Act and to ensuring equal opportunity in employment for qualified persons with disabilities. I will fully comply with this policy. _____ (Initials)

3. Lingo Staffing, Inc. strictly prohibits illegal or inappropriate discrimination or harassment of any kind, including discrimination or harassment on the basis of sex, gender, race, color, religion, national origin, creed, citizenship status, ancestry, age, sexual orientation, marital status, pregnancy, medical condition, mental and physical disability (actual or perceived), veteran status or any other characteristic protected by applicable law or local ordinance. It is the responsibility of each employee, whether or not employed in a supervisory or managerial capacity, to conscientiously follow this policy in all of his or her daily work activities. _____ (Initials)

4. It is the responsibility of each employee, including myself, to ensure that discrimination or harassment on any of these bases does not occur within the workplace. If I believe that any kind of illegal or inappropriate discrimination or harassment is occurring by an employee, vendor, client, or visitor, I am required to immediately report my concerns to the attention of my supervisor, the Office Manager, or any officer of the Company. _____ (Initials)

5. I have the assurance of Lingo Staffing, Inc. that no reprisals and/or retaliation will be taken against me as the result of any complaint alleging discrimination or workplace harassment, so long as the complaint was not filed in bad faith or for an improper purpose. _____ (Initials)

6. I will not retaliate against any other employee of Lingo Staffing, Inc. as a result of any complaint alleging unlawful discrimination and/or harassment. _____ (Initials)

My signature below signifies that I have carefully read this Acknowledgement of Non-Discrimination and Anti-Harassment Policy and I agree to observe the policies set forth.

_____ _____
Employee's Signature Date

VSI **260100-LIN** OFFICE USE ONLY LOCATION _____ Rehire Date __/__/____

ENROLLMENT FORM

ESC/MEC S P1DM v18.1

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name | Home Phone

Social Security # | Date of Birth / / | Sex M F

Address | Apt. #

City | Zip | State

B. MEDICARE INFORMATION

Do you or any of your dependents receive medicare benefits?
☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. This plan is underwritten by BCS Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only	☐ **$22.76**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + 1	☐ **$46.18**	**$10.80**	**$4.92**	**$0.90**	
Employee + Family	☐ **$61.67**	**$17.82**	**$6.56**	**$1.80**	
	☐ **NO** to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name | Relationship

D. REQUIRED DEPENDENT INFORMATION

Name | Social Security # | Date of Birth / / | Sex M F | Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

Name | Social Security # | Date of Birth / / | Sex M F | Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

Name | Social Security # | Date of Birth / / | Sex M F | Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82601000-M-LIN **Monthly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. This plan satisfies the federal healthcare reform Individual Mandate. This is an offer of ACA compliant coverage and by purchasing this plan, you will not be taxed for failing to purchase insurance required by the Affordable Care Act. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ **$62.00** Employee Only ☐ **$92.87** Employee + 1 ☐ **$113.29** Employee + Family ☐ **NO** to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage. I understand that open enrollment is only available for a limited time, and I understand that making no benefit selection is a declination of coverage.

DATE __/__/____ ▶ **SIGNATURE**