ACTION LABOR & Staffing Connection TARGETING SAFETY

NEW EMPLOYEE INFORMATION FORM

EMPLOYEES ARE ASSIGNED TO ALL POSITIONS WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, AGE, MARITAL OR VETERAN STATUS, OR THE PRESENCE OF A NON-JOB RELATED MEDICAL CONDITION OR HANDICAP.

PLEASE PRINT – ALL INFORMATION MUST BE PROVIDED

PERSONAL

FIRST NAME	MIDDLE	LAST	DATE

STREET ADDRESS	CITY	STATE	ZIP	PHONE
				( )

SOCIAL SECURITY NUMBER	DL#/ID#	STATE

EMAIL ADDRESS

OPTIONAL:
Please enter your Facebook handle
https://facebook.com/_____

Please enter your Instagram handle
https://instagram.com/_____

IN CASE OF EMERGENCY PLEASE NOTIFY: NAME PHONE ( )

Please list any additional trade skills, certification, tool experience, etc. that may be helpful in finding a job assignment for you.

__Carpenter
__Electrician/Technician
__Plumber
__Pipefiiter
__Equipment Operator
__Cement & Concrete Finisher
__Foreman
__Painter
__Roofer
__Welder
__Sheet Metal Worker
__Carpet Installer
__Maintenance Mechanic
__Gatekeeper
__Driver
__Security Guard
__Flagger
__Insulation Worker
__Glazier
__Iron-Worker
__Estimator
__Buckhoist Operator
__Boom Lift Operator
__Mason
__Landscaper
__Flooring Installer
__Fencer

Please select any certifications, license or training:

__OSHA 30
__OSHA 10
__MOT Flagger
__CDLA Driver
__Forklift Operator
__HVAC Tech
__Electrical Contractor License
__Certified Lead Carpenter
__ACI Certification
__Certified Crane Operator
__Certified Heavy Equipment Operator
__Certified Welder
__Other_____

How did you hear about us? ☐ Website ☐ Craigslist ☐ Careerbuilder ☐ Referral_____
☐ Indeed ☐ Instagram ☐ Facebook ☐ Flyer ☐ Other_____

Do you prefer paycard or check? ☐ Check ☐ Paycard

DESCRIPTION OF WORK ASSIGNMENTS AND WORKING CONDITIONS

ACTION LABOR IS A DAY LABOR TEMPORARY EMPLOYMENT COMPANY
THE WORK ASSIGNMENTS WE OFFER ARE MANUAL AND VERY STRENUOUS:

- ❖ WAREHOUSE WORK WHICH INCLUDES HEAVY LIFTING, LOADING AND UNLOADING;
- ❖ CONSTRUCTION SITE CLEANUP, DIGGING AND LIFTING HEAVY OBJECTS.

ACTION LABORS WORKING CONDITIONS

1. WORKERS MUST BE **AVAILABLE AND READY** TO WORK EACH DAY AT CHECK-IN TIME.
2. ACTION LABOR SUPPORTS A **DRUG FREE WORKPLACE.** THE USE OR POSSESSION OF **DRUGS** OR **ALCOHOL** BEFORE OR DURING THE WORK DAY **SHALL BE GROUNDS FOR IMMEDIATE AND PERMANENT DISMISSAL WITHOUT EXCEPTION!**
3. WORKERS ASSIGNED ACTUAL WORK WILL BE ISSUED AND DISPATCHED WITH **WORK ORDERS** ½ HOUR BEFORE THE REPORT TIME.
4. WORKERS ARE NOT PERMITTED TO GO TO A JOB SITE WITHOUT A **WORK ORDER.**
5. WORKERS WITH RETURN **WORK ORDERS** MUST BE PRESENT TO BE DISPATCHED-OR THEY WILL BE REPLACED!
6. **ANYONE ALTERING, CHANGING OR DEFACING WORK ORDERS, OR SUBMITTING WORK ORDERS FOR HOURS OTHER THAN ACTUALLY WORKED WILL BE TERMINATED.**
7. PAYCHECKS WILL ONLY BE ISSUED FOR ACTUAL HOURS WORKED FROM **ORIGINAL WORK ORDERS.**
8. WORKERS ARE REQUIRED TO BE DRESSED APPROPRIATLEY FOR **HEAVY** INDUSTRIAL LABOR. THIS INCLUDES **SHIRTS, LONG PANTS** AND **HARD SOLED-SHOES.**
9. WORKERS ARE TO WEAR AND USE EACH PIECE OF SAFETY EQUIPMENT ISSUED TO THEM BY **ACTION LABOR.**
10. IF A JOB IS CANCELLED FOR ANY REASON. THE WORKER WILL BE PAID FOR **ONLY ACTUAL HOURS WORKED.**
11. IF A WORKER IS FIRED FROM, OR WALKS OFF ANY JOB, THE WORKER WILL **ONLY** BE PAID FOR THE **ACTUAL HOURS WORKED. EITHER EVENT SHALL BE GROUNDS FOR IMMEDIATE AND PERMANENT DISMISSAL.**
12. WORKERS MAY BE REQUIRED TO WORK A TWELVE HOUR SHIFT. OVERTIME WILL BE PAID OVER 40 HOURS IN A WORK WEEK.
13. WORKERS ARE REQUIRED TO REPORT TO THE OFFICE EACH DAY THEY CHOOSE TO WORK AT CHECK-IN TIME. FAILURE TO SIGN IN FOR WORK PLACEMENT MAY DISQUALIFY YOU FOR UNEMPLOYMENT BENEFITS.

ARE YOU ABLE TO PERFORM THE FUNCTIONS DESCRIBED WITHOUT REASONABLE ACCOMODATIONS?

☐ YES, I CAN PERFORM THE TASKS AS DESCRIBED WITHOUT REASONABLE ACCOMODATIONS
☐ NO, I CANNOT PROVIDE THE TASKS AS DESCRIBED WITHOUT REASONABLE ACCOMODATIONS

I HAVE READ, FULLY UNDERSTAND AND AGREE TO ABIDE BY ACTION LABOR'S WORK CONDITIONS.

_____ _____
Signature **Date**

EMPLOYEE SAFETY ORIENTATION

Construction:
Stay clear of suspended or overhead loads.
Wear safety glasses when required.
Use proper tools on the job.
Wear hard hat at all times.

Heavy Lifting:
Lift using your legs, not your backs
Get help to move heavy objects.
Do not twist with a load – lift straight up.
Wear a back brace.

HAZARD COMMUNICATION
If working with chemicals such as paints, solvents, cleaners, etc. make sure you know the location of Emergency Eye Wash and Showers. And ***always handle chemicals with extreme caution.***

Other Precautions:
Always wear the proper clothes while working – long pants, long sleeves, work boots.
Always wear safety equipment and supplies issued to you.
If you think you need other safety equipment or supplies, call this office.
Do not perform jobs that are different than the one specified on your work ticket.
Do not operate heavy equipment or machinery.
Do not drive any vehicles.
Make sure you understand the job before you start working. If unsure, ask your supervisor.
Always be alert and aware of your working area. Advise a supervisor of all unsafe conditions.
Beware of all caution signs.
WORK SMART and BE SMART on job sites.
Drink plenty of water while working outside under the sun.
Seek first aid for all injuries and notify your supervisor immediately.
Observe Bloodborne Pathogen Standards.

Important Information

ALL INJURIES MUST BE REPORTED TO ACTION LABOR IMMEDIATLEY!

Medical treatment of injuries must be performed at a facility authorized by this office.

_____ _____
Signature **Date**

PRE-EMPLOYMENT DRUG & ALCOHOL SCREEN CONSENT FORM

To the Applicant:

Action Labor is a designated drug-free workplace. We do not offer employment to any applicant who refuses a drug/alcohol test or any applicant who receives a positive drug/alcohol test result for any controlled or illegal substance(s) or alcohol intoxication. Please complete the questionnaire below.

Applicant Name: _____

Are you currently under the influence of alcohol?

❍ Yes ❍ No

Are you currently under the influence of any illegal or controlled substance (marijuana, methamphetamines, cocaine, other)?

❍ Yes ❍ No

Have you used any illegal or controlled substance(s) within the past 30 days prior to your application today?

❍ Yes ❍ No

I understand that Action Labor is a drug-free workplace. I also understand Action Labor will not offer employment if any of the questions above were answered "yes", if I do not consent to a pre-employment drug test/alcohol test, or if I test positive for any illegal or controlled substance(s). I understand I may obtain my own drug/alcohol test from an approved drug testing facility and provide Action Labor with these results if I am refused employment for any positive drug/alcohol test result. If offered employment by the company, I understand I may be tested at any time, for any reason and without my prior notice for alcohol and/or illegal or controlled substance intoxication prior to beginning an assignment or during my work day. My signature below will also serve as consent to participate in any such post-accident or random drug/alcohol test administered by the company and at the company's discretion. I understand if offered employment, my refusal to participate in a post-accident or random drug/alcohol test may result in my immediate termination with the company. I promise to remain drug-free during my employment with Action Labor.

Applicant Signature:_____ Date: _____

DRUG-FREE WORKPLACE PROGRAM

PRE-EMPLOYMENT DRUG & ALCOHOL SCREEN WORKSHEET

Branch Manager: The following procedures **MUST** be followed to complete the pre-employment drug-screen process. Complete this form for each applicant and include with the application file or employee file. **INITIAL EACH STEP TO INDICATE THE STEP HAS BEEN COMPLETED.**

Applicant Name: _____Date:_____

_____ Pre-Employment Drug & Alcohol Screen Consent received from Applicant.

_____ Pre-Employment Drug & Alcohol Screen Consent Form reviewed by Branch Manager for any "Yes" responses.

If "Yes", advise the applicant our company has a designated Drug-Free Workplace program and our policy prevents us from employing any applicant who has used any illegal or controlled substance in the past 30 days. Advise the applicant to apply again for employment after 30 days.

If "No", proceed to the next step.

_____ Administer the drug screen at branch office.

Test Results: ☐ Negative ☐ Positive

_____ Administer the alcohol screen at branch office.

Test Results: ☐ Negative ☐ Positive

If results are "Negative", continue the employment process accordingly.

If results are "Positive", advise the applicant our Drug-Free Workplace policy prevents the employment of any applicant who tests "positive" for illegal or controlled substances and alcohol abuse. Advise the employee an independent approved drug/alcohol test may be administered at the applicant's request and considered for employment if a favorable test result is provided. Advise the applicant to reapply for employment with the company 30 days following the test date.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income . . . . . **1** $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $

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

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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.

ADDENDUM TO EMPLOYMENT APPLICATION
SUBSTANCE ABUSE POLICY STATEMENT

Action Labor is committed to providing a safe work environment and to fostering the well-being and health of its employees. That commitment is jeopardized when any Action Labor's employee **illegally uses on the job, comes to work under the influence, or possesses, distributes or sells drugs or alcohol in the workplace.** Therefore, Action Labor has established the following policies. Any violations are grounds for immediate termination.

	EMPLOYEE INITIALS
1. It is a violation of Company policy for any employee to possess, sell, trade or offer for sale illegal drugs or alcohol or otherwise engage in the illegal use of drugs or alcohol on the job.	_____
2. It is a violation of Company policy for anyone to report to work under the influence of illegal drugs or alcohol.	_____
3. No prescription drug shall be brought upon the premises of Action Labor or any client of Action Labor by any person other than the person for whom the drug is prescribed by a licensed medical practitioner and said drug shall be used in the manner, combination, and quantity prescribed.	_____
4. All employees will be tested for use of Drugs/Alcohol immediately after the occurrence of an accident/injury on the job. Refusal to be tested is grounds for termination. Test results will be released directly to Action Labor and retained as confidential.	_____
5. A Voluntary Drug Free Certified Program has been established for certain job assignments.	_____

EMPLOYEE ACKNOWLEDGEMENT OF ACTION LABOR'S DRUG POLICY

I, _____, acknowledge and represent that I have read and fully understand the terms and conditions of Action Labor's Substance Abuse Policy Statement, and this acknowledgement and representation is evidenced by my signature appearing below. In addition, I acknowledge, warrant, and agree that the scope and course of my employment with Action Labor requires me to provide my services without illegally using drugs or alcohol on the job and requires me not to come to work wither under the influence or in possession of drugs or alcohol. I further warrant and represent that I understand and agree that in the event of any accident/injury that may happen to me while on the job, I will be tested for drugs/alcohol use immediately.

_____ _____

Signature **Date**

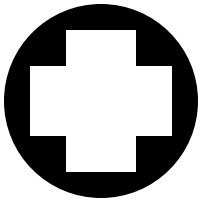
RELEASE OF MEDICAL RECORDS

You are hereby authorized to give the bearer (or sender), or any representative thereof, who represents my employer, and copy for them requested information regarding any medical treatment provided by you.

Please send this information to:
ACTION LABOR
624 Nottingham Blvd.
West Palm Beach, FL 33405

_____
Print Name

_____
Signature



NEW EMPLOYEE SAFETY CHECKLIST

_____1. Employee understands company commitment to Safety / Quality / Service.
_____2. Understands that 90% of all accidents are caused by unsafe actions of the employee him/herself and that he/she is responsible for safety.
_____3. Understands instructions on reporting unsafe or faulty equipment / conditions.
_____4. Understands instructions on reporting accidents and near – misses.
_____5. Understands instructions on safe lifting procedures.
_____6. Understands instructions on use of personal protective equipment (gloves, goggles, safety shoes, etc.)
_____7. Understands personal responsibility to be informed of proper work procedures when using any hand, power or pneumatic tool.
_____8. Understands the importance of knowing the proper handling of any chemicals used on the job including the review of MSDS's prior to using any chemical.
_____9. Understands the importance of observing all rules concerning fire prevention including proper use and handling of all the flammable materials and chemicals, location of approved smoking area, locations of fire exits, and the location and use of fire extinguishers.
_____10. Understands the importance of knowing the location of first – aid kits and knowing who is responsible and qualified to perform first aid if necessary.
_____11. Understands the risks associated with blood-borne pathogens and the necessity to wear rubber gloves and avoid contact with blood or any other bodily fluids if administering first aid to others.
_____12. Understands the importance of asking questions of client supervisor / trainers if ever unsure of any proper / safe / work procedures.
_____13. Understands the importance of informing Safety Coordinator of any change in job assignment.
_____14. IS committed to working safely, staying alert, and understands our highest priority is to the safety of its employees and client's employees. Understands our company expects all employees to work safely and will not tolerate unsafe work habits, horseplay, the use of drugs or alcohol on the job, or any actions by the employee needlessly placing him/herself or others at risk.
_____15. Employee has received and understands the Safety Handbook.

_____ _____

Date Employee's Signature

_____

Branch Manager's Signature

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Branch Manager.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Waterfield Florida Staffing, LLC dba Action Labor	82-4558588
5. Employer address	**6. Employer phone number**
624 Nottingham Blvd.	561-683-1211

7. City	8. State	9. ZIP code
West Palm Beach	FL	33405

10. Who can we contact about employee health coverage at this job?	
Human Resources	
11. Phone number (if different from above)	**12. Email address**
	hr@actionlabor.com

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☐ Some employees. Eligible employees are:

Those who work an average of at least 130 hours per month based on Action Labor's look back or initial measurement period, per ACA guidelines.

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

All dependents can be covered at the employee's expense.

☐ We do not offer coverage.

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

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

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

OMB 0938-0990

MODEL INDIVIDUAL **NON-CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from your Employer About Your Prescription Drug Coverage and Medicare For Plan 05302

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Your employer has determined that the prescription drug coverage offered by the Group Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Group Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. **You can keep your current coverage from the Group Plan; However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

IF YOUR GROUP PLAN IS AN EMPLOYER/UNION SPONSORED GROUP PLAN and you decide to drop your current coverage with your employer, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however

you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Group Plan.

IF YOU ARE LOSING CREDITABLE COVERAGE WITH YOUR CURRENT GROUP PLAN, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the Group Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Group Plan coverage may/may not be affected.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

If you do decide to join a Medicare drug plan and drop your current Group Plan coverage, be aware that you and your dependents may/may not be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact your Human Resources Group Plan Administrator for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).