SECTION 1- EMPLOYEE INFORMATION

Worksite Employer: ____

Full Employee Name: ______________________________ Gender: ☐ Male ☐ Female

Date of Birth ____/______/________ SSN# ____________________ Telephone # ____________________

Mailing Address: ____

City State Zip Code

E-mail Address: ____

Emergency Contact Name: ____

Relationship: ______________________________ Telephone # ____________________

SECTION 2 – EMPLOYEE PAY SETUP-TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR / MANAGER

Pay Rate: ______________ Job Title: ____________________ Work State: ______________

Supervisor: ______________________________ Work Location/Department: ____________________

Workers' Comp Code: ____________________ Drug Test Control #: ____________________

Check one in each category:

PAY PERIOD:

☐ Weekly ☐ Semi-monthly
☐ Bi-weekly ☐ Monthly

CLASSIFICATION:

☐ Hourly ☐ Commission
☐ Salaried with O/T
☐ Salaried Only

STATUS:

☐ Full time (30hrs/wk)
☐ Part time____________hrs
☐ Temporary
☐ Seasonal

Check all that apply:

☐ Owner ☐ Officer ☐ Key Employee ☐ Highly Compensated

Any garnishment orders, including child support?

☐ Yes ☐ No *If yes, please provide document copies.*

Worksite Employer Hire Date: ______________________________

Kymberly Group Payroll Solutions, Inc. Hire Date: ______________________________

PLEASE MAKE CERTAIN THAT YOU RECEIVE A WORKSITE EMPLOYEE HANDBOOK. ANY QUESTIONS SHOULD BE DIRECTED TO CUSTOMER SERVICE AT (407) 228-6428.

SECTION 3- WORKSITE EMPLOYEE AGREEMENT

In consideration of any offer of employment by Kymberly Group Payroll Solutions, Inc. ("KGPS"), I hereby acknowledge, understand and agree that the following constitute terms and conditions of my employment:

1. **Co-Employment**: KGPS has entered into a co-employment agreement with my Worksite Employer. I will be an employee of both KGPS and my worksite employer. My worksite employer is responsible for hiring, determining my compensation, supervising, scheduling the work to be performed, assessing my performance, handling any disciplinary issues up to and including termination of employment and reporting hours worked to KGPS. KGPS is responsible for administrative tasks such as issuing payroll checks, withholding taxes and administering benefits and workers' compensation claims.

2. **Handbook**: I hereby acknowledge receipt of the KGPS Employee Handbook ("Handbook") and agree to be bound by its terms. I understand that the Handbook does not establish a contract of employment. I further understand that the Handbook can be changed at any time, including its provisions regarding wages, hours, benefits, and terms and conditions of employment. The Handbook does not constitute a guarantee of present or future employment policies.

3. **At Will Empowerment**: I am an at-will employee of both my Worksite Employer and KGPS. This agreement does not constitute a contract of employment nor is my employment for a specific period of time. This means that either KGPS or I may terminate my employment at any time, for any reason or no reason, with or without prior notification according to the statutes of at-will employment. I further understand that there are no representations, warranties, terms, covenants or conditions made by KGPS other than those contained in this Agreement. I understand that neither KGPS nor my Worksite Employer has the authority to change my at-will employment status.

4. **Introductory Period**: I understand that there is a ninety (90) day introductory period. I understand that if I am terminated for unsatisfactory work performance, KGPS will not have its account charged for the full amount of unemployment benefits.

5. **Wage Claim Assignment**: By signing this agreement, I assign to KGPS my right to assert a priority wage claim against my Worksite Employer under 11 U.S.C. 507 (a)(3) in the event that a Bankruptcy Petition is filed under title 11 of the United States Code or by or on behalf of my Worksite Employer.

6. **Benefits**: In the event that my Worksite Employer has a policy providing paid leave benefits such as vacation, sick leave, paid time off or severance pay, my Worksite Employer is solely responsible for paying me any accrued benefits under such policies during employment and at the time of termination.

7. **Termination of Employment**: I Understand that I must contact KGPS Processing Center if my employment at my current worksite is involuntarily ended. I understand that no one at my current worksite has the right to speak to KGPS, as to whether or not I may continue employment with KGPS beyond any involuntary termination from my current worksite location. I further realize that my failure to contact KGPS within two (2) business days of my involuntary termination from my current worksite will be considered as voluntary resignation of my employment with KGPS without regard why my employment ceased at my worksite location. Such voluntary termination may disqualify me from collecting unemployment benefits.

8. **Discrimination and Harassment**: KGPS is a zero-tolerance employer for discrimination or harassment in the workplace. In the event that I am subjected to any type of discrimination, including discrimination based on my race, color, religion, national origin, age, sex, marital status, disability or any other protected class, or subjected to any type of harassment, including sexual harassment, I will immediately notify my worksite supervisor, if possible. Otherwise, I will contact the KGPS Director of Human Resources at (407)228-6428.

9. **Binding Arbitration and Choice of Law**: KGPS and I agree to arbitrate and resolve any and all disputes arising out of my employment by my Worksite Employer and KGPS, through binding arbitration administered by the American Arbitration Association ("AAA") under its Employment Alternate Dispute Resolution rules rather than through litigation. Accordingly, I agree to not bring any claim or suit against KGPS or my Worksite Employer, their supervisors, managers, employers or other agents. I understand that by signing this agreement, I waive my right to trial by jury. Discovery may be initiated by any party for a period of sixty (60) days following the filing of a claim for arbitration. Any award of the AAA may be entered in any Court of appropriate jurisdiction. This agreement to arbitrate does not prohibit me from filing any claim or charge with any state or federal agency that would otherwise take my claim or charge. The laws of the State of Florida shall govern the arbitration and be used to interpret and construe this agreement.

10. **Workers' Compensation**: In recognition of the fact that any work-related injuries which I may sustain are covered by the state workers' compensation laws, and to avoid the circumvention of such laws which may result from suits against my Worksite Employer based on the same injury or injured, and to the extent provided by law, I hereby waive and forever release any rights that I may have to make claims or brings suit against my Worksite Employer and/or KGPS for damages based upon injuries which are covered under such workers' compensation laws. I understand that for purposes of workers' compensation, I am an employee of both KGPS and my Worksite Employer. In the event of injury, I understand that my sole remedy lies in coverage under KGPS's workers' compensation policy.

11. **Injuries:** In the event that I am injured on the job, I will immediately notify KGPS Risk Management Department at (407)228-6428 and my Worksite Employer. I understand that workers' compensation claims may be under managed care, which means that I must seek treatment only as directed by KGPS or the insurance company case manager. I further understand that any unauthorized treatment for an alleged injury will not be reimbursed under any conditions unless the alleged injuries are life threatening.

12. **Drug Testing**: As a condition of employment, I agree to submit to a drug and alcohol test in conjunction with any reported on-the-job injury within twenty-four (24) hours and understand that failure to do so will automatically result in the denial of benefits or payments for the injury. I further understand and agree that I will submit to a drug and alcohol test if I cause or contribute to an on-the-job injury, which results in the injury to others or me. I also understand that my refusal to subject to a drug and alcohol test under these stated conditions may result in my immediate termination.

13. **Summarization of Agreement**: This agreement, along with the Handbook, constitutes the entire understanding between KGPS and me. I understand that neither my Worksite Employer nor KGPS has the authority to modify the terms of this Agreement. If one or more of the provisions of this Agreement are determined to be invalid, illegal or unenforceable, the validity and enforceability of the remaining provisions of this Agreement shall not be in any way affected, impaired or prejudiced.

Print Name:______________________________ Signature: ______________________________

Date: ________________________

SECTION 4- WORKERS' COMPENSATION QUESTIONNAIRE

THIS QUESTIONNAIRE SHOULD NOT BE ANSWERED UNLESS THE APPLICANT HAS ACCEPTED A CONDITIONAL OFFER OF EMPLOYMENT AND HAS NOT COMMENCED EMPLOYMENT.

1. Have you ever had a job-related injury?
   - ☐ No (If no, go to question #2)
   - ☐ Yes (if yes, please list all job-related injuries below or attach a separate piece of paper)

Part of body affected:______________________________________ Related to work: ☐ No ☐ Yes

Date of Injury:________________ Status of Claim: ☐ Open ☐ Closed Job Restrictions: ☐ No ☐ Yes

List Restrictions:____

2. Have you ever had or been treated for any of the following conditions or diseases:	**YES**	**NO**
1. Repetitive Stress Trauma:______________________________	☐	☐
2. Back or neck problems or injury:__________________________	☐	☐
3. Head injury:______________________________________	☐	☐
4. Knee Injury: _____________________________________	☐	☐
5. Diabetes:_______________________________________	☐	☐
6. Alcoholism:_____________________________________	☐	☐
7. Drug Addiction:__________________________________	☐	☐
8. Major Illness in past (5) years:__________________________	☐	☐

SECTION 5- EEO INFORMATION

COMPLETED BT EITHER THE EMPLOYEE VOLUNTAIRILY OR BY EMPLOYER OBSERVATION

Kymberly Group Payroll Solutions, Inc. ("KGPS") and your Worksite Employer are subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights law and regulations. In order to comply with these laws, KGPS invites employees to voluntarily self-identify their race and ethnicity by completing this Data Record.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Again, this information has no impact on any employment decision and is to be completed only ***after*** an offer of employment has been accepted. This information will be kept confidential and is used for no purpose other than EEO reporting.

Employee Name:____

DATE OF BIRTH: Month______________Day_________Year____________ Gender: ☐ Male ☐ Female

PLEASE CHECK THE APPLICABLE BOX BELOW

- ☐ White
- ☐ Black of African American
- ☐ Hispanic or Latino
- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Two or more races

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)

EMPLOYMENT ACKNOWLEDGEMENT AGREEMENT

I hereby acknowledge that I have received this company's Drug Free Workplace Handbook, which includes the company Drug Free Workplace policy, employee assistance information, a listing of drugs being tested for, common over-the-counter medications which may alter a drug test and educational material on substance abuse. I have also been given the opportunity to voluntarily complete a Medication Disclosure Form.

I freely and voluntarily agree and realize that as part of my employment, I may be subjected to future drug and/or alcohol screens for post-accident, reasonable suspicion, job placement, routine fitness-for-duty, return to work, follow-up, and/or random testing at the company's discretion. I understand that a refusal to submit a blood, urinalysis, hair and/or breath test will result in immediate termination from employment. I understand that a tampered or an adulterated drug and/or alcohol specimen will be considered a refusal to test, resulting in immediate termination. I understand that a confirmed positive drug and/or alcohol test will result in immediate termination of employment, but if I am able to successfully complete substance abuse treatment at my expense, and if my job is still available, I may be given one chance to be rehired, upon a negative return to work drug and/or alcohol test. I understand that I will be subject to the company rehabilitation agreement and I will undergo random follow-up drug and/or alcohol tests for a period of 2 years. I understand that a confirmed positive drug and/or alcohol follow up test or any violation of the rehabilitation agreement will result in termination of employment. I understand that this company reserves the right not to offer employment to a former employee who was terminated in violation of this policy, even if a job is available.

I agree to voluntarily submit to a blood, urinalysis, hair and/or breath test for drug and alcohol use as part of my ongoing employment, and I release my employer from any liability resulting from my participation in such a screening. I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits under Florida's workers' compensation law (Florida Statutes 440.101, 440.102). I also understand that a refusal to test under this circumstance will automatically result in forfeiture of my eligibility for medical and indemnity benefits and immediate termination from employment. I understand that a confirmed positive drug and/or alcohol test, a tampered with or an adulterated specimen or a refusal to test may result in forfeiture of unemployment benefits under Florida law.

I hereby give my consent to release the results of my blood, urinalysis, hair and/or breath test to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment. By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel/physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administrating the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as defense to any legal action to which I am party. I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review Officer.

I also understand that the Drug-Free Workplace policy and related documents are not intended to constitute a contract between this employer and myself. As an employee, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, and have received a written 60-day notification of this program, if applicable.

____/________/________

Employee Signature Print Name Date

As a job applicant, I freely and voluntarily agree to a hair or urinalysis drug screen as part of my application for employment and I understand that a refusal to test, a positive confirmed drug test or a tampered with or an adulterated specimen will disqualify me from employment, even if I have started work pending the results of the drug test. I understand I am still completing the application process and will not officially be an employee until the company receives a negative pre-employment drug test result. If I am employed by this company, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, as stated above.

____ /__________/______

Employee Signature Print Name Date

DIRECT DEPOSIT AUTHORIZATION AND CHANGE REQUEST

Employee Name: ____ **Social Security #:** ______________________

I hereby authorize Kymberly Group Payroll Solutions, Inc. to initiate credit and/or debit entries (if necessary) and adjustments for any credit entries in error to my account. **Deposit entries are to be made to the following checking accounts, savings accounts, or Rapid! PayCard accounts:**

Depository Account #1

Bank Name: ____ Phone Number: ________________________

City: _____________________________________ State: ______________ Zip Code: __________________________

Routing/Transit Number: ________________________ Account Number: ______________________________________

Type of Account (select one): ☐Checking ☐Savings Select One: ☐Activate New Direct Deposit ☐Cancel Existing Direct Deposit

Amount of Paycheck: _________________________ or Percentage of Paycheck: ________________________

Depository Account #2

Bank Name: ____ Phone Number: ________________________

City: _____________________________________ State: ______________ Zip Code: __________________________

Routing/Transit Number: ________________________ Account Number: ______________________________________

Type of Account (select one): ☐Checking ☐Savings ☐Activate New Direct Deposit ☐Cancel Existing Direct Deposit

Amount of Paycheck: _________________________ or Percentage of Paycheck: ________________________

Please attached a VOIDED CHECK if depositing to a checking account and/or a VOIDED DEPOSIT TICKET if depositing to a savings account.

☐I wish to request a Rapid! PayCard Visa Payroll Card to use for automatic direct deposit of my paycheck.

☐I do not wish to participate in automatic direct deposit. I wish to receive a live check with each payroll.

This authority is to remain in full force and effect until Kymberly Group Payroll Solutions, Inc. has received written notification from me of its termination within a reasonable time and manner to allow Kymberly Group Payroll Solutions, Inc. to act upon said request. There will be approximately one pay cycle of pre-noting until direct deposit is established. ALL FINAL PAYCHECKS WILL BE ISSUED AS LIVE PHYSICAL CHECKS, NOT DIRECT DEPOSIT.

____ ____

Employee Signature Date