FOR CDL DRIVER's PERSONNEL FILE

J. Severino Construction, Inc.

937 West 52nd Street
P.O. Box 603
Ashtabula, Ohio 44005-0603
Office: 440-992-4274
Fax: 440-992-4275

DOCUMENTS LISTED BELOW MUST BE SUBMITTED TO THE OFFICE WITHIN TWO (2) DAYS OF YOUR HIRE DATE TO AVOID PAYROLL PROCESSING DELAYS

_____ Emergency Contact Form

_____ W-4 Federal Withholding

_____ Ohio Withholding

_____ Direct Deposit Form – Voided Check or Letter From Bank

_____ Form I-9 -- Employment Eligibility Verification – Complete BOTH Pages

_____ Payroll Deduction Letter

_____ New Health Insurance Marketplace Coverage Information

_____ Receipt of Employee Handbook -- Sign

_____ Copy of Driver's License AND Social Security Card

_____ CDL Self-Certification Authorization

_____ E-Verify

**If you have any questions concerning the completion of your employment documents, please call the office between 8:00am and 3:00pm.

Sign _____
Date _____

J. SEVERINO CONSTRUCTION, INC.

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Address: _____

City, State, Zip: _____

Home #: _____

Cell #: _____

J. SEVERINO CONSTRUCTION, INC.

Complete Payroll Direct Deposit Information

Name _____ SS # _____

☐ I do NOT want Direct Deposit. Signature _____

☐ I DO want Direct Deposit. I authorize my employer to deposit my wages/salary to the following bank accounts:

Bank Account # 1 ☐ Checking ☐ Savings

Bank Name _____

I wish to deposit (check one):

- ☐ Entire Net Pay
- ☐ _____ % of Net
- ☐ Specific Dollar Amount $ _____

Please attach one of the following (check one):

- ☐ Voided check (deposit slip are NOT accepted)
- ☐ Bank letter or specification sheet (See your local bank representative)

Bank Account # 2 ☐ Checking ☐ Savings

Bank Name _____

I wish to deposit (check one):

- ☐ Entire Net Pay
- ☐ _____ % of Net
- ☐ Specific Dollar Amount $ _____

Please attach one of the following (check one):

- ☐ Voided check (deposit slip are NOT accepted)
- ☐ Bank letter or specification sheet (See your local bank representative)

Workers Signature _____ **Date** _____

By signing above, I am agreeing that I am either the accountholder or have the accountholder to authorize my employer to make direct deposits into the named account.

Accountholder Signature _____

(If worker doesn't have authority to authorize deposits to the accountholder's account.)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶**START HERE.** **Read instructions carefully before completing this form. The instructions must be available during completion of this form.**
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:			Date *(mm/dd/yyyy):*
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print 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 Birth Abroad issued by the Department of State (Form FS-545)
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.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
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.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
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		**8.** Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

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PAYROLL DEDUCTIONS

I hereby authorize J. Severino Construction, Inc. to deduct the following items (if applicable) from my check:

Medical, Dental, and/or Vision Insurance
Cash Advance Repayments
Credit Card Purchases made with the company card for personal use
And Etc.

J. Severino Construction, Inc. will promptly will notify employees with the amount of any deduction prior to the deduction being taken out.

_____ _____

Signature Date

_____

Printed Name

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

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 Jodie Spring.

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)
J. Severino Construction, Inc.	81-5154776
5. Employer address	**6. Employer phone number**
937 West 52nd Street	440-992-4274

7. City	8. State	9. ZIP code
Ashtabula	Ohio	44004

10. Who can we contact about employee health coverage at this job?	
Jodie Spring	
11. Phone number (if different from above)	**12. Email address**
	jodie@severinoconstruction.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:

All full time employees after 30 days from start date.
We pay 66% of monthly premium.

☐ Some employees. Eligible employees are:

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

However, premiums are paid in full by the employee.

☐ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☑ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $43.93
b. How often? ☑ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Please sign to acknowledge that you have read the above information.

Signature: _____

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Receipt of Employee Handbook and Employment-At-Will Statement (All Other Employees)

This is to acknowledge that I have received a copy of the J. Severino Construction, Inc. Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities and obligations of employment with the company. I understand and agree that it is my responsibility to read the Employee Handbook and to abide by the rules, policies and standards set forth in the Employee Handbook.

I also acknowledge that my employment with J. Severino Construction is not for a specified period of time and can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no manager or employee has the authority to enter into an employment agreement-express or implied-providing for employment other than at-will.

I also acknowledge that, except for the policy of at-will employment, the company reserves the right to revise, delete and add to the provisions of this Employee Handbook. All such revisions, deletions or additions must be in writing and must be signed by the president of the company. No oral statements or representations can change the provisions of this Employee Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company, with or without cause or notice, at any time. No Implied contract concerning any employment-related decision, term of employment or condition of employment can be established by any other statement, conduct, policy or practice.

I understand that the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and J. Severino Construction concerning the duration of my employment, the circumstances under which my employment may be terminated and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings and representations concerning my employment with the company.

If I have questions regarding the content or interpretation of this Employee Handbook, I will bring them to the attention of my supervisor.

Name _____

Date _____

EMPLOYEE SIGNATURE_____

New Hire Must File with BMV

OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

CDL SELF-CERTIFICATION AUTHORIZATION

New federal regulations require **ALL** Commercial Driver License (CDL) holders to self-certify their type of commercial driving. All CDL holders must submit a self-certification in order to be issued and maintain their CDL.

NAME OF DRIVER	OHIO DRIVER LICENSE NUMBER

Please mark only one of the following self-certification categories that apply to you. (see page 2 for category detail)

I certify my commercial driving is:

- ☐ Category 1: Non-Excepted Interstate: CDL holders who drive across state lines or transport freight that has or will cross state lines and must meet federal medical requirements subject to 49 CFR part 391. **Must submit a medical card to the Ohio Bureau of Motor Vehicles (BMV).**
- ☐ Category 2: Excepted Interstate: CDL holders who drive across state lines but do not need to meet federal medical requirements. Operating exclusively in transportation or operations excepted under 49 CFR 390.3(f), 391.2, 39168 or 398.3
- ☐ Category 3: Non-Excepted Intrastate: CDL holders who drive exclusively in Ohio and do not drive across state lines, but are required to meet state medical requirements.
- ☐ Category 4: Excepted Intrastate: CDL holders who do not use the CDL for business purposes and are not required to meet state medical requirements. Operating exclusively in transportation or operations excepted from all or part of the State driver qualification requirements. (R.C. 4506.03(B)(1-10))

SIGNATURE OF APPLICANT	DATE
X	

If you mark category 1, you must also submit a copy of your completed Medical Examiners Certificate.

- ☐ I have included a Medical Examiners Certificate.

The CDL Self-Certification Authorization form and the Medical Examiners Certificate, if applicable, must be submitted to the Ohio Bureau of Motor Vehicles and processed prior to the issuance of the CDL. The Self-Certification Authorization form and the Medical Examiners Certificate can be submitted by mail, fax, e-mail, Regional Reinstatement Office or a Deputy Registrar. The forms must be legible or a delay in processing will occur.

Mail the forms to:
Ohio BMV
CDL / In-State Violations Unit
P.O. Box 16784
Columbus, OH 43216-6784
Include your name, address and contact number on all mailings

Fax the forms to:
(614) 308-5181 OR
e-mail to: cdl@dps.ohio.gov
Include your name, address and contact number on all faxes and e-mails.

Submit the forms in person to:
A Regional Reinstatement Office OR a Deputy Registrar. Locations can be found by visiting www.bmv.ohio.gov

RESTRICTED

SELF-CERTIFICATION CATEGORIES

All Class A, B, or C CDL holders and all drivers applying for a Class A, B, or C CDL, at issuance, must certify to one of the self-certification categories listed:

Category 1: Non-Excepted Interstate: Operates or expects to operate a commercial vehicle in interstate commerce (across state lines) and is subject to the requirements under 49 C.F.R. part 391.

- All Class A, B, and C drivers who do NOT fall under any of the other categories
- All Class A, B, and C drivers granted a medical variance, federal vision or diabetes exemptions, or Skill Performance Evaluation certificate (SPE) (V restriction)

Category 2: Excepted Interstate: Operates or expects to operate a commercial vehicle in interstate commerce (across state lines) but engages in operations exclusively excepted under 49 C.F.R. 390.3(f), 391.2, 391.68 or 398.3.

- School bus operations
- Transportation performed by the federal government, a state, or any political subdivision of a state
- Occasional transportation of personal property by individuals not for compensation or in the furtherance of a commercial enterprise
- The transportation of human corpses or sick and injured persons
- The operation of fire trucks and rescue vehicles while involved in emergency and related operations
- A nine (9) to fifteen (15) passenger van, including the driver, weighing less than 26,001 GVWR, not for compensation
- Apiarian industries (Beekeepers)
- Either a driver of a commercial motor vehicle used primarily in the transportation of propane winter heating fuel or a driver of a motor vehicle used to respond to a pipeline emergency

Category 3: Non-Excepted Intrastate: Operates a commercial vehicle in intrastate commerce (exclusively within the State of Ohio) and subject to state driver qualification requirements.

- Ohio drivers granted a waiver for vision OR insulin-controlled diabetes by the public utilities commission
- K2 / K3 Restriction

Category 4: Excepted Intrastate: Operates a commercial vehicle in intrastate commerce (exclusively within the State of Ohio) but operating exclusively in transportation or operations excepted from all or part of the state driver qualification requirements under Ohio Revised Code (R.C.) 4506.03(B)

- A farm truck
- Fire equipment for a fire department, volunteer or non-volunteer fire company, fire district, or joint fire district
- A public safety vehicle used to provide transportation or emergency medical service for ill or injured persons
- A recreational vehicle
- A commercial motor vehicle that is operated for nonbusiness purposes. "Operated for nonbusiness purposes" means that the commercial motor vehicle is not used in commerce as "commerce" is defined in 49 C.F.R. 383.5, as amended, and is not regulated by the public utilities commission pursuant to R.C. Chapter 4919., 4921., or 4923
- A motor vehicle that is designed primarily for the transportation of goods and not persons, while that motor vehicle is being used for the occasional transportation of personal property by individuals not for compensation and not in the furtherance of a commercial enterprise

RESTRICTED