Employee Personal Information

Company: _____

Employee Information

Last Name: _____

First Name: _____

Middle: _____

Date of Birth: _____

Social Security Number: _____

Marital Status

☐ Married

☐ Single

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Country: _____

Primary E-Mail: _____

Secondary E-Mail: _____

Emergency Contact Information

Contact 1:

Last Name: _____

First Name: _____

Relationship: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Equal Employment Opportunity (EEO) Voluntary Self-Identification Form

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may 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.

First Name: _____ Last Name: _____

Position: _____

Gender Identification (Please Check One)

☐ Female ☐ Male ☐ Decline Self-Idenification

Race/Ethnicity Identification (Please Check One)

☐ American Indian or Alaska Native (Not Hispanic or Latino)

☐ Asian (Not Hispanic or Latino)

☐ Black or African American (Not Hispanic or Latino)

☐ Hispanic or Latino

☐ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)

☐ Two or More Races (Not Hispanic or Latino)

☐ White (Not Hispanic or Latino)

☐ Decline Self-Identification

_____ _____

Date Signature

Ideal HR's Copy

Acknowledgement Of Employer

Dear Employee;

_____ ("Client") has entered into a co-employment agreement with Ideal HR for professional employer services. Title 40 of the South Carolina Code of Laws requires that we provide you with a written explanation stating, substantially, the terms of the agreement between Client Company and us.

As a professional employer organization (PEO), we have agreed to assume responsibility for payment of wages to assigned employees and for the collection and payment of payroll taxes on assigned employees. Additionally, we have agreed to retain the right of direction and control over assigned employees and the right to hire, fire, discipline, and reassign employees pursuant to Title 40. We have also agreed to retain the right of control over the adoption of employment and safety policies, and the management of workers' compensation claims, claim filings and related procedures as required by Title 40.

Because we are operating under and subject to the Workers' Compensation Act of South Carolina, in case of accidental injury or death to an employee, the injured employee, or someone acting on his or her behalf, shall immediately notify Ideal HR or Client, _____(address)_____(Phone number) for Chosen Party. Failure to give immediate notice may cause serious delay in the payment of compensation to you or your beneficiaries, and may result in failure to receive a compensation benefits. Notice to or acknowledgment of the occurrence of an injury on the part of Client or Ideal HR and its workers' compensation insurer or Client and its workers' compensation insurer, or both.

Should you have any questions or concerns regarding this agreement, you may contact Ideal HR at (864) 286-9009 or the South Carolina Department of Consumer Affairs, which licenses and regulates PEOs, at 293 Greystone Boulevard, Suite 400, Columbia, SC 29205, or by telephone at (803) 734-4200 or (800) 922-1594.

_____

Name (Printed)

_____ _____

Date Signature

Employee's Copy

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_____

Name (Printed)

_____ _____

Date Signature

Ideal HR's Copy

Acknowledgement of the Drug-Free Workplace Program

I, _____ understand that Ideal HR and its client company _____ maintains a Drug-free workplace policy requiring all employees to report to work in a substance free condition.

I have received and read, or had read to me, a copy of this policy and I understand the consequences of violating the policy. If I did not understand the policy, I have asked for and have received an explanation. I specifically understand that if I either refuse to be tested or test positive for drugs or alcohol, I can be subject to discipline, up to and including termination. I also understand that being under the influence of drugs or alcohol at the time of an on the job injury can adversely affect my claim for workers' compensation benefits.

I also understand that as a condition of my **initial** and/or **continued** employment, as a part of initial and routinely scheduled fitness for duty physical examinations when required by the company, random (if applicable), where reasonable suspicion of drug use exists, the Company will require me to undergo substance screening urinalysis, blood (for alcohol), hair follicle, or other testing procedures and I hereby agree to submit to such tests, including follow-up to rehabilitation testing and the required post accident testing.

I further consent to the results of any such drug screen(s) being released to the Company's authorized representative by the Medical Review Officer (MRO), and understand that I am legally authorized to receive a copy of the consent form if requested. The results will not be released to any additional parties without my written authorization.

I release any testing facility personnel and/or physicians who have tested me from any liability arising from a release or use of any and all test results, written reports, medical records, and data concerning my test(s) to the appropriate Company officials. I further release all Company officials from liability arising from the release or use of the test results.

I ACKNOWLEDGE THAT I AM EMPLOYED "AT WILL," WHICH MEANS THAT EITHER I (the employee) OR IDEAL HR AND ITS CLIENT COMPANY (the employer), CAN TERMINATE THE EMPLOYMENT RELATIONSHIP AT ANY TIME, WITH OR WITHOUT CAUSE OR NOTICE. I ALSO UNDERSTAND THAT THE DRUG-FREE WORKPLACE POLICY AND ANY RELATED DOCUMENTS DO NOT CREATE A CONTRACT OF EMPLOYMENT OR IN ANY WAY ALTER MY AT-WILL EMPLOYMENT STATUS.

I acknowledge receipt of a copy of this policy.

Print Name	Date		Signature

Employee's Copy

Acknowledgement of the Drug-Free Workplace Program

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I acknowledge receipt of a copy of this policy.

Print Name	Date		Signature

Ideal HR's Copy

SECTION 125 Premium Pre-Tax Notice

This is not an offer of benefits
This is a notice regarding pre-tax premiums if coverage is available.

Per IRS Code, you cannot change or revoke this salary reduction agreement during the year unless you have a change in election event, including: marriage, divorce, birth or adoption of a child, death of spouse or child, commencement or termination of spouse or dependent's employment affecting benefit eligibility, and other events as listed in the Section 125 Summary Plan Description.

Pre-tax means that Social Security (FICA) and other taxes will not be withheld on the amount of your salary reduction under this agreement. This agreement will automatically terminate if the Plan is terminated or discontinued, or if you cease to receive compensation from the Company which, before reduction hereunder, is at least equal to the amount of that reduction. The Plan Administrator may reduce or otherwise modify this agreement in the event she/he believes it advisable in order to satisfy certain provisions of the IRS Code.

Your premiums for any benefits selected will automatically be deducted from your salary on a pre-tax basis. Unless notified of a change prior to the start of a new plan year, the prior year elections will be continued and cannot be changed until the next open enrollment period unless a change in election event occurs. If your required contributions for elected benefits increase or decrease while this agreement remains in effect, your salary deduction will automatically be adjusted to reflect that increase or decrease.

_____
Name (Printed)

_____ _____
Date Signature

Employee Copy

SECTION 125 Premium Pre-Tax Notice

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This is a notice regarding pre-tax premiums if coverage is available.

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_____
Name (Printed)

_____ _____
Date Signature

Rules Related to Electronic Document Distribution

Section 125

By signing below and providing an email address I authorize my employer to provide electronic distribution of all Section 125 documentation including but not limited to; Summary Plan Description, Summary of Materials Modification and/or Summary Annual Report.

I also understand that these documents may be available for review on any common website utilized by my employer (such as a Time and Attendance system or company intranet) that I have reasonable access to as part of my employment. A paper copy is available upon request, free of charge. It is my right to withdraw this consent for electronic delivery at any time, without charge, by submitting the request in writing to the Benefits department at Ideal Business Solutions.

It is my responsibility to inform Ideal Business Solutions of any change(s) that might affect the receipt of the document(s) delivery (ie. Change of email address, etc...)

_____
Primary Email Address

_____
Secondary Email Address

_____ _____
Employee Signature Date

Terms of Employment

I acknowledge that I will be paid the amount of $ _____ per: _____

I further understand that my normal hours of work are from: _____

I will be paid by: Ideal HR at (address) 31 Boland Ct Greenville SC 29644

I will be paid on _____ (day) of each _____ pay period.

I understand that my employment is “at-will,” meaning either I or my employer can terminate my employment at any time and for any reason and that this Terms of Employment form is not a contract of employment and does not alter my “at-will” employment status in any way. All wages are subject to withholding for federal, state, and local taxes and any other normal or required deductions.

_____
Name (Printed)

_____ _____
Date Signature