



TRAVEL CENTER entertainment

Date _____

Please Print Clearly **APPLICATION FOR EMPLOYMENT**

Please Answer All Questions. Résumés Are Not A Substitute For A Completed Application But May Be Attached.

I UNDERSTAND THAT NEITHER THIS APPLICATION NOR ANY COMMUNICATION BY A MANAGEMENT REPRESENTATIVE IS INTENDED TO CREATE OR DOES CREATE A CONTRACT OF EMPLOYMENT, OFFER, OR PROMISE OF EMPLOYMENT. I ACKNOWLEDGE THAT IF HIRED BY THE COMPANY, EMPLOYMENT IS ON AN AT-WILL BASIS. THIS MEANS THE COMPANY IS FREE TO TERMINATE MY EMPLOYMENT AT ANY TIME, WITH OR WITHOUT CAUSE OR ADVANCE NOTICE, IN ACCORDANCE WITH STATE LAW, AND ACCEPTANCE OF EMPLOYMENT IS NOT A CONTRACT OF EMPLOYMENT FOR ANY SPECIFIED TIME. SIMILARLY, I AM FREE TO TERMINATE MY EMPLOYMENT WITH THE COMPANY AT ANY TIME FOR ANY REASON. THIS AT-WILL PROVISION MAY BE MODIFIED OR WAIVED ONLY IN A WRITTEN AGREEMENT SIGNED BY AN AUTHORIZED REPRESENTATIVE OF THE COMPANY AND ME. I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF THE COMPANY, AND I UNDERSTAND THAT THE COMPANY HAS COMPLETE DISCRETION TO MODIFY SUCH RULES AND REGULATIONS AT ANY TIME, EXCEPT THAT IT WILL NOT MODIFY ITS POLICY OF EMPLOYMENT AT-WILL.

We are an equal opportunity employer. Applicants are considered for positions without regard to race, religion, sex, national origin, age, disability, or any other consideration made unlawful by applicable federal, state, or local laws.

Position Applied For _____ Social Security Number _____

Name _____ Telephone Number () _____

Present Address (Street, Apt. or Unit No.) _____

City / State / Zip _____ Desired Salary _____

If under the age of 18, can you produce the necessary work certificate at the time of employment? Yes No

Type of employment desired? Full-time Part-time (Specify Hours) _____

Are you willing to work overtime? Yes No Date on which you can start _____

Have you ever applied to this Company before? Yes No

If Yes, when did you apply? _____ Where did you apply? _____

Within the past ten (10) years, have you been convicted of a felony? (Do not include convictions that were sealed, eradicated, erased, or expunged; convictions that resulted in referral to a diversion program; or marijuana-related convictions that are more than two (2) years old.) Yes No

If Yes, please explain so that individual circumstances can be considered.

NOTE

- *Criminal convictions will not automatically disqualify an applicant from a particular job. The Company will consider the nature of the crime, its seriousness, whether the conviction(s) substantially relates to the position's functions and qualifications, the frequency of convictions, the applicant's age at the time of conviction, the time elapsed since the date of conviction or completion of jail sentence, the applicant's entire work and educational history, and employment references and recommendations.*
- *An ex-offender who is denied employment may, upon written request, receive a statement of the reason(s) for denial within 30 days of the applicant's request for such information.*

CALIFORNIA APPLICANTS: This does not include convictions under California Health & Safety Code §§ 11357(a) or (b), 11360(c), 11364, 11365, or 11550 related to marijuana which occurred two or more years before the instant application.

CONNECTICUT APPLICANTS: Applicants are not required to disclose the existence of any arrest, criminal charge, or conviction, the records of which have been erased. Criminal records subject to erasure are records pertaining to a finding of delinquency or the fact that a child was a member of a family with service needs, an adjudication as a youthful offender, a criminal charge that has been dismissed or nolledd (not prosecuted), a criminal charge for which the person was found not guilty, or a conviction for which the offender received an absolute pardon. Any person whose criminal records have been erased is deemed to have never been arrested within the meaning of the law as it applies to the particular proceedings that have been erased, and may so swear under oath.

MASSACHUSETTS APPLICANTS: Applicants for employment with a sealed record on file with the Massachusetts Commissioner of Probation may answer "No Record" with respect to all inquiries relating to prior convictions.

Have you ever initiated an act of violence in the workplace? Yes No

If Yes, please explain so that individual circumstances can be considered. (A Yes answer will not necessarily disqualify you from employment.) _____

List special technical skills that you feel qualify you for the job for which you are applying (i.e., computer programming/language, software, equipment operation, special tools or machines, etc.):

| Education | School Name and Location | Course of Study | Graduate? | # of Years Completed | Degree/Major |
|----------------------------------|--------------------------|-----------------|-----------|----------------------|--------------|
| High School | | | | | |
| College | | | | | |
| Bus./Tech./Trade or Post College | | | | | |

Honors Received _____

WORK EXPERIENCE

Start with your present or last place of employment. You may include any verifiable work performed on a volunteer basis, internships, or military service.

Employer

Name _____ Address _____ Type of Business _____

Phone (_____) _____ Dates Employed From ____/____/____ To ____/____/____

Job Title _____ Supervisor's Name _____

May we contact? Yes No

Wages Start _____ Final _____ Reason for Leaving _____

Duties _____

Employer

Name _____ Address _____ Type of Business _____
 Phone (_____) _____ Dates Employed From ____/____/____ To ____/____/____
 Job Title _____ Supervisor's Name _____
 May we contact? Yes No
 Wages Start _____ Final _____ Reason for Leaving _____
 Duties _____

Employer

Name _____ Address _____ Type of Business _____
 Phone (_____) _____ Dates Employed From ____/____/____ To ____/____/____
 Job Title _____ Supervisor's Name _____
 May we contact? Yes No
 Wages Start _____ Final _____ Reason for Leaving _____
 Duties _____

REFERENCES

Please list the names of additional work-related references we may call. Individuals with no prior work experience may list school or volunteer related references.

| NAME | POSITION | COMPANY | WORK RELATIONSHIP (i.e., supervisor, co-worker) | TELEPHONE # |
|------|----------|---------|--|-------------|
| | | | | |
| | | | | |

APPLICANT CERTIFICATION

I understand and agree that if driving is a requirement of the job for which I am applying, my employment and/or continued employment is contingent on possessing a valid driver's license and automobile liability insurance in an amount equal to the minimum required by the state where I reside.

I understand that the Company may now have, or may establish, a drug-free workplace or drug and/or alcohol testing program consistent with applicable federal, state, and local law. If the Company has such a program and I am offered a conditional offer of employment, I understand that if a pre-employment (post-offer) drug and/or alcohol test is positive, the employment offer may be withdrawn. I agree to work under the conditions requiring a drug-free workplace, consistent with applicable federal, state, and local law. I also understand that all employees of the location, pursuant to the Company's policy and federal, state, and local law, may be subject to urinalysis and/or blood screening or other medically recognized tests designed to detect the presence of alcohol or controlled drugs. If employed, I understand that the taking of alcohol and/or drug tests is a condition of continual employment and I agree to undergo alcohol and drug testing consistent with the Company's policies and applicable federal, state, and local law.

If employed by the Company, I understand and agree that the Company, to the extent permitted by federal, state, and local law, may exercise its right, without prior warning or notice, to conduct investigations of property (including, but not limited to, files, lockers, desks, vehicles, and computers) and, in certain circumstances, my personal property.

I understand and agree that as a condition of employment and to the extent permitted by federal, state, and local law, I may be required to sign a confidentiality, non-compete, and/or conflict of interest statement.

I certify that all the information on this application, my résumé, or any supporting documents is complete and accurate to the best of my knowledge. I understand that any falsification, misrepresentation, or omission of any information may result in disqualification from consideration for employment or, if employed, disciplinary action, up to and including immediate dismissal.

I UNDERSTAND THAT NEITHER THIS APPLICATION NOR ANY COMMUNICATION BY A MANAGEMENT REPRESENTATIVE IS INTENDED TO CREATE OR DOES CREATE A CONTRACT OF EMPLOYMENT, OFFER, OR PROMISE OF EMPLOYMENT. I ACKNOWLEDGE THAT IF HIRED BY THE COMPANY, EMPLOYMENT IS ON AN AT-WILL BASIS. THIS MEANS THE COMPANY IS FREE TO TERMINATE MY EMPLOYMENT AT ANY TIME, WITH OR WITHOUT CAUSE OR ADVANCE NOTICE. IN ACCORDANCE WITH STATE LAW, AND ACCEPTANCE OF EMPLOYMENT IS NOT A CONTRACT OF EMPLOYMENT FOR ANY SPECIFIED TIME. SIMILARLY, I AM FREE TO TERMINATE MY EMPLOYMENT WITH THE COMPANY AT ANY TIME FOR ANY REASON. THIS AT-WILL PROVISION MAY BE MODIFIED OR WAIVED ONLY IN A WRITTEN AGREEMENT SIGNED BY AN AUTHORIZED REPRESENTATIVE OF THE COMPANY AND ME. I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF THE COMPANY, AND I UNDERSTAND THAT THE COMPANY HAS COMPLETE DISCRETION TO MODIFY SUCH RULES AND REGULATIONS AT ANY TIME, EXCEPT THAT IT WILL NOT MODIFY ITS POLICY OF EMPLOYMENT AT-WILL.

I authorize the Company or its agents to confirm all statements contained in this application and/or résumé as it relates to the position I am seeking and to the extent permitted by federal, state, or local law. I agree to complete any requisite authorization forms for the background investigation.

I authorize and consent to, without reservation, any party or agency contacted by this employer to furnish the above-mentioned information. I hereby release, discharge and hold harmless, to the extent permitted by federal, state, and local law, any party delivering information to the Company or its duly authorized representative pursuant to this authorization from any liability, claims, charges, or causes of action which I may have as a result of the delivery or disclosure of the above requested information. I hereby release from liability the Company and its representative for seeking such information and all other persons, corporations, or organizations furnishing such information.

If hired by this Company, I understand that I will be required to provide genuine documentation establishing my identity and eligibility to be legally employed in the United States. I also understand this Company employs only individuals who are legally eligible to work in the United States.

Applicant Signature _____ Date _____

If the applicant is a minor, the foregoing release and consent must be signed by the applicant's parent or legal guardian. Signature by the applicant's parent or legal guardian constitutes acknowledgement by the applicant and the parent or legal guardian that the Company, to the extent permitted by federal, state, and local law, can test the applicant for controlled substances, conduct inspections of property without notice, and communicate screen results to Company personnel who need to know, the applicant, and the applicant's legal guardian.

Parent/Legal Guardian

Witness

Date

Date

UNDER MARYLAND LAW, AN EMPLOYER MAY NOT REQUIRE OR DEMAND, AS A CONDITION OF EMPLOYMENT, PROSPECTIVE EMPLOYMENT, OR CONTINUED EMPLOYMENT, THAT AN INDIVIDUAL SUBMIT TO OR TAKE A LIE DETECTOR OR SIMILAR TEST. AN EMPLOYER WHO VIOLATES THIS LAW IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT EXCEEDING \$100.

UNDER MASSACHUSETTS LAW, IT IS UNLAWFUL FOR AN EMPLOYER TO REQUIRE OR TO ADMINISTER A LIE DETECTOR TEST AS A CONDITION OF EMPLOYMENT OR CONTINUED EMPLOYMENT.

FEDERAL AND/OR STATE LAW MAY PROHIBIT THE USE OF POLYGRAPH OR SIMILAR TESTS AS WELL.

THIS APPLICATION MAY NOT BE APPLICABLE FOR ALL INDUSTRIES.



Click to Return

Print Form

backgrounds usa

Consent Form - Disclosure of Information:

Name: _____

Social Security #: _____ - _____ - _____ Home Phone #: _____

Driver's License #: _____ State Issued: _____

Name as it appears on license: _____ Date of Birth: _____

High School Graduation Date (if applicable): _____

College Graduation Date (if applicable): _____

Or, if you attended college but did not graduate, When did you attend: _____

Home Address: _____

City: _____ State: _____ Zip: _____

I hereby give consent for a consumer report for employment or tenancy purposes. I hereby authorize, without reservation, any law enforcement agency, administrator, state agency, state repository, former employer, corporation, credit agency, educational institution, city, state, federal court, military institution, information service bureau, employer or insurance company contacted by **Backgrounds USA**, to furnish any and all information. I do understand the investigation will include information from law enforcement agencies, state agencies and public records information, such as credit, social security, criminal, motor vehicle and workers' compensation in accordance with the American with Disabilities Act. This report will include information as to my character work habits, performance and experience, along with the reasons for termination of past employment from previous employers. This releases the aforesaid parties from any liability and responsibility for collecting the above information at any time.

According to the Fair Credit Reporting Act (Law 91-508) SS 606:

A person may not procure or cause to be prepared an investigative consumer report on any consumer unless it is clearly and accurately disclosed to the consumers that an investigative consumer report including information as to his character, general reputation, personal characteristics and mode of living and employment history, whichever are applicable, may be made. I also understand that if I am denied employment because of the consumer investigation, it is my right to have the name of the agency or agencies disclosed to me within the time allowed. This authorization, in original or copy form, shall be valid for this and any further reports or updates that may be requested.

Signed: _____ Date: _____

Company Requesting Information: C & R Games

Please Sign and Fax this form to:

FAX: (303) 455-4771 or mail to: **Backgrounds USA** 1760 Gaylord St, Denver, CO 80206

(Name of Job Applicant/Employee)

(Street Address)

(City, State, Zip Code)

(Date)

C & R Games, Inc. dba
Travel Center Entertainment
12662 Bermuda Triangle Road
Chester, Virginia 23836

I, authorize, your insurance Agent/Insurance Company to obtain a MVR solely to determine whether I am an acceptable driver for underwriting purposes under the employer's commercial auto policy. I am assured the Agent/Insurance Company will not show or discuss the contents of the MVR with your office but will merely state whether the record is acceptable or unacceptable from an underwriting perspective.

(Name)

(Date of Birth)

(State of License & Number)

(Social Security Number)

(Signature)

If the nature of the record determines an underwriting denial, I will be furnished information on how to obtain a copy of my record from the appropriate reporting agency.

NEW EMPLOYEE INFORMATION

(Print all Information, Sign & Date This Form)

New Hire Rehire

PERSONAL DATA

Last Name: _____ First Name: _____ Initial: _____

Street Address: _____

P.O. Box #: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____

E-Mail Address: _____

EMPLOYMENT DATA

Sex: Male Marital Status: Single
 Female Married

Job Title: _____ Date of Hire: _____

Rate of Pay: _____ Hourly Salary

Work Location (state): _____ Full-Time Part-Time Temporary

For Office Use: The following should be attached to this form for all new and rehire employees:

Application W-4 Tax Form State Tax Form I-9 Form w/ ID's

Background Check WOG Disclosure Driving Record Request Form

Start Date: _____ Supervisor: _____

Company Handbook Given to Employee at Start Date: Yes No

Employee Signature: _____ Date: _____

Form W-4 (2008)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2008 expires February 16, 2009. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$900 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits,

adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2008. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent. **A** _____

B Enter "1" if: **B** _____

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) **E** _____

F Enter "1" if you have at least \$1,500 of child or dependent care expenses for which you plan to claim a credit **F** _____

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. **G** _____

- If your total income will be less than \$58,000 (\$86,000 if married), enter "2" for each eligible child.
- If your total income will be between \$58,000 and \$84,000 (\$86,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have 4 or more eligible children.

H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) **H** _____

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

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

| | | |
|---|--|---|
| Form W-4 Department of the Treasury Internal Revenue Service | <h2>Employee's Withholding Allowance Certificate</h2> <p>► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p> | OMB No. 1545-0074 <h1 style="font-size: 2em;">2008</h1> |
| 1 Type or print your first name and middle initial. Last name | | 2 Your social security number |
| Home address (number and street or rural route) | | 3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |
| City or town, state, and ZIP code | | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/> |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) | | 5 _____ |
| 6 Additional amount, if any, you want withheld from each paycheck | | 6 \$ _____ |
| 7 I claim exemption from withholding for 2008, and I certify that I meet both of the following conditions for exemption. | | |
| <ul style="list-style-type: none"> • Last year I had a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. | | |
| If you meet both conditions, write "Exempt" here | | 7 _____ |
| Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete. | | |
| Employee's signature (Form is not valid unless you sign it.) | | |
| 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | | 9 Office code (optional) |
| | | 10 Employer identification number (EIN) |

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2008 tax return.

- 1 Enter an estimate of your 2008 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2008, you may have to reduce your itemized deductions if your income is over \$159,950 (\$79,975 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) 1 \$ _____
- 2 Enter: $\left\{ \begin{array}{l} \$10,900 \text{ if married filing jointly or qualifying widow(er)} \\ \$ 8,000 \text{ if head of household} \\ \$ 5,450 \text{ if single or married filing separately} \end{array} \right\}$ 2 \$ _____
- 3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2008 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 \$ _____
- 5 Add lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919) 5 \$ _____
- 6 Enter an estimate of your 2008 nonwage income (such as dividends or interest) 6 \$ _____
- 7 Subtract line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____
- 8 Divide the amount on line 7 by \$3,500 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 Add lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than "3." 2 _____
- 3 If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet 3 _____

Note. If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 _____
- 5 Enter the number from line 1 of this worksheet 5 _____
- 6 Subtract line 5 from line 4 6 _____
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____
- 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
- 9 Divide line 8 by the number of pay periods remaining in 2008. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2007. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Table 2

| Married Filing Jointly | | All Others | | Married Filing Jointly | | All Others | |
|---|-----------------------|---|-----------------------|--|-----------------------|--|-----------------------|
| If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from HIGHEST paying job are— | Enter on line 7 above | If wages from HIGHEST paying job are— | Enter on line 7 above |
| \$0 - \$4,500 | 0 | \$0 - \$6,500 | 0 | \$0 - \$65,000 | \$530 | \$0 - \$35,000 | \$530 |
| 4,501 - 10,000 | 1 | 6,501 - 12,000 | 1 | 65,001 - 120,000 | 830 | 35,001 - 80,000 | 830 |
| 10,001 - 18,000 | 2 | 12,001 - 20,000 | 2 | 120,001 - 180,000 | 980 | 80,001 - 150,000 | 980 |
| 18,001 - 22,000 | 3 | 20,001 - 27,000 | 3 | 180,001 - 310,000 | 1,160 | 150,001 - 340,000 | 1,160 |
| 22,001 - 27,000 | 4 | 27,001 - 35,000 | 4 | 310,001 and over | 1,230 | 340,001 and over | 1,230 |
| 27,001 - 33,000 | 5 | 35,001 - 50,000 | 5 | | | | |
| 33,001 - 40,000 | 6 | 50,001 - 65,000 | 6 | | | | |
| 40,001 - 50,000 | 7 | 65,001 - 80,000 | 7 | | | | |
| 50,001 - 55,000 | 8 | 80,001 - 95,000 | 8 | | | | |
| 55,001 - 60,000 | 9 | 95,001 - 120,000 | 9 | | | | |
| 60,001 - 65,000 | 10 | 120,001 and over | 10 | | | | |
| 65,001 - 75,000 | 11 | | | | | | |
| 75,001 - 100,000 | 12 | | | | | | |
| 100,001 - 110,000 | 13 | | | | | | |
| 110,001 - 120,000 | 14 | | | | | | |
| 120,001 and over | 15 | | | | | | |

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also 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, and the District of Columbia for use in administering their tax laws, and using it 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.

LISTS OF ACCEPTABLE DOCUMENTS

| LIST A | LIST B | LIST C |
|---|---|---|
| Documents that Establish Both Identity and Employment Eligibility | Documents that Establish Identity | Documents that Establish Employment Eligibility |
| <ol style="list-style-type: none"> 1. U.S. Passport (unexpired or expired) 2. Certificate of U.S. Citizenship (Form N-560 or N-561) 3. Certificate of Naturalization (Form N-550 or N-570) 4. Unexpired foreign passport, with I-551 stamp or attached Form I-94 indicating unexpired employment authorization 5. Permanent Resident Card or Alien Registration Receipt Card with photograph (Form I-151 or I-551) 6. Unexpired Temporary Resident Card (Form I-688) 7. Unexpired Employment Authorization Card (Form I-688A) 8. Unexpired Reentry Permit (Form I-327) 9. Unexpired Refugee Travel Document (Form I-571) 10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (Form I-688B) | <p style="font-size: 1.5em; margin: 0;">OR</p> <ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center; margin: 0;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor or hospital record 12. Day-care or nursery school record | <p style="text-align: center; font-size: 1.5em; margin: 0;">AND</p> <ol style="list-style-type: none"> 1. U.S. social security card issued by the Social Security Administration (other than a card stating it is not valid for employment) 2. Certification of Birth Abroad issued by the Department of State (Form FS-545 or Form DS-1350) 3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. ID Card for use of Resident Citizen in the United States (Form I-179) 7. Unexpired employment authorization document issued by DHS (other than those listed under List A) |

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

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1 - Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. The employer is responsible for ensuring that Section 1 is timely and properly completed.

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. Employers must record: 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. However, employers are still responsible for completing the I-9.

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:

- examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C).
- record the document title, document number and expiration date (if any) in Block C, and
- complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS

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

Employment Eligibility Verification

Please 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 eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

| | | | |
|----------------------------------|-------|----------------|--------------------------------|
| Print Name: Last | First | Middle Initial | Maiden Name |
| Address (Street Name and Number) | | Apt. # | Date of Birth (month/day/year) |
| City | State | Zip Code | Social Security # |

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 or national of the United States
- A Lawful Permanent Resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #)

| | |
|----------------------|-----------------------|
| Employee's Signature | Date (month/day/year) |
|----------------------|-----------------------|

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.

| | |
|---|------------|
| Preparer's/Translator's Signature | Print Name |
| Address (Street Name and Number, City, State, Zip Code) | |
| Date (month/day/year) | |

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

| List A | OR | List B | AND | List C |
|---------------------------------|----|--------|-----|--------|
| Document title: _____ | | _____ | | _____ |
| Issuing authority: _____ | | _____ | | _____ |
| Document #: _____ | | _____ | | _____ |
| Expiration Date (if any): _____ | | _____ | | _____ |
| Document #: _____ | | _____ | | _____ |
| Expiration Date (if any): _____ | | _____ | | _____ |

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

| | | |
|--|---|-----------------------|
| Signature of Employer or Authorized Representative | Print Name | Title |
| Business or Organization Name | Address (Street Name and Number, City, State, Zip Code) | |
| | | Date (month/day/year) |

Section 3. Updating and Reverification. To be completed and signed by employer.

| | | |
|--|--|---------------------------|
| A. New Name (if applicable) | B. Date of Rehire (month/day/year) (if applicable) | |
| C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility. | | |
| Document Title: | Document #: | Expiration Date (if any): |

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 (month/day/year) |
|--|-----------------------|

| | |
|-------------------------|-------|
| Paychex Use Only | |
| Client Number | _____ |
| Worker Number | _____ |
| PRS | _____ |
| Date | _____ |
| Verified By | _____ |

PAYCHEX

Direct Deposit/Access Card Signup Form

Worker Instructions:

1. Complete the "WORKER - Required Information" section.
2. Complete the Direct Deposit, Access Card, or both sections to specify where you want your pay deposited.
3. Sign the bottom of the form.
4. Retain a copy of this form for your records. Return the original to your employer.

Employer Instructions:

1. Complete the "EMPLOYER - Required Information" section.
2. Return this form to your local Paychex office.

WORKER - Required Information

PLEASE PRINT

Worker Name _____

Social Security Number _____

EMPLOYER - Required Information

PLEASE PRINT

Company Name _____

Office/Client Number _____ / _____

Federal ID Number _____

Complete for DIRECT DEPOSIT

I authorize my employer to deposit my wages/salary to the following bank account(s):

Bank Account #1 Checking Savings

Bank Name _____

Bank Account #2 Checking Savings

Bank Name _____

I wish to deposit (check one):

- Entire Net Pay
- _____ % of Net
- Specific Dollar Amount \$ _____ .00

I wish to deposit (check one):

- Entire Net Pay
- _____ % of Net
- Specific Dollar Amount \$ _____ .00

Please attach one of the following (check one):

- Voided check (deposit slips are not accepted)
- Bank letter or specification sheet*
- *See your local bank representative.

Please attach one of the following (check one):

- Voided check (deposit slips are not accepted)
- Bank letter or specification sheet*
- *See your local bank representative.

Complete for ACCESS CARD

I authorize my employer to deposit my wages/salary to an Access Card account. I agree to the terms and conditions of the Paychex Access Card Program including the \$2.00 monthly maintenance fee, the \$1.50 per ATM withdrawal fee, the \$3.00 over-the-counter cash advance fee, and the \$15.00 lost or stolen card replacement fee.

I wish to deposit (check one):

- Entire Net Pay _____ % of Net Specific Dollar Amount \$ _____ .00

Please print the address where the Access Card statements should be mailed.

Street Address _____ Apt. # _____ City _____ State _____ Zip _____

Home Phone No. (_____) _____ - _____ Date of Birth ____ / ____ / ____

Mother's Maiden Name _____

Additional Card Requested.

Additional Cardholder Name _____

Additional Cardholder Social Security No. _____ - _____ - _____

Worker Signature _____

Date ____ / ____ / ____

Return this original form to your employer.

U.S. GOVERNMENT PRINTING OFFICE: 2007

PLEASE PRINT THROUGHOUT THIS FORM
all sections that apply.

| | | | | | | |
|------------------------------------|--|--|---|---|---|---|
| To Be Completed by Employer | | <input type="checkbox"/> New | <input type="checkbox"/> Dependent Add/Delete | <input type="checkbox"/> Change Name/Address | <input type="checkbox"/> Cancel | <input type="checkbox"/> Date of Change |
| Group Specifics | | Reason for Application | | Product Selection | | Employee Type |
| Position/Title | | <input type="checkbox"/> New Group Plan | <input type="checkbox"/> Annual Open Enrollment | Health <input type="checkbox"/> Yes <input type="checkbox"/> No | Life <input type="checkbox"/> Yes <input type="checkbox"/> No | Active <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hours Worked | | <input type="checkbox"/> New Hire | <input type="checkbox"/> Status Change | Dep Life <input type="checkbox"/> Yes <input type="checkbox"/> No | Dental <input type="checkbox"/> Yes <input type="checkbox"/> No | COBRA/Std Cont <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Plan Selected | | <input type="checkbox"/> Life event/date | <input type="checkbox"/> Other | Vision <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | Hourly <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical | | <input type="checkbox"/> Date of Hire | | | | Salary <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dental | | | | | | Union <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | Non-Union <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | | | | | | | | | | |
|--------------------------------|--|------------|------|----|-----------|-----|------------------------|---------------|------------|--|------------|--|
| A. Employee Information | | First Name | | MI | Last Name | | Social Security Number | | Home Phone | | Work Phone | |
| Address | | Apt # | City | | State | Zip | | Email Address | | | | |

| | | | | | | | | | |
|------------------------------|------------|--|--------|------------------------|-----------|--------|--------|---|---------------------------------|
| B. Family Information | | List All Enrolling (Attach sheet if necessary) | | | | | | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | |
| Last Name | First Name | MI | Sex | Relationship** | Birthdate | Height | Weight | Full Time | Physician*(First and Last Name) |
| Employee | | | M F | Self | | | | Student | |
| | | | M F | Spouse/Dom. Partner | | | | | |
| | | | M F | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care) for yourself and each of your covered dependents, for UnitedHealthcare Select and Select Plus only. **For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on a separate sheet.

| | | | | | | | | | | |
|--|---------|------|----------|----------|--------|--------|-----|-----|------------------|--|
| C. Product Selection (Please check all that apply)* | | | | | | | | | Dual Option Plan | |
| Person | Medical | Life | Sup Life | Sup AD&D | Dental | Vision | STD | LTD | Number | |
| Employee | | \$ | \$ | \$ | | | | | | |
| Spouse | | \$ | | | | | | | | |
| Dependents | | \$ | | | | | | | | |

| | | |
|---|--|--------------|
| *Benefit offerings are dependent upon employer election | Life Beneficiary's Full Name and Address | Relationship |
|---|--|--------------|

| | | | | | |
|--|---|---|--|---|--|
| D. Other Coverage Information | | List dates covered | | List all family members covered | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Has anyone on this application been covered with health benefits, including coverage with UnitedHealthcare within the past 2 years? | Reason <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease | | Covered by Part <input type="checkbox"/> A <input type="checkbox"/> B | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you or any of your dependents covered by Medicare? | Date Medicare became effective | | Claim Number | |
| If yes, Name of Medicare Beneficiary | | | | | |

| | | | | | |
|--|--|---|--|---|--|
| E. Waiver of Coverage | | Declining coverage due to existence of other coverage: | | I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form. | |
| I decline coverage for: | | <input type="checkbox"/> Spouse's Employer's Plan | <input type="checkbox"/> Individual Plan | | |
| <input type="checkbox"/> Myself and all dependents | | <input type="checkbox"/> Covered by Medicare | <input type="checkbox"/> Medicaid | | |
| <input type="checkbox"/> Spouse | | <input type="checkbox"/> COBRA from Prior Employer | <input type="checkbox"/> VA Eligibility | | |
| <input type="checkbox"/> Dependent Children | | <input type="checkbox"/> Tri-Care | <input type="checkbox"/> Other | | |
| | | <input type="checkbox"/> I (we) have no other coverage at this time | | | |
| | | Employee Initials | | Date | |

F. Signature I authorize United HealthCare Insurance Company and its affiliates ("The Company and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to The Company and Affiliates. I understand the purpose of the disclosure and use of my information is to allow The Company and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying The Company in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

the plan provides, for my dependents, I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

| | | |
|------|---|----------------------------------|
| Date | Employee Signature for all applying and waiving | Spouse Signature (if applicable) |
|------|---|----------------------------------|

G. Medical History

Employee Name _____ SSN _____ Group Name _____

Have you - or any person listed in section B "Family Information" on the front of this form - consulted with or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium.**

| | |
|--|---|
| 1A Cancer/Tumor <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Other _____ |
| 1B Heart/Circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Phlebitis <input type="checkbox"/> Skin Ulcer <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Other _____ |
| 1C Reproductive <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Current Pregnancy (due date____) <input type="checkbox"/> Multiples Expected (#____) <input type="checkbox"/> Pregnancy Complications (Current or Past) <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other _____ |
| 1D Intestinal/Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Hiatal Hernia/Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Other _____ |
| 1E Brain/Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Other _____ |
| 1F Lung/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other _____ |
| 1G Eyes/Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____ |
| 1H Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Neurogenic Bladder <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____ |
| 1I Bones/Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint Injury <input type="checkbox"/> Pituitary Dwarfism <input type="checkbox"/> Pulled/Strained Muscle <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Other Back/Neck Disorder <input type="checkbox"/> Other _____ |
| 2 Mental Health/Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Other _____ |
| 3 Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Organ _____ |
| 4 Medication <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Current Medications <input type="checkbox"/> Medications Taken Within The Past Year |
| 5 Other <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Abnormal Test Or Physical Results <input type="checkbox"/> Condition or Congenital Disorder Not Mentioned Above <input type="checkbox"/> Treatment Or Surgery Discussed Or Advised, But Not Yet Done <input type="checkbox"/> Unexplained Weight Change |
| 6 Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Anyone On This Application Used Tobacco Products In The Past 12 Months Name _____ |

Please give details below (if additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

| Question # | Person | Condition/Diagnosis | Treatment/Complications | Physician's Name | Dates Treated | Prognosis |
|------------|--------|---------------------|-------------------------|------------------|---------------|-----------|
| | | | | | | |
| | | | | | | |
| | | | | | | |

**CONFIDENTIALITY AND NON-DISCLOSURE
AGREEMENT**

THIS AGREEMENT is hereby made and entered into this _____ day of _____, 20___, by and between WORLDS OF GAMES L.L.C., located at 2027 Madison Street, Shelbyville 37160, a Tennessee Corporation (hereinafter referred to as the "Corporation"), and _____ (hereinafter referred to as the "Interested Party").

WITNESSETH:

WHEREAS, the Corporation owns and possesses certain confidential information with respect to a newly developed business product, including, but not limited to, income projections, expenses, licensing areas, customers, strategic plans, business methods and other information regarding the ownership and operation of its business and product (all of the foregoing is hereinafter referred to as the Confidential Information);

Whereas, the Interested Party desires to view and examine the business product for the purpose of evaluating same and for the purpose of determining whether to enter into a licensing agreement with the Corporation regarding the purchase and/or use of the business product and the Confidential Information;

Whereas, the Corporation is willing to provide and divulge certain Confidential Information to the Interested Party and to allow the Interested Party to inspect and examine the business product upon the terms and conditions hereinafter set forth:

Now, Therefore, for and in consideration of the mutual covenants and agreements herein contained, the sufficiency of which is hereby acknowledged, the parties agree, as follows:

1. **Disclosure of Information.** The Corporation may from time to time disclose and/or provide certain Confidential Information to the Interested Party so this Interested Party may evaluate a possible transaction between himself/herself and the Corporation.
2. **Confidential Nature.** The Interested Party recognizes and acknowledges the confidential nature and competitive value of the Confidential Information and that damage could result to the Corporation if any of the Confidential Information is disclosed to any third party.
3. **Use of Confidential Information.** The Interested Party shall use the Confidential Information solely for the purpose of evaluating a possible transaction between himself/itself and the Corporation with the next four (4) years, whether it be entering into a licensing

agreement for the purchase directly from the Corporation of the business product. The Interested Party shall safeguard the Confidential Information and not allow it to be viewed, except by itself and its proper Representatives.

4. **Representatives.** The Interested Party may disclose the Confidential Information to its directors, officers, key employees, advisors, accountants, attorneys, and investment bankers (herein collectively referred to as the "Representatives"), so long as such individuals are individuals truly "key" to evaluating the transaction being contemplated and agree in writing to keep such Confidential Information confidential and to be bound by this Agreement to the same extent as the Interested Party and as if they were parties hereto. The Interested Party shall be responsible and liable for any breach of this Agreement by its Representatives.
5. **Non-Disclosure of Confidential Information.** Neither the Interested Party nor its Representatives, nor any of them, shall, for a period of Four years from the date hereof, disclose any of Confidential Information to any third person or entity without prior written consent of the Corporation, except as required by applicable law or legal process. The Interested Party and its Representatives shall give the Corporation prior and prompt notice and consult with the Corporation on the advisability of seeking a protective order or other means to preserve the confidential treatment of such Confidential Information before any disclosure, whatsoever; and the Interested Party and its appropriate Representatives shall seek a protective order before disclosure, if requested by the Corporation and not prohibited by law.
6. **Non-Disclosure of Discussions.** Without the prior consent of the Corporation, neither the Interested Party nor its Representatives shall disclose to any person or entity either the fact that discussions or negotiations are taking place concerning a possible transaction between the Interested Party and the Corporation, or any of the terms, conditions, or other facts with respect to a possible transaction, including the status thereof. The Corporation agrees that it shall not, without the Interested Party's consent, make any disclosure relating to such discussions or negotiations with the Interested Party, except for such disclosure which might be required by applicable law.
7. **Transaction Not Consummated.** In the event the possible transaction being contemplated by and between the Corporation and the Interested Party is not consummated, the Interested Party and its Representatives, acting alone or as part of any group, shall not for a period of Four years from the date of this Agreement, without prior written consent of the Corporation, (use of the Confidential Information for any purpose without the prior written consent of the Corporation.
8. **Return of Copies.** Upon the request of the Corporation at any time, the Confidential Information and all copies thereof shall be returned to the Corporation and not retained by the Interested Party or the Representatives in any form for any reason. However, the

Interested Party and the Representatives may destroy, in lieu of returning any summaries, notes, analyses, or studies prepared by the Interested Party or the Representatives in connection with the Confidential Information.

9. **Other Information.** Notwithstanding anything else herein contained, this Agreement shall not apply to information obtained by the Interested Party that is generally available to the public other than by actions of the Interested Party or the Representatives in violation of this Agreement, to the extent that such information is or was lawfully obtained from some source other than the Corporation, its employees, directors, officers, agents, advisors, or representatives.
10. **Accuracy.** Although the Corporation has included in the Confidential Information materials that it believes to be relevant for the purpose of the Interested Party's investigation, the Corporation makes no representation or warranty as to the accuracy or completeness of the Confidential Information. The Corporation and its officers, directors, employees, agents, advisors, and representatives shall have no liability to the Interested Party or the Representatives arising out of the use or analysis of the Confidential Information by the Interested Party or the Representatives.
11. **Remedies.** In addition to the recovery of damages and without limiting any other remedies available in law or equity, the Corporation shall be entitled to immediate injunctive or other equitable relief in the event of a breach or threatened breach of any provisions of the Agreement. Failure or delay by the Corporation in exercising any right, power or privilege hereunder shall not be deemed to be a waiver thereof nor shall any single or partial exercise thereof preclude any other or further exercise of any right, power or privilege.
12. **Captions.** The captions contained in this Agreement are for reference purposes only and shall in no way be deemed to limit or broaden the provisions of this Agreement.
13. **Binding Effect.** This Agreement shall be binding upon, and inure to the benefit of, the parties hereto and their respective successors, (heirs), (assigns), and (personal and) legal representatives, and shall remain effective should the possible transaction contemplated by and between the parties fail to occur.
14. **Severability.** Should any provision of this Agreement be determine to be invalid, illegal, and unenforceable by a court of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect the other provisions herein contained, which shall remain in full force and effect.
15. **Applicable Law.** This Agreement shall be interpreted under and construed in accordance with the laws of the State of Tennessee.

16. Amendment. This Agreement shall be amended only by a writing signed by both parties hereto.

In Witness Whereof, the parties hereto have executed this Agreement on the day and date first above written.

WORLDS OF GAMES, LLC

BY: _____
DWAYNE KEITH HEFLIN, CEO

INTERESTED PARTY

BY: _____
NAME TITLE