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: _____

Security Question (Password Retrieval)

Question: _____

Answer: _____

Please note that your security question and answer can be changed once you first login to your Time & Attendance account (if applicable)

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

I understand that IDEAL BUSINESS SOLUTIONS, LLC (DBA - IDEAL HR) is my employer of record for the purposes of payroll, payroll taxes, payroll deductions, overtime pay, and applicable benefits.

I understand that if I have any questions regarding those items listed above I should contact IDEAL HR at 31 Boland Ct, Greenville, SC 29615. Telephone number: (864) 286-9009.

By my signature I acknowledge that I have received a copy of this document.

_____
Name (Printed)

_____ _____
Date Signature

Employee's Copy

Acknowledgement Of Employer

I understand that IDEAL BUSINESS SOLUTIONS, LLC (DBA - IDEAL HR) is my employer of record for the purposes of payroll, payroll taxes, payroll deductions, overtime pay, and applicable benefits.

I understand that if I have any questions regarding those items listed above I should contact IDEAL HR at 31 Boland Ct, Greenville, SC 29615. Telephone number: (864) 286-9009.

By my signature I acknowledge that I have received a copy of this document.

_____
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	Social Security Number	Date	Signature
_____	_____	_____	_____

Employee'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	Social Security Number	Date	Signature
_____	_____	_____	_____

Ideal HR's Copy

Section 125

SECTION 125

To be eligible for insurance benefits, you must be 18 years of age or older and must meet your company's required number of hours worked per week. Dropping below the required hours worked per week may result in the cancellation of insurance benefits.

Should I elect not to enroll in insurance when first eligible, I understand the insurance company can decline to provide insurance for up to 12 months and may impose pre-existing condition exclusions for up to 18 months.

In addition, I understand that the insurance company may impose a 12 month pre-existing condition exclusion if I have not had continuous coverage for at least the 12 previous months. The number of month's coverage I have had in the previous 12-month period will shorten the exclusion period.

I authorize my employer/group to deduct from my pay and remit the employee's portion of the insurance for the cost of my coverage to the insurance company. The deductions will be made where possible on a pre-tax basis using section 125 of the IRS Code of 1986, as amended.

I understand that under the Section 125 rules that I will not be allowed to make changes or cancel coverage that have a pre-taxed premium unless my groups plan has an Open Enrollment. If no Open Enrollment is offered in my Groups Plan, changes in coverage and/or cancellation of coverage can be made within 30 days of a qualifying event as described in the IDEAL HR Section 125 Summary Plan Document.

_____
Name (Printed)

_____ _____
Date Signature

Employee's Copy

Section 125

SECTION 125

To be eligible for insurance benefits, you must be 18 years of age or older and must meet your company's required number of hours worked per week. Dropping below the required hours worked per week may result in the cancellation of insurance benefits.

Should I elect not to enroll in insurance when first eligible, I understand the insurance company can decline to provide insurance for up to 12 months and may impose pre-existing condition exclusions for up to 18 months.

In addition, I understand that the insurance company may impose a 12 month pre-existing condition exclusion if I have not had continuous coverage for at least the 12 previous months. The number of month's coverage I have had in the previous 12-month period will shorten the exclusion period.

I authorize my employer/group to deduct from my pay and remit the employee's portion of the insurance for the cost of my coverage to the insurance company. The deductions will be made where possible on a pre-tax basis using section 125 of the IRS Code of 1986, as amended.

I understand that under the Section 125 rules that I will not be allowed to make changes or cancel coverage that have a pre-taxed premium unless my groups plan has an Open Enrollment. If no Open Enrollment is offered in my Groups Plan, changes in coverage and/or cancellation of coverage can be made within 30 days of a qualifying event as described in the IDEAL HR Section 125 Summary Plan Document.

_____
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: _____ at (address) _____

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

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS (Credits)

NOTE: PLEASE ALLOW 10 DAYS IN ORDER FOR CHANGES TO YOUR DIRECT DEPOSIT INFORMATION TO TAKE EFFECT

I (we) hereby authorize Ideal Business Solutions, LLC, Company Tax ID Number (20-1364634), to initiate credit entries (and either debit or credit entries which are necessary for corrections), to my (our) checking and/or savings account(s) indicated below.

Please list all accounts each time you make a change as this form will replace all previous forms.

Change to be made effective on: _____ Company: _____

DEPOSITORY (BANK NAME/BRANCH)	**BANK TRANSIT/ABA NUMBER**	**ACCOUNT NUMBER**	**Type:** Checking Savings Credit Union	**Deposit Amount by % or flat $**

This authority is to remain in full force and effect until Ideal Business Solutions, LLC has received **written** notification from me (or either of us) of this termination in such time and in such manner as to afford Ideal Business Solutions, LLC a reasonable opportunity to act on it **(minimum of 10 days)**.

(Note: For your Direct Deposit to work properly)

A "pre-note" is created using the information on this form. The pre-note process involves our banks verifying the information you have submitted on this form.

Payrolls from your company must be submitted to Ideal Business Solutions 3 days prior to the direct deposit date or there will be a delay of your money reaching your bank.

Different banks post direct deposited funds into accounts at different times during the day, morning, afternoon, and sometimes evenings.

If your financial situation is such that you must know the exact time of day you will have your money deposited, this benefit may not be for you at this time.

PLEASE ATTACH A COPY OF A VOIDED CHECK(s) DIRECT DEPOSIT SLIPS ARE NOT ACCEPTABLE

By signing this form you agree that the information contained in this document is correct.
Please sign and date this form before clicking the **Send to Ideal HR** button.

_____
Print Name

_____ _____
Date Signature

_____ _____
Date Signature (For accounts requiring 2 signatures)