329 BONAVENTURE ROAD – PHONE 234-1329
SAVANNAH, GEORGIA 31404

Application for Employment

Name: ____

Address: ____

Telephone: ____

Date of Birth: ____

Email: ____

Drivers License Number: _____________ State: ____ Expiration:______

Marital Status: ( ) Single ( ) Married ( ) Divorced

Education / Licenses / Certifications:

____

____

____

Plumbing Experience: ( ) Yes ( ) No

____

____

____

Previous Employment:

____

____

____

____

329 BONAVENTURE ROAD – PHONE 234-1329
SAVANNAH, GEORGIA 31404

This job requires the ability to push, pull, and/or lift a minimum of fifty pounds (50 lbs). Do you have any problems or concerns with this physical requirement? If so, please explain.

____
____
____
____
____
____

This job requires I certify that this information is accurate and complete:

______________________________________ ________________
Signature Date

329 BONAVENTURE ROAD – PHONE 234-1329
SAVANNAH, GEORGIA 31404

Employee Information Sheet

Date: _____________

Name: ____________________________

Address: ____
____

Cell Phone: ____

Home Phone: _______________________________________

Emergency Contact Person: ____________________________

Emergency Contact Phone: ____________________________

Shirt Size:_______________________________________

Please remember to notify the office if there are any changes in this information

Form G-4 (Rev. 05/13/21)

2211004013

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: Enter 0 or 1..[ ]

B. Married Filing Joint, both spouses working:
Enter 0 or 1 ....[ ]

C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 ....[ ]

D. Married Filing Separate:
Enter 0 or 1 ....[ ]

E. Head of Household:
Enter 0 or 1 ....[ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $____________

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
Yourself: ☐ Age 65 or over ☐ Blind
Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300...............$_______________

2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

A. Federal Estimated Itemized Deductions (If Itemizing Deductions)...........................$_______________

B. Georgia Standard Deduction (enter one): Single/Head of Household $4,600
Each Spouse $3,000 $_______________

C. Subtract Line B from Line A (If zero or less, enter zero)..$_______________

D. Allowable Deductions to Federal Adjusted Gross Income ....$_______________

E. Add the Amounts on Lines 1, 2C, and 2D ....$_______________

F. Estimate of Taxable Income not Subject to Withholding ....$_______________

G. Subtract Line F from Line E (if zero or less, stop here)...$_______________

H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above ....$_______________

(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) ___________ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) ___________
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**

a) I claim exemption from withholding because I incurred no Georgia income tax liability last year **and** I do not expect to have a Georgia income tax liability this year. **Check here** ☐

b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as provided on page 2. My state of residence is ________________. My spouse's (servicemember) state of residence is ________________ . The states of residence must be the same to be exempt. **Check here** ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature____ Date _________________

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Taxpayer Services Division, P.O. Box 105499, Atlanta, GA 30359

9. EMPLOYER'S NAME AND ADDRESS: **EMPLOYER'S FEIN:**___________________________

EMPLOYER'S WH#:___________________________

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

A. Single – enter 1 if you are claiming yourself
B. Married Filing Joint, both spouses working – enter 1 if you claim yourself
C. Married Filing Joint, one spouse working – enter 1 if you claim yourself or 2 if you claim yourself and your spouse
D. Married Filing Separate – enter 1 if you claim yourself
E. Head of Household – enter 1 if you claim yourself

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number on Line H here.
Failure to complete and submit the worksheet will result in automatic denial on your claim.

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3-5.

Line 8:

a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You cannot claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

EXAMPLES: Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld $500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was $0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore you **qualify** to claim exempt.

b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:

1. The servicemember is present in Georgia in compliance with military orders;
2. The spouse is in Georgia solely to be with the servicemember;
3. The servicemember maintains domicile in another state; and
4. The domicile of the spouse is the same as the domicile of the servicemember or the spouse of the servicemember has elected to use the same residence for purposes of taxation as the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 the employer should not report any of the wages as Georgia wages.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Worksheet for calculating additional allowances. Enter the information as requested by each line. For Line 2D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

Do not complete Lines 3-7 if claiming exempt.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue. Employers should honor the properly completed form as submitted unless otherwise notified by the Department. Such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

(c)
- ☐ **Single** or **Married filing separately**
- ☐ **Married filing jointly** or **Qualifying surviving spouse**
- ☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ ______

Multiply the number of other dependents by $500 . . . . . $ ______

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) | **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . **1** $ ______

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . **2a** $ ______

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . **2b** $ ______

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . **2c** $ ______

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . . . **3** ______

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . **4** $ ______

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . **1** $ ______

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . . **2** $ ______

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . **3** $ ______

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $ ______

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . **5** $ ______

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. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may 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, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use 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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Form **W-11** (Rev. June 2010)
Department of the Treasury Internal Revenue Service

Hiring Incentives to Restore Employment (HIRE) Act Employee Affidavit

▶ **Do not send this form to the IRS. Keep this form for your records.**

OMB No. 1545-2173

To be completed by new employee. Affidavit is not valid unless employee signs it.

I certify that I have been unemployed or have not worked for anyone for more than 40 hours during the 60-day period ending on the date I began employment with this employer.

Your name ______________________ Social security number ▶ ______

First date of employment ___/___/___ Name of employer ______________________

Under penalties of perjury, I declare that I have examined this affidavit and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature ▶ Date ▶ / /

Instructions to the Employer

Section references are to the Internal Revenue Code.

Purpose of Form

Use Form W-11 to confirm that an employee is a qualified employee under the HIRE Act. You can use another similar statement if it contains the information above and the employee signs it under penalties of perjury.

Only employees who meet all the requirements of a qualified employee may complete this affidavit or similar statement. You cannot claim the HIRE Act benefits, including the payroll tax exemption or the new hire retention credit, unless the employee completes and signs this affidavit or similar statement under penalties of perjury and is otherwise a qualified employee.

A "qualified employee" is an employee who:

- begins employment with you after February 3, 2010, and before January 1, 2011;
- certifies by signed affidavit, or similar statement under penalties of perjury, that he or she has not been employed for more than 40 hours during the 60-day period ending on the date the employee begins employment with you;
- is not employed by you to replace another employee unless the other employee separated from employment voluntarily or for cause (including downsizing); and
- is not related to you. An employee is related to you if he or she is your child or a descendent of your child, your sibling or stepsibling, your parent or an ancestor of your parent, your stepparent, your niece or nephew, your aunt or uncle, or your in-law. An employee also is related to you if he or she is related to anyone who owns more than 50% of your outstanding stock or capital and profits interest or is your dependent or a dependent of anyone who owns more than 50% of your outstanding stock or capital and profits interest.

If you are an estate or trust, see section 51(i)(1) and section 152(d)(2) for more details.

Do not send this form to the IRS. Keep it with your other payroll and income tax records.

Paperwork Reduction Act Notice. The Paperwork Reduction Act of 1980 requires that when we ask you for information we must first tell you our legal right to ask for the information, why we are asking for it, and how it will be used. We must also tell you what could happen if we do not receive it and whether your response is voluntary, required to obtain a benefit, or mandatory under the law. 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 stated in Code section 6103.

Our legal right to ask for information is Internal Revenue Code section 6001 and the purpose of the form is stated in the instructions. This collection of the information is required to obtain certain tax benefits.

If you do not retain this record or give fraudulent information, we may have to disallow certain exemptions and credits, and you also may be charged penalties and be subject to criminal prosecution. This could make the tax higher or delay any refund. Interest may also be charged.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . . . 1 hr., 25 min.
Preparing the form . . . . 25 min.
Learning about the law or the form . . . . . 24 min.

If you have comments regarding the accuracy of this time estimate or you have suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this address.

Please keep this notice with your records. It may help you if we ask you for other information. If you have any questions about the rules for filing and giving information, please call or visit any Internal Revenue Service office.

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation
*(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: ______________ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		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 **For persons under age 18 who are unable to present a document listed above:** 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

Georgia New Hire Reporting Form

Federal and state legislation (Georgia statute 19-11-9.2), requires all Georgia employers, both public and private, to report to the New Hire Reporting Program all newly hired, rehired, or returning to work employees. Information about new hire reporting and online reporting is available on our website: www.GA-newhire.com

Send completed forms to:

Georgia New Hire Reporting Center
PO Box 3068 Trenton, NJ 08619-0068
Fax toll-free: (888) 541-0521 or (404) 525-2983

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

1	2	3

A	B	C

EMPLOYER INFORMATION

Federal Employer ID Number (FEIN): ***(Please enter the same FEIN used to report the employee's quarterly wages)***

__ - _______

Employer Name:

Employer Address: ***(Please use the address where the Wage Withholding Orders should be sent)***

Employer City: **State:** **Zip Code:**

Contact Name:

Employer Phone: **Extension:** **Employer Fax: (optional)**

Email Address:

EMPLOYEE INFORMATION

Employee Social Security Number (SSN):

___ - __ - ____

Employee First Name: **Middle Initial:**

Employee Last Name:

Employee Address:

Employee City: **State:** **Zip Code:**

Start Date (MMDDYY): **Date of Birth:** **Medical Insurance Available: (optional)**

Yes ☐ **No** ☐

Medical Insurance Company Name: (optional)

Rev Date:02/24/17

Reports must be submitted within 10 days of hire or rehire date.

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

Questions? Call us toll-free at (888) 541-0469 or (404) 525-2985

Procedures for a Criminal History/Background Check

Georgia Crime Information Center (GCIC)

Chatham County Sheriff's Office
Criminal History/Fingerprint Unit
P.O. Box 10026
Savannah, Ga 31412
912-652-7657
912-652-7658
912-651-3791 (fax)

GCIC Report (name search background check)
Complete the CHRI Release/Waiver, which can be obtained at the Chatham County Sheriff's Office Criminal History/Fingerprint Unit. **This release/waiver must be signed by the subject**. ***"Providing your social security number is OPTIONAL. However, failure to provide your social security number might delay the processing of your criminal background check. Should you provide your social security number, it will be submitted to federal and state agencies for purposes of confirming your identity and obtaining any relevant criminal history."***

Return the request form and a processing fee of $15.00 to the Chatham County Sheriff's Office at the above address or the waiver may be presented in person to the cashier's window at the Chatham County Sheriff's Complex **(cash only)**. **The cashier is open 24 hours**. **Note: If you are mailing the release/waiver, the processing fee must be in the form of a cashier's check or money order and a copy of the subject's I.D. must be attached to the release/waiver. PLEASE DO NOT MAIL CASH! Personal checks and credit/debit cards cannot be accepted in any case.**

The processing of the criminal history/background check will take 3-5 business days. The request form will be completed by a Sheriff's Department Supervisor. In the case of a no record response, a copy of the request form marked **"No Record"** will be released to the subject or to the person identified in the "Release To" section on the waiver. Also, in the case of a **"No Record"** response, a printout may or may not accompany the response due to confidential information on other individuals that may be returned. If a **"record"** is found, a printed record will be attached to the request form and the form so marked.

Chatham County Sheriff's Office
Criminal History/Fingerprint Unit
1050 Carl Griffin Drive
Savannah, Ga 31405

Chatham County Sheriff's Department
CHRI Release/Waiver

By my signature below, I hereby request, authorize and direct Sheriff Al St. Lawrence or his appointed designee and the Chatham County Sheriff's Department to perform a Georgia background investigation which includes, but may not be limited to an electronic background search of G.C.I.C. and local records. The purpose of this background search or investigation is to ascertain and determine if any criminal history records exist or closely resemble the identifying information, which I am providing herein. I understand that failure to provide accurate or complete information will result in a negative search effort, or improper records being accessed.

Furthermore, I authorize and direct that any information or records which are produced or discovered as a result of this background investigation are to be released and transmitted to the persons identified below for whatever purpose they require. I am fully aware that the information or records produced as a result of this inquiry **contain confidential and privileged information which would not otherwise be released without my consent, request or authorization**. I hereby specifically waive any privilege or confidentiality existing under state or federal law regarding access or release of such information including but not limited to protection afforded under OCGA 50-18-72 and OCGA 15-18-52.

In making this release authorization, I agree TO HOLD HARMLESS, SHERIFF AL ST LAWRENCE, AND ALL EMPLOYEES OF THE CHATHAM COUNTY SHERIFF'S DEPARTMENT, AND CHATHAM COUNTY GOVERNMENT, FROM ANY CIVIL LIABILITY OF ANY KIND OR DESCRIPTION.

PLEASE PRINT CLEARLY

SUBJECT INFORMATION

Last Name First Middle Maiden

Address City State Zip Phone#

Race: ______ Sex:______ Birth Date:_______/_______/________ Eyes:______ Hair:_______

SSN: ______ - ______ - ________ Height: _______ Weight:_______ State/Place of Birth:________________
(OPTIONAL)

[ ] WILL PICK UP **[X] PLEASE MAIL**

RELEASE TO: (COMPLETE THIS SECTION IF YOU WANT YOUR BACKGROUND TO BE RELEASED OR MAILED TO SOMEONE OTHER THAN YOURSELF)

NAME: Chelsey Buck **COMPANY:** Hutson Plumbing Company

MAILING ADDRESS: 329 Bonaventure Road Savannah, GA 31404

SPECIAL EMPLOYMENT PROVISIONS (CHECK IF APPLICABLE)

[ ] EMPLOYMENT/VOLUNTEER WITH CHILDREN (W)
[ ] EMPLOYMENT /VOLUNTEER WITH ELDER CARE (N)
[ ] EMPLOYMENT/VOLUNTEER WITH MENTALLY DISABLED (M)

BACKGROUND PURPOSES

[ ] ADOPTION (E)
[ ] FOSTER CARE (W)
[ ] PERSONAL RECORD INSPECTION
[ ] OTHER ____________________________

AUTHORIZATION

Prior to signing this request authorization, I have fully read and understand the provision of this writing. My request is freely made without fear of punishment or promise of reward, and with full and complete understanding of the consequences of my action.

________________________________ ______/______/______ ______________________________
Legal Signature Date Witness

CCSO DEPARTMENT RESPONSE

[ ] No GCIC Record
[ ] No Local Record
[ ] Records Found, Attached
[ ] Fingerprints needed for positive Identification

____ ________/________/20____
Chatham County Sheriff Department Official Date

Any further dissemination is protected under State and Federal Law

Revised April 2011

HEALTHCARE ENROLLMENT FORM

Employer Information (employer use only)

Group Name:	Group #:
Date of Hire:	Effective Date:
Department (if applicable):	
Status: Active ❑ Retired ❑	Medicare
COBRA ❑ COBRA Effective Date:	
Employer Initials:	Date:

For New Enrollments/Please check one:	For changes/Please check all that apply:
❑OPEN ENROLLMENT ❑NEWLY ELIGIBLE/REASON ____________________ ❑NEW HIRE/DATE OF HIRE ____/____/____	❑PLAN CHANGE ❑ADD DEPENDENT/QUALIFYING EVENT (birth, marriage, etc.) ______________ ❑NAME CHANGE ❑ADDRESS CHANGE

❑ *I do not wish to elect health coverage at this time*

PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION.

APPLICANT'S LAST NAME	FIRST NAME	MI	GENDER ❑MALE ❑FEMALE	EMPLOYEE STATUS ❑ACTIVE ❑RETIREE DATE __/__/__	SOCIAL SECURITY NUMBER
ADDRESS (NUMBER, STREET, APARTMENT)					DATE OF BIRTH
CITY	COUNTY	STATE	ZIP + 4	CONTACT INFORMATION HOME: ( ) - CELL: ( ) - WORK: ( ) - E-mail:	

PRIOR HEALTH COVERAGE: Date(s) for which you or your dependents over age 19 had coverage during the 12 months prior to your effective date.
COVERAGE DATES FROM: ______________ TO: __________________ FROM: ______________ TO: __________________
(Please provide detail on reverse side of this form) WILL YOU CONTINUE THIS COVERAGE WHILE ENROLLED IN YOUR EMPLOYER'S GROUP HEALTH PLAN? Yes ❑ No ❑

COVERAGE INFORMATION	PLAN SELECTION (Please indicate on line below.)
MEDICAL & RX: ❑ Single ❑ Family ❑ Other (please specify) __________	Plan name: ______________________________

MEMBER INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
SPOUSE					❑Husband ❑Wife
CHILD					❑Daughter ❑Son
CHILD					❑Daughter ❑Son
CHILD					❑Daughter ❑Son
CHILD					❑Daughter ❑Son
CHILD					❑Daughter ❑Son

While enrolled in your employer's group health plan, will you or your dependent (s) be covered by any of the following: If additional space is required, please attach a separate sheet.

CHECK YES or NO for MEDICARE ❑YES (please list all covered members) ❑NO	LAST NAME	FIRST	MI	ID NO. ______________ Part A Effective Date ______________ Part B Effective Date ______________
OTHER HEALTH COVERAGE ❑YES (please list all covered members) ❑NO *including no fault and/or workers' compensation (in the event of an injury)	LAST NAME OF POLICY HOLDER	FIRST	MI	INSURANCE NAME PHONE NO.

AUTHORIZATION: I have read and agree to the authorization on the reverse side of this form.

Subscriber's Signature	Date

PRIOR HEALTH COVERAGE (CONTINUED)

Health Insurance Company (include address and phone number of previous carrier)	ID No.	Coverage from Month/Year	Coverage to Month/Year

CERTIFICATION & CONSENT

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement. This application cannot be processed if birth date(s) and Social Security Number(s) are not completed. I understand that any person who knowingly and with intent to defraud, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto or commits a fraudulent act which is a crime, may be subject to the maximum penalties allowed by law and adverse action by the employer.

329 BONAVENTURE ROAD – PHONE 234-1329
SAVANNAH, GEORGIA 31404

2022 Health Insurance Rates

Coverage Type	Weekly Rate
Employee Only	$ 76.65
Employee & Spouse	$ 138.92
Employee & Children	$ 124.55
Employee & Family	$ 201.69

Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)

*Employer Name: Hutson Plumbing Company, Inc.		Effective Date:	Group ID: G000ANVU
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: $	☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Annually	*Date of Hire:	Hours Worked Per Week:

Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:		MI:
*SSN/ID Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:		E-mail Address:	
*City:	*State:	*Zip Code:	Telephone: ( ) -

Basic Life and AD&D Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life and AD&D - Employee - Your employer pays 90% of the premium for this coverage.	☐	☐	$25,000	$_____________

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the applicable policy as well as your age and/or salary on the effective date of the coverage.

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable policy, and that a waiting period may apply.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF EMPLOYEE ____ **DATE** ________/________/________

Additional Information

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*

Employer Access

Guide to Submitting Member Enrollment Requests

Managing employee benefits can be time consuming. But Mutual of Omaha offers quick, convenient options that simplify plan administration.

Secure Online Plan Administration

Spend less time on paperwork and expedite transactions with our secure online portal. Through Employer Access, you can quickly and easily enroll, update or terminate employee coverage from a single screen.

Once you log in to the secure portal:

- Click on the "Members" tab and search for the member's name
- Access functions such as updating eligible employee roster, sending Evidence of Insurability (EOI), and editing or terminating employees
- Click the green "New Enrollment" button to add new employees

Employees who were terminated and rehired need to be added to the roster via a request to our service team.

Questions or Need Assistance?

Contact your Dedicated Service Team.

Not registered to use our portal?

If you are not a registered user of Employer Access, go to **mutualofomaha.com**.

1) Click on **Sign In**

2) Select **Plan Administrator**

3) Click the **Sign Up Button** *(bottom of the screen)*

See the next page for more convenient enrollment options!

Content is subject to change. Insurance products and services are offered by Mutual of Omaha Insurance Company or one of its affiliates. Products are not available in all states. Each company is solely responsible for its own contractual and financial obligations.

Options When Using Paper Enrollment

Enrollment Form

If you prefer using the paper enrollment process, each employee must complete and sign an enrollment form.

Enrollment forms must be filled out completely to avoid delays in processing; required fields are marked with an asterisk (*). Return completed forms to your Dedicated Service Team.

Note: A new hire enrollment form was included in your welcome email.

Excel Spreadsheet

If you prefer to capture new employee information in a spreadsheet format, Mutual of Omaha will accept an Excel file. To expedite your request, please include the information listed here.

Type of Change Requested (Hires, Qualifying Life Event, etc.)

Effective Date of Change

- Member's First and Last Name
- Date of Birth (Employee and Spouse)
- Date of Hire or Rehire
- Signature Date (Contributory/Voluntary)
- SSN (optional but strongly preferred for Dental/Vison)
- Salary: Annual or Hourly
- Hours Worked per Week
- Coverage Elections by Product
- Tobacco Status, if Applicable
- Class (if more than one class)
- Bill Group (if receiving separate bills)
- Location Code (if receiving one bill and employees are itemized by location/department)
- Termination Date (last date worked)

Dental & Vision Benefits Require:

- Address
- Dependents: First and Last Name, Date of Birth & Gender

Important *We must receive all required information before completing the enrollment process.*

Underwritten by
United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company
Mutual of Omaha Affiliates

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 877-5176
Fax (402) 997-1865

Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name: Hutson Plumbing Company   Group ID: G000ANVU

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name: *First Name: MI:

*Social Security Number: *Birth Date (MM/DD/YYYY):   *Gender: *Marital Status:

*Street Address: Email Address:

*City: *State: *ZIP Code: Telephone: (   )

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation-Employer Paid Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation-Employer Paid Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Primary Beneficiary Designation-Voluntary Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation-Voluntary Coverage

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Agreement and Signature

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

Signature of Employee/Member____ Date ____________________

SIMPLE IRA
Salary Deferral Election

For employer/employee use only

Important information

- If you are opening a new account, you must attach a completed application to this form. Your employer will forward the completed application to American Funds Service Company® on your behalf.
- Return this completed form to your employer. **Do not send this form to American Funds Service Company or Capital Bank and Trust Company.**℠

General information

Please type or print clearly.

Name of employee	Name of company
	HUTSON PLUMBING

Payroll election

See the table at the bottom of this page for deferral and catch-up limits. Select one of the following five options.

A. ☐ **New election for NEW participants** — I am opening a new account (the application is attached). I elect to have the following amount withheld from my compensation and contributed to the SIMPLE IRA plan.

Pre-tax deferrals of ☐ ________% **OR** ☐ $ ________ Effective date ________ (mm/dd/yyyy)

B. ☐ **Change deferrals** — I am currently participating in the SIMPLE IRA plan and wish to change my election.

Pre-tax deferrals of ☐ ________% **OR** ☐ $ ________ Effective date ________ (mm/dd/yyyy)

C. ☐ **Maintain deferrals** — I am participating in the SIMPLE IRA plan and wish to maintain my current deferral election.

D. ☐ **Suspend deferrals** — I wish to stop deferring to the SIMPLE IRA plan as of the effective date specified below.

Effective date ________ (mm/dd/yyyy)

E. ☐ I do not wish to make any pre-tax salary deferrals at this time.

Signature

If electing salary deferrals, I authorize my employer to withhold the amount/percentage specified above from each paycheck as of the effective date provided, which will reduce my compensation under this election (my elective deferral contributions). I may revoke or update this election at any time as permitted by my employer. My elective deferral contributions are not subject to federal (or state, if applicable) income tax until distributed from the Plan. If I revoke this election, I acknowledge that, contingent upon the terms of the SIMPLE IRA Plan, I may be prohibited from submitting another Salary Deferral Election until the enrollment period immediately preceding the next plan year. The revocation or update will be effective as soon as administratively possible by my employer after they have received the notice. I also understand that my elective deferral contributions are subject to gain or loss in accordance with my selected investments.

X ________________________   ___/___/___

Signature of employee   Date (mm/dd/yyyy)

Year	Deferral limit	Catch-up limit*
2021	$13,500	$3,000
2022	$14,000	$3,000

*You must be at least 50 years old to make a catch-up contribution.

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SIMPLE IRA Application

To be completed by employer

HUTSON PLUMBING
Name of company

BOYCE YOUNG
Employer contact

(912) 234-1329 Ext.
Daytime phone

329 BONAVENTURE ROAD
Company address

THUNDERBOLT
City

GA
State

31404
ZIP

Check A or B.

A. ☐ **New plan** (must be accompanied by a copy of the employer's completed and signed *SIMPLE IRA Adoption Agreement*)

B. ☑ **Existing plan** (provide Plan ID for reference) 89735104

To be completed by employee

1 Information about you

Important: *This section must be completed, and the application must be signed in Section 7 before an account can be established. Please type or print clearly.*

☐☐☐-☐☐-☐☐☐☐
SSN of SIMPLE IRA owner

☐☐-☐☐-☐☐☐☐
Date of birth (mm/dd/yyyy)

Country of citizenship of SIMPLE IRA owner

First name | MI | Last

Residence address (physical address required — **no P.O. boxes**) | City | State | ZIP

Mailing address (if different from residence address) | City | State | ZIP

Email address*

( )
Daytime phone

* Your privacy is important to us. For information on our privacy policies, visit **www.capitalgroup.com.**

Please mail or fax this form to the appropriate service center.

(If you live outside the U.S., mail the form to the Indiana Service Center.)

Indiana Service Center

American Funds Service Company
P.O. Box 6164
Indianapolis, IN 46206-6164

Overnight mail address
12711 N. Meridian St.
Carmel, IN 46032-9181

Fax (888) 421-4371

Virginia Service Center

American Funds Service Company
P.O. Box 2560
Norfolk, VA 23501-2560

Overnight mail address
5300 Robin Hood Rd.
Norfolk, VA 23513-2430

Fax (888) 421-4371

If you have questions or require more information, contact your financial professional or call American Funds Service Company at (800) 421-4225.

CAPITAL GROUP® AMERICAN FUNDS®

SIMPLE IRA Application

2 Financial professional

This section must be filled out completely by the financial professional(s).

We authorize American Funds Service Company (AFS) to act as our agent for this account and agree to notify AFS of purchases made under a Statement of Intention or Rights of Accumulation. If applicable, we have provided a copy of our SEC Form CRS to the investor named on this application.

BRIAN MARKOWITZ
Name(s) of financial professional(s)

26 JG
Professional/team ID #

3FE
Branch number

(912) 692-1040 Ext.
Daytime phone

530 STEPHENSON AVENUE
Branch address

SAVANNAH
City

GA
State

31405
ZIP

RAYMOND JAMES
Name of broker-dealer firm (as it appears on the Selling Group Agreement)

X
Signature of person authorized to sign for the broker-dealer — **required**

3 Investment instructions

I elect to invest my contributions in Class A shares of the American Funds Target Date Retirement Series® fund with the year closest to my 65th birthday unless I complete the *SIMPLE IRA Transfer Election* form or elect otherwise below.

If you wish to systematically transfer your contributions to another custodian, investments must be in the money market fund. You'll need to complete the *SIMPLE IRA Transfer Election* form, available from your financial professional.

A. ☐ Invest 100% of my contributions in Class A shares of the American Funds Target Date Retirement Series® fund with the year closest to my 65th birthday. New funds for future retirement dates may be added to the series as needed.

Target Date Fund 2065 (designed for those born 1998 or later)
Target Date Fund 2060 (designed for those born 1993–1997)
Target Date Fund 2055 (designed for those born 1988–1992)
Target Date Fund 2050 (designed for those born 1983–1987)
Target Date Fund 2045 (designed for those born 1978–1982)
Target Date Fund 2040 (designed for those born 1973–1977)
Target Date Fund 2035 (designed for those born 1968–1972)
Target Date Fund 2030 (designed for those born 1963–1967)
Target Date Fund 2025 (designed for those born 1958–1962)
Target Date Fund 2020 (designed for those born 1953–1957)
Target Date Fund 2015 (designed for those born 1948–1952)
Target Date Fund 2010 (designed for those born 1947 or earlier)

OR

B. ☐ Invest my contribution as instructed below. For a quick guide to fund names, numbers, minimums and share class restrictions, go to **www.capitalgroup.com/fundguide**. If you do not select a share class, this investment will be placed in Class A shares. (The percentage you elect must equal the minimum of $25 per fund. You may customize your investment strategy by selecting a combination of funds.)

Select a share class: ☐ Class A **OR** ☑ Class C

Fund name or number	Percentage (whole % only)	Fund name or number	Percentage (whole % only)
	%		%
	%		%
	%		%
		Total	%

Notes:
- To make changes to your fund selections and/or percentage allocations in the future, notify your employer.
- To rebalance funds or set up an automatic exchange plan, visit **www.capitalgroup.com**.
- To add bank information for future redemption requests, include a completed *Add/Update Bank Information* form.
- The $10 setup fee will be deducted from your account.

01/21

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SIMPLE IRA Application

4 Beneficiary designation

We encourage you to consult a professional regarding the tax-law and estate planning implications of your beneficiary designation. All stated percentages must be whole percentages (e.g., 33%, not 33.3%). If the percentages do not add up to 100%, each beneficiary's share will be based proportionately on the stated percentages. When percentages are not indicated, the beneficiaries' shares will be divided equally.

Notes:
- Your spouse may need to sign in Section 6. If you wish to name more than one trust or entity, customize your designation or need more space, attach a separate page. Include the name, address, relationship, date of birth or trust, SSN/TIN and percentage for each beneficiary.
- If you name a trust as beneficiary, provide the full legal name of the trust. Example: "The Davis Family Trust."

A. Primary Beneficiary(ies): If any designated Primary Beneficiary(ies) dies before I do, that beneficiary's share will be divided proportionately among the surviving Primary Beneficiaries unless otherwise indicated. If no Primary Beneficiaries survive me, assets will be paid to the named Contingent Beneficiaries, if any.

1. First name (print) ____ MI ____ Last name ____ Suffix ____

OR Name of trust or other entity (print) ____

Address ____ City ____ State ____ ZIP ____

☐ Spouse* ☐ Child of owner ☐ Other person ☐ Trust ☐ Other entity   Date of birth or trust (mm/dd/yyyy) ____ SSN/TIN ____ ____% Whole % only

2. First name (print) ____ MI ____ Last name ____ Suffix ____

Address ____ City ____ State ____ ZIP ____

☐ Spouse* ☐ Child of owner ☐ Other person   Date of birth (mm/dd/yyyy) ____ SSN ____ ____% Whole % only

3. First name (print) ____ MI ____ Last name ____ Suffix ____

Address ____ City ____ State ____ ZIP ____

☐ Spouse* ☐ Child of owner ☐ Other person   Date of birth (mm/dd/yyyy) ____ SSN ____ ____% Whole % only

4. First name (print) ____ MI ____ Last name ____ Suffix ____

Address ____ City ____ State ____ ZIP ____

☐ Spouse* ☐ Child of owner ☐ Other person   Date of birth (mm/dd/yyyy) ____ SSN ____ ____% Whole % only

* By naming my spouse as a beneficiary, I elect to treat such spouse as a beneficiary while we are married. Effective immediately upon the divorce, annulment or other lawful dissolution of my marriage, the designation shall be null and void, unless after the dissolution of my marriage I affirmatively elect to name my former spouse as my non-spouse beneficiary.

Continued on next page

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SIMPLE IRA Application

4 Beneficiary designation

(continued)

Important: Section 4-A must be completed prior to completing Section 4-B.

B. Contingent Beneficiary(ies): If no Primary Beneficiary survives me, pay my benefits to the following Contingent Beneficiary(ies). If any designated Contingent Beneficiary(ies) dies before I do, that beneficiary's share will be divided proportionately among the surviving Contingent Beneficiaries unless otherwise indicated. If no Contingent Beneficiaries survive me, assets will be paid according to the Custodial Agreement default designation.

1. First name (print) ______ MI ______ Last name ______ Suffix ______

OR Name of trust or other entity (print) ______

Address ______ City ______ State ______ ZIP ______

☐ Spouse* ☐ Child of owner ☐ Other person ☐ Trust ☐ Other entity Date of birth or trust (mm/dd/yyyy) ______ SSN/TIN ______ ______% Whole % only

2. First name (print) ______ MI ______ Last name ______ Suffix ______

Address ______ City ______ State ______ ZIP ______

☐ Spouse* ☐ Child of owner ☐ Other person Date of birth (mm/dd/yyyy) ______ SSN ______ ______% Whole % only

3. First name (print) ______ MI ______ Last name ______ Suffix ______

Address ______ City ______ State ______ ZIP ______

☐ Spouse* ☐ Child of owner ☐ Other person Date of birth (mm/dd/yyyy) ______ SSN ______ ______% Whole % only

4. First name (print) ______ MI ______ Last name ______ Suffix ______

Address ______ City ______ State ______ ZIP ______

☐ Spouse* ☐ Child of owner ☐ Other person Date of birth (mm/dd/yyyy) ______ SSN ______ ______% Whole % only

5. First name (print) ______ MI ______ Last name ______ Suffix ______

Address ______ City ______ State ______ ZIP ______

☐ Spouse* ☐ Child of owner ☐ Other person Date of birth (mm/dd/yyyy) ______ SSN ______ ______% Whole % only

* By naming my spouse as a beneficiary, I elect to treat such spouse as a beneficiary while we are married. Effective immediately upon the divorce, annulment or other lawful dissolution of my marriage, the designation shall be null and void, unless after the dissolution of my marriage I affirmatively elect to name my former spouse as my non-spouse beneficiary.

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5 Decline telephone and website exchange and/or redemption privileges (optional)

Telephone and website exchange and redemption privileges will automatically be enabled on your account unless you decline below. To decline these privileges, read the individual statements and check the applicable box(es).

Note: If either option is declined, no one associated with this account, including your financial professional, will be able to request exchanges or redemptions by telephone or via the website. Requests would need to be submitted in writing.

Exchanges: I **DO NOT** want the option of using the telephone and website exchange privilege. ☐

Redemptions: I **DO NOT** want the option of using the telephone and website redemption privilege. ☐

6 Spousal consent to beneficiary designation — if required

If you are married to the IRA owner and he or she designated a Primary Beneficiary(ies) other than you, please consult your financial professional about the state-law and tax-law implications of this beneficiary designation, including the need for your consent.

I am the spouse of the IRA owner named in Section 1, and I expressly consent to the beneficiary(ies) in Section 4 or attached.

______________________	X ______________________	___ / ___ / ______
Name of spouse of IRA owner (print)	Signature of spouse of IRA owner	Date (mm/dd/yyyy)

This document may not be signed using Adobe Acrobat Reader's "fill and sign" feature.

7 Your signature

I hereby establish an American Funds SIMPLE IRA, appoint Capital Bank and Trust Company℠ (CB&T) as Custodian and acknowledge that I have received, read and agree to the *SIMPLE IRA Custodial Agreement.* I understand that I and all shareholders at my address will receive one copy of fund documents (such as annual reports and proxy statements) unless I opt out by calling **(800) 421-4225**.

I have read and agree to the terms of the current prospectus(es) of the funds selected in the investment instructions section and consent to the $10 setup fee and the annual custodial fee (currently $10). I understand that any dividends and capital gains will be reinvested for all my fund selections. I understand that amounts invested may not be redeemed for 7 business days.

I agree to the conditions of the telephone and website exchange/redemption authorization unless I checked the box(es) in Section 5 and agree to indemnify and hold harmless CB&T; any of its affiliates or mutual funds managed by such affiliates; and each of their respective directors; officers; employees; and agents for any loss, expense or cost arising from such instructions once the telephone and website exchange and redemption privileges have been established.

I certify, under penalty of perjury, that my Social Security number in this application is correct. I authorize the financial professional assigned to my account to have access to my account and to act on my behalf with respect to my account. If applicable, I acknowledge that I have received and read a copy of my financial professional's SEC Form CRS. I designate the beneficiary(ies) specified in this application and certify that, if I am married and have not named my spouse as Primary Beneficiary, I have consulted my financial professional about the need for spousal consent. If no beneficiary is named, the Custodial Agreement default will apply.

I understand that to comply with federal regulations, information provided on this application will be used to verify my identity. For example, my identity may be verified through the use of a database maintained by a third party. If CB&T is unable to verify my identity, I understand it may need to take action, possibly including closing my account and redeeming the shares at the current market price, and that such action may have tax consequences, including a tax penalty.

If this document is signed electronically, I consent to be legally bound by this document and subsequent terms governing it. The electronic copy of this document should be considered equivalent to a printed form in that it is the true, complete, valid, authentic and enforceable record of the document, admissible in judicial or administrative proceedings. I agree not to contest the admissibility or enforceability of the electronically stored copy of this document.

X ______________________	___ / ___ / ______
Signature of SIMPLE IRA owner	Date (mm/dd/yyyy)

This document may not be signed using Adobe Acrobat Reader's "fill and sign" feature.

For fax and mailing instructions, see the maps on page 1.

329 BONAVENTURE ROAD – PHONE 234-1329
SAVANNAH, GEORGIA 31404

Company Attendance Policy

Absence from Work:

An employee who is ill or who requires the day off is to call the office (or have someone call the office for them) *before* 7:30 AM the morning of every absence. Said employee contacting only their supervisor or a coworker will not suffice as communicating their absence to administration. The employee who will not be coming to work must alert the *office* to their absence before 7:30 AM the morning before that and every absence. Exceptions to these absences are: vacation, long-term illness or pre-approved leave of absence.

Sick Leave:

For every two months that an employee works, they will receive one sick day. This is a total of 6 sick days for every 1 year of employment. If the time is not used by the employee, it will be carried over into the next year and added to your vacation time. The employee may use this additional vacation time at his own discretion. If an employee desires to be paid for time off that he has accrued, he must notify the office no later than the Monday afternoon when he turns in his time sheet for that pay period. The office will never assume that you want pay for time off.

______________________________________ ____________________

Employee Signature Date

329 BONAVENTURE ROAD – PHONE 234-1329
SAVANNAH, GEORGIA 31404

Company Documentation Policy

Plumbers:

Plumbers are responsible for knowing each day if they are reporting to a contract job or a T&M job. If they work on a T&M job, they MUST do a full and complete write up each and every day that they perform work. Do NOT wait until the job is complete to perform write up(s). The new T&M write up form has a box to check and sign off once the job is complete, so that the office knows when to bill out completely.
All write ups should include at minimum:

- Job name
- Contractor
- Service Address
- Work Performed
- ALL Materials Used
- ANY Equipment Used & Whether it is HPC-owned or rented
- Concrete Cutting Tickets

Additionally, if possible, any and all invoices for materials purchased should be included with each daily write up. Please request when making purchases from vendors that the vendor includes the TOTAL price on the ticket. If you have questions about this policy and what you need to include, please ask and we'll be happy to clarify.

All Employees:

On your time sheet, you are responsible for listing the **CORRECT**:

- Job Name
- Contractor
- Service Address
- **FULL** Job Description – Include as much detail as possible.

It is very important that you document the correct information, especially the correct date. There is no excuse for not writing a date, or writing an incorrect date, as there are calendars in the office that you may reference. If you aren't sure of the date, ask someone.
ALL time sheets are to be turned in daily. Final time sheets are due every Monday, as the weekly pay period begins on Tuesday and ends on Monday. Do not expect to be paid for hour(s) worked that were not documented on the time sheet for that pay period.

______________________________	________________
Employee Signature	Date

329 BONAVENTURE ROAD – PHONE 234-1329
SAVANNAH, GEORGIA 31404

Company Vehicle Safety Policy

Contents

2 … Summary

2 … Employee Responsibilities

3 … Safety Committee Responsibilities

3 … Requirements for New Employees

3 … Requirements for Drivers Under 21

3 … Licensing

3 … Use of Personal Vehicles for Company Business

4 … Motor Vehicle Record (MVR) Review

4 … Reporting Incidents Involving Motor Vehicles

4 … Department of Transportation (DOT) Regulated Vehicles

5 … Drug Testing and MVR Checks After Incidents Involving Vehicles

5 … Point System for Screening Employees Who Have Poor Driving Records

6 … Point Classification Table

7 … Requalification for Employees Who Have Poor Driving Records

7 … Pre-Trip Walk-Around Inspections

7 … Vehicles Service and Maintenance Intervals

7 … Records Kept on Company Vehicle

8 … Mobile Phone Use

8 … Definitions of Terms Used in this Policy

9 … MVR Consent Form

10… Vehicle Use Agreement

329 BONAVENTURE ROAD – PHONE 234-1329
SAVANNAH, GEORGIA 31404

Summary

It is the policy of Hutson Plumbing Company that our passenger vehicles (including light-duty trucks) will be used only for our company business and will be operated only by authorized persons who meet the driver criteria in our vehicle safety program.

This policy applies to our company-owned vehicles and private or rental vehicles authorized for use on company business.

All employees must comply with federal, state, and local laws and policies and be "job-ready" when they are on company business. Job-ready means that employees must be physically and mentally able to do their jobs. Employees must not use intoxicants, drugs or medications that could impair their judgment or ability to drive. Managers and supervisors have the right to determine an employee's job readiness.

Employees who drive on company business must have a valid driver's license and a satisfactory driving record.

Violations of this policy may result in revocation or restriction of employee authorization to drive a company-owned or private vehicle on company business, reassignment, demotion, suspension, or dismissal.

All employees must sign a statement stating that they have read and understand this policy and the consequences for violating it.

Employee Responsibilities

Supervisors are responsible for ensuring that employees under their direction comply with all elements of this policy.

The appropriate manager must verify, in writing, that employees have valid driver's licenses and are qualified to operate company vehicles before they begin driving on company business.

Employees who drive on company business must follow all parts of this policy. They must do a walk around inspection of any vehicle before driving it and they must not use a company vehicle for personal business unless it is approved, in writing by the appropriate manager.

When operating company vehicles, employees should remember that their driving habits reflect on all company employees. Company vehicles must be used legally, courteously, and safely.

Employees are strongly encouraged to plan mini breaks every two hours during long periods of driving and to allow for no more than 10 hours driving per day in good driving conditions.

Employees must use and require seat belts to be worn by their passengers.

Smoking is not permitted in any company vehicles.

Employees are responsible for the care of vehicles assigned to them and may be held liable for improper care and abuse of the vehicle. Misconduct could lead to withdrawal of driving privileges and/or disciplinary actions, up to and including dismissal.

Safety Committee Responsibility

The company safety committee must investigate any incident that involves a company vehicle. The purpose of the investigation is to identify the cause of an incident and to determine how it could have been prevented – not to assess fault.

Requirements for New Employees

New employees who drive on company business must read and sign an MVR consent form that permits Hutson Plumbing Company to complete a motor vehicle background check.

The appropriate manager will review this vehicle safety policy with each new employee who drives on company business. The employee must watch a vehicle safety video and complete a written test and score at least 80 percent.

Requirements for Drivers Under 21

Drivers under the age of 21 are prohibited from operating vehicles or trucks that transport hazardous materials.

Licensing

Employees who drive on company business must have a current, valid license for the vehicles they drive. Licenses will be photocopied and kept in employees' files.

Use of Personal Vehicles for Company Business

The appropriate manger must review and approve use of a personal vehicle for company business.

Employees who drive personal vehicles on company business must provide evidence of automobile liability insurance as required by the state of Georgia. A current certificate or proof of insurance must be kept in the employee's file.

This company does not provide liability insurance for employees who use their own vehicles on company business. Employees who use their personal vehicles on company business are

responsible for all liability resulting from use of their vehicles.
Any employee who drives a personal vehicle on company business and who does not maintain insurance coverage on that vehicle will be reassigned to a non-driving position or, if a non-driving position is not available, will be terminated.

Motor Vehicle Record (MVR) Review

The appropriate manager will review the driver's MVR annually and score it using the company-developed point classification system for vehicle incidents and violations.

Reporting Incidents Involving Motor Vehicles

An incident report packet is in the glove box of each company vehicle. The packet contains instructions on what to do in case of an incident. Drivers should become familiar with the instructions before using vehicles.

Employees or their supervisors are responsible for completing and filing all necessary reports within the time periods required by this policy. Failure to file a report may cause the loss of the employee's license, driving privileges, and liability insurance coverage.

Employees must immediately notify their supervisor of any accident, collision, or vandalism.

Employees or their supervisors must immediately report to the appropriate manger all collisions, accidents, or vandalism involving vehicles they use on company business.

If the incident results in injuries or fatalities, employees or their supervisors must report them to the appropriate manager immediately after ensuring the injured have or will receive necessary medical treatment.

Employees or their supervisors, must forward copies of all vehicle accident forms to the appropriate manager.

Employees involved in vehicle crashes should discuss details of the incident only with police officers, appropriate state officials, or the representative of the company insurance carrier. Drivers are prohibited from signing or making any statements regarding responsibility for vehicle crashes.

Department of Transportation (DOT) Regulated Vehicles

Any vehicle travelling across state lines with a gross vehicle weight rating over 10,000 lbs. (including any towed items or actual weight of vehicle and any tows) is subject to DOT regulations. Each driver must have a DOT compliant Driver File Maintained in the Safety Department before being allowed to drive vehicles within this classification.

In addition to a DOT compliant driver file, any driver of a vehicle with a gross vehicle weight rating (including tows) over 26,000 lbs. (or actual weight of vehicle and any tows) must possess a valid commercial driver's license and follow DOT regulations.

Any vehicle carrying hazardous materials at a level to which placarding is required under DOT regulations (regardless of the vehicle's gross vehicle weight rating or actual weight) must possess a valid CDL license with hazardous materials endorsement.

The Safety Department will be responsible for evaluating the applicability of DOT regulations to this company's operations and ensure compliance with those regulations. All drivers of DOT regulated vehicles will have responsibilities beyond those outlined in this policy and will receive additional training and information.

Drug Testing and MVR Checks After Incidents Involving Vehicles

After each incident, regardless of who is at fault, the appropriate manager will require a drug test within eight hours and obtain the driver's motor vehicle record (MVR) within three business days.

Point System for Screening Employees Who Have Poor Driving Records

This company uses a point system to screen employees who have poor driving records.

- 3-5 points: Employee will receive a letter of reprimand.
- 6-8 points: Employee will receive a letter of reprimand and be suspended without pay for one day and must successfully complete a driver improvement course.
- 9-11 points: Employee will receive a letter of reprimand and be suspended without pay for two days and must successfully complete a driver improvement course.
- 12+ points: Employee will either be reassigned to a non-driving position if available, or, if a non-driving position is not available, the driver will be terminated. Before reinstatement to a driving position, the employee will be required to successfully complete a driver improvement course and follow the procedures as outlined in the Re-qualification section of this policy.

Employees who have 6 or more points in 36 months must successfully complete a driver improvement course within 60 days of notification by the appropriate manager and provide a written certificate of completion to the safety committee.

Points for vehicle incidents and violations are determined from the point classification table below.

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Point classification table

Incident	Points
Incident was beyond the driver's control	0
Driving aggressively or discourteously	1
Failing to make allowance for adverse light, road, weather, vehicle load or traffic conditions.	1
Operating a vehicle with defective equipment.	1
Failing to properly adjust vehicle mirrors, seat, headrest or sun visor.	1
Failing to secure loose objects inside the vehicle.	1
Failing to heed warning labels of medications.	1
Fatigue, falling asleep at the wheel.	2
Exceeding posted speed limit.	2
Lack of proper type or valid license or failing to comply with license restriction.	2
Failing to maintain sufficient clearance when operating vehicle.	2
Following too closely (tailgating).	2
Failing to signal intentions.	2
Overloading vehicle or not following operating manual.	2
Operating vehicle in an unsafe manner.	2
Improperly backing the vehicle.	2
Disregarding stop signs or signals.	3
Making an improper turn, lane change or other movement errors.	3
Driving on the wrong side of the road.	3
Failing to yield the right-of-way or other failure to yield error.	3
Committing involuntary manslaughter or criminally negligent homicide.	12

Attempting to elude a law officer or hit/run.	12

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Point classification table	
Incident	**Points**
Operating a vehicle while operator's license is suspended or revoked.	12
Operating vehicles under the influence of alcohol or drugs.	12
Total points	

Requalification for Employees Who have Poor Driving Records

Employees who have been reassigned to non-driving positions for poor driving records may re-qualify after 6 months under the following conditions:

- Employees must send a written request to the appropriate manager stating why they should be re-qualified. Re-qualification requires the appropriate manager's approval.
- Employees must also complete a driver improvement class which may include remedial and behind-the-wheel training before resuming the driving duties.

Pre-Trip Walk-Around Inspections

Employees are responsible for conducting walk-around inspections of their vehicles before driving each day or shift and note any defects or damage. Employees must also note defects or damage to seats, seat belts, interior lights, engine warning lights, rearview mirrors, and emergency equipment.

Employees must report defects or damage to the appropriate manager immediately. The appropriate manager will evaluate the report and ensure that all hazards are repaired promptly. Vehicles that are unsafe to drive must be placed out of service immediately.

Vehicle Service and Maintenance Intervals

Vehicle service and maintenance intervals are determined by the vehicle manufacturer. Maintenance will be performed by a qualified auto or truck mechanic. A signed and dated record of all maintenance work must be kept in the vehicle file. Vehicles that are unsafe to drive must be placed out of service until repairs are completed.

Records Kept on Company Vehicles

This company keeps the following records on each company-owned vehicle:

- Monthly vehicle inspection report. Identifies damage or defective equipment.
- Vehicle history report. Provides a complete history of the costs of maintenance, parts, and labor associated with the vehicles.

All company reports and records are confidential and must not be released to third parties without the consent of the company president and the company's attorney.

Mobile Phone Use

Employees who use a mobile phone in a company vehicle should remember that their number one priority is obeying the rules of the road. Hutson Plumbing Company requires that you do the following when you use a mobile phone when you are driving a company vehicle:

- Find a safe place to pull off the road and place your call.
- If you receive a call while driving, let the call go to voicemail and answer when it is safe to do so.
- Employees who use hands-free devices may accept calls while driving but must find a safe place to pull off the road to place calls.

Definitions of Terms Used in This Policy

Accident. An unplanned or unintended incident involving a motor vehicle that results in injury, death, or damage.

Collision. An unplanned or unintended incident in which a motor vehicle contacts another vehicle, person, or object.

Crash. An incident involving one or more vehicles in motion.

Incident. An event that resulted – or could have resulted – in personal harm or property damage.

Injury. Physical harm or damage to a person.

Motor vehicle. Any licensed mechanically or electrically powered device designed to be operated on public roads and streets.

Passenger. Any person in a vehicle other than the driver.

Preventable incident. One in which the driver failed to do everything that could have been done to avoid it.

Remedial training. Training required following an incident to upgrade and renew skills and demonstrate proficiency.

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MVR Consent Form

I have reviewed information in this company's vehicle safety policy, watched the vehicle safety video, and scored at least 80 percent on the written test.

I understand that it is my responsibility to operate company vehicles safely and follow the requirements of the company vehicle safety policy. I also understand that the company will periodically review my motor vehicle record (MVR) and assess my eligibility to drive a motor vehicle on company business.

I authorize this company to obtain my MVR. This authorization remains valid as long as I am an employee or employee candidate and may only be rescinded in writing.

The undersigned gives permission to Bishop Durden Insurance to order Motor Vehicle Reports for the Purpose of the insurance quotations and underwriting information. All information remains confidential and will only be used for insurance purposes.

______________________________ ____________________
Printed Name Phone Number

____
Street Address City State Zip Code

_______________ _________________________ ______________
Social Security Number Driver's License Number Date of Birth

____________________________________ _______________
Employee Signature Today's Date

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Hutson Plumbing Company - Vehicle Use Agreement

Employee Name: ____________________License number: ____________State issued: _____

Using company-owned vehicles

- Employees and passengers must wear seat belts while the vehicle is in motion.
- The vehicle must be maintained in accord with Hutson Plumbing Company's maintenance requirements. Employees must report all mechanical problems to their supervisors immediately.
- Employees must report any motor vehicle incident that results in damage, injury, or a citation to their supervisors immediately.
- Employees must have a valid driver's license for the vehicles they will operate, must follow all license restrictions, and must have their license in their possession when they are driving. A driver whose license is suspended, revoked, or terminated will notify the company immediately.
- Employees' spouses and children are not allowed to operate company vehicles.
- Hitchhikers are not permitted in company vehicles.
- Employees are responsible for all traffic and parking violations they receive when using company vehicles.
- Modifying or adding accessories to a company vehicle is prohibited.
- Radar detectors are prohibited.
- Employees are not allowed to operate vehicles at any time while under the influence of alcohol or drugs.

Using personal vehicles for company business

Authorization to use a personally owned vehicle for company business is permitted under the following conditions:

- Employees and passengers must wear seat belts while the vehicle is in motion.
- Employees must have the appropriate license to operate their vehicles.
- Employees must provide proof of insurance upon hire and each time their policy is renewed or updated.
- Employees must provide a copy of their insurance certificates to their supervisors.
- Employees must notify this company of all vehicle accidents or violations involving vehicles driven on company business.
- This company is authorized to review the driver's MVR annually as long as the driver is a company employee.
- The vehicle owner is responsible for mechanical repairs.
- Employees are not allowed to operate vehicles while under the influence of alcohol, drugs, or other medications that could impair their ability to drive safely.
- Employees must always comply with all state and federal laws and regulations.

I have read, understand, and agree to comply with th1is0 Vehicle Use agreement.

Employee's signature and date: ____

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Company Cell Phone Policy

Hutson Plumbing's cell phone policy offers general guidelines for using personal and company cell phones during work hours. The purpose of this policy is to help us all get the most out of the advantages cell phones offer our company while minimizing the potential distractions, accidents, and frustrations that improper cell phone use can cause. This policy applies to all Hutson Plumbing employees.

Cell Phone Use Guidelines:

In general, cell phones should not be used when they could pose a security or safety risk, or when they distract from work tasks. The following are Hutson Plumbing Company's basic guidelines for proper employee cell phone use during work hours:

- Never use a cell phone while operating a motor vehicle.
- Never use a cell phone while operating equipment.
- Do not use cell phones to access games or any internet material that is not directly related to work during work hours.
- Avoid using cell phones for personal tasks during work hours.

At Hutson Plumbing, we realize that cell phones can be great tools for our employees. We encourage our employees to use cell phones for:

- Making or receiving work calls in appropriate places and situations.
- Other work-related communication, such as text messaging or emailing in appropriate places and situations.
- Scheduling and keeping track of work-related appointments.
- Carrying out work-related research.
- Keeping track of work tasks and obligations.
- Keeping track of work contacts.

Disciplinary Action:

Improper use of cell phones may result in disciplinary action. Continued use of cell phones at inappropriate times or in ways that distract from work may lead to having cell phone privileges revoked. Any violation of the above stated policy is subject to an official write up. Per Hutson Plumbing policy, upon the accumulation of three write ups, a review is initiated, and the employee may be subject to termination. Cell phone usage for illegal or dangerous activity, for the purposes of harassment, or in ways that violate the company confidentiality policy may result in employee termination.

____________________________________ ________________

Employee Signature Date

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LETTER TO ALL EMLPOYEES

The illegal use of drugs and the abuse of alcohol are problems that invade the workplace, endangering the health and safety of the abusers and those who work around them. This company is committed to creating and maintain a workplace free of substance abuse without jeopardizing valued employees job security.

To address this problem, our company has developed a policy regarding the illegal use of drugs and the abuse of alcohol that we believe best serves the interests of all employees. Our policy formally and clearly states that the illegal use of drugs or abuse of alcohol or prescription drugs will not be tolerated. As a means of maintaining our policy, we have implemented pre - employment and active employee drug testing. This policy was designed with 2 basic objectives in mine: (1) employees deserve a work environment that is free from the effects of illegal drug use of alcohol abuse and the problems associated with such, and (2) this company has a responsibility to maintain a healthy and safe workplace.

To assist us in providing a safe and healthy workplace, we maintain a resources file of information of various means of employee assistance in our community, including but not limited to drug and alcohol abuse programs. Employees are encourage to use this resource file, which is located in our administrative office. In addition, we will distribute this information to employees for their confidential use.

An employee whose conduct violates this company's substance abuse policy will be disciplined up to and including termination.

I believe it is important that we all work together to make this company a drug-free workplace and a safe, rewarding place to work.

B. Lynn Moody

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As part of our Drug Free Workplace Program, an online Employee Assistance Program resource guide is available for your use. This service allows all employees to seek help on the internet regarding a variety of topics, including substance abuse, gambling, financial concerns, care for elderly, domestic violence, and many other problems that affect us personally and in the workplace.

Employee family members are also welcome to use this service. Simply provide them with the login name and password.

To access this resource guys, use the login name and password on the Website address listed below. The login name and password will be the same for all employees and users, while all searches will remain completely confidential.

www.eapworklife.com

Click on login at the top of webpage

Username: Council
Password: livedrugfree

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Treatment Resource List

Georgia Therapy Associates Inc	Savannah	109 Minus Avenue
Recovery Place Inc	Intensive Outpatient Program	835 East 65th Street
Health Quest Frontiers Inc		6555 Abercorn Street
Assisted Recovery Center of GA Inc		308 Commercial Drive
Turning Point of Savannah		600 Commercial Court
MedMark Services Inc	Turning Point Savannah	600 Commercial Court
Recovery Place Inc	Womens Residential Treatment	12350 Mercy Boulevard
Behavioral Health Branch	Substance Abuse Program	MCCS Building 17 Tritoli Street
Fraser Center		203 Mary Lou Drive
Army Substance Abuse Program		808 Worcester Avenue
Beaufort County	Alcohol and Drug Abuse Department	P.O. Box 311
New Life Center Commission on Alcohol	And other Drug Abuse Services	651 Gray Highway
Malinda Graham and Associates Inc		1518 Airport Road
First Choice Recovery of Statesboro		1215-B Merchant Way
Willingway Hospital	Substance Abuse Services	311 Jones Mill Road
Pineland MH/MR/SA CSB	Womens Place	P.O. Box 745
Bulloch Recovery Resources		18 Simmons Center
Pineland MH/MR/SA CSB	Womens Outpatient Program	209 South College Street

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Drug-Free Workplace Policy

Purpose and Goal

Hutson Plumbing Co. is committed to protecting the safety, health and well being of all employees and other individuals in our workplace. We recognize that alcohol abuse and drug use pose a significant threat to our goals. We have established a drug-free workplace program that balances our respect for individuals with the need to maintain an alcohol and drug free environment.

- Hutson Plumbing encourages employees to voluntarily seek help with drug and alcohol problems.

Covered Workers

Any Individual who conducts business for the organization, is applying for a position or is conducting business on the organization's property is covered by our drug free workplace policy. Our policy includes, but its not limited to executive management, managers, supervisors, full time employees and part time employees.

Applicability

Our drug free workplace policy is intended to apply whenever anyone is representing or conducting business for the organization. Therefore, this policy applies during all working hours, whenever conducting business or representing the organization, while on call, paid standby and while one organization property.

Prohibited Behavior

It is a violation of our drug free workplace policy to use, possess, sell, trade, and/or offer for sale alcohol, illegal drugs, or intoxicants.

Notification of Convictions

Any employee who is convicted of a criminal drug violation in the workplace must notify the organization in writing within five calendar days of conviction. The organization will take appropriate action within 30 days of notification. Federal contracting agencies will be notified when appropriate.

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Drug Testing

To ensure the accuracy and fairness of our testing program. All testing will be conducted according to Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines where applicable and will include a screening test; a confirmation test; the opportunity for a split sample; review by a medical Review Officer, including the opportunity for employees who test positive to provide a legitimate medical explanation, such as a physicians prescription, for the positive result; and a documents chain of custody.

All drug testing information will be maintained in separate confidential records.

Each employee, as a condition of employment, will be required to participate in ore-employment, random, post-accident and reasonable suspicion testing upon selection or request of management.

The substances that will be tested for are: Amphetamines, Cannabinoids (THC), Cocaine, Opiates and Phencyclidine (PCP).

Testing for the presence of metabolites of drugs will be conducted by the analysis of urine.

Any employee who tests positive will be immediately removed from duty, required to pass a return to duty test and sign a Return to Work Agreement, subject to ongoing, unannounced, follow up testing for a period of 5 years and terminated immediately if he/she tests positive a second time or violates the Return to Work Agreement.

An employee will be subject to the same consequences of a positive test if he/she refuses the screening or test, adulterates or dilutes the specimen, substitutes the specimen with that from another person or sends an imposter, will not sign the required forms or refuses to cooperate in the testing process in such a way that prevents completion of the test.

Consequences

One of the goals of our drug free workplace program is to encourage employees to voluntarily seek help with alcohol and/or drug problems. If, however, an individual violates the policy, the consequences are serious.

In the case of applicants, if he or she violates the drug free work place policy, the offer of employment can be withdrawn. The applicant may reapply after six months and must successfully pass a pre-employment drug test.

If an employee violates the policy, he/she will be subject to progressive disciplinary action and may be required to enter rehabilitation. An employee required to enter rehabilitation that fails to successfully complete it and/or repeatedly violates the policy will be terminated from employment. Nothing in this policy prohibits the employee from being disciplined or discharged for other violations and/or performance problems.

Return to Work Agreements

Following a violation of the drug free workplace policy, an employee may be offered an opportunity to participate in rehabilitation. In such cases, the employee must sign and abide by the terms set forth in a Return to Work Agreement as condition of continued employment.

Assistance

Hutson Plumbing recognizes that alcohol and drug abuse and addiction are treatable illnesses. We also realize that early intervention and support improve the success of rehabilitation. To support our employees, our drug free workplace policy:

- Encourages employees to seek help if they are concerned that they or their family members may have a drug or alcohol problem.
- Encourages Employees to utilize the services of qualified professionals in the community to assess the seriousness of suspected drug or alcohol problems and identify appropriate sources for help
- Allows the use of accrued paid leave while seeking treatment for alcohol and other drug problems

Treatment for alcoholism and/or other drug use disorders may be covered by the employee benefit plan. However, the ultimate financial responsibility for recommended treatment belongs to the employee.

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Confidentiality

All information received by the organization through the drug free workplace program is confidential communication. Access to this information is limited to those who have a legitimate need to know in compliance with relevant laws and management policies.

Shared Responsibilities

A safe and productive drug free workplace is achieved through cooperation and shared responsibility. Both employees and management have important roles to play.

All employees are required to not report to work or be subject to duty while their ability to perform duties is impaired due to on or off duty use of alcohol or other drugs.

In Addition, Employees are encouraged to:

- Be concerned about working in a safe environment.
- Support fellow workers seeking help.
- Report dangerous behavior to their supervisor.

It is the supervisor's responsibility to:

- Inform employees of the drug free workplace policy.
- Observe employee performance.
- Investigate reports of dangerous practices.
- Document negative changes and problems in performance.
- Counsel employees as to expected performance improvement.
- Clearly state consequences of policy violations.

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Communication

Communicating our drug free workplace policy to both supervisors and employees is critical to our success. To ensure all employees are aware of their role in supporting our drug free workplace program:

- All employees will receive a written copy of the policy.
- The policy will be reviewed in orientation sessions with new employees.
- All employees will receive an update of the policy annually with their paycheck.
- Posters and brochures will be available at all locations.
- Employee education about the dangers if alcohol and drug use and the availability of help will be provided to all employees.
- Every supervisor will receive training to help him/her recognize and manage employees with alcohol and other drug problems.

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ACTIVE EMPLOYEE CERTIFICATION OF AGREEMENT

I do hereby certify that I have received and read the Hutson Plumbing Company's Substance Abuse and Testing Policy and have had the Georgia Worker's Compensation Drug-Free Workplace certification program (O.C.G.A. 346-410) explained to me. I understand that if my performance indicates that it is necessary, or in the case of random testing, I will submit to a substance abuse test. I also understand that failure to comply with a substance abuse test or a positive result may affect my right to obtain workers' compensation benefits. I further agree to and herby authorize the release of the results of said tests to the company. Nothing in this consent form is to be construed as a contract between parties.

Name (Please Print): ___________________________________

Signature: ____

Date: ______________________

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Workers Comp Notice

To all employees,

We care about everyone at Hutson Plumbing's safety as the first priority in our daily duties. Our sincerest efforts are made to give everyone the safest place to work in the construction trade. This consists of continual training and working with our insurance carriers to make any and all recommendations for safety improvements within every facet of our organization. It is our sincerest hope that no one ever has to report an injury while on the job at Hutson Plumbing. However, if you have an injury on the job you must report that injury directly to an approved executive of Hutson Plumbing. A list of the approved executives is included at the bottom of this memo for you to reference at any time. Only the approved executives have the most current and pertinent information needed to file your claims and make sure you are taken care of in the unfortunate event of an injury. Your fellow employees and/or anyone not listed as an "approved executive" below is not an acceptable person to report to and does not constitute an official injury report. To assure everyone has received and understands this info please sign and date below.

Approved Executives:

1. Lynn Moody
2. Boyce Young

____
Signed

____
Print Name

____
Date

329 BONAVENTURE ROAD – PHONE 234-1329
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NOTICE OF PROBATIONARY EMPLOYEE STATUS UPON INITIAL HIRING

I, ____________________________, hereby understand and acknowledge that the purposed for which I am being hired for employment at Hutson Plumbing Company (the "Employer") are subject to a probationary period of six (6) months following the date of this document.

I further understand and acknowledge that because my employment with Hutson Plumbing Company is subject to the probationary period, I may not be eligible for certain employment benefits including but not limited to:

- **Leave Pursuant to the Family & Medical Leave Act (FMLA):** I understand that I may not qualify for leave under the FMLA due to the number of work hours required under such act.
- **Unemployment Benefits:** I understand that there are a number of requirements needed to fulfill eligibility for unemployment benefits in Georgia, and that I may not be eligible for such benefits if my employment with Hutson Plumbing Company is terminated during this probationary period.
- **Vacation Pay:** I understand that I may be excluded from obtaining vacation pay during the probationary period, but if excluded from obtaining vacation pay, the vacation time that I accrued while on the probationary period will be available to me when and if I am hired as a full-time employee after the termination of the probationary period.

I further understand and acknowledge that during my probationary employment with Hutson Plumbing Company, my blood, breath, or urine shall be subject to drug and alcohol testing at my employer's request.

I further understand and acknowledge that my employment with Hutson Plumbing Company can be terminated at the will of my employer for any reason at any time, notwithstanding a reason specifically prohibited by Georgia or Federal law.

I further understand and acknowledge that my employment status will be revisited by my superiors at Hutson Plumbing Company at the end of the probationary period if I am still employed with Hutson Plumbing Company at the end of such period.

I further understand and acknowledge that this notice does not constitute a contract, and its only purpose is to notify me of some of the limitations that a probationary employee may face while employed with Hutson Plumbing Company. I also understand and acknowledge that these are not the only restrictions for probationary employees in Georgia, and it is my responsibility to seek independent legal advice as to my rights as a probationary employee before I Sign this document. By signing below, I certify that I have either sough independent legal advice as to my rights as a probationary employee, or I hereby waive the right to do so.

____
Signature of Above-Named Probationary Employee

329 BONAVENTURE ROAD – PHONE 234-1329
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MVR Consent Form

I have reviewed information in this company's vehicle safety policy, watched the vehicle safety video, and scored at least 80 percent on the written test.

I understand that it is my responsibility to operate company vehicles safely and follow the requirements of the company vehicle safety policy. I also understand that the company will periodically review my motor vehicle record (MVR) and assess my eligibility to drive a motor vehicle on company business.

I authorize this company to obtain my MVR. This authorization remains valid as long as I am an employee or employee candidate and may only be rescinded in writing.

The undersigned gives permission to Bishop Durden Insurance to order Motor Vehicle Reports for the Purpose of the insurance quotations and underwriting information. All information remains confidential and will only be used for insurance purposes.

______________________________ ____________________

Printed Name Phone Number

____

Street Address City State Zip Code

_______________ ________________________ ______________

Social Security Number Driver's License Number Date of Birth

____________________________________ _______________

Employee Signature Today's Date

Employee Time-Off Request Form

Today's Date: ____

Employee's Name: ____________________________________

Time-Off Request: _________________ ____ Days ____Hours

Beginning on: ____

Ending on: ____

Reason For Request

____Vacation ____Personal Leave

____Jury Duty ____Medical Leave Other:______________

I understand that this request is subject to approval by my employer.

Employee's Signature:_________________________ Date:________________

\- -

____Approved ____Rejected

Employer's Signature: _______________________ Date:__________________

Print Name:_______________________

COMPANY BY-LAWS

THE OWNERS AND MANAGEMENT OF HUTSON PLUMBING CO., INC. HAVE ADOPTED THE FOLLOWING BY-LAWS AND REVISIONS ON MAY 1, 2007, TO BE EFFECTIVE IMMEDIATELY. THESE BY-LAWS HAVE BEEN DESIGNED TO HELP YOU UNDERSTAND ALL COMPANY POLICIES ANO PROCEDURES. IF AT ANY TIME, THERE IS ANY PART YOU DON'T UNDERSTAND, PLEASE FEEL FREE TO SCHEDULE AN APPQINTMENT WITH THE MANAGEMENT. WE WILL ALWAYS DO OUR BEST TO ANSWER ANY QUESTIONS OR MISUNDERSTANDING THAT YOU MAY HAVE.

SECTION I

- TIME SHEETS WILL BE FILLED OUT ON A DAILY BASIS BY EACH EMPLOYEE.
- ONLY THE PERSON RESPONSIBLE FOR DRIVING THE TRUCK TO AND FROM THE JOB MUST REPORT TO THE SHOP. IT IS NOT MANDATORY FOR THE OTHER MAN WORKING ON THE TRUCK TO COME TO THE SHIP, BUT WE DO OFFER HIM THE COURTESY IF HE WOULD LIKE TO RIDE IN A HUTSON PLUMBING VEHIVLE TO THE JOB. IF HE GOES DIRECTLY TO THE JOB HIS TIME STARTS FOR THE DAY WHEN HE BEGINS ANY ACTIVITY THAT IS AN INTEGRAL PART OF HIS JOB. IF HE OPREFERS TO COME TO THE SHIP ACCORDING TO THE STARTING TIME ASSIGNED BY MANAGEMENT, HIS DAY WIL BEGIN WHEN HE STARTS ANY ACTIVITY THAT IS AN INTEGRAL PART OF HIS JOB.
- THE EMPLOYEE WHO DRIVES THE TRUCK ENDS HIS DAY WHEN HE RETURNS HIS TRUCK TO THE SHOP AND COMPLETES ANY ACTIVITY THAT IS AN INTEGRAL PART OF HIS JOB. THE OTHER MANS TIME ENDS WHEN HE LEAVES THE JOB SITE.
- EACH EMPLOYEE WILL BE GIVEN A PAID BREAK IN THE MORNING AND AFTERNOON. THIS TIME AND ANY BREAK TAKEN, WHICH SHOULD TOTAL NO MORE THAN THIRTY MINUTES DAILY, WILL BE LISTED ON THE TIME SHEET AS “BREAKTIME”.
- THE MANAGEMENT RESERVES THE RIGHT TO REVIEW ALL EMPLOYEES’ TIME ON WEDNESDAY OF EACH WEEK TO MINIMIZE OVERTIME. OVERTEIME WILL BE PAID ONLY AFTER 40 HOURS HAVE BEEN WORKED (SEE OVERTIME POLICY EXPLAINED AT THE END OF THESE BY-LAWS)
- ANY TIME SHEETS TURNED IN ADTER THURSDAY 8:00 AM WILL BE COMPENSATED THE FOLLOWING WEEK. REMEMBER, IT IS YOUR RESPONSIBILITY TO KEEP UP WITH YOUR TIME ON A DAILY BASIS AND IT US UP TO YOUR RESPONSIBILITY TO BE SURE THAT THE TIME SHEET HAS BEEN TURNED IN TO THE OFFICE IN A TIMELY MANNER. TIME IS CALCULATED ON THURSDAY MORNINGS.
- PAYROLL IS RUN ON THURSDAY MORNINGS. PLEASE ADVISE ANY PERSON WHO MAY PICK UP YOUR PAYROLL CHECK THAT THE CHECKS WILL BE READY ON THURSDAY AT 2:00 PM.

SECTION II

THE FOLLOWING DRESS CODE WILL BE STRICTLY ENFORCED:

SHIRTS: YOUR CHOICE BUT MUST BE WORN DURING ALL WORKING HOURS.

SHOES: YOUR CHOICE UNLESS REGULATION BOOTS ARE REQUIRED EITHER BY GENERAL CONTRACTOR OR O.S.H.A

PANTS: MUST BE LONG; **NO SHORTS WILL BE TOLERATED**

SECTION III

SICK LEAVE – WILL BE HANDELD AS FOLLOWS:
AN EMPLOYEE WHO IS ILL OR WHO REQUIRES THE DAY ODD IS TO CALL THE OFFICE, OR HAVE SOMEONE CALL, BEFORE 7:30 AM EVERY MORNING OF ABSEENCE.
EXCEPTIONS ARE: VACTION, LONG-TERM ILLNESS OR PRE-APPROVED LEAVE OF ABSENCE.

- FOR EVERY TWO MONTHS WORKED, YOU GET ONE SICK DAY

JAN & FEB	1 DAY
MAR & APR	1 DAY
MAY & JUN	1 DAY
JUL & AUG	1 DAY
SEPT & OCT	1 DAY
NOV & DEC	1 DAY

THIS IS A TOTAL OF 6 SICK DAYS FOR 1 YEAR WORKED.

*IF THE TIME IS NOT USED BY THE EMPLOYEE. IT WILL BE CARRIED OVER INTO THE NECT YEAR ADDED TO YOUR VACATION TIME AND THE EMPLOYEE MAY USE IT AT HIS DISCRETION. IF YOU ARE OUT FOR ANY REASON, THE EMPLOYEE IS STILL RESPONSIBLE FOR NOTIFYING THE OFFICE IF HE DESIRES TO BE PAID FOR TIME OFF, IF HE HAS THE ACCUMULATED TIME. YOU ARE REQUIRED TO INFORM THE OFFICE NO LATER THAN WEDNESDAY AFTERNOON IF YOU DESIRE PAY FOR A SICK DAY. THE OFFICE WILL NEVER ASSUMER YOU WANT PAY FOR TIME OFF.

VACATION – AN EMPLOYEE IS ELIGIBLE AFTER HE HAS WORKED TWELVE (12) MONTHS. AFTER TWELVE MONTHS OF EMPLOYMENT THE EMPLOYEE WILL EARN FIVE (5) VACATION DAYS TO BE USED IN THE CALENDAR YEAR. AN EMPLOYEE MAY TAKE VACATION OFF WHENVER HE SO DESIRES. PRIOR APPROVAL OF MANAGEMENT IS REQUIRED AT LEAST ONE (1) WEEK IN ADVANCE, IF POSSIBLE. IF THE EMPLOYEE WOULD PREFER PAY IN LIEU OF TIME OFF, HE MUST WAIT UNTIL JULY 1ST. IF HE HAS ACCRUED TIME FROM PREVIOUS YEARS AND WOULD LIKE PAY IN LIEU OF TIME OFF, HE MAY ASK FOR THIS AT ANY TIME OF THE YEAR.

EXTRA DAY-OFF BENEFIT – AFTER TEN (10) CONSECUTIVE YEARS OF SERVICE WITH HUTSON PLUMBING, YOU WILL RECEIVE ONE (1) EXTRA VACATION DAY PER YEAR UP TO (15) YEARS FOR A TOTAL OF FIVE (5) EXTRA VACATION DAYS PER YEAR (TEN (10) TOTAL VACATION DAYS PER YEAR MAXIMUM). ANY UNUSED VACATION TIME WILL BE CARRIED OVER TO THE NEXT YEAR AND MAY BE USED AT THE EMPLOYEE'S DISCRETION.

IN ADDITION TO THE SICK LEAVE AND VACATION AS OUTLINE ABOVE HUTSON PLUMBING WILL OBSERVE THE FOLLOWING NATIONAL HOLIDAYS:

- NEW YEARS DAY
- MEMORIAL DAY
- JULY 4TH
- LABOR DAY
- THANKSGIVING DAY
- CHRISTMAS

SECTION IV

HEALTH INSURANCE – AN EMPLOYEE IS ELIGIBLE FOR HEALTH INSURANCE COVERAGE AFTER HE HAS COMPLETED NINETY (90) DAY. HUTSON PLUMBING CO., INC. TRIES TO PROVIDE THE MSOT COST EFFICIENT COVERAGE THAT IS AVAILABLE OT US. WE RESERVE THE RIGHT TO CHANGE INSRUANCE COMPANIES IFI WE FEEL IT IS ADVISABLE WITHOUT PRIOR APPROVAL FROM THE EMPLOYEES. SINCE THE OWNERS PAY A LARGE PERVENTAGE OF THE PREMIUMS, WE ARE ALWAYS SHOPPING FOR AN INSURANCE THAT BETTER SERVES OUR NEEDS AND AT A RATE THAT WE ALL CAN AFFORD.

SECTION V

RETIREMENT – THIS IS A TAC DEFERRED PROGRAM TO WHICH THE EMPLOYER CONTRIBUTES A PERVENTAGE OF THE EMPLOYEES ANNUAL SALARY. THIS PERCENTAGE, BASED ON COMPANY PROFITS FOR THE YEAR AND DETERMINED BY THE OWNERS OF HUTSON PLUMBING, IS THE SAME FOR EVERY EMPLOYEE. IF THE COMPANY, ACCORDING TO THE YEARLY AUDIT, DOES NOT REPORT A MARGIN OF PROFIT FOR THE YEAR, THE OWNERS RESERVE THE RIGHT TO ABSTAIN FROM ANY CONTRIBUTORY ACTION FOR THAT YEAR. THE CONTRIBUTION CAN ONLY BE DEPOSITED TO A FINANCIAL INSTITUTION OR STOCK PROGRAM. IT IS NOT MANDATORY TO LEAVE THE CONTRIBUTION ON DEPOSIT; BUT, IF YOU DO REDEEM IT, IT MUST BE REPORTED AS TAXABLE INCOME. ALL RULES FOR THIS PROGRAM ARE OUTLINED BY THE FEDERAL GOVERNMENT AND CANNOT BE MODIFIED; HOWEVER, BUSINESS OWNERS HAVE THE RIGHT TO DISCONTINUE THE PROGRAM AT ANY TIME. REQUIREMENT FOR ELIGIBILITY: THE EMPLOYEE MUST HAVE COMPLETED THREE (3) FULL YEARS AND WORKED SOME PORTION OF THE 4TH YEAR CONSECUTIVELY.

EXPLANATION OF OVERTIME POLICY – THE LAWS FOR THE STATE OF GEORGIA REQUIRE OVERTIME PAY ONLY AFTER YOU HAVE PHYSICALLY WORKED FORTY (40) HOURS FOR A AY PERIOD WHICH IS BASED ON A 5-DAY WORK WEEK.

HOWEVER, HUTSON PLUMBING CO., INC., WILL PAY OVERTIME AS FOLLOWS:

- AFTER 40 HOURS PHYSICALLY WORKED
- IF YOU MISS A DAY DURING THE PAY PERIOD DUE TO A NATIONAL HOLIDAY BUT YOU ARE ASKED TO WORK ON A SATURDAY OR SUNDAY (EXAMPLE: IF JULY 4TH FALLS ON A MONDAY, TUESDAY, OR WEDNESAYD OF A PAY PERIOD, OVERTIME WILL BE PAID FOR WORK PERFORMED ON THE PREVIOUS SATURDAY OR SUNDAY)
- ID YOU ARE CALLED IN TO WORK AT NIGHT. THIS TIME BEGINS AT 6:00 PM

*OVERTIME WILL NOT BE PAID IF YOU WORK ON THE WEEKEND IF YOU HAVE MISSED TIME DURING REGULAR WORKING HOURS DUE TO ANY REASON OTHER THEN A NATIONAL HOLIDAY.