

Minnesota Clerical, Inc.  
Payroll Specialist



*A step in the right direction!*

Welcome to Minnesota Clerical, Inc.

There is a signed Client Services Agreement between MN Clerical, Inc. and its clients recognizing that the staff will be co-employees of MN Clerical, Inc. The Agreement is established to assist with the payroll portion of employee staffing, while the client oversees all aspects of the employment. Please list MN Clerical, Inc. as employer on all wage verification, unemployment benefits, etc.

Please find attached the necessary forms that need to be completed, signed, dated, and returned to the office please return either by mail, FAX or SECURE email. Please have our site client review your I-9 form, proper ID complete certification section, sign, and

date. The Employee Handbook is attached for your reference. Please review with our Client the ESST requirements(last page of packet) which can be covered under PTO these hours are tracked internally by our client per MN DOL compliance and should be made available for employee review. Attached information to the file is MN Paid Leave notice for 1/1/2026. There is no health insurance coverage available through Minnesota Clerical Inc.

An overview of reporting hours and direct deposit of your payroll is as follow: The pay periods run bi-weekly; every other Saturday is the end of a pay period. The time card is to be emailed to Minnesota Clerical, Inc. by the last day of the pay period please include your employee number this will be assigned when packet is returned CC: client the time card for review The payroll is processed and direct deposited to the employee account on that Friday after the last day of the pay period(reference pay period list available on company website). You will receive an Email invite from SAGE HR to set up an account to review your pay stub.

MN Clerical, Inc. does offer at no cost to eligible employees the following benefits: \$25k life insurance, LTD, and AD&D coverage. If you work 25+ hours per week please complete the life beneficiary form in the packet. There is a voluntary employee sponsored benefit package available to you, including dental, vision, many AFLAC products please reference on our website listed below or contact the office.

If you have any questions on the employee packet, or payroll reporting please feel free to give me a call. I look forward to working with you and will handle the payroll processing with over forty years of experience.

Sincerely,

Roxanne L. Olsen  
President

Minnesota Clerical, Inc  
17230 Uplander Street NW  
Andover MN 55304  
Office: 763-753-7243 Fax: 763-753-7246  
[www.mnclericalinc.com](http://www.mnclericalinc.com)



MN Clerical, Inc. considers applicants for all positions without regard to race, color, creed, religion, sex, sexual orientation, marital status, age, national origin, veteran/military status, status with regard to public assistance, membership or activity on a local commission, disability, familial status or any other legally protected status.

1. Title of position(s) for which you are applying:	2. Date of Application		
3. Are you available to work: <input type="checkbox"/> Regular Full-Time <input type="checkbox"/> Regular Part-Time			
<b>Days &amp; Hours Available:</b>			
4. Name:	5: Cell Phone:	6. Salary Desired?	
8: Work Phone			
May we contact you at this number? Yes <input type="checkbox"/> No <input type="checkbox"/>			
9. Address			
Street	City	State	Zip
10. Are you over the age of 18? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Have you ever submitted an application with the company before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been employed with the company before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give dates:			
12. Is anyone related to you employed by MN Clerical, Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please give their name and relationship to you:			
13. Do you have a valid drivers license? (For driving positions only.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you been convicted of any moving violations in the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain:			
Do you have restrictions for travel on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Are you legally eligible to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If hired, you will be required to provide proof of such eligibility.			
15. Can you, with or without reasonable accommodation, perform the essential functions of this job?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
(If you have questions about the function of the job, please ask the interviewer before answering this question.)			
16. How did you hear about us?			
<input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Employment Agency <input type="checkbox"/> Current Employee: _____ <input type="checkbox"/> Other: _____			
email address			

## CANDIDATE STATEMENT

### ■ PLEASE READ CAREFULLY BEFORE SIGNING ■

I hereby certify that all of the information provided by me in this application (or any other accompanying or required documents) is correct, accurate and complete to the best of my knowledge. I understand that the falsification, misrepresentation or omission of any facts in said documents will be the cause for denial of employment or immediate termination of employment regardless of the timing or circumstances of discovery.

I understand that the submission of an application does not guarantee employment. I further understand that, should an offer of employment be extended by MN Clerical, Inc. that such employment with the Company is **AT WILL**, for no specified duration and may be terminated by either the Company or myself at anytime, with or without cause or notice. I understand that none of the documents, policies, procedures, actions, statements of the Company or its representatives used during the employment process is deemed a contract of employment, real or implied. I understand that no representative of the Company, except the president, has the authority to enter into any agreement guaranteeing any conditions of employment or any agreement contrary to the foregoing statements and that any such agreements must be made in writing and signed by the president of MN Clerical, Inc..

In consideration for employment with MN Clerical, Inc., if employed, I agree to conform to the rules, regulations, policies and procedures of the Company at all times and understand that such obedience is a condition of employment. I understand that due to the nature of the Company's business, attendance and punctuality are considered essential requirements of every job at the Company and that poor attendance or tardiness will result in disciplinary action.

I authorize you to communicate with persons listed as references, former employers, and any others with whom you desire to check. I agree to hold such persons harmless with respect to any information they may give about me.

If employed, I agree to engage in no outside activity which would involve a material conflict of interest with, or which could reflect adversely on the Company. I understand this decision is to rest with the Company.

If employed, I agree to hold in strictest confidence any information concerning the Company which may come to my knowledge.

I understand that if employed by the Company, I may be required to sign a confidentiality disclosure and/or, a non-compete agreement.

I understand that if offered a position with the Company I may be required to submit to a pre-employment medical examination, drug screening and background check as a condition of employment. I understand those unsatisfactory results from, refusal to cooperate with, or any attempt to affect the results of these pre-employment tests and checks will result in withdrawal of any employment offer or termination of employment if already employed.

I hereby authorize any and all schools, former employers, references, courts and any others who have information about me to provide such information to MN Clerical, Inc. and/or any of its representatives, agents or vendors and I release all parties involved from any and all liability for any and all damage that may result from providing such information.

I understand that this application is considered current for three months. If I wish to be considered for employment after this period I must fill out and submit a new application.

I understand that in the event that employment disputes arise between the Company and me, the Company and I will resolve these disputes through an Alternative Dispute Resolution Agreement. The ADR Agreement provides for final and binding arbitration. This ADR Policy applies to all disputes. **THE ADR AGREEMENT DOES, HOWEVER, PRECLUDE ME FROM PERSUING COURT ACTION REGARDING ANY SUCH DISPUTES.**

I understand that an offer of employment is conditional on my providing documentation necessary to establish my identity and eligibility to work in the United States in accordance with the requirements of the Immigration and Naturalization Services I-9 form, and completion of the company's standard employee agreement concerning patents and confidential information.

In consideration of my employment, I agree to abide by all policies and regulations of the Company.

**My signature is evidence that I have read, understood, and agree with the above statements.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



**Have you ever been convicted of a criminal offense?**

Do not include convictions that were sealed, eradicated or expunged, or convictions that result in referral to a diversion program.

   Yes    No

Saying yes is not a bar to employment at MN Clerical, Inc. Please provide additional information in the space below or an extra sheet, if necessary. MN Clerical, Inc will make an individualized assessment of the information provided, taking into account factors including, but not limited to, the nature of the crime, the time elapsed, the facts and circumstances surrounding conviction, the nature of the job applied for and business necessity.



# 2026 W-4MN, Minnesota Employee Withholding Certificate

## Employees

Complete Form W-4MN so your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year and when your personal or financial situation changes. If no Form W-4MN is in effect, the number of withholding allowances claimed will be zero.

First Name and Initial	Last Name	Social Security Number
Permanent Address		<b>Marital Status (Check one):</b>
City	State	ZIP Code
<input type="checkbox"/> Single; Married, but legally separated; or <input type="checkbox"/> Spouse is a nonresident alien <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate		

**Complete Section 1 OR Section 2, then sign the bottom and give the completed form to your employer.**

### Section 1 — Determining Minnesota Allowances

A Enter "1" if no one else can claim you as a dependent ..... **A** \_\_\_\_\_

B Enter "1" if any of the following apply: ..... **B** \_\_\_\_\_

- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are \$1500 or less

C Enter "1" if you are married, or enter "0" if you are married and have either a working spouse or more than one job. (*Entering "0" may help you avoid having too little tax withheld.*) . **C** \_\_\_\_\_

D Enter the number of dependents you will claim on your tax return. ..... **D** \_\_\_\_\_

E Enter "1" if you will use the filing status Head of Household (*see instructions*). ..... **E** \_\_\_\_\_

F Add steps A through E. If you plan to itemize deductions on your 2026 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. .... **F** \_\_\_\_\_

**1** Minnesota Allowances. Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet ..... **1** \_\_\_\_\_

**2** Additional Minnesota withholding you want deducted for each pay period (*see instructions*) ..... **2** \$ \_\_\_\_\_

### Section 2 — Exemption From Minnesota Withholding

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding (*see Section 2 instructions for qualifications*). If applicable, check one box below to indicate why you believe you are exempt:

A I meet the requirements and claim exempt from both federal and Minnesota income tax withholding.

B Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:

- I had no Minnesota income tax liability last year.
- I received a refund of all Minnesota income tax withheld.
- I expect to have no Minnesota income tax liability this year.

C All of these apply:

- My spouse is a military service member assigned to a military location in Minnesota.
- My domicile (legal residence) is in another state.
- I am in Minnesota solely to be with my spouse. My state of domicile is \_\_\_\_\_.

D I am an American Indian that resides and works on a reservation for which I am enrolled (*see instructions*).  
Enter the reservation name: \_\_\_\_\_  
Enter your Certificate of Degree of Indian Blood (CDIB)/Enrollment number: \_\_\_\_\_

E I am a member of the Minnesota National Guard or an active-duty U.S. military member and claim exempt from Minnesota withholding on my military pay.

F I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay.

*I certify that all information provided in Section 1 OR Section 2 is correct. I understand there is a \$500 penalty for filing a false Form W-4MN.*

Employee's Signature

Date

Daytime Phone Number

**Employees:** Give the completed form to your employer.

## Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. Incomplete forms are considered invalid. We may assess a \$50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer	Minnesota Tax ID Number	Federal Employer ID Number (FEIN)
Address	City	State
		ZIP Code

**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.

**2026****Step 1:  
Enter  
Personal  
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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.)		
<b>Caution:</b> To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

**TIP:** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

**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, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

**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) Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . .

**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):

- (a) Multiply the number of qualifying children under age 17 by \$2,200 . . . . .
- (b) Multiply the number of other dependents by \$500 . . . . .

3(a)	\$
3(b)	\$

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . .

3

\$

**Step 4:  
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.** Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . . . .

4(b)

\$

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

4(c)

\$

Exempt from  
withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . . .

**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  
employmentEmployer identification  
number (EIN)



# Employment Eligibility Verification

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

USCIS

Form I-9

OMB No.1615-0047

Expires 07/31/2026

**START HERE:** Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

**ANTI-DISCRIMINATION NOTICE:** All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

**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 (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number (if any)	City or Town State ZIP Code	
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address		Employee's Telephone Number
<b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): <input type="checkbox"/> 1. A citizen of the United States <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.) <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) <input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any) _____		
Signature of Employee		Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Check here if you used an alternative procedure authorized by DHS to examine documents.					

**Certification:** I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name MINNESOTA CLERICAL INC		Employer's Business or Organization Address, City or Town, State, ZIP Code 17230 UPLANDER ST NW ANDOVER MN 55304

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

\* Documents extended by the issuing authority are considered unexpired.

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

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

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	OR	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. A Social Security Account Number card, unless the card includes one of the following restrictions:  (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph	3. 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. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card	4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:  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 individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record	5. U.S. Citizen ID Card (Form I-197)
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		6. Military dependent's ID card	6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card	7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document	For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="http://uscis.gov/i-9-central">uscis.gov/i-9-central</a> .
		9. Driver's license issued by a Canadian government authority	The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b> , document, not a List C document.
		<b>For persons under age 18 who are unable to present a document listed above:</b>	
		10. School record or report card	
		11. Clinic, doctor, or hospital record	
		12. Day-care or nursery school record	

### Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.
• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.			
• Form I-94 with "RE" notation or refugee stamp issued to a refugee.			

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



# Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS  
Form I-9

Supplement A  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**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		Date (mm/dd/yyyy)	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	Middle Initial (if any)	
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date (mm/dd/yyyy)	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	Middle Initial (if any)	
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date (mm/dd/yyyy)	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	Middle Initial (if any)	
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date (mm/dd/yyyy)	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )	Middle Initial (if any)	
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**BENEFICIARY DESIGNATION FORM**  
Life Insurance Company of North America



Employer Name \_\_\_\_\_  
 Employee Name \_\_\_\_\_ Employee Social Security # \_\_\_\_\_  
 Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ *please enter all dates in mm/dd/yyyy format*

**Primary and Contingent Beneficiaries** – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

<b>Basic Term Life Insurance, Life Insurance Company of North America - Policy No.</b>				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

  

<b>Basic Accident Insurance, Life Insurance Company of North America - Policy No.</b>				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

If you need additional space using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

**Note: This form is not complete without your signature. Please sign the form where indicated.**

**Community Property Laws** - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Owner Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# Minnesota Clerical, Inc. Benefits Election/Waiver Form

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Part A - Employee and Family Member Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ Spouse's Age \_\_\_\_\_  
Home Address \_\_\_\_\_ # of Dependents \_\_\_\_\_  
City, State and Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Email Address \_\_\_\_\_



## Part B - Plan Election and/or Waiver

Please check the boxes to indicate your plan election(s) and/or waiver(s) below.

Plan Name	Elect Single Coverage	Elect Family Coverage	Waive Coverage
Critical Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short-Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
voluntary life insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accident Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Specified-Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Confinement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity or Sickness			
Hospital Intensive Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Part C - Signature

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Whether you are electing or waiving coverage, **please return this form to Minnesota Clerical, Inc.** Once the Plan Administrator receives this election/waiver form, a representative will contact you to discuss your enrollment in more detail. If form is not returned to our office, employees has waived coverage.

Minnesota Clerical, Inc.  
Payroll Specialist



*A step in the right direction!*

## PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

Please check one:  New Participant  
 Change in Account

Employee Name: \_\_\_\_\_

Employee Number: \_\_\_\_\_ SS #: \_\_\_\_\_

Until revoked by me in writing Minnesota Clerical, Inc. is hereby authorized to deposit my net pay each pay period directly to my bank or financial institution as shown below. I authorize the financial institution(s) listed below to accept and credit entries by Minnesota Clerical, Inc. to debit my account(s).

Bank or Financial Institution: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Account Number: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Please check one:  Checking Account

Savings Account

If requesting a specific amount be deposited each pay period to an account please indicate the amount: \$ \_\_\_\_\_

*For accuracy, please attach a voided check or for savings a deposit slip*

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Minnesota Clerical, Inc.*  
17230 Uplander Street NW\* Andover MN 55304\* 763-753-7243 Fax: 763-753-7246

Employee's Name: \_\_\_\_\_

Please Print

Signature

Position: \_\_\_\_\_

Date: \_\_\_\_\_

## Employee notice

1. Employee:		Address:
Phone number:		Email address:
Date employment began:		
2. Legal name of employer:		Main office/principal place of business address:
Phone number:		Email address:
Operating name of employer (if different):		
Mailing address (if different):		
3. Employment status (exempt or non-exempt):		
<input type="checkbox"/> Employee is exempt from: <input type="checkbox"/> minimum wage <input type="checkbox"/> overtime <input type="checkbox"/> other provisions of Minnesota Statutes 177		
Legal basis for exemption:		
<input type="checkbox"/> Employee is non-exempt (entitled to overtime, minimum wage, other protections under Minn. Stat. 177)		
4. Rate or rates of pay		
Paid by: Hour <input type="checkbox"/> Shift <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Salary <input type="checkbox"/> Piece <input type="checkbox"/> Commission <input type="checkbox"/> Other method <input type="checkbox"/>		
Overtime is owed after: hours		
Allowances claimed:		
\$ per meal for meal allowance (max = 60% of one hour of adult minimum wage per meal)		
\$ per day for lodging allowance (max = 75% of one hour of adult minimum wage per day) (or fair market value)		
5. Leave benefits available:		
<input type="checkbox"/> Sick leave <input type="checkbox"/> Paid vacation <input type="checkbox"/> Other paid time off		
How benefits are accrued: Number of hours _____ or days _____		
per <input type="checkbox"/> year <input type="checkbox"/> month <input type="checkbox"/> per pay period <input type="checkbox"/> per hours worked		
Terms of use:		
6. Deductions that may be made from employee's pay and amounts:		
7. Number of days in the pay period: Regularly scheduled payday:		
Date employee will receive first payment of wages earned:		
8. Other information relevant to this position:		
I, the employee, have received a copy of this notice: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer signature	Date	Employee signature
		Date