TBL Security Services llc

Application For Employment

We are an Equal Opportunity Employer and committed to excellence through diversity.

Please print or type. The application must be fully completed to be considered. Please complete each section, even if you attach a resume.

Personal Information

Name

D.O.B:

SSN:

Address	City	State	Zip

Phone number	Email address

Are you legally eligible to work in the US?

Yes ☐ No ☐

Are you a veteran?

Yes ☐ No ☐

If selected for employment are you willing to submit to a background check?

Yes ☐ No ☐

Position

Position you are applying for	Available start date	Desired pay

Employment desired

Full time ☐ Part time ☐ Seasonal/Temporary ☐

Education

School name	Location	Years attended	Degree received	Major

References (business and professional only)

Name	Title	Company	Phone

Employment History

Employer (1)	Job title		Dates employed
Work phone	Starting pay rate		Ending pay rate
Address	City	State	Zip
Employer (2)	Job title		Dates employed
Work phone	Starting pay rate		Ending pay rate
Address	City	State	Zip
Employer (3)	Job title		Dates employed
Work phone	Starting pay rate		Ending pay rate
Address	City	State	Zip
Employer (4)	Job Title		Dates employed
Work phone	Starting pay rate		Ending pay rate
Address	City	State	Zip
Employer (5)	Job title		Dates employed
Work phone	Starting pay rate		Ending pay rate
Address	City	State	Zip

Signature Disclaimer

I certify that my answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my employment being terminated.

Name (please print)	Signature
Date	

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

2024

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 *www.ssa.gov*.
City or town, state, and ZIP code		

(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, and when to use the estimator at *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* for 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 (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 . . . . . ☐

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)

Form 89-350-20-8-1-000 (Rev. 08/20)

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name _____ SSN _____

Employee's Residence _____ (Number and Street) _____ (City or Town) _____ (State) _____ (Zip Code)

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION

	Marital Status	Personal Exemption Allowed	Amount Claimed
EMPLOYEE:	1. Single	☐ Enter $6,000 as exemption . . . . ▶	$
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	2. Marital Status (Check One)	(a) ☐ Spouse **NOT** employed: Enter $12,000 ▶	$
		(b) ☐ Spouse **IS** employed: Enter that part of $12,000 claimed by you in multiples of $500. See instructions 2(b) below. ▶	$
	3. Head of Family	☐ Enter $9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d)below . . . . . ▶	$
EMPLOYER:	4. Dependents Number Claimed	You may claim $1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim $1,500 for each dependent excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by $1,500. Enter amount claimed...▶	$
Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	5. Age and blindness	• Age 65 or older ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ Single Multiply the number of blocks checked by $1,500. Enter the amount claimed . . . . . ▶ * **Note:** No exemption allowed for age or blindness for dependents.	$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5... ▶		$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer . . . . . ▶		$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write **"Exempt"** on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▶		_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ **Date:** _____

INSTRUCTIONS

1. **The personal exemptions allowed:**

(a) Single Individuals	$6,000	(d) Dependents	$1,500
(b) Married Individuals (Jointly)	$12,000	(e) Age 65 and Over	$1,500
(c) Head of family	$9,500	(f) Blindness	$1,500

2. **Claiming personal exemptions:**

(a) Single Individuals enter $6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of $12,000.

If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of $500. For example, the taxpayer may claim $6,500 and the spouse claims $5,500; or the taxpayer may claim $8,000 and the spouse claims $4,000. The total claimed by the taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter $9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. **Total Exemption Claimed:**
Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. **A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.**

5. **PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION.**

6. **IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENIFIT OF EXEMPTION.**

To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.

Direct Deposit Authorization Form

I (we) hereby authorize TBL SECURITY SERVICES, hereinafter called COMPANY, to initiate credit entries to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Financial Institution Name Branch

Address City/State Zip

Routing Number Account Number Type of Acct: ___Checking ____ Savings

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

Print Individual Name Signature

Apartment # Date

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM

Pre-employment Employment Questionnaire

Name: _____ Date: _____

1. Are you currently under a doctor's care? Yes / No
2. Are you currently on workers 'compensation? Yes / No
3. Are you currently on disability? Yes / No.
4. Do you have any disabilities that would prevent you from standing for long periods of time? Yes / No.
5. Do you have any disabilities that would prevent you from walking long distances? Yes / No.
6. Have you ever been convicted of a felony? Yes / No. If so, when, where, and for what?

   _____

   _____

   _____
7. Have you ever been convicted of any domestic violence crimes? Yes / No. If so, when, where?

   _____

   _____

   _____
8. Do you have any physical conditions that would prevent you from carrying a firearm? Yes / No.

9. Do you have a valid driver's license? Yes / No. If no, why?

   _____

   _____

   _____

10. Do you currently possess a legal marijuana card issued by a physician? Yes / No. If yes, a copy of the card will be placed into the employee folder.
11. Do you currently possess a valid concealed carry permit? Yes /No? If yes, when does it expire? _____
12. Can you lift and/or carry weight greater than 30 pounds? Yes / No
13. Can you climb a ladder? Yes / No.
14. Can you traverse stairs? Yes / No.
15. Do you ingest over the counter products not prescribed by a licensed physician, that contain CBD or THC?
    Yes / No.

I, _____ affirm that all the questions above were truthfully answered to the best of my knowledge. I acknowledge that any question that were intentionally answered falsely will nullify any and all agreements made between the applicant and TBL Security Services.

_____ _____

Applicant Signature Date

TBL COMPANY EMPLOYEE HANDBOOK ACKNOWLEDGEMENT

Recieved By: _____

Dated: _____

This handbook remains the property of TBL.

This Employee Handbook has been prepared to help each employee understand the policies of TBL, and to prevent any misunderstandings about the relationship between the employee and TBL, and its clients.

This acknowledgement shall be read, understood, signed and dated by the employee, and returned to TBL for filing. By signing, you acknowledge that you have thoroughly read the handbook in its entirety, understand it, and have had the opportunity to ask questions of TBL.

I understand that the TBL Employee Handbook is not a contract for employment. I understand that my employment with TBL is an "at-will" relationship, which means that both TBL and I have the right to terminate the employment relationship at any time, with or without cause or notice. I understand that the "at-will" nature of the employment relationship cannon be modified in any manner.

I understand and agree that this handbook may be unilaterally modified or amended by TBL at any time.

I agree to comply completely with all provisions and policies contained within this handbook.

Employee Signature:

_____

Dated: _____

Witness:

_____

Payroll Statement of Understanding

Every new TBL employee will be provided with login information to access Officer Reports. It is the sole responsibility of the employee to ensure they clock in and clock out through the Officer Reports app to get paid correctly.

If an incident arises that that the app does not allow you to clock in or clock out effectively then it is the sole responsibility of the employee to contact their Site Supervisor and inform them of the incident. If the incident is confirmed to be credible by the Site Supervisor, the employee will have their time corrected by a Regional Manager.

Individual paper time sheets will no longer be accepted or considered.

I, _____ understand and acknowledge the above statement.

_____ _____

Signature Date

Employee Health Insurance Disclosure Form

Employee Name: _____

Employee DOB: _____/_____/_____

Employee Social Security Number: _____-_____-_____

This is a disclosure that is stating that I either accept or deny Health Insurance coverage offered by TBL Security Services. By signing this statement I either accept the charges that come with the company's health coverage or acknowledge that I am responsible for my own medical treatments I receive.

☐ I accept health coverage that is offered by TBL Security Services and the cost for it each month.

☐ I decline health coverage at this time and I will be responsible for my own medical treatments.

Employee Signature: _____

Witness: _____

Height:

Weight:

Phone #:

Employee Information Sheet

Allstate | PRODIGY BENEFIT MANAGEMENT | CITADEL

Name: _____ Cell: _____

Address: _____ Zip: _____

SS#: _____-_____-_____ Email: _____

Date of Birth: _____ Gender: M F Tobacco Use: No Light Heavy

Occupation: _____ Employment Start Date: _____

Spouse Name: _____ Spouse DOB:_____ M / F

Spouse SS#: _____-_____-_____ Spouse Tobacco Use: No Light Heavy

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Dependent Name: _____ DOB: _____ M / F

Dependent Name: _____ DOB: _____ M / F

Dependent Name: _____ DOB: _____ M / F

Dependent Name: _____ DOB: _____ M / F

Dependent Name: _____ DOB: _____ M / F

Who Do You Want Your Beneficiary to be?: **If Spouse, Check Here** ☐

Beneficiary Name: _____ Relationship: _____

Check the box of the policy type you would like to have if there is any allotment left over after your life insurance policy: Critical Illness ☐ Accident ☐

Do you currently have an American Heritage or Allstate Life Insurance Policy? Yes No

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If you have any questions, see your benefits advisor on site or call 866-826-5309.

I agree that my elections may be entered on my behalf based on the above information

Signature_____ Date _____

Everything Below This Line Is For Office Use ONLY.

_____

_____

_____

_____

EMPLOYEE ALLOTTMENT	TOTAL PREMIUM

Employee Understanding and Disclosure

ATTENTIVE offers the ability to help you control costs of medical coverage and extend the allowance to you through your employer's Self-Insured Medical Reimbursement Plan (SIMRP), which focuses on Preventative Care Management© (PCM). You can receive reimbursement for your contribution by participating in the PCM Program.

Pre-tax contributions are made under the IRS Section 125 Cafeteria Plan. Standard tax savings are based on current state and federal income tax rates.

In accordance with your employer's Self-Insured Medical Reimbursement Plan (SIMRP), you may be reimbursed up to 100% of the premiums charged to you by your employer, if you meet certain criteria established by your employer.

I understand the savings and estimates are estimates; I should consult an accountant or tax expert. I further understand and acknowledge the Plan Administrator has entered a contractual arrangement with my employer and me.

I understand that if the total premium "After Tax Allotment" exceeds my "After Tax Allotment," the difference will be deducted from my current net pay. With signature below, I understand participation in the PCM Program requires me to login to my Personal Portal to fulfill my utilization requirements of 1 (One) per year. This may include, taking the health risk assessment, or when applicable, talking with a designated coach. All shared medical information is for my use only, and it will not be disclosed to my employer.

I further understand and agree to pay ATTENTIVE an administrative fee that will be deducted from the gross tax savings I may receive because of my pretax contribution.

I understand that failure to satisfy my participation requirements may lead to removal from the PCM Program and reimbursements of any premiums paid under the SIMRP may become taxable. I further understand that all Section 125 rules apply, and I cannot stop this plan until open enrollment each year, or in the case of a qualifying life change. Furthermore, participation in the PCM Program requires compliance regarding all HRA, HSA and FSA regulations. I understand the information above will be kept on file for ATTENTIVE's records and mine.

I also affirm that I have coverage for major medical insurance through an employer-sponsored plan.

I further understand that I will be emailed and/or SMS text once per month, pertaining my ATTENTIVE PROGRAM. (Msg & Data rates may apply)

Company Name:_____

☐ I wish to **participate** in the Attentive SIMRP program offered under the Section 125 plan

Signature_____ **Date**_____

Printed Name: _____ **Email:** _____

Date of Birth:_____ **Last 4 of Soc.Sec #:**_____ **Phone:**_____

Address: _____

Company Name:_____

☐ I wish to **decline to participate** in the Attentive SIMRP program offered under Section 125 plan

Signature: _____ **Date:** _____