R & D Thiel
A Division of Carpenter Contractors of America, Inc.
Carpenter Components of Illinois
2340 Newburg Road • Belvidere, IL 61008
Telephone: (815) 544-1699
Fax: (815) 544-7132

— PLANT —
EMPLOYMENT APPLICATION

Date _____ Street Address _____

Name _____ City, State, Zip _____

Social Security No. _____ Phone (_____) _____

(Check all boxes which apply. Fill all blanks which apply.)

SKILLS

- Wall Framing ☐
- Trim ☐
- Fascia ☐
- Truss Set-up Table ☐
- Saw Operator ☐
- Warehouse/Shipping ☐
- Fork Lift ☐
- Lumber Yard ☐
- Other _____

EXPERIENCE **No. of Years**

- Leadman _____
- Foreman _____
- Superintendent _____
- Own Business _____

☐ I did not work for this company before

☐ I worked for this company before

When _____

Foreman _____

EMPLOYMENT HISTORY

Name & Address of Co.	Date		What Did You Do?	Reason For Leaving?
	From	To		

POST-HIRE PHYSICAL STATUS

WEIGHT _____ HEIGHT _____ COLOR OF HAIR: _____

Are you presently or have you during the last six months been under a physician's care or in a hospital? ☐ YES ☐ NO

Do you have any disabilities? ☐ YES ☐ NO

Have you ever been compensated for, or do you currently have outstanding, a job-related injury or claim? ☐ YES ☐ NO

If Yes to any of the above, please explain: _____

_____

_____

PHYSICAL HISTORY

Answer YES or NO to the following questions. If YES to any, include date and comment if this was a result of an on-the-job injury.

DO YOU NOW OR HAVE YOU EVER HAD:	YES	NO	DATE	COMMENTS
KNEE INJURIES				
BACK INJURIES				
BROKEN RIBS				
ARM INJURIES				
HEAD INJURIES				
NECK INJURIES				
SHOULDER INJURIES				
EPILEPSY				
DIABETES				
HEART TROUBLE				
HIGH BLOOD PRESSURE				
HEAD ACHES / DIZZINESS				
HERNIA				

Employee Signature: _____ Date: _____

Carpenter Components of Illinois
PLANT EMPLOYEE SAFETY RULES

1. Hard hats, clean safety glasses, and work shoes with ankle support must be worn on the shop floor at all times.
2. No alcohol or drugs will be used on the job.
3. Smoking is allowed ONLY in designated areas of the office/lunchroom.
4. Fighting, horseplay, drug or alcohol use on the plant property will result in immediate dismissal.
5. Use only single-fire nailguns for wall panel framing. Keep hands away from the line of fire.
6. Be sure, before using air nailers, staplers, etc., that they are in proper working condition. Report broken equipment or hazardous conditions to your supervisor so that repairs can be made.
7. Ask your supervisor if you need additional equipment or instruction to get the job done correctly and safely.
8. Lift with your legs, not your back; get assistance with loads beyond your ability to handle without strain.
9. Wear seat belts at all times in company vehicles.
10. You are responsible for keeping the area where you work clean, neat, and clear of slip and fall hazards, debris, hoses, cords, plates, grease and oil.
11. You are responsible for your tools. Put them away at the end of the day.
12. Watch out for other employees nearby before moving a piece of equipment, truss press, forklift, etc. You are not alone!
13. Do not remove or bypass any guards on any machinery.
14. DO NOT operate any piece of equipment unless you are trained and authorized by your supervisor to operate.
15. Do not walk on/over conveyor rollers.
16. Use only 30 psi air to clean equipment. Do not use air to blow off dust from yourself.
17. If you have an accident, no matter how small, or if you are injured on the job, you MUST REPORT the accident/injury TO A SUPERVISOR IMMEDIATELY. All non-emergency treatments for accidents must be authorized by your Supervisor.
18. Safety is an attitude: I will think before I act, and I will act safely.
19. I will not let those around me work unsafely; if necessary I will report unsafe behavior to my supervisor; I am my brother's keeper when it comes to safety in the plant.

I have read these company rules, understand them, and will obey them.

New Hire's Signature: _____ Date: _____

EMPLOYEE DATA SHEET

INSTRUCTIONS:

After you have been hired, supply the additional information listed below. Then complete the attached forms, and give them to your Foreman.

Date of Birth: _____

- ☐ Carpenter
- ☐ Non-Union
- ☐ Union Member
- ☐ Truck Driver

Person to be notified in case of emergency:

Name: _____

Relationship: _____

Address: _____

Phone: _____

[redacted] to

[redacted] regarding conviction. _____

SAFETY PROGRAM:	Yes
I received a hard hat, which I will return upon leaving employment.	
I received safety glasses, which I will return upon leaving employment.	
The company safety rules were explained to me and I was given a copy of them.	
The Hazcam program was explained to me and I was given an outline of my training.	
The safe use of air-powered nailers and staplers was explained to me and I was given a copy of a Paslode safety leaflet.	

STATEMENT AND SIGNATURE

In completing and submitting this application, I understand and agree; (1) That any misstatement of material facts will be sufficient reason for dismissal; (2) That my previous employers may be asked for information concerning my employment, character, ability and experience; (3) That I agree to mandatory, final and binding arbitration before a single neutral arbitrator as my sole and exclusive remedy for all disputes, claims or controversies arising out of or relating to my application or candidacy for employment, employment and/or cessation of employment including, but not limited to statutory rights. Arbitration shall be by the American Arbitration Association under its National Rules for the Resolution of Employment Disputes. If my claim does not involve statutory rights, I understand that I must file my demand for arbitration within six (6) months of the challenge action.

Employee Signature _____

Date _____

THIS SECTION TO BE COMPLETED BY FOREMAN

I have checked the following items:

- Federal W-4 (completed form attached)
- State W-4 (completed form attached)
- Form I-9 (completed form attached)
- Union card: Local number _____
  County _____
- Union dues Authorization and Assignment, or I have examined documents from union indicating the authorization is in their possession.
- Employee information card (completed blue card attached)
- Fall Protection Training given as per 1926.503

_____ Wage Rate

I agree to hire on at this starting wage rate.

Date _____

Employee Signature _____

Foreman Signature _____

PRE-HIRE JOB DESCRIPTION

JOB TITLE	TRUSS BUILDER WALL PANEL BUILDER LUMBER YARD LABORER SAWYER (SAW OPERATOR)
WORK SCHEDULE	TO REPORT EVERY DAY TO ASSIGNED WORK AREA, MONDAY THROUGH FRIDAY, WITH OPTIONAL SATURDAY OVERTIME, WITH LUNCH AND BREAK
TRAINING REQUIRED	TRAINING PROGRAM AVAILABLE: ALSO ON THE JOB TRAINING AS DEEMED NECESSARY BY SUPERVISOR

PHYSICAL DEMANDS:

Body positions:	20% standing, 65% walking, 10% kneeling.
Stooping/Bending:	Bending spine at waist down and forward: frequently; when doing any part of job.
Crouching:	Bending spine and legs down and forward: occasionally; when nailing components.
Climbing:	Ascending stairs, truss tables, lumber loads, etc., using the feet & legs and hands & arms: occasionally.
Balancing:	Maintain equilibrium to prevent falling when walking, standing, crouching: constantly; when doing any part of job.
Twisting:	Body movements and turns at the waist: occasionally
Lifting:	Raising or lowering objects from one level to another/ upward pulling included: frequently; when picking up and setting material for floor, wall and truss components.

MUST BE ABLE TO LIFT MAXIMUM WEIGHT: 75 POUNDS

(More than 75 lbs. requires 2 or more employees)

Carrying:	Moving objects by holding objects in the hands or arms or on shoulder: occasionally; when carrying lumber or materials.
Reaching:	Extending the hands and arms in any direction: occasionally.
Pushing:	Exerting force on objects to move them away from body: occasionally.
Handling:	Holding, grasping, turning, or otherwise working with hand tools, power tools, and carrying lumber and materials: frequently.
Fingering:	Picking, pinching with fingers: frequently.

I am capable of performing all the above essential physical elements of the job.

Applicant's Signature _____ Date _____

Illinois Withholding Allowance Worksheet

General Information

Complete this worksheet to figure your total withholding allowances.

Everyone must complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4.

If you have more than one job or your spouse works, you should figure the total number of allowances you are entitled to claim. Your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

☐ No one else can claim me as a dependent.

☐ I can claim my spouse as a dependent.

1 Write the total number of boxes you checked. 1 _____

2 Write the number of dependents (other than you or your spouse) you will claim on your tax return. 2 _____

3 Add Lines 1 and 2. Write the result. This is the total number of basic personal allowances to which you are **entitled**. 3 _____

4 If you want to have additional Illinois Income Tax withheld from your pay, you may reduce the number of basic personal allowances or have an additional amount withheld. Write the total number of basic personal allowances you elect to claim on Line 4 and on Form IL-W-4, Line 1. 4 _____

Step 2: Figure your additional allowances

Check all that apply:

☐ I am 65 or older. ☐ I am legally blind.

☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Write the total number of boxes you checked. 5 _____

6 Write any amount that you reported on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. 6 _____

7 Divide Line 6 by 1,000. Round to the nearest whole number. Write the result on Line 7. 7 _____

8 Add Lines 5 and 7. Write the result. This is the total number of additional allowances to which you are **entitled**. 8 _____

9 If you want to have additional Illinois Income Tax withheld from your pay, you may reduce the number of additional allowances or have an additional amount withheld. Write the total number of additional allowances you elect to claim on Line 9 and on Form IL-W-4, Line 2. 9 _____

Note If you have non-wage income and you expect to owe Illinois Income Tax on that income, you may choose to have an additional amount withheld from your pay. On Line 3 of Form IL-W-4, write the additional amount you want your employer to withhold.

✂ — — — — — — — — Cut here and give the certificate to your employer. Keep the top portion for your records. — — — — — — — — ✂

Illinois Department of Revenue

IL-W-4 Employee's Illinois Withholding Allowance Certificate

Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Name

Street address

City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate. ☐

1 Write the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 _____

2 Write the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 _____

3 Write the additional amount you want withheld (deducted) from each pay. 3 _____

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature Date

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

This form is authorized under the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in this form not being processed and may result in a penalty.

Illinois Department of Revenue

Form IL-W-4

Employee's Illinois Withholding Allowance Certificate and Instructions

Who must complete Form IL-W-4?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay (see Publication 130, Who is Required to Withhold Illinois Income Tax). If you are claiming exempt status from Illinois withholding, you must check the exempt status box on Form IL-W-4 and sign and date the certificate. Do not complete Lines 1 through 3.

If you are a resident of Iowa, Kentucky, Michigan, or Wisconsin, or a military spouse, see Form W-5-NR, Employees Statement of Nonresidence in Illinois, to determine if you are exempt.

Note If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

When must I file?

You must file Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You should complete this form and give it to your employer on or before the date you start working for your employer. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your previously claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

Example: If you have a baby and file a new Form IL-W-4 with your employer to claim an additional exemption for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have filed takes effect or until your employer is required by the department to disregard it. Your employer is required to disregard your Form IL-W-4 if you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption. Also, if the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4, your employer must also disregard your Form IL-W-4. Finally, if you claim 15 or more exemptions on your Form IL-W-4 without claiming at least the same number of exemptions on your federal Form W-4, and your employer is not required to refer your federal Form W-4 to the IRS for review, your employer must refer your Form IL-W-4 to the department for review. In that case, your Form IL-W-4 will be effective unless and until the department notifies your employer to disregard it.

What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax. Therefore, your employer will withhold Illinois Income Tax based on your compensation minus the exemptions to which you are entitled.

What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (*e.g.*, your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

If you are a partner in a same-sex civil union, and are subject to federal income tax on health benefits your employer pays for your partner, these benefits are not taxed by Illinois. Your employer will still withhold Illinois tax on these benefits unless you choose to claim additional allowances to reduce your withholding by including the amount of these benefits on Line 6 of the Withholding Allowance Worksheet.

Note If you have more than one job or your spouse works, you should figure the total number of allowances you are entitled to claim. Your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

What if I underpay my tax?

If the amount withheld from your compensation is not enough to cover your tax liability for the year, (*e.g.*, you have non-wage income, such as interest or dividends), you may reduce the number of allowances or request that your employer withhold an additional amount from your pay. Otherwise, you may owe additional tax at the end of the year. If you do not have enough tax withheld from your pay, and you owe more than $500 tax at the end of the year, you may owe a late-payment penalty. You should either increase the amount you have withheld from your pay, or you must make estimated tax payments.

For additional information on penalties, see Publication 103, Uniform Penalties and Interest. Visit our website at **tax.illinois.gov** to obtain a copy.

Where do I get help?

- Visit our website at **tax.illinois.gov**
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to
  ILLINOIS DEPARTMENT OF REVENUE
  PO BOX 19044
  SPRINGFIELD IL 62794-9044

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4		6
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here		7 $
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed		8 $
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck		9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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 who claims no withholding allowances; 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 possessions 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.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

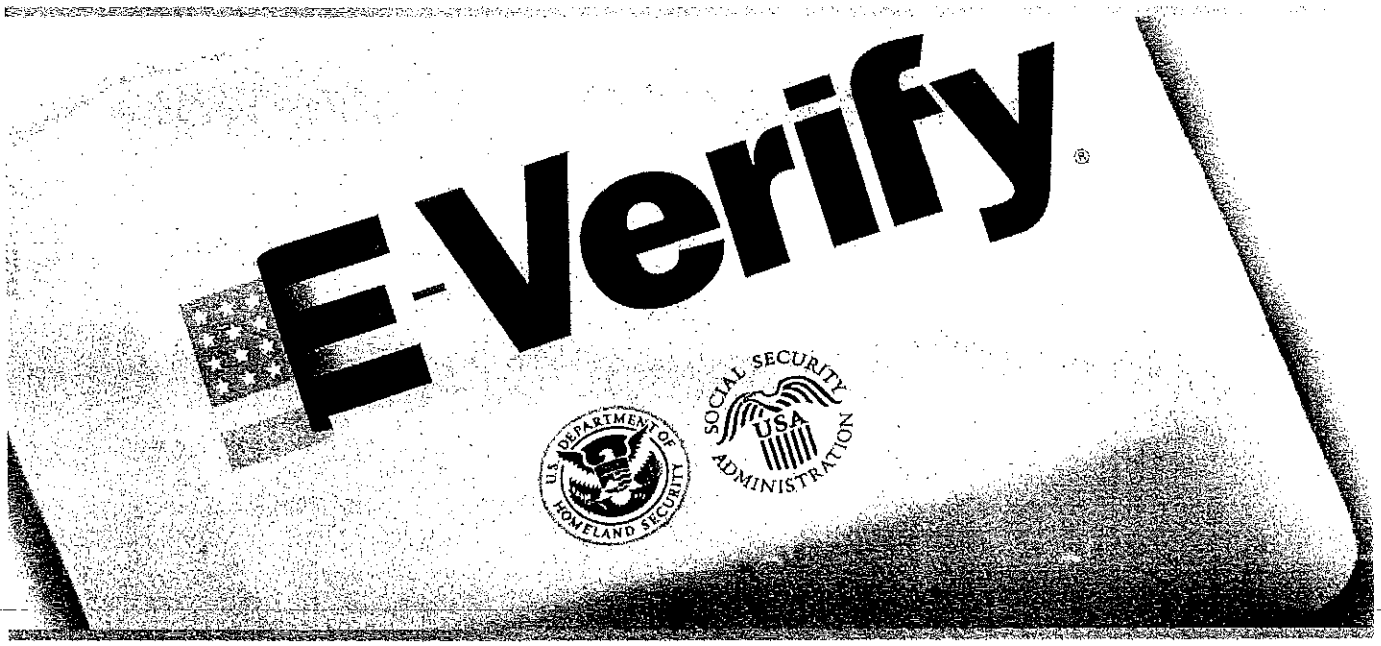
Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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		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 Birth Abroad issued by the Department of State (Form FS-545)
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. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
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.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
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		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

This Organization Participates in E-Verify



This employer will provide the Social Security Administration (SSA) and, if necessary, the Department of Homeland Security (DHS), with information from each new employee's Form I-9 to confirm work authorization.

IMPORTANT: If the Government cannot confirm that you are authorized to work, this employer is required to give you written instructions and an opportunity to contact DHS and/or the SSA before taking adverse action against you, including terminating your employment.

Employers may not use E-Verify to pre-screen job applicants and may not limit or influence the choice of documents you present for use on the Form I-9.

To determine whether Form I-9 documentation is valid, this employer uses E-Verify's photo matching tool to match the photograph appearing on some permanent resident cards, employment authorization cards, and U.S. passports with the official U.S. government photograph. E-Verify also checks data from driver's licenses and identification cards issued by some states.

If you believe that your employer has violated its responsibilities under this program or has discriminated against you during the employment eligibility verification process based upon your national origin or citizenship status, please call the Office of Special Counsel at 800-255-7688, 800-237-2515 (TDD) or at www.justice.gov/crt/osc.

E-Verify Works for Everyone

For more information on E-Verify, please contact DHS:

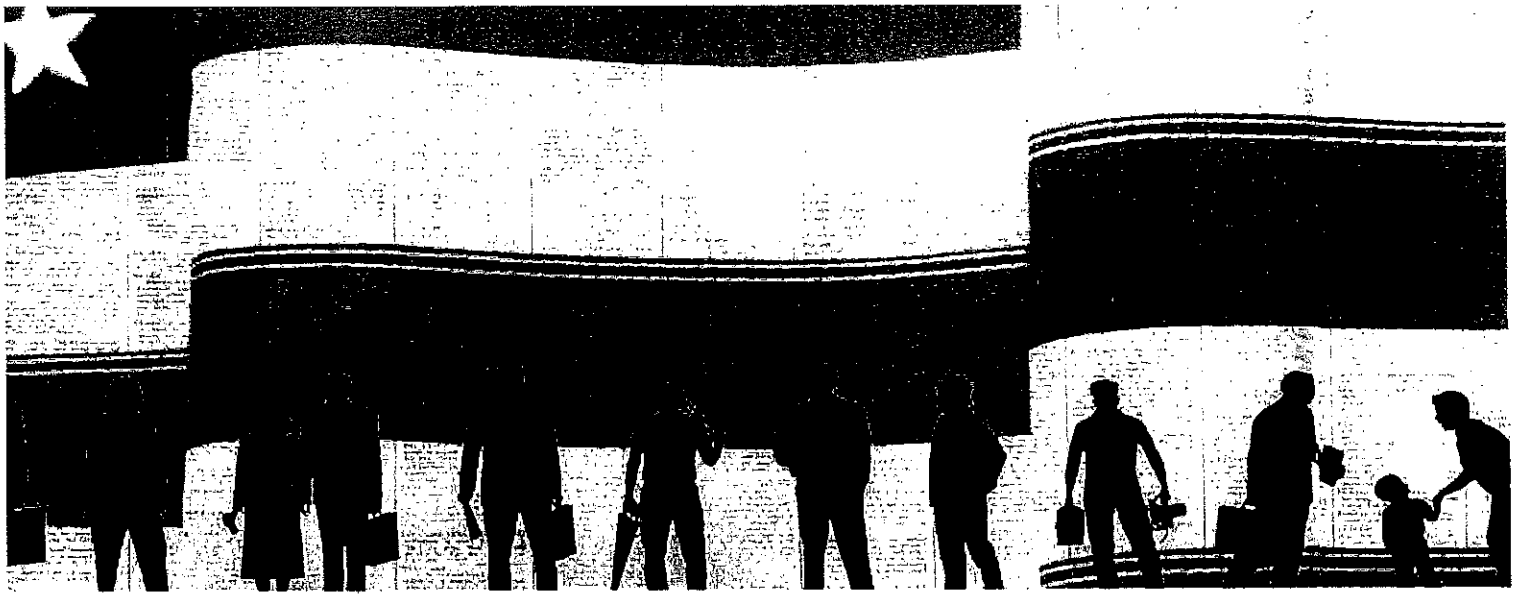
888-897-7781

www.dhs.gov/E-Verify

NOTICE:
Federal law requires all employers to verify the identity and employment eligibility of all persons hired to work in the United States.

E-VERIFY IS A SERVICE OF DHS AND SSA

IF YOU HAVE THE RIGHT TO WORK
Don't let anyone take it away.



If you have the legal right to work in the United States, there are laws to protect you against discrimination in the workplace.

You should know that –

- In most cases, employers cannot deny you a job or fire you because of your national origin or citizenship status or refuse to accept your legally acceptable documents.
- Employers cannot reject documents because they have a future expiration date.
- Employers cannot terminate you because of E-Verify without giving you an opportunity to resolve the problem.
- In most cases, employers cannot require you to be a U.S. citizen or a lawful permanent resident.

If any of these things have happened to you, contact the Office of Special Counsel (OSC).

For assistance in your own language:
Phone: 1-800-255-7688 or
(202) 616-5594
For the hearing impaired:
TTY 1-800-237-2515 or
(202) 616-5525

E-mail: osccrt@usdoj.gov

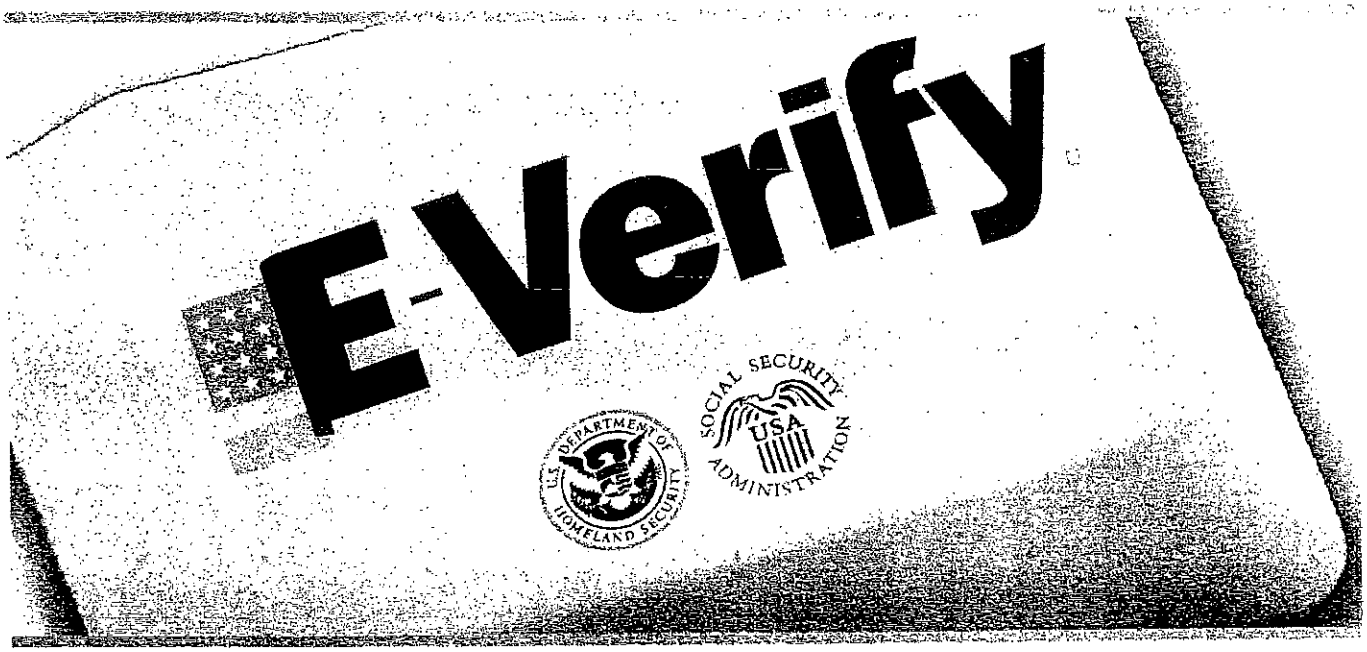
Or write to:
U.S. Department of Justice – CRT
Office of Special Counsel – NYA
950 Pennsylvania Ave., NW
Washington, DC 20530

U.S. Department c
Civil Rights Divisi

Office of Special C
Immigration-Rela
Employment Prac

www.justice.gov/

Esta organización participa en E-Verify



Este empleador proporcionará a la Administración del Seguro Social (SSA, por sus siglas en inglés) y, de ser necesario, al Departamento de Seguridad Nacional (DHS, por sus siglas en inglés) la información incluida en el Formulario I-9 de todo empleado nuevo con el propósito de confirmar su autorización de trabajo.

IMPORTANTE: Si el gobierno no puede confirmar que usted tiene autorización para trabajar, el empleador debe suministrarle las instrucciones por escrito y darle la oportunidad de ponerse en contacto con DHS o SSA antes de sancionarlo de cualquier forma o finalizar la relación laboral.

Los empleadores no pueden utilizar E-Verify para realizar preselecciones de solicitantes y no pueden limitar ni influenciar la selección de los documentos que usted presente para su inclusión en el Formulario I-9.

Para determinar si los documentos incluidos en el Formulario I-9 son válidos, este empleador utiliza la técnica de comparación fotográfica para comparar la fotografía que aparece en las Tarjetas de Residente Permanente, Tarjetas de Autorización de Empleo y pasaportes de los EE. UU. con la fotografía oficial del gobierno de los EE. UU. Asimismo, E-Verify verifica los datos incluidos en licencias de conducir y tarjetas de identificación emitidas por algunos estados.

Si considera que su empleador ha infringido sus responsabilidades en virtud de este programa o lo ha discriminado durante el proceso de verificación de la elegibilidad de empleo por su origen nacional o estatus de ciudadanía, comuníquese con la Oficina del Consejero Especial llamando al 800-255-7688, 800-237-2515 (para personas con impedimentos auditivos) o visitando www.justice.gov/crt/osc

E-Verify funciona para todos

Para obtener más información sobre E-Verify, comuníquese con DHS al:

888-897-7781

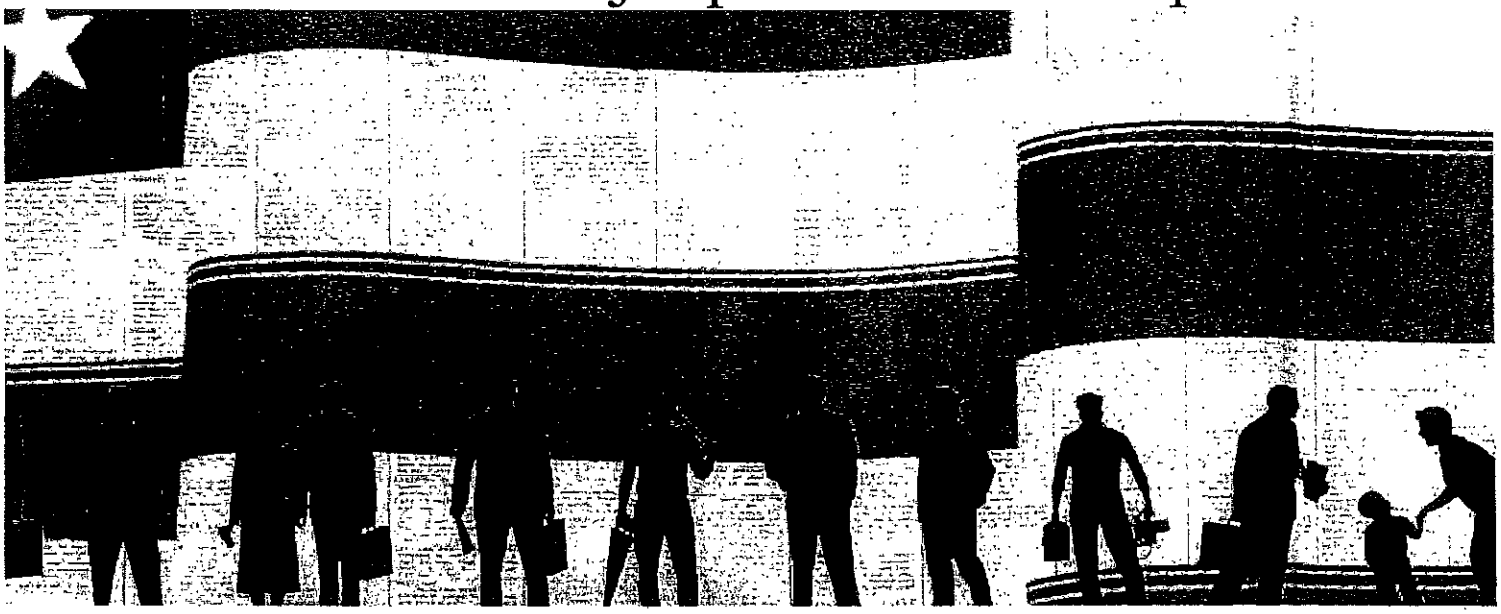
www.dhs.gov/E-Verify

AVISO:
La ley federal exige a todos los empleadores que verifiquen la identidad y la elegibilidad de empleo de todas las personas contratadas en los Estados Unidos.

E-VERIFY IS A SERVICE OF DHS AND SSA

SI USTED TIENE DERECHO A TRABAJ

no deje que nadie se lo quite.



Si usted tiene el derecho a trabajar legalmente en los Estados Unidos, existen leyes que lo protege contra la discriminación en el trabajo.

Usted debe saber que:

- En la mayoría de los casos, los empleadores no pueden negarle un empleo o despedirlo debido a su país de origen o estatus migratorio, o negarse a aceptar sus documentos válidos y legales.
- Los empleadores no pueden rechazar documentos por que tienen una fecha de vencimiento futura.
- Los empleadores no pueden despedirlo debido a E-Verify, sin darle una oportunidad de resolver el problema.
- En la mayoría de los casos, los empleadores no pueden exigir que usted sea ciudadano estadounidense o residente legal permanente.

Si usted se ha encontrado en alguna de estas situaciones, contacte a la Oficina del Consejero Especial (OSC).

Para ayuda en su propio idioma:
Teléfono: 1-800-255-7688 o
202-616-5594
Para las personas con discapacidad auditiva:
TTY 1-800-237-2515 o
202-616-5525

E-mail: osccrt@usdoj.gov

O escriba a:
U.S. Department of Justice - CRT
Office of Special Counsel- NYA
950 Pennsylvania Avenue, NW
Washington, DC 20530

Departamento
División de De

Oficina del Co
Prácticas Inju
Relacionadas

www.justic

Carpenter Contractors of America, Inc.
Carpenter Components of Illinois
Drug Testing Program
Written Corporate Program

I. Introduction

DEFINITIONS: Prohibited substances include illegal drugs (including controlled substances, look-alike drugs and designer drugs), alcoholic beverages and drug paraphernalia in the possession of or being used by an employee on the job. The company also reserves the right to have a designated company physician determine if a prescription drug or medication produces hazardous effects and may restrict the use of any such drug or medication accordingly.

II. General Policy

Our company has had and continues to have a policy of no drug use at work. Our company is committed to providing a safe and healthy work environment. Consequently, the use, possession, concealment, transportation, promotion or sale of prohibited items and substances are strictly prohibited on company premises.

Employees are also prohibited from reporting to work while under the influence of any drug, intoxicant, or other substance that will in any way adversely affect their working ability.

Accordingly, Carpenter Components of Illinois adopt the following Drug and Alcohol testing program for all plant employees.

III. Drug Testing Program - POST ACCIDENT TESTING

An employee shall provide a urine specimen at the health care facility to which he/she reports after a reportable accident (bodily injury to a person as a result of injury that requires medical treatment away from the scene of the accident) occurring while on Carpenter Components of Illinois premises, time or business.

All chain of possession procedures utilized under this program for the testing of controlled substances and alcohol use shall be the same as those approved by the US Department of Health and Human Services, National Institute of Drug Abuse, as they are now in effect or as hereafter amended.

IV. Disciplinary Action

Any refusal or failure to submit to testing required under this policy will be treated as a positive test and the employee will be subject to immediate discharge.

An employee who tests positive for the use of a controlled substance or alcohol shall be unqualified to work for Carpenter Components of Illinois. Further, a positive test result shall be grounds for the immediate dismissal of the employee.

V. Effective Date

This amended employee Drug and Alcohol testing program shall be effective Monday, November 2, 1998 and Carpenter Components of Illinois reserves the right to further modify or amend this program at any time, without prior notice.

VI. Confidentiality

Employee records with regard to testing under this policy will be collected and maintained on separate forms and in separate files and are to be treated as medical records and the testing results are to be used in accordance with applicable local, state and federal laws.

® R & D Thiel, Inc.
Belvidere, Illinois

Dear Employee,

You have most likely heard about Healthcare Reform, also known as the Affordable Care Act (ACA) or Obamacare. While it has taken time for many of the changes brought about by the ACA to come to light, January 1, 2014 is the date that some of the most significant changes that could affect you go live.

You may have heard many things about the ACA which are confusing or contradictory, which is typical for a set of rules as complex as these. We wanted to take this opportunity to break it down for you in a very simple way, so that you understand what's coming in the near future and how we are preparing to embrace the ACA and its requirements.

Beginning January 1, 2014, all US citizens, and people working in the country legally, will be required to have health insurance that meets certain minimum guidelines. If you do not obtain health insurance that meets these minimum guidelines, you will be required to a pay a penalty.

Here are some important points to keep in mind regarding this requirement:

- Beginning October 1, 2013, the government will be opening the Health Insurance Exchanges, now called "Marketplaces"
- Marketplaces will offer you access to coverage regardless of any medical conditions you may have as well as offer health insurance coverage for both individuals and families
- Generally, if you are a full-time employee of Carpenter Contractors of America, you will not be eligible for subsidized coverage from the Marketplace; however, if your family income drops below a certain level, you may regain eligibility for a subsidy
- If you are not eligible for a subsidy, you will pay the full cost of Marketplace coverage; we do not provide financial assistance for Marketplace coverage
- Coverage from Carpenter Contractors of America is available on a tax-free basis, while coverage from the Marketplace is only available on an after-tax basis

You will be receiving a "Marketplace Notice" from us giving more detail about the Marketplaces and how to access them. We are legally obligated to provide this notice to you, and while we encourage you to evaluate all of your options, understand that the Marketplace is not your only option. We plan on continuing to offer a competitive, comprehensive health insurance package to our full-time employees.

If you have any questions please do not hesitate to contact Kris Mayborne or Bob Johnston.

Sincerely,

Kris Mayborne and Bob Johnston

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kris Mayborne or Bob Johnston. 815-544-1699

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
Carpenter Contractors of America		36-2477689
5. Employer address		6. Employer phone number
2340 Newburg Road		815.544.1699
7. City	8. State	9. ZIP code
Belvidere	IL	61008
10. Who can we contact about employee health coverage at this job?		
Kris Mayborne and Bob Johnston		
11. Phone number (if different from above)	12. Email address	
	KrisM@rdthiel.com and BobJ@rdthiel.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    All Full-time Salaried Non-Union employees of the Employer. Full-Time means an employee who is regularly scheduled to work a minimum of 20 hours per week and who is on the permanent payroll and personnel records as an Employee of the Employer. This also includes eligible Dependents of a covered employee who terminated coverage under the Plan because of the employee being enrolled in Medicare.
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    A Spouse, and dependent children to age 26.
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☑ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

R & D Thiel, Inc.
Belvidere, Illinois

Estimado Empleado,

A estas alturas, es muy probable que ha oído hablar de la Reforma de Salud, también conocida como el Affordable Care Act (La Ley de Asistencia Asequible) o Obamacare, que fue promulgada el 23 de marzo de 2010. Aunque ha tomado tiempo para muchos de los cambios producidos por ACA para llegar a luz, el 1 de enero de 2014 es la fecha en la cual empezarán algunos de los cambios más significativos que le podrían afectar a usted.

Puede haber oído muchas cosas confusas o contradictorias acerca de ACA, lo cual es típico de un conjunto de reglas tan complejas como estas. Queremos aprovechar esta oportunidad para explicárselo de la manera mas sencilla posible, para que pueda entender lo que viene en el futuro cercano y como nosotros, como su empleador, nos estamos preparando para los requisitos de ACA. Comenzando el 1 de enero de 2014, los ciudadanos estadounidenses y todas las personas trabajando legalmente en el país serán obligados a tener seguro médico que cumpla con ciertas normas mínimas. Si no obtiene un seguro médico que cumpla con estas normas mínimas, se le requerirá que pague una multa.

Siguiente se encuentran algunos puntos importantes que debe tener en cuenta con respecto a este requisito:

- A partir del 1 de octubre de 2013, el gobierno abrirá los intercambios de seguro médico – ahora llamados "Mercados"
- Los Mercados ofrecerán acceso a cobertura sin importar cualquier condición médica que pueda tener y ofrecerá cobertura para individuos tanto como para familias
- Por lo general, si usted es empleado a tiempo completo de Carpenter Contractors of America, no será elegible para la cobertura subsidiada del mercado, sin embargo, si su ingreso cae por debajo de cierto nivel, puede volver a ser elegible para un subsidio
- Si no es elegible para un subsidio, usted pagará el costo total de la cobertura del Mercado; no proporcionamos asistencia financiera para la cobertura del Mercado
- La cobertura de Carpenter Contractors of America está disponible en una base libre de impuestos, mientras que la cobertura del Mercado solo está disponible en una base después de impuestos

Usted recibirá un "Aviso del Mercado" con más detalles sobre los Mercados y como accederlos. Estamos legalmente obligados a proporcionarle este aviso y, mientras le recomendamos que evalue todas sus opciones, queremos que entiendan que el Mercado no es su única opción. Nuestra intención es que le continuemos ofreciendo un seguro médico comprensivo a nuestros empleados de tiempo completo.

Como siempre, si tiene alguna pregunta por favor no dude en ponerse en contacto con the Construction Industry Fund, Kris Mayborne or Bob Johnston .
Atentamente,

Carpenter Contractors of America, Inc.

R & D Thiel, Inc.
2340 Newburg Road
Belvidere, IL 61008
Phone: 815-544-1699
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Carpenter Contractors of America
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Nuevas opciones de cobertura en el mercado de seguros médicos y su cobertura médica

Formulario aprobado
OMB N.° 1210-0149
(caduca el 30-11-2013)

PARTE A: Información general

Cuando entren en vigencia las partes clave de la ley de salud en el 2014, habrá una nueva forma de adquirir seguros médicos: a través del mercado de seguros médicos. A fin de ayudarle mientras evalúa las opciones para usted y su familia, este aviso brinda información básica sobre el nuevo mercado y la cobertura médica basada en el empleo que brinda su empleador.

¿Qué es el mercado de seguros médicos?

El mercado está diseñado para ayudarle a encontrar un seguro médico que satisfaga sus necesidades y se ajuste a su presupuesto. El mercado ofrece opciones de compra en un solo sitio, para buscar y comparar opciones de seguros médicos privados. También es posible que sea elegible para un nuevo tipo de crédito tributario que reduce su prima mensual de inmediato. El periodo de inscripción para la cobertura de seguro médico a través del mercado comienza en octubre del 2013 para cobertura que comienza el 1.° de enero del 2014.

¿Puedo ahorrar dinero en las primas del seguro médico que ofrece el mercado?

Es posible que tenga la oportunidad de ahorrar dinero y reducir su prima mensual, pero solo si su empleador no ofrece cobertura médica u ofrece una cobertura médica que no cumple con determinadas normas. Los ahorros en la prima por la cual puede ser elegible dependen de los ingresos de su familia.

¿La cobertura médica del empleador afecta la elegibilidad para los ahorros en la prima a través del mercado?

Sí. Si su empleador brinda cobertura médica que cumple con determinadas normas, no será elegible para un crédito tributario a través del mercado y es posible que desee inscribirse en el plan de salud de su empleador. No obstante, es posible que sea elegible para un crédito tributario que reduce la prima mensual o para una reducción en la cuota de los costos si su empleador no brinda cobertura o no brinda cobertura que cumple con determinadas normas. Si el costo del plan de su empleador que le brindaría cobertura a usted (y no, a los demás miembros de la familia) supera el 9.5 % del ingreso anual de su familia, o si la cobertura médica que brinda su empleador no cumple con la norma de "valor mínimo" establecida por la Ley del Cuidado de Salud a Bajo Precio (Affordable Care Act o ACA, por sus siglas en inglés), es posible que sea elegible para un crédito tributario.[1]

Nota: Si adquiere un plan de salud a través del mercado en lugar de aceptar la cobertura médica que brinda su empleador, es posible que pierda las contribuciones (si las hay) que el empleador da para la cobertura médica que brinda. Además, las contribuciones del empleador (así como sus las contribuciones como empleado para la cobertura médica que brinda el empleador) a menudo se excluyen del ingreso sujeto a impuesto federal y estatal. Los pagos para la cobertura médica a través del mercado se realizan después de impuestos.

¿Cómo puedo obtener más información?

Para obtener más información sobre la cobertura que brinda el empleador, consulte el resumen de la descripción del Plan o comuníquese con Kris Mayborne or Bob Johnston, 815-544-1699.

El mercado puede ayudarlo a evaluar sus opciones de cobertura, incluida su elegibilidad para la cobertura a través del mercado y sus costos. Visite HealthCare.gov para obtener más información, incluida una solicitud en línea de cobertura de seguros médicos e información de contacto para un mercado de seguros médicos en su área.

[1] Un plan de salud patrocinado por el empleador cumple con la "norma de valor mínimo" si la participación del plan en los costos totales de beneficios permitidos cubiertos por el plan no es inferior al 60 por ciento de dichos costos.

PARTE B: Información sobre la cobertura médica que brinda su empleador

Esta sección incluye información sobre la cobertura médica que brinda su empleador. Si decide completar una solicitud de cobertura médica en el mercado, deberá brindar esta información. Esta información está enumerada de forma tal que coincida con la solicitud del mercado.

3. Nombre del empleador		4. Número de identificación del empleador (EIN, por sus siglas en inglés)
Carpenter Contractors of America		36-2477689
5. Dirección del empleador		6. Número de teléfono del empleador
2340 Newburg Road		815.544.1699
7. Ciudad	8. Estado	9. Código postal
Belvidere	IL	61008
10. ¿Con quién podemos comunicarnos en relación con la cobertura médica del empleado en este empleo?		
Kris Mayborne / Bob Johnston		
11. Número de teléfono (si difiere del que figura arriba)	12. Dirección de correo electrónico	
	KrisM@rdthiel.com / BobJ@rdthiel.com	

A continuación, encontrará información básica sobre la cobertura médica que brinda este empleador:

- Como su empleador, ofrecemos un plan de salud para los siguientes:
  - ☐ Todos los empleados.
  - ☑ Algunos empleados. Los empleados elegibles son los siguientes:
    Full-time Salaried Non-Union employees of the Employer. Full-Time means: employee who is regularly scheduled to work a min. of 20 hrs per week and is on the permanent payroll and personnel records as an Employee of the Employer. This also includes eligible Dependents of a covered employee who termed coverage under the Plan because of the employee being enrolled in Medicare.
- En cuanto a los dependientes:
  - ☑ Sí ofrecemos cobertura médica. Los dependientes elegibles son los siguientes:

    A Spouse and dependent children to age 26.

  - ☐ No ofrecemos cobertura médica.

☐ Si marca esta opción, esta cobertura médica cumple con la norma de valor mínimo. Asimismo, el costo de la cobertura se pretende que sea asequible para usted según los salarios de los empleados.

** Incluso si el objetivo de su empleador es brindarle cobertura asequible, es posible que sea elegible para obtener un descuento en la prima a través del mercado. El mercado utilizará el ingreso de su grupo familiar, junto con otros factores, para determinar si es elegible para recibir un descuento en la prima. Si, por ejemplo, sus salarios varían de una semana a la otra (tal vez es un empleado por hora o trabaja con comisiones), si fue contratado recientemente a mitad de año o si tiene otras pérdidas de ingreso, aún así es posible que reúna los requisitos para recibir un descuento en la prima.

Si decide adquirir cobertura a través del mercado, visite **HealthCare.gov** para obtener instrucciones sobre cómo hacerlo. Aquí encontrará la información del empleador que debe ingresar cuando visita **HealthCare.gov** para saber si puede obtener un crédito tributario para reducir las primas mensuales.

La siguiente información corresponde a la Herramienta de cobertura del empleador a través del mercado. Los empleadores no tienen la obligación de completar esta sección, pero hacerlo ayudará a garantizar que los empleados entienden sus opciones de cobertura.

13. Actualmente, ¿el empleado es elegible para la cobertura que brinda el empleador o lo será en los próximos 3 meses?

☐ Sí. (Continúe).
13a. Si el empleado no es elegible actualmente, incluso como resultado de un período de espera o de prueba, ¿cuándo será elegible para la cobertura?_____(dd/mm/aaaa). (Continúe).
☑ No. (DETÉNGASE y devuelva este formulario al empleado).

14. ¿El empleador brinda un plan de salud que cumple con la norma de valor mínimo*?
☐ Sí. (Pase a la pregunta 15). ☐ No. (DETÉNGASE y devuelva el formulario al empleado).

15. Para el plan de menor costo que cumple con la norma de valor mínimo* ofrecido **únicamente al empleado** (no incluya los planes familiares): Si el empleador dispone de programas de bienestar, incluya la prima que el empleado pagaría si recibiera el descuento máximo para los programas para dejar de fumar y no recibiera ningún otro descuento sobre la base de los programas de bienestar.
a. ¿Cuánto tendría que pagar el empleado en lo que respecta a las primas para este plan? $_____
b. ¿Con qué frecuencia? ☐ Semanalmente ☐ Cada 2 semanas ☐ Dos veces al mes ☐ Mensualmente ☐ Trimestralmente ☐ Anualmente

Si el año del plan está por finalizar y usted sabe que los planes de salud ofrecidos sufrirán una modificación, pase a la pregunta 16. Si no lo sabe, DETÉNGASE y devuelva el formulario al empleado.

16. ¿Qué modificación hará el empleador para el nuevo año del plan?
☐ El empleador no brindará cobertura médica.
☐ El empleador comenzará a brindar cobertura médica a los empleados o modificará la prima para el plan de menor costo disponible únicamente para el empleado, que cumple con la norma de valor mínimo*. (La prima debe reflejar el descuento para los programas de bienestar. Vea la pregunta 15).

a. ¿Cuánto tendrá que pagar el empleado en lo que respecta a las primas para dicho plan? $_____

b. ¿Con qué frecuencia? ☐ Semanalmente ☐ Cada 2 semanas ☐ Dos veces al mes ☐ Mensualmente ☐ Trimestralmente ☐ Anualmente

Fecha de la modificación (dd/mm/aaaa): _____

* Un plan de salud patrocinado por el empleador cumple con la "norma de valor mínimo" si la participación del plan en los costos totales de beneficios permitidos cubiertos por el plan no es inferior al 60 por ciento de dichos costos (Artículo 36B(c)(2)(C)(ii) del Código Tributario de 1986).