

ACTS of SOUTH CAROLINA

Dear Candidate,

Welcome to *ACTS* of South Carolina, Inc! We hope that you will find your assignment with us both challenging and rewarding. Please complete the following paper work and return them to this office as soon as possible (use the enclosed envelope or you may come to our office at any time on or before your start date). Check off the side box as you complete the documents.

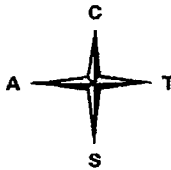
- | | |
|---|---|
| <input type="checkbox"/> Employee Information Sheet ¹ | <input type="checkbox"/> Supplier's I.D. Card Information |
| <input type="checkbox"/> Employment Attachment Form ¹ | <input type="checkbox"/> Direct Deposit Authorization Form ³ |
| <input type="checkbox"/> Employment Eligibility Verification (I-9) ² | <input type="checkbox"/> Healthcare Overview & Enrollment Sheets |
| <input type="checkbox"/> W-4 Form ¹ | <input type="checkbox"/> 401K Enrollment and Beneficiary Forms ⁴ |

If you have any questions regarding your paperwork, please contact me at (803) 652-8600 or toll free at (866) 232-2287. We need the above completed and returned to our office as soon as possible in order to ensure that your transition into our system is seamless.

Sincerely,

Marianne Scogin
Human Resources Manager

- ¹ – Sign and complete all applicable areas.
- ² – Complete Form I-9 and provide a photocopy of drivers' license and social security card (or other acceptable documentation listed on second page of the I-9).
- ³ – Complete and provide a voided or Xerox copy of your check.
- ⁴ – If interested, check out the investment options on www.mfs.com and complete this form or call Human Resources for a copy of the Summary Plan Description.



ACTS of South Carolina, Inc.

EMPLOYEE INFORMATION SHEET

Employee Name: _____

Local Telephone: _____

Local Address: _____

E-mail Address: _____

Permanent Telephone: _____

Permanent Address: _____

Employee S.S. No: _____

Date of Birth: _____

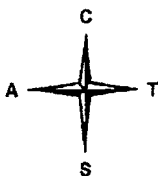
Whom To Notify In Case of Emergency:

Name: _____

Relationship: _____

Address: _____

Telephone No: _____



ACTS of South Carolina, Inc.
EMPLOYMENT ATTACHMENT FORM

Please provide the following information to be used for internal tracking and reporting to government agencies.

This information will be detached from any agreement/application and will in no way be used in consideration of employment.

ACTS-SC is an Equal Opportunity Employer and does not discriminate because of age, race, color, gender, religious beliefs, national origin, physical disability, or veteran status.

Employee Name: _____ Date: _____

S.S. No: _____

Date of Birth: _____

Sex: M _____ F _____

Race: Caucasian _____ Black _____

American Indian/Alaskan Native _____

Asian/Pacific Islander _____

Hispanic _____

Disability: Hearing Impaired _____ Mobility Impaired _____

Vision Impaired _____ Speech Impaired _____

Other _____

Veteran Status: Air Force _____ Navy _____ Marines _____

Vietnam Era _____ Other _____

Employee Signature: _____

ACTS of South Carolina, INC.

SUPPLIER'S ID CARD INFORMATION

Employee Name: _____

Please list below any medical condition or illness you currently have:

This is to certify that the above information is accurate to the best of my knowledge.

Employee Signature

Date

ACTS of South Carolina, Inc. PAYROLL DIRECT DEPOSIT AUTHORIZATION

I hereby authorize ACTS-SC, Inc. (ACTS) to directly deposit my pay in the bank account(s) listed below in the percentages specified. (If two or three accounts are designated, deposits are to be made in whole percentages of pay to total 100%.) *I have attached a voided personalized check (checking accounts) and/or ACH slip/bank certification (savings accounts) for each account specified below.* This authorization is to remain in force until ACTS has received written authorization from me of its termination or change. Also, I hereby grant ACTS the right to correct any such electronic funds transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

Name (Print) _____

Address (Street, City, Zip) _____

Signature _____ Date _____

BANK 1:

Name of Bank _____ Telephone _____

Bank Address: _____

Account Number:	□	□	□	□	□	□	□	□	□	□	□	□	□
ABA (Routing) Number:	□	□	□	□	□	□	□	□	□	□	□	□	□

Checking Savings Amount: \$ _____ or _____ % Payroll Expenses

BANK 2:

Name of Bank _____ Telephone _____

Bank Address: _____

Account Number:	□	□	□	□	□	□	□	□	□	□	□	□	□
ABA (Routing) Number:	□	□	□	□	□	□	□	□	□	□	□	□	□

Checking Savings Amount: \$ _____ or _____ % Payroll Expenses

BANK 3:

Name of Bank _____ Telephone _____

Bank Address: _____

Account Number:	□	□	□	□	□	□	□	□	□	□	□	□	□
ABA (Routing) Number:	□	□	□	□	□	□	□	□	□	□	□	□	□

Checking Savings Amount: \$ _____ or _____ % Payroll Expenses

Note: *This system imposes a two-week pre-note period. Your direct deposit will start with your third paycheck following processing of this authorization. During your pre-note period, we will mail your checks to your address indicated above.*