



# Anderson Columbia Co., Inc.

PO Box 1829  
Lake City, FL 32056  
Phone (386) 752-7585

"We are an Equal Employment Opportunity Employer"

Date: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Name: \_\_\_\_\_ Are you 18  Yes  
Years or Older  No  
Last First Middle

Present Address: \_\_\_\_\_  
Street City State Zip Code

Phone Number: \_\_\_\_\_ Referred By: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Phone Relationship

## EMPLOYMENT DESIRED

Position: \_\_\_\_\_ Date You Can Start: \_\_\_\_\_ Salary Desired: \_\_\_\_\_

Are you employed now? \_\_\_\_\_ If so, may we inquire of your present employer? \_\_\_\_\_

Have you ever worked for this company before? \_\_\_\_\_ Where? \_\_\_\_\_ When? \_\_\_\_\_

## EDUCATION

High School: \_\_\_\_\_ Diploma? \_\_\_\_\_

College: \_\_\_\_\_ Degree? \_\_\_\_\_

Vocational School: \_\_\_\_\_ Certificate? \_\_\_\_\_

Special Skills: \_\_\_\_\_

Have you ever been convicted of, pled guilty, nolo contendere, or no contest to a crime?  Yes  No

If yes, give details (date, place, offense(s), disposition, etc.) \_\_\_\_\_

Have you ever been charged with a crime and either been placed on court ordered probation, had adjudication with held, or entered a pretrial intervention program?  Yes  No

If yes, give details (date, place, offense(s), disposition, etc.) \_\_\_\_\_

### PREVIOUS EMPLOYMENT

List below all of your employers in the last 10 years beginning with your current or most recent employer.

Date Month/Year	Name Address/Phone	Position Job Duties	Salary	Reason for Leaving
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From: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_

To: \_\_\_\_\_

Did you work for any of these employers under a different name?  Yes  No

If yes, which employers and under what names? \_\_\_\_\_

Please explain any gaps in your employment history. \_\_\_\_\_

Have you received any written reprimands or disciplinary suspensions?  Yes  No  
If yes, please explain: \_\_\_\_\_

Have you ever been discharged or asked to resign?  Yes  No  
If yes, please explain: \_\_\_\_\_

**DRIVING RECORD**

Complete only if probability of driving a company vehicle or on company business exists for the position in which you are applying.

Do you have a valid driver's license?  Yes  No

What class of license do you possess? \_\_\_\_\_

Have you had a suspension or probation of your license within the last five years?  Yes  No

How many speeding or other moving violations have you received in the last three years? \_\_\_\_\_

List below all traffic violations on your record for the last five years and all motor vehicle accidents in which you were involved.

Date	Location	Description	Result

**REFERENCES**

List three people not related to you, whom you have known at least one year.

Name	Address	Business	Years Acquainted

# POST HIRING MEDICAL QUESTIONNAIRE

## *Welcome to Our Company!*

This questionnaire is necessary to provide your employer with information for the special Disability Trust Fund, to comply with the Americans with Disabilities Act and to protect your employer's rights under Chapter 440, Florida Statutes. Further, this information will allow your employer to evaluate and provide reasonable accommodation for any qualifying disability you may have.

**THIS FORM IS TO BE USED ONLY AFTER AN OFFER OF EMPLOYMENT HAS BEEN MADE TO YOU.**

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Social Security No: \_\_\_\_\_

Answer YES or NO to the following questions. If your answer is YES list the appropriate date of injury or treatment and give the details (doctor, hospital, city, state, etc.) in the space for details. Be sure to specify which numbered questions you are providing the details for in the right-hand column.

<b>DO YOU OR HAVE YOU EVER HAD:</b>		<b>DETAILS</b> ( <i>date of injury/treatment, etc.</i> ):
1. A back injury?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. A herniated intervertebral disc in your back?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Back surgery for removal of a disc?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. A neck injury?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. A herniated disc in your neck?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Neck surgery for removal of a disc?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. A knee injury? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Which knee?		_____
8. Surgery on either of your knees?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Which knee?		_____
9. Meniscectomy (knee surgery)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
10. Patellectomy (knee surgery)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
11. Ruptured cruciate ligament (knee)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
12. A shoulder injury?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Which shoulder?		_____
13. Surgery on either of your shoulders?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Which one?		_____
14. An elbow injury? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Which elbow?		_____
15. Surgery on either of your elbows? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Which elbow?		_____
16. Amputation of a foot, leg, arm, hand, finger, or toe?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
17. Epilepsy?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
18. Diabetes?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
19. Cardiac disease (heart trouble)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
20. Total loss of sight in one or both eyes or partial loss of corrected vision of more than 75% bilaterally?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**DO YOU OR HAVE YOU EVER HAD:**

**DETAILS** (date of injury/treatment, etc):

- 21. Residual disability from poliomyelitis?.....  Yes  No \_\_\_\_\_
- 22. Cerebral palsy?.....  Yes  No \_\_\_\_\_
- 23. Multiple sclerosis?.....  Yes  No \_\_\_\_\_
- 24. Parkinson's Disease?.....  Yes  No \_\_\_\_\_
- 25. Hemophilia?.....  Yes  No \_\_\_\_\_
- 26. Chronic osteomyelitis?.....  Yes  No \_\_\_\_\_
- 27. Surgical or spontaneous fusion of a major weight-bearing joint?.....  Yes  No \_\_\_\_\_
- 28. Hyperinsulinism?.....  Yes  No \_\_\_\_\_
- 29. Muscular dystrophy?.....  Yes  No \_\_\_\_\_
- 30. Thrombophlebitis?.....  Yes  No \_\_\_\_\_
- 31. Total deafness?.....  Yes  No \_\_\_\_\_
- 32. Have you ever been classified as mentally retarded?  Yes  No \_\_\_\_\_
- 33. Any permanent physical condition which constitutes a 20% impairment of a member or of the body as a whole?.....  Yes  No \_\_\_\_\_
- 34. Are you now or have you ever been obese (30% or more over normal body weight)?.....  Yes  No \_\_\_\_\_
- 35. Head injury?.....  Yes  No \_\_\_\_\_
- 36. Any injury, operation or any disability not covered By the above questions?.....  Yes  No \_\_\_\_\_
- 37. One or more back injuries or a disease process of the back resulting in disability over a total of 120 days?.....  Yes  No \_\_\_\_\_
- 38. Any permanent physical impairment which is a result of a prior industrial accident?.....  Yes  No \_\_\_\_\_  
Employer at the time of the accident? \_\_\_\_\_
- 39. Received compensation for disability from a source  Yes  No \_\_\_\_\_
- 40. Is there any question you do not understand?.....  Yes  No \_\_\_\_\_  
Which question? \_\_\_\_\_

*All statements and information given in this application are true, to the best of my knowledge and belief. I understand that any misstatements or omissions in the answers given by me in this questionnaire may result in a decision to rescind the conditional job offer, or to discharge me if discovered only after I have been hired.*

Name of Employee (Printed): \_\_\_\_\_

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

**TO BE COMPLETE BY EMPLOYER**

Reviewed by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

# Anderson Columbia Co., Inc. Drug-Free Workplace Policy

## STATEMENT OF POLICY:

Anderson Columbia Co., Inc. (the Company) recognizes the problem of substance abuse in our society, and has implemented a drug-free workplace policy that complies with the State of Florida, Department of Labor and Employment Security, Division of Workers' Compensation, Florida Statute 440.101 and 440.102. The purpose of this policy is to deter the use of drugs and alcohol in the workplace by establishing standards and procedures for drug testing of employees and job applicants. Substance abuse testing at the Company includes pre-employment, random, post-accident, and reasonable suspicion. A positive confirmed drug test will result in disciplinary action, including termination, for current employees and a refusal to hire job applicants. Additionally, a positive confirmed drug test may impact an injured employee's workers' compensation benefits.

## CONFIDENTIALITY:

All information, reports, discussions with testing labs, and drug screening results, written or otherwise, received by the Company are confidential communications. However, such information may be obtained in discovery, or used in a legal proceeding pursuant to a court order.

## TESTING & PRESCRIPTION / NON-PRESCRIPTION DRUG USE:

The Company may test for any or all the following drugs at the cut-off levels established by State of Florida Statutes or HRS as appropriate. Employees and job applicants are reminded to confidentially report the use of prescription or non-prescription drug use to the drug testing entity prior to and after the administration of the drug test. It is the employee's responsibility to inform their immediate supervisor when they are taking a prescribed drug or medication that can or will interfere with one's work. Listed in the brackets [ ] are some of the more common prescribed or non-prescribed drugs that could affect the drug testing results.

Alcohol [All liquid medications containing ethyl alcohol (ethanol). As an example, Vicks Nyquil is 25% (50 proof) ethyl alcohol, Comtrex is 20% (40 proof), Contac Severe Cold Formula Night Strength is 25% (50 proof) and Listerine is 26% (54 proof)]. Cutoff level is 0.05g/dl%.

Amphetamines [Obetrol, Biphphetamine, Desoxyn, Dexedrine, Didrex]. Cutoff level of 500 ng/ml.

Cannabinoids [Marinol (Dronabinol, THC)]. Cutoff level of 15 ng/ml.

Cocaine [Cocaine HCl topical solution (Roxanne)]. Cutoff level of 150 ng/ml.

Phencyclidine Not legal by prescription. Cutoff level of 25 ng/ml.

Methaqualone Not legal by prescription. Cutoff level of 150 ng/ml.

Opiates [Paregoric, Parepectolin, Donnagel PG, Morphine, Tylenol with Codeine, Empirin with Codeine, APAP with Codeine, Aspirin with Codeine, Robitussin AC, Guiatuss AC, Novahistine DH, Novahistine Expectorant, Dilaudid (Hydromorphone), M-S Contin and Roxanol (morphine sulfate), Percodan, Vicodin, etc.] Cutoff level of 300 ng/ml.

Barbiturates [Phenobarbital, Tuinal, Amytal, Nembutal, Seconal, Lotusate, Fiorinal, Fioricet, Esgic, Butisol, Mebaral, Butabartital, Butabital, Phrenilin, Triad, etc.] Cutoff level of 150 ng/ml.

Benzodiazepines [Ativan, Azene, Clonopin, Dalmane, Diazepam, Librium, Zanax, Serax, Traxene, Valium, Verstran, Halcion, Paxipam, Restoril, Centrax.] Cutoff level of 150 ng/ml.

Methadone [Dolophine, Methadose.] Cutoff level of 150 ng/ml.

Propoxyphene [Darvocet, Darvon N, Dolene, etc.] Cutoff level of 150 ng/ml.

The individual being tested shall be provided an opportunity to set forth on the urine custody and control form information concerning prescription or non-prescription medications taken or administered or any other relevant medical information.

**FAILURE TO SUBMIT:**

Failure to submit to drug screen testing is insubordination and is grounds for suspension without pay or discharge from employment. Job applicants who fail to report for drug testing will not be considered for employment with the Company. If an injured employee involved in an accident refuses to submit to a test for alcohol or other drugs, he forfeits his eligibility workers' compensation benefits.

**EMPLOYEE ASSISTANCE / REHABILITATION PROGRAMS:**

Listed below are a few of the entities offering Employee Assistance Programs (EAP) or drug / alcohol rehabilitation programs. The Company encourages employees to contact these organizations, or similar organizations, to seek help in addressing abuse issues.

- Alcoholics Anonymous, (386) 758-4282, alcohol abuse
- Praxis Network, Inc., (386) 752-9937, drug rehabilitation
- Crossroads, (386) 752-6003, drug rehabilitation
- Another Way, (386) 717-2702, domestic violence
- Catholic Charities, (386) 754-4283, counseling, emergency assistance

**CONTESTING RESULTS:**

An employee who receives a positive confirmed drug test may contest the results to the Medical Review Officer (MRO) within five (5) working days after receiving written notification of the test result. Personnel can provide the name and telephone number of the MRO. If the MRO still feels the positive test is valid, the employee or job applicant may contest the results pursuant to the rules established by the Florida Agency for Healthcare Administration. Their toll-free number is 888-419-3456.

**ADMINISTRATIVE / CIVIL ACTION:**

Job applicants and employees have the responsibility of notifying the drug testing laboratory of any administrative or civil actions brought pursuant to Florida Statutes, Chapter 440.101 or 440.102. The laboratory will maintain the sample until the case or administrative appeal is settled.

**MEDICAL REVIEW OFFICER CONSULTATION:**

Job applicants and employees may consult the Medical Review Officer (MRO) for technical information regarding prescriptions and non-prescriptions medications. Personnel can provide the name and telephone number of the MRO.

## Drug-Free Workplace Acknowledgement

I do hereby certify that I have received and read the Anderson Columbia Co., Inc. Drug-Free Workplace Policy regarding substance abuse, and have had the entire policy explained to me. I understand that complying with this policy is a condition of my employment.

I understand that if conditions as specified in the policy indicate it is necessary, I will submit to substance abuse screening. I also understand that failure to comply with a request for drug screening or a positive result may lead to termination of employment.

I agree to submit to a drug screen as part of my application for employment. I understand that either refusal to submit to the drug screen, or failure to qualify according to the minimum standards established by Anderson Columbia Co., Inc. for this screen, may disqualify me from further consideration for employment. I will be tested for drugs from one or all of the following categories: amphetamines, cannabinoids, cocaine, phencyclidine, methaqualone, opiates, barbiturates, benzodiazepines, methadone, propoxyphene, and alcohol.

I further understand that upon commencement of employment with Anderson Columbia Co., Inc., I may be required to submit to drug screening per company policy. I understand that refusal to take a required drug screen or failure to meet the minimum standards set for the screen, may result in immediate suspension or discharge.

If I am injured in the course and scope of my employment and test positive, I forfeit my eligibility for medical and indemnity benefits under the Workers' Compensation Act upon exhaustion of the remedies provided in the Florida Statute 440.102(5).

I have read in full and understand the above statements and conditions of employment as specified by company policy.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Drivers License Number

\_\_\_\_\_  
State

## Release Form

In connection with my application for employment (including contract for services) with Anderson Columbia Co., Inc., I understand that an investigative consumer report is being requested. This report will include information as to my character, work habits, performance and experience, along with reasons for termination of past employment from previous employers. Further, I understand that Anderson Columbia Co., Inc., will be requesting information concerning my driving record and/or information from various federal, state and other agencies which maintain records concerning traffic offenses, accidents, etc., as well as information concerning (1) previous driving record requests made by others from such state agencies; (2) state provided driving records; (3) claims involving me in the files of insurance companies. I also understand that quarterly MVR's will be run on Drivers and I am not allowed to have more than seven points on my license at any time. If so, this will lead to immediate dismissal. I also understand that a criminal background report will be requested.

I hereby consent to collection by Anderson Columbia Co., Inc., of blood, urine or saliva samples from me, and for Anderson Columbia Co., Inc., to conduct other necessary medical tests for substances. Further, I hereby give my consent for the release of the test results and other relevant medical information to authorized Anderson Columbia Co., Inc., representatives for review.

I certify that I have not take, within the past 72 hours, any over-the-counts drugs or prescription drugs other than those listed below:

Over-The-Counter-Drugs  
(i.e. aspirin, Contact, Nyquil)

Prescription Drugs

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize, without reservations, any party or agency contacted by Anderson Columbia Co., Inc., to furnish the above mentioned information. Photocopies of this form are acceptable.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's Name (Please Print)

**Anderson Columbia Co., Inc. is a Drug-Free Workplace**

## 90 Day Probation Notice

I understand that after accepting a position with the company, the first 90 days of employment will be considered a probationary period, where I may be terminated without advance notice or cause.

Furthermore, I acknowledge that I have received the company's Employee Manual and Safety Manual and agree to comply with them as a condition of continued employment.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

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### Authority to Release Check to a Third Party

I, \_\_\_\_\_, give the company permission to allow

\_\_\_\_\_ to pick up my paycheck.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

# Form W-4 (2011)

**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 2011 expires February 16, 2012. 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 cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

**Basic instructions.** If you are not 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 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. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b>	Enter "1" if: { • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } . . . . .	<b>B</b> _____
<b>C</b>	Enter "1" for your <b>spouse</b> . 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.) . . . . .	<b>C</b> _____
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____
<b>F</b>	Enter "1" if you have at least \$1,900 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .	<b>F</b> _____
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" <b>additional</b> if you have six or more eligible children . . . . .	<b>G</b> _____
<b>H</b>	Add lines A through G and enter total here. ( <b>Note.</b> This may be different from the number of exemptions you claim on your tax return.) ▶ For accuracy, <b>complete all worksheets that apply.</b> { • If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2. • If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld. • If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.	<b>H</b> _____

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

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <b>2011</b>	
▶ 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.					
1 Type or print your first name and middle initial.		Last name		2 Your social security number	
Home address (number and street or rural route)			3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> 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. ▶ <input type="checkbox"/>		
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 2011, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> 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 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions . . . . .	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$11,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,500 \text{ if head of household} \\ \$5,800 \text{ if single or married filing separately} \end{array} \right\}$ . . . . .	2	\$ _____
3	<b>Subtract</b> line 2 from line 1. If zero or less, enter "-0-" . . . . .	3	\$ _____
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919) . . . . .	4	\$ _____
5	<b>Add</b> lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet</i> in Pub. 919.) . . . . .	5	\$ _____
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest) . . . . .	6	\$ _____
7	<b>Subtract</b> line 6 from line 5. If zero or less, enter "-0-" . . . . .	7	\$ _____
8	<b>Divide</b> the amount on line 7 by \$3,700 and enter the result here. Drop any fraction . . . . .	8	_____
9	Enter the number from the <b>Personal Allowances Worksheet</b> , line H, page 1 . . . . .	9	_____
10	<b>Add</b> lines 8 and 9 and enter the total here. If you plan to use the <b>Two-Earners/Multiple Jobs Worksheet</b> , also enter this total on line 1 below. Otherwise, <b>stop here</b> 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 <b>Deductions and Adjustments Worksheet</b> ) . . . . .	1	_____
2	Find the number in <b>Table 1</b> below that applies to the <b>LOWEST</b> paying job and enter it here. <b>However</b> , 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 <b>more than or equal to</b> 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. <b>Do not</b> 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	<b>Subtract</b> line 5 from line 4 . . . . .	6	_____
7	Find the amount in <b>Table 2</b> below that applies to the <b>HIGHEST</b> paying job and enter it here . . . . .	7	\$ _____
8	<b>Multiply</b> 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 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. 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**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$5,000 -	0	\$0 - \$8,000 -	0	\$0 - \$65,000	\$560	\$0 - \$35,000	\$560
5,001 - 12,000 -	1	8,001 - 15,000 -	1	65,001 - 125,000	930	35,001 - 90,000	930
12,001 - 22,000 -	2	15,001 - 25,000 -	2	125,001 - 185,000	1,040	90,001 - 165,000	1,040
22,001 - 25,000 -	3	25,001 - 30,000 -	3	185,001 - 335,000	1,220	165,001 - 370,000	1,220
25,001 - 30,000 -	4	30,001 - 40,000 -	4	335,001 and over	1,300	370,001 and over	1,300
30,001 - 40,000 -	5	40,001 - 50,000 -	5				
40,001 - 48,000 -	6	50,001 - 65,000 -	6				
48,001 - 55,000 -	7	65,001 - 80,000 -	7				
55,001 - 65,000 -	8	80,001 - 95,000 -	8				
65,001 - 72,000 -	9	95,001 - 120,000 -	9				
72,001 - 85,000 -	10	120,001 and over	10				
85,001 - 97,000 -	11						
97,001 - 110,000 -	12						
110,001 - 120,000 -	13						
120,001 - 135,000 -	14						
135,001 and over	15						

**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.

## Instructions

Read all instructions carefully before completing this form.

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

### What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

### When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

### Filling Out Form I-9

#### Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

**Noncitizen nationals of the United States** are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

**Employers should note** the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present

in **Section 2** evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

#### Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

#### Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

#### Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers (Form M-274)*. You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

### Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B; and:
  1. Examine any document that reflects the employee is authorized to work in the United States (see List A or C);
  2. Record the document title, document number, and expiration date (if any) in Block C; and
  3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3**.

### What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

### USCIS Forms and Information

To order USCIS forms, you can download them from our website at [www.uscis.gov/forms](http://www.uscis.gov/forms) or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at [www.uscis.gov](http://www.uscis.gov) or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at [www.uscis.gov/e-verify](http://www.uscis.gov/e-verify) or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at [www.uscis.gov](http://www.uscis.gov).

### Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

### Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

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### Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

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

**Form I-9, Employment Eligibility Verification**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification** *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) \_\_\_\_\_
- An alien authorized to work (Alien # or Admission #) \_\_\_\_\_ until (expiration date, if applicable - month/day/year)

Employee's Signature \_\_\_\_\_ Date (month/day/year) \_\_\_\_\_

**Preparer and/or Translator Certification** *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

**Section 2. Employer Review and Verification** *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title: _____		_____	AND	_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

**CERTIFICATION:** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name Tonya Wasson	Title HR Manager
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) Anderson Columbia PO Box 1829 Lake City, FL 32056		Date (month/day/year)

**Section 3. Updating and Reverification** *(To be completed and signed by employer.)*

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____

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	Date (month/day/year)
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## LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

### LIST A

Documents that Establish Both  
Identity and Employment  
Authorization

### LIST B

Documents that Establish  
Identity

### LIST C

Documents that Establish  
Employment Authorization

OR

AND

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. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	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)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
	4. Voter's registration card	
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the 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	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
	6. Military dependent's ID card	
	7. U.S. Coast Guard Merchant Mariner Card	5. Native American tribal document
	8. Native American tribal document	6. U.S. Citizen ID Card (Form I-197)
	9. Driver's license issued by a Canadian government authority	
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	<b>For persons under age 18 who are unable to present a document listed above:</b>	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

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

Name: \_\_\_\_\_ Position for which you are applying: \_\_\_\_\_

**VETERANS' PREFERENCE INFORMATION**

Completion of the Veterans' preference section below is made on a voluntary basis and kept confidential in accordance with the Americans with Disabilities Act. Listed below are the four Veterans' Preference categories.

- 1. A veteran with a service-connected disability who is eligible for or receiving compensation, disability retirement, or pension under public laws administered by the US Department of Veterans' Affairs and the Department of Defense, or
- 2. The spouse of a veteran who cannot qualify for employment because of a total and permanent disability, or the spouse of a veteran missing in action, captured, or forcibly detained by a foreign power, or
- 3. A veteran of any war who has served on active duty for one day or more during a wartime period, excluding active duty for training, and who was discharged under honorable conditions from the Armed Forces of the United States of America, or
- 4. The un-remarried widow or widower of a veteran who died of a service-connected disability.

A DD214 or comparable document, which serves as a certificate of release or discharge, must be furnished at the time of application. In addition, applicants claiming categories 1,2, or 4 above must furnish supporting documentation in accordance with the provision of Rule 55A7.013, FAC. Wartime periods are defined in 1.01.FS. Veterans' Preference shall expire after an eligible person has been employed by the state or an agency of a political subdivision of the state. Under Florida law, preference in appointment shall be given by the state to those persons in categories 1 and 2 and then those in categories 3 and 4. Veterans' Preference is only available to Florida residents.

If an applicant claiming Veterans' Preference for a vacant position is not selected, he/she may file a complaint with the Florida Department of Veterans' Affairs, PO Box 31003, St Petersburg, Florida 33731-8903. A complaint must be filed within 21 days of the applicant receiving notice of the hiring decision made by the employing agency or within 3 months of the date of the application is filed with the employer if no notice is given.

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**VETERANS' PREFERENCE CLAIM**

If eligible, which Veterans' Preference category are you claiming? \_\_\_\_\_  
(Please indicate number from the Veterans' Preference section above.)

Have you ever been employed by any governmental entity within the state of Florida?  Yes  No

Are you a resident of the state of Florida?  Yes  No

NOTE: If you are claiming Veterans' Preference you must meet the criteria and substantiate your claim by furnishing a DD 214 (Certificate of Release or Discharge from Active Duty) and any other required supporting documentation with your application.

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**EEO SURVEY**

Although the following information is not mandatory, it is requested to aid Anderson Columbia Co., Inc. in its commitment to Equal Employment Opportunity and Affirmation Action. Refusal to answer will not result in adverse treatment of any applicant. Applicants who believe they have been discriminated against may file a complaint with the Florida Commission of Human Relations, Building F, Suite 240, 325 John Knox Road, Tallahassee, Florida 32303.

Position for which you are applying: \_\_\_\_\_

Sex:  Male  Female Date of birth: \_\_\_\_\_

Race: (Check only one)

- White  Black  Asian  Hawaiian/Pacific Islander  Hispanic  
 Native American  Two or More Races

# Initial 401(k) Notification to Employees

## ELIGIBILITY

Employees are eligible to participate in the 401(k) plan after completing six months of service, and must also be at least 18 years old.

## ENROLLMENT

Employees will automatically be enrolled in the 401(k) plan on the first day of the month after completing 6 months of employment. If an employee does not want to be enrolled in the plan, he/she must complete the attached election form and return it to Personnel in the Lake City office.

## CONTRIBUTIONS

Each pay period Anderson Columbia will deduct 4% of the pre-tax salary to contribute to the 401(k) plan. To increase or decrease the percentage deducted, complete the attached election form and return it to the Lake City office.

## INVESTMENTS

The plan offers a variety of investment options, and is flexible in design that provides the employee with the opportunity to determine how he/she wants contributions invested. Simply visit Mass Mutual at their website, [www.massmutual.com](http://www.massmutual.com), or call 1-800-743-5274. If an employee does not customize investment allocations, all contributions will be invested in Mass Mutual Conservative Journey.

Employees may also contact Saunders Financial Advisory Group, the investment advisors on the Anderson Columbia 401(k) plan. They are the resource to discuss all the investment options available in the current 401(k) plan. Saunders Group will help you with investment selections based on your age, risk tolerance and financial goals. You may contact them via toll free telephone at 800-817-1660 or via email at [ADM@SaundersGroup.com](mailto:ADM@SaundersGroup.com)

## WITHDRAWALS

401(k) plans are long term investments designed to help employees prepare for retirement. As a result, withdrawals may be made from 401(k) plans only upon one of the following qualifying events:

- Normal Retirement
- Disability
- Age 59 ½
- Death
- Hardship
- Separation of Service

# Anderson Columbia Co., Inc. 401(k) Salary Reduction Plan

## Acknowledgement Form

By signing this acknowledgement, I am indicating that I have received the following information regarding the Anderson Columbia 401(k) Plan:

- Notification of the availability of the 401(k) Plan
- Description of plan features
- Description of available investment options
- Enrollment Election Form

I further indicate my understanding that if I make no further elections with respect to the plan, 4% of my salary will be withheld and invested into the plan. The investment of this amount is described in the Employee Notice.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Social Security Number

## Enrollment Election Form

Please make the appropriate selection:

- Yes – I want to participate in the Anderson Columbia 401(k) Plan. I authorize my employer to automatically deduct \_\_\_\_\_% of my salary, per payroll period, on a pre-tax basis for the plan.

I understand that if I do not indicate a percentage in the space above, my employer will automatically deduct 4% of my salary, per payroll period, for the plan.

I am aware that I have the ability to customize my investment allocations or transfer between investment options by logging into [www.massmutual.com](http://www.massmutual.com) or by calling Mass Mutual at 800-743-5274. I realize that if I do not customize my investment allocations, my contributions will be invested in the Mass Mutual Conservative Journey.

- No – I decline to participate in the Anderson Columbia 401(k) plan at this time. I understand that if my circumstances change, I may elect to enroll in the plan during open enrollment.

*Please Note: If any information is missing, your request will not be processed.*

\_\_\_\_\_  
Employee Name (Please Print)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## Employment Application Certification

I hereby certify that all of the facts and information listed on this employment application are true and complete. I understand that any false, incomplete or misleading information given by me on this application is sufficient cause for rejection of this application. I also understand and agree that any such false, incomplete, or misleading information discovered on this application at any time after I am employed may result in my dismissal.

I hereby authorize the company to investigate all statements contained in this application, to interview the references and previous employers listed in this application, and to obtain a report from a consumer reporting agency to be used for employment purposes in accordance with the Fair Credit Reporting Act. I authorize the references and previous employers listed to give the company all facts, opinions and evaluations concerning my previous employment and any other information they may have, personal or otherwise, and release all such parties from any liability which may allegedly arise from furnishing such information to the company, including but not limited to, any liability for defamation or invasion of privacy.

If I am offered employment, I understand that such an offer will be conditioned upon satisfactory results of a background investigation and/or company medical examination or inquiry, including a drug screen test. If then employed, I understand that I will be required to serve a 90 day probationary period. I further understand that my employment and compensation can be terminated, with or without cause or notice, at any time, regardless of the successful completion of my probationary period, at the option of either the company or myself. I understand that no supervisor or other representative of the company other than the president of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing.

I understand that there is the possibility that construction work locations may require travel to locations outside of my area of residence.

I understand and voluntarily agree as a condition of employment or my continued employment, that I may be requested by the company to submit to a urinalysis or other drug screen test and that my failure to take such tests when requested to do so or unsatisfactory test results will disqualify me from consideration for employment, or if I am employed, may result in my immediate dismissal.

I certify that I have read and agree to the above.

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Applicant Signature

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Date