Welcome to the Sports Page Grill

Please complete the New Hire Paperwork and return as soon as possible

***you will not be able to work until the paperwork is finished and turned in

Please let the Manager know if you have any questions

The policies and procedures set forth in this employee handbook are not a binding employment contract. This handbook provides general guidelines only and none of its provisions are binding or contractual in nature. Understand that all employment with The Sports Page Grill is "at-will," meaning that employment may be terminated at any time, with or without notice, for any reason or no reason, by either The Sports Page Grill or the employee.

This handbook is not a contract guaranteeing employment for any specific period of time. While we certainly hope that your employment relationship with The Sports Page Grill will be successful and long term, either The Sports Page Grill or the employee may end this relationship at any time, with or without cause, notice or reason. No manager, supervisor, or representative has the authority to enter into any agreements guaranteeing you employment for any specific period of time. Further, any employment agreement entered into by The Sports Page Grill will not be enforceable unless it is in writing.

This handbook replaces and supersedes all earlier personal, policies and guidelines.

Employee Signature:_____

Date:_____

Sports Page
GRILL
EST. 1999

I hereby authorize Sports Page Grill to initiate credit entries and, if necessary, debit correction and adjustment entries to my account at the financial institution listed below. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the U.S. laws and regulations.

Bank/Financial Institution Name_____

Branch _____

Address_____

City, State, Zip _____

Routing Number_____

Account Number_____

Account Type: Checking Savings

This authorization is to remain in full force and effect until Sports Page Grill has received written notification from me of its termination in such a time and manner as to afford Sports Page Grill and your bank or financial institution a reasonable time to act upon it.

Name_____

Date_____

Signature _____

Please attach a voided check or financial institution account verification letter to this form.

We ask that all of our servers and bartenders be I-PACT certified while working at the Sports Page.

Steps to become certified:

- Go to www.i-pact.com
- Go to (New User) and create an account.
- In the employer section type in “Sports Page Bar and Grill” and the retailer type section select “Restaurant”.
- Complete the short course of videos and questions provided.
- After the course is done complete and PASS the short quiz. (If you do not pass it the first time you can go right back in and re-take it.)
- Print off the certification provided at the end of the course and bring it into a manager on duty to put in your file. If you do not have access to a printer; we can print it off here at work.

Sports Page GRILL
INDIANOLA

ATTENDANCE POLICY: EFFECTIVE 10/8/2017

Tardies: You will be counted as tardy for your shift if you show up more than 5 minutes after your scheduled start time unless prior arrangements have been made with the manager on duty

Note: This does not enable you to always show up 5 minutes late. If you are deemed to be habitually between 1-5 minutes late you will lose this grace period.

1st Offense: Verbal Warning
2nd Offense: Written Warning
3rd Offense: Termination

Absences: If you're unable to attend work on a day you are scheduled due to illness or otherwise, you are required to find someone to work your shift. If you are unable to find a cover for your shift, and you are too ill to come to work, you must provide ***AT LEAST THREE HOURS NOTICE*** to the manager on duty that you will not be able to make it in. You must provide a note from your doctor excusing you from work. If you don't have a doctors not OR if you don't provide at least three hours notice it will be counted as an unexcused absence.

1st Offense: Written Warning
2nd Offense: Termination

VERBAL WARNING: The manager will notify you of the infraction and that is has been recorded. For six months from the date of the infraction any other infraction that would otherwise result in a verbal will now result in a written warning

WRITTEN WARNING: The manager will notify you of the infraction, and have you sign a written document that shows you have been notified. For six months from the date of this infraction any other infraction which would otherwise result in a written warning will now result in termination of employment.

WORK OPPORTUNITY TAX CREDIT

New Hire Steps

- Please call 1-800-237-3279 (open 24 hours a day, 7 days a week). Provide them with the following dates
  - Job Offer Date _____
  - Hire Date _____
  - Start Date _____
- Enter the Company Code: 187607
- Answer the questions using your voice or the buttons on your phone
- Depending on your responses you may be transferred to a live person who may ask for the following
  - Company Name: The SP Grill, Inc.
  - Location or Store Number: 001
- You may be asked to electronically sign the form for the WOTC program of the phone.

Once completed you will be provided with a confirmation number. Please write it down on this sheet and turn in with new hire paperwork.

CONFIRMATION NUMBER: _____

NONHARRASSMENT POLICY

The SP Grill, Inc. strictly prohibits sexual and other forms of harassment. We will not tolerate harassment by, or toward you based on sex, race, or any other grounds.

Regarding sexual harassment, The SP Grill, Inc. forbids unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. These are considered particularly improper when the behavior:

- Either explicitly or implicitly becomes a term or condition of employment;
- Forms the basis for an employment decision affecting you; or
- Substantially interferes with your work performance or creates an intimidating, hostile or offensive work environment.

The following are some examples of unacceptable behavior;

- Written or verbal communication of epithets, slurs, derogatory jokes and comment, foul language, unwanted sexual advances, invitations or comments;
- Display of derogatory and/or sexually oriented posters, photographs, cartoons, drawings or gestures;
- Physical conduct such as assault, unwanted touching, blocking or normal movement, or interference with work because of sex, race, or any other reason; Threats and demands related to sexual requests to gain employment or continued employment, to avoid some other loss, or to receive employment benefits, and
- Retaliation for having reported, or threatened to report, harassment.

NONDISRIMINATION AND NONHARASSMENT COMPLAINT PROCEDURES

If you feel you have been discriminated against or harassed based on your sex or any other grounds, you should report the incident to your manger, or the owner.

You may take this step without fear of retaliation. Your complaint will be held in confidence to the maximum extent possible, and it will be investigated promptly, thoroughly, and objectively. If SP Grill, Inc.'s investigation reveals discrimination or harassment has occurred, the employee who committed these abuses will be disciplined and could be discharged.

_____ _____

Name (Please Print) Signature

_____

Date

Conditional Employee or Food Employee Reporting Agreement

The Purpose of this agreement is to inform conditional or food employees of their responsibility to notify the person in charge when they experience any of the conditions listed so that the person in charge can take appropriate steps to preclude the transmission of foodborne illness.

I AGREE TO REPORT TO THE PERSON IN CHAGRGE:

Any onset of the following symptoms, while either at work or outside of work, including the date of onset:

1. Diarrhea
2. Vomiting
3. Jaundice
4. Sore Throat with fever
5. Infected cuts or wounds, or lesions containing pus on the hand, wrist, an exposed body part, or other body part and the cuts, wounds, or lesions are not properly covered (such as boils and infected wounds, however small)

Future Medical Diagnosis

Whenever diagnosed as being ill with Norovirus, typhoid fever (salmonella Typhi), shigellosis (Shigella spp. Infection), **Escherichia coli O157:H7 or other EHEC/STEC infection or hepatitis A (hepatitis A virus infection)**

Future Exposure to Foodboure Pathogens:

1. Exposure to or suspicion of causing any confirmed disease outbreak of Norovirus, typhoid fever, shigellosis, E. Coli O157:H7 or other EHEC/STEC infection, or hepatitis A.

2. A household member diagnosed with Norovirus, typhoid fever, shigellosis, illness due to EHEC/STEC infection, or hepatitis A.

3. A household member attending or working in a setting experiencing a confirmed disease outbreak of Norovirus, typhoid fever, shigellosis, E. Coli O157:H7 or other EHEC/STEC infection, or hepatitis A.

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the Food Code and this agreement to comply with:

1. Reporting requirements specified above involving symptoms, diagnoses, and exposure specified;
2. Work restrictions or exclusions that are imposed upon me; and
3. Good hygienic practices

Conditional Employee Name (please print) _____
Signature of Conditional Employee _____Date_____
Food Employee Name (please print) _____
Signature of Food Employee _____Date_____
Signature of Permit Holder or Rep. _____Date_____

Equal Employment Advisory Council
Revised Alternative "Suggested Employee Questionnaire"
for Self-Identification of Race/Ethnicity

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM

Anti-Discrimination Notice. It is an unlawful employment practice for an employer to fail or refuse to hire or discharge any individual, or otherwise to discriminate against any individual with respect to that individual's terms and conditions of employment, because of such individual's race, color, religion, sex, or national origin.

This employer is subject to certain nondiscrimination and affirmative action recordkeeping and reporting requirements which require the employer to invite employees to voluntarily self-identify their race/ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable federal laws, executive orders, and regulations, including those which require the information to be summarized and reported to the Federal Government for civil rights enforcement purposes.

If you choose not to self-identify your race/ethnicity at this time, the federal government requires this employer to determine this information by visual survey and/or other available information.

For civil rights monitoring and enforcement purposes only, all race/ethnicity information will be collected and reported in the seven categories identified below. The definitions for each category have been established by the federal government. If you choose to voluntarily self-identify, you may mark only one of the boxes presented below.

INVITATION TO SELF-IDENTIFY

PLEASE ANSWER THE FOLLOWING QUESTION

What is your race/ethnicity? Please mark the **one box** that describes the race/ethnicity category with which you primarily identify.

- ◯ **Hispanic or Latino**: a person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- ◯ **White**: a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- ◯ **Black or African American**: a person having origins in any of the black racial groups of Africa.
- ◯ **Asian**: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ◯ **Native Hawaiian or Other Pacific Islander**: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ◯ **American Indian or Alaska Native**: a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ◯ **Two or More Races**: a person who primarily identifies with two or more of the above race/ethnicity categories.

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

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. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

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

Employee's Withholding Allowance Certificate

► **Whether you're 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

2019

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 filing separately, check "Married, but withhold at higher Single rate."	
	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 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, 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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 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

Centralized Employee Registry Reporting Form
To be completed by the employer within 15 days of hire. Please print or type.

Submit this information online at www.iowachildsupport.gov
or fax to 1-800-759-5881 or mail to Centralized Employee Registry, PO Box 10322, Des Moines IA 50306-0322.

EMPLOYER INFORMATION

FEIN Required ___ ___ - ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___
FEIN plus last 3-digit suffix used when filing Iowa withholding tax.

Employer Phone Number _____

Name _____

Address _____

_____

City _____ State _____ ZIP _____

Questions: For A through D below, please see instructions on back for definitions and clarification.

A. Is dependent health care coverage available? ..... Yes ☐ No ☐

B. Approximate date this employee qualifies for coverage (MMDDYY) ..... _____-_____-_____

C. Employee start date (MMDDYY) ..... _____-_____-_____

D. Address where income withholding and garnishment orders should be sent, if different from address above.

Address _____

City _____ State ___ ____ ZIP _____

EMPLOYEE INFORMATION

Employee Date of Birth _____-_____-_____ Employee Social Security Number ___ ___ ___-___ ___-___ ___ ___

Last Name _____ First name _____ Middle Initial _____

Address _____

City _____ State ___ ____ ZIP _____

DETACH HERE

Iowa Department of REVENUE

2019 IA W-4
Employee Withholding Allowance Certificate
https://tax.iowa.gov
To be completed by the employee

Marital Status: Single (or married but legally separated) ☐ Married ☐

Print your full name _____ Social Security Number _____

Home Address _____ City _____ State _____ ZIP _____

EXEMPTION FROM WITHHOLDING

If you do not expect to owe any Iowa income tax and have a right to a full refund of ALL income tax withheld, enter "EXEMPT" here _____
and the year effective here _____ . Nonresidents may not claim this exemption.
Check this box if you are claiming an exemption from Iowa tax based on the Military Spouses Residency Relief Act of 2009 ..... ☐
If claiming the military spouse exemption, enter your state of domicile here ..... _____

IF YOU ARE NOT EXEMPT, COMPLETE THE FOLLOWING:

1. Personal allowances ..... 1. _____
2. Allowances for dependents ..... 2. _____
3. Allowances for itemized deductions ..... 3. _____
4. Allowances for adjustments to income ..... 4. _____
5. Allowances for child and dependent care credit ..... 5. _____
6. **Total allowances. Add lines 1 through 5** ..... 6. _____
7. Additional amount, if any, you want deducted each pay period ..... 7. _____

Employee: I certify that I am entitled to the number of withholding allowances claimed on this certificate, or if claiming an exemption from withholding, that I am entitled to claim the exempt status.

Employee Signature _____

Date _____

Employers: Detach this part and keep in your records. However, if the employee is claiming more than 22 withholding allowances or an exemption from withholding when wages are expected to exceed $200 per week, complete the section below and send it to the Iowa Department of Revenue. See Employer Withholding Requirements on the back of this form.

Employer Name _____

Employer Address _____

_____ FEIN _____

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 _____.

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)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ 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)