INVOPEO
innovative national value outsourcing

Employee Information Form

Client Company Name: TBI Services Group

Employees, please fill out all information requested below. Employers are responsible for all information on second page. Incomplete forms will not be accepted.

Employee Details

Social Security Number	First Name (As appears on Social Security Card or Valid ID)	Last Name (As appears on Social Security Card or Valid ID)

Middle Name	Nickname (If applicable)	Date of Birth

Gender

Racial or Ethnic Group
- ☐ White / Caucasian
- ☐ Black / African American
- ☐ American Indian / Alaskan
- ☐ Asian / Pacific Islander
- ☐ Hispanic / Latino
- ☐ Other

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Civil Union
- ☐ Other

Employee Contact

Resident Address Line 1	Resident Address Line 2

City	State	County	Zip Code

Mailing Address Line 1 (If different from Resident)	Mailing Address Line 2

City	State	County	Zip Code

Phone Number	Email Address

INVO PEO Global Life Beneficiary Election: Please provide the name and social security number of the person you would like to designate for the AEG Global Life Benefit, (if applicable).

~~Beneficiary Name:~~ N/A ~~SSN:~~ N/A

-Second Page To Be Completed By Employers Only-

Education

High School: ______________________ Address: ______________________

From: ________ To: ________ Did you graduate? YES ☐ NO ☐ Diploma: ______________

College: ______________________ Address: ______________________

From: ________ To: ________ Did you graduate? YES ☐ NO ☐ Degree: ______________

Other: ______________________ Address: ______________________

From: ________ To: ________ Did you graduate? YES ☐ NO ☐ Degree: ______________

Previous Employment

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary: $__________ Ending Salary: $__________

Responsibilities: ____

From: ________ To: ________ Reason for Leaving: ______________________

____

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary: $__________ Ending Salary: $__________

Responsibilities: ____

From: ________ To: ________ Reason for Leaving: ______________________

____

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary: $__________ Ending Salary: $__________

Responsibilities: ____

From: ________ To: ________ Reason for Leaving: ______________________

Employee Agreement

I, ______________________________ (print your name), acknowledge that I have been hired as an at-will leased/ assigned employee of INVO PEO (hereafter referred to as "INVO") which is a Professional Employer Organization (PEO) and agree to the following:

I understand and agree that I am employed in a co-employment relationship where the duties and responsibilities that are applicable to me are set forth in the Client Service Agreement entered between the client for whom I am working and INVO. I understand that there is no contract of employment between myself and INVO and that INVO has no liability with regards to any employment agreement between me and the client for whom I am working. I understand that either INVO or I can terminate this co-employment relationship at any time as I am an at-will employee.

I understand that INVO's client at all times ultimately remains obligated to pay me my regular hourly rate of pay if I am a non-exempt employee and to pay me my full salary if I am an exempt employee, in the case that INVO does not receive payment from the client for whom I am working for and for service which I have performed. I understand and agree that INVO does not assume responsibility of payment of bonuses, commissions, severance pay, deferred compensation, profit sharing, vacation, sick or other paid time off, or for any other payments where payment for such items has not been received by INVO from the client for whom I am working, however, INVO does assume this responsibility where such payment has been received from the client.

I recognize the fact that any work-related injuries which might be sustained by me are covered by the state workers' compensation statutes. To avoid the circumvention of such state statutes which may result from suits against the customers or clients of INVO or against INVO based upon the same injury or injuries, and to the extent permitted by law, I hereby waive and forever release any rights I might have to make claims or bring suit against any client or customer of INVO for damages based upon injuries which are covered under such workers' compensation statutes. I also agree to comply with any and all drug testing policies which may be adopted and I specifically agree to post-accident drug testing in any situation where it is allowed by law.

I agree and understand that if at any time during my employment I am subjected to any type of discrimination, including discrimination because of race, sex, disability, color, age, national origin, ancestry, religion, veteran status, military status, union status, or in retaliation, or if I am subjected to any type of harassment, including sexual harassment, that I will immediately contact an appropriate person in the client company for whom I am working. I understand and agree that INVO does not have actual control over my workplace and as such is not in any position to end or remediate any discrimination, harassment or retaliation which may be occurring. The responsibility to end such inappropriate conduct will rest with the client company; however, INVO may attempt to facilitate a resolution. Should I choose to not contact the client company for any reason, I may contact INVO's human resources department at 1-866-986-0118 in order to obtain assistance in the resolution of such matters.

I understand and agree that as an assigned employee of INVO that I am expressly prohibited from performing any work outside the state in which I am currently performing services (the "home state") for the client during my status as an assigned employee except as allowed pursuant to the workers' compensation benefits through INVO or the applicable workers' compensation carrier.

I understand and agree that in the event I am terminated from the client for whom I am working, that I am required as part of my co-employment with INVO to notify an INVO representative within 48 hours of my termination.

______________________________ ______________

Employee Signature Date

TBI Services Group, Inc.
Achieving High Performance

Rev. 03/2021

WOTC SCREENING FORM

Our company participates in the federal Work Opportunity Tax Credit Program. Your responses to the following questions will be confidential and used only to assist us in complying with the requirements of this program. Your answers will not affect your employment or any benefits you may be receiving. Thank you for your cooperation!

PLEASE COMPLETE ALL SECTIONS OF THIS FORM.

Name: ____________________

Address: ____________________ **City:** ____________________

State: ____________________ **Zip Code:** ____________________ **Phone:** ____________________

SS#: ____________________ **Pay Rate: $** ____________________ **Date of Birth:** ____________________

Position: ____________________

Please read each statement below and check "YES" to any statement that applies to you:

#	Question	Yes	No
1	Have you worked for this employer before?	☐	☐
2	Have **you,** or any **immediate member** of your family, **EVER** received Temporary Assistance to NeedyFamilies (TANF, Welfare)?	☐	☐
3	Have **you,** or a **member of your family**, received Supplemental Nutrition Assistance Program **(SNAP)**benefits **(FOOD STAMPS) ANYTIME** over the last 6 months?	☐	☐
4	Have you been **UNEMPLOYED** the last 6 months and at **ANYTIME** received unemployment compensation?	☐	☐
5	I personally received **Supplemental Security Income** (SSI) or (SSDI) Supplemental Security DisabilityIncome anytime during the last 2 months.	☐	☐
6	I participated in a rehab program approved by the state, the Ticket to Work program, or the Department of Veterans Affairs.	☐	☐
7	I am **a Veteran** of the United States Armed Forces. **IF NO, SKIP TO #13**	☐	☐
8	I am a **Veteran** who received **Supplemental Nutrition Assistance Program (SNAP**) benefits (FOODSTAMPS) ANYTIME over the last 6 months.	☐	☐
9	I am a **Veteran** who was **UNEMPLOYED** for more than 4 weeks, but less than 6 months, during the past year.	☐	☐
10	I am a **Veteran** who was **UNEMPLOYED** for more than 6 months during the past year.	☐	☐
11	I am a **Veteran** discharged from active duty within the last 12 months and entitled to **compensation** for a **service-connected disability.**	☐	☐
12	I am a **Veteran** receiving **compensation for a service-connected disability** who was unemployed for at least 6 months during the last 12 months.	☐	☐
13	During the **last 12 months**, I was convicted of a felony or released from prison for a felony.	☐	☐

Under penalties of perjury, I declare the above information is, to the best of my knowledge, true, correct, and complete. I agree that I am voluntarily providing the information on this form and it is not a condition of employment my signature authorizes release of information to the appropriate government agency, such as Motor Vehicles, Unemployment Insurance or Veterans, to verify my eligibility under WOTC. TBI Services Group, Inc. , utilizes a third party named Tax Credit Group, Inc., located in Dubuque, Iowa to process IRS Form 8850 Prescreening Notice and applicable forms required under the WOTC program. By signing or submitting below, you agree to allow Tax Credit Group, Inc., to process the WOTC and any required information or forms on behalf of TBI Services Group, Inc. This is a proprietary form developed by Tax Credit Group, Inc., Any duplication, modification or unauthorized use without written consent is strictly prohibited. All Rights Reserved © Copyright 2020.

Date: ____________________

TBi® Services Group, Inc.
Achieving High Performance

POST-OFFER CONFIDENTIAL Medical Questionnaire

Name:______________________________ **last 4 SSN:**______________

About this Questionnaire: This Questionnaire is not being used as a basis for deciding whether to employ you. It should be completed only *after* a conditional offer of employment has been made, but *before* you begin work.

Instructions: Please circle YES or NO for each of the following questions. If your answer is YES, provide complete details in the chart below. Be sure to indicate the question number to which you are providing the details.

Note: Where permitted by state law, any person who falsely represents his/her condition in writing at this time may be denied Workers' Compensation Benefits.

1. Do you have or have you ever had a head injury resulting in a blackout or concussion? YES NO
2. Do you have or have you ever had a back or spinal injury? YES NO
3. Do you have or have you ever had a neck injury? YES NO
4. Do you have or have you ever had a knee or ankle injury? YES NO
5. Do you have or have you ever had a shoulder or elbow injury? YES NO
6. Do you have or have you ever had epilepsy? YES NO
7. Do you have or have you ever had diabetes? YES NO
8. Do you have or have you ever had heart trouble, stroke or cardiovascular disorder? YES NO
9. Do you have or have you ever had a total loss of sight in one or both eyes? YES NO
10. Do you have or have you ever had multiple sclerosis? YES NO
11. Do you have hemophilia (free bleeding)? YES NO
12. Do you have or have you ever had a lung disorder or difficulty breathing? YES NO
13. Do you have or have you ever had high blood pressure? YES NO
14. Do you have or have you ever had allergies or asthma? YES NO
15. Have you ever had a hernia? YES NO
16. Do you have or have you ever had carpal tunnel (repetitive motion) syndrome? YES NO
17. Have you ever filed a Workers' Compensation claim? YES NO
18. Do you have or have you ever had any condition other than those listed in 1-17 which might affect your ability to perform the job which you have been offered? YES NO

Give complete details for each question above to which you answered "Yes."
Attach additional sheets if necessary.

Q#	Nature of Condition	Date	Treatment	Physician/Hospital

All statements given on this Questionnaire are true and correct to the best of my knowledge and belief.

Signature:______________________________ **Date:**__________________

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) **Social security number**

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ ________

Multiply the number of other dependents by $500 . . . . . . $ ________

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
TBI Services Group, Inc 5674 Cleaves Circle, Suite 101 Arlington TN 38002		81-0679370

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

		Additional Information
Document Title 2 (if any)		
Issuing Authority		
Document Number (if any)		
Expiration Date (if any)		
Document Title 3 (if any)		
Issuing Authority		
Document Number (if any)		
Expiration Date (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Walsh, Paul VP		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
TBI Services Group, Inc.	**5674 Cleaves Dr., Suite 101, Arlington TN 38002**

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Payroll Payment Request

Please complete this form to notify INVO PEO how to process your wages. Form *must* be submitted at least two business days prior to processing day.

Employee Name:______________________________Employee SSN: ____________________

☐ **Direct Deposit**

Employee Authorization and Acknowledgement of All Terms

- **For any returned direct deposit due to invalid information provided, a $25.00 fee will be charged to the employee.** To avoid this charge, include a voided check or letter from your bank with your correct bank account number and ABA routing number when submitting this form. This additional information is not required for processing.
- It takes at least one pay cycle for new direct deposits or changes to take effect.
- Should you change your banking branch, institution or account numbers, please notify your payroll department at least ten (10) days in advance so there is adequate time for change to take place.
- Errors or omissions on this form or any failure to notify INVO PEO of changes in a timely manner may result in delay of your payroll funds being deposited. INVO PEO will not reissue any unsuccessful direct deposit until the original transaction is returned to INVO PEO by the originating bank. This process may take up to 5 days. INVO PEO is not responsible for these delays and will not reimburse any fees the employee may incur as a result of outdated or inaccurate information provided by employee

I agree to these terms and authorize INVO PEO to direct deposit my payroll check to the checking and/or savings account(s) listed below. In the event that funds are deposited into my account(s) in error, I authorize INVO PEO to debit my account to correct the error.

Account Type (C)hecking (S)avings	ABA Routing Number (9 Digit Number)	Account Number	Bank Name	For multiple accounts, specify the percentage or dollar amount to be deposited in each
C or S				
C or S				
C or S				

☐ **Paycard**

Paycard Number: ____________________________

Deposit Amount:____________or ☐ All

By providing the information requested above and signing below, I hereby elect and consent to receive my wages, including but not limited to off cycle wage payments and wage payments upon discharge, by electronic transfer of wages to a paycard. In addition, to the extent permitted by applicable law, I hereby authorize INVO PEO to make all of my deposits and deposit adjustments, including those involving off cycle wage payments and wage payments upon discharge, to my paycard, and I authorize the bank where such funds are deposited to accept such deposits and make such adjustments. I acknowledge I have received a copy of the terms, conditions, and fees associated with using such paycard. This authorization shall remain in effect until fourteen (14) days after INVO PEO receives written notice from me terminating my authorization.

Alternatively, if you would prefer to receive wages via check, please contact your supervisor.

Employee Signature____________________________ Date____________________________

Sample documents should NOT be construed as legal advice, guidance or counsel. Employers should consult their own attorney about their compliance responsibilities under the FCRA and applicable state law. PeopleFacts expressly disclaims any warranties or responsibility or damages associated with or arising out of information provided. Employers seeking credit reports must provide additional notices pursuant to state law.

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

EMPLOYER ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by PeopleFacts LLC. 480 W Dussel Dr Suite 100 Maumee, OH 43537 800-772-0130 www.peoplefacts.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature: ______________________________ Date: ______________