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New Hire Paperwork Checklist

- ☐ 1. Signed Offer Letter
- ☐ 2. I-9 with Supporting Documents
- ☐ 3. Direct Deport with Voided Check
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Instructions for Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit **www.justice.gov/crt/about/osc**.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. 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.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**
2. **A noncitizen national of the United States:** 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.
3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.
4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:

   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CBP).

   (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

   (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on **www.uscis.gov/I-9Central** before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include **(1)** the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and **(2)** the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.

2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.

3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.

4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.

5. Sign and date the attestation on the date Section 2 is completed.

6. Record the employer's business name and address.

7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents 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. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.

2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.

3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.

2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.

2. Record the number and other required document information from the actual document presented.

3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at **www.uscis.gov/I-9Central** for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or

2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.

2. Complete Block B with the date of rehire if you rehire an employee within 3 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. Also complete the "Signature of Employer or Authorized Representative" block.

3. Complete Block C if:

  a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or

  b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

  To complete Block C:

    a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and

    b. Record the document title, document number, and expiration date (if any).

4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

  For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no 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 **"USCIS Privacy Act Statement"** below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274).*

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at **I-9Central@dhs.gov**, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

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 the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at **E-Verify@dhs.gov** or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028.**

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

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

USCIS Privacy Act Statement

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

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire 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.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: 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 employer will keep this form and make it 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.

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 35 minutes per response, including the time for reviewing instructions and completing and retaining 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 Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►**START HERE. 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 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 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	E-mail Address	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):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ____________ . Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: ____________

OR

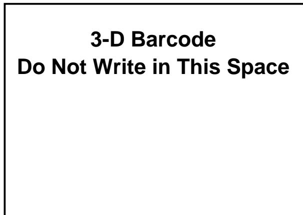
2. Form I-94 Admission Number: ____________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________

Country of Issuance: ____________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)



Signature of Employee:	Date *(mm/dd/yyyy)*:

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.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

Employer Completes Next Page

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	**List B** Identity	AND	**List C** Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				**3-D Barcode** **Do Not Write in This Space**
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

Certification

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

The employee's first day of employment *(mm/dd/yyyy)*: ________________ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative		Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name	

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A

Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
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
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   a. Foreign passport; and
   b. Form I-94 or Form I-94A that has the following:
   (1) The same name as the passport; and
   (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
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

OR

LIST B

Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   (1) NOT VALID FOR EMPLOYMENT
   (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

DIRECT DEPOSIT FORM

EMPLOYEE INFORMATION

Effective Date: _____ / _______ / _______

Employee # /SS #: ______________

First Name: ______________ Last Name: ______________

DIRECT DEPOSIT INFORMATION: MUST ATTACH A VOIDED CHECK

Each payday please deposit my pay as specified into the account(s) listed below:

☐ **New** ☐ **Change** ☐ **Discontinue Direct Deposit to this Account**
☐ **Entire Net Pay**

Amount: ______________

Branch Address: ______________

Account Number: ______________ Account Type: ☐ **Checking** ☐ **Savings**

ABA Routing #: ______________

Each payday please deposit my pay as specified into the account(s) listed below:

☐ **New** ☐ **Change** ☐ **Discontinue Direct Deposit to this Account**
☐ **Entire Net Pay**

Amount: ______________

Bank Name: ______________

Branch Address: ______________

Account Number: ______________ Account Type: ☐ **Checking** ☐ **Savings**

ABA Routing #: ______________

Please attach a voided account check to implement direct deposit. You are allowed up to three accounts for direct deposit. Attach an additional form for a third account.

I hereby authorize The Nielsen Company to deposit my net pay directly into my checking and/or savings account. I also authorize my bank to make adjusting debit entries as may be required to correct any credits erroneously made to my account. I agree that this authorization agreement will remain in effect until I provide written notification to The Nielsen Company to end this service.

Employee Signature: ______________ **Date:** ______________

Form W-4 (2016)

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 2016 expires February 15, 2017. 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 $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

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

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

The exceptions do not apply to supplemental wages greater than $1,000,000.

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A Enter “1” for **yourself** if no one else can claim you as a dependent . . . . **A** ______

B Enter “1” if:
- You 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** ______

C Enter “1” for your **spouse.** But, you may choose to enter “-0-” if you are married and have either a working spouse or more than one job. (Entering “-0-” may help you avoid having too little tax withheld.) . . . . **C** ______

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . **D** ______

E Enter “1” if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** ______

F Enter “1” if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ______
(**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $70,000 ($100,000 if married), enter “2” for each eligible child; then **less** “1” if you have two to four eligible children or **less** “2” if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter “1” for each eligible child . . **G** ______

H Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ► **H** ______

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2016

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

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $ ______

7 I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write “Exempt” here . . . . ► **7** ______

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

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

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

Deductions and Adjustments Worksheet

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

1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . . **1** $ ______

2 Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately } . . . **2** $ ______

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . **3** $ ______

4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) **4** $ ______

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) . . . **5** $ ______

6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . **6** $ ______

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . **7** $ ______

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction . . . **8** ______

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . **9** ______

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** ______

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

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

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1** ______

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" . . . **2** ______

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . **3** ______

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

4 Enter the number from line 2 of this worksheet . . . **4** ______

5 Enter the number from line 1 of this worksheet . . . **5** ______

6 **Subtract** line 5 from line 4 . . . **6** ______

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . **7** $ ______

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . **8** $ ______

9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** $ ______

Table 1

Married Filing Jointly: If wages from **LOWEST** paying job are—	Enter on line 2 above	All Others: If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

PERSONAL DATA FORM

NAME AND STATUS					
Date of Hire:					
First Name:	MI:		Last Name:		
SSN#:	Marital Status:		Birth Date:		
CONTACT INFORMATION (LEGAL ADDRESS FOR INCOME TAX PURPOSES)					
Street Address:	City:			State	Zip
Home Phone:		Cell Phone:			
EMERGENCY CONTACT					
Contact Name:	Relationship:				
Street Address:	City:			State	Zip
Home Phone:		Cell Phone:			
Special Medical Alert:					

Signature____ **Date**____________________________

Veteran Self-Identification Form

Nielsen is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment. These classifications are defined as follows

If you believe you belong to any of the categories of protected veterans listed below, please indicate by checking the appropriate box below (Choose all that apply).

❑A "**disabled veteran**" is one of the following:

- a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; **or**
- a person who was discharged or released from active duty because of a service-connected disability.

❑A **"recently separated veteran**" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

❑An **"active duty wartime or campaign badge veteran"** means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

❑An "**Armed Forces service medal veteran"** means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

❑I am a protected veteran, but I choose not to self-identify the classifications to which I belong.

❑ I am not a protected veteran

❑ I decline to disclose my veteran status

____   _______________

Signature   **Date**

If you are a disabled veteran, it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services, or other accommodations. This information will assist us in making reasonable accommodations for your disability. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are consistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

EQUAL EMPLOYMENT OPPORTUNITY (EEO)
SELF-IDENTIFICATION FORM

Qualified applicants are considered for employment without regard to race, religion, sex, national origin, age, marital status, sexual orientation, veteran status, disability, or other protected characteristic.

The employer is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, the employer invites employees to voluntarily self-identify their race or 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 laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

This detachable form will be kept in a confidential file separate from your application for employment.

Name (Last, First, MI): ______________________________

Street Address: ______________________________

City, State, Zip Code: ______________________________

Position Applied For: ____________ Date Applied: ______

Gender Identification (check one)

____ Female ____ Male

Race/Ethnic Identification (check one):

______ **Hispanic or Latino** - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

If you did not check “Hispanic or Latino” above, please select one of the following race/ethnic identifications.

______ **White (Not Hispanic or Latino)** - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

______ **Black or African American (Not Hispanic or Latino)** - A person having origins in any of the black racial groups of Africa.

______ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)** - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

______ **Asian (Not Hispanic or Latino)** - 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.

______ **American Indian or Alaska Native (Not Hispanic or Latino)** - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

______ **Two or More Races (Not Hispanic or Latino) -** All persons who identify with more than one of the above five races.

______ Decline self-identification

______________________________ ____________
Applicant’s Signature Date

____
Applicant’s Printed Name

Voluntary Self-Identification of Disability

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

<u>Please check one of the boxes below</u>:

☐ YES, I HAVE A DISABILITY (or previously had a disability)

☐ NO, I DON'T HAVE A DISABILITY

☐ I DON'T WISH TO ANSWER

____________________________ ____________________

Your Name Today's Date

Voluntary Self-Identification of Disability

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

Confidentiality Agreement and Assignment of Rights

In consideration of my employment and the compensation paid to me by The Nielsen Company (US), LLC. or any of its affiliated companies (hereinafter collectively "Nielsen"), I agree as follows:

1. During the term of my employment, I agree to devote my best efforts to the interest of Nielsen, and will not, during the term of this Agreement, undertake or engage in any other employment, occupation or business enterprise, other than ones in which I am a passive investor, which are either directly or indirectly related to my employment with Nielsen without prior written approval of an officer of Nielsen. I agree to observe any and all rules and regulations which the company may now or shall hereafter establish governing the conduct of its business or its employees.

2. I represent and warrant that my employment by Nielsen will not conflict with and will not be constrained by any prior employment or consulting agreement or relationship. I represent and warrant that I do not possess confidential information arising out of prior employment which will be useful in connection with my employment by Nielsen nor have I brought any documents or things to Nielsen from my previous employers. If I later find that confidential information belonging to any former employer might be useful in connection with Nielsen's business, I will not intentionally disclose to Nielsen or use on behalf of Nielsen any confidential information belonging to any of my former employers. However, during my employment by Nielsen I shall, in the performance of my duties, use all information which is generally known and used by persons with training and experience comparable to my own, and all information which is common knowledge in the industry or otherwise legally in the public domain.

3. I acknowledge that during the term of my employment I will have access to and become acquainted with various trade secrets and proprietary information that is or may be used in the present or future research, development, or operation of Nielsen's business Nielsen and which Nielsen desires or is obligated to keep confidential ("Confidential Information"). I acknowledge that such Confidential Information may be owned by Nielsen or owned or licensable by third parties that have disclosed it to Nielsen under limited license or other grant of right to Nielsen to use said Confidential Information. By way of example only, I understand that such third party disclosers include but are not limited to the present and prospective clients, cooperators, vendors, contractors, licensors, joint developers, and joint venture partners of Nielsen, or other third parties that disclose Confidential Information ("Disclosers") to Nielsen. A non-exhaustive list of examples of types of information that Nielsen or Disclosers may consider Confidential Information is attached hereto as Attachment A. Except as specifically required by my employment with Nielsen, I agree that I shall not allow access to, disclose or cause to be disclosed any of such Confidential Information, directly or indirectly, or use them in any way, either during the term of employment with Nielsen or at any time thereafter. All such Confidential Information shall be and remain the exclusive property of Nielsen or the Discloser thereof.

4. For the purpose of this agreement, Confidential Information shall include but not be limited to: company, industry, and product information and information disclosed to me or known by me as a consequence of or through my employment with Nielsen. By way of example only, this shall include information conceived, originated, discovered, or otherwise developed by me, which may or may not be generally known in the relevant industry. Such Confidential Information includes but is not limited to trade secrets, reports, publications, proposals, marketing and sales plans, prospective or current customer list, financial information, costs, pricing information, programs, plans, illustrations, software, designs of data and data bases, and all concepts or ideas in or reasonably related to the business of Nielsen or clients, cooperators, vendors, contractors, licensors, joint developers, and joint venture partners of Nielsen or their products, systems, processes and services including information relating to research, development, Inventions, manufacture, purchasing, accounting, engineering, data base creation and processing, marketing, merchandising and selling. Such Confidential Information may be embodied in hard copy, software, computer readable form, or otherwise.

5. I understand that regardless of whether it is a primary objective of my employment with Nielsen, from time to time I may use my skill and ability to make new discoveries, or conceive or devise new ideas, techniques, processes, inventions, and improvements relating to current, planned or future Nielsen business activities including without limitation research or development, products, systems, services, methods, and related designs, articles or methods of manufacture, distribution or management

thereof (“Inventions”). I also understand that I may conceive, devise or otherwise develop such Inventions on Nielsen time and/or with company resources. I agree to disclose and submit to Nielsen for evaluation all such Inventions promptly after the discovery, conception, devise or development thereof. I further understand that in the course of my employment with Nielsen I may be assigned to or otherwise will develop works of authorship (including but not limited to reports, presentations, publications, proposals, plans, programs, plans, illustrations, software and the like) relating to such current, planned or future research or development, products, systems, services, methods or the like of Nielsen (“Developed Works”). I agree to assign, and by these presents do hereby assign and transfer, all of my entire right, title and interest in and to all such Inventions and Developed Works to Nielsen (or its designated affiliated company), its successors, assigns or nominees. Any inventions not discovered, conceived, devised or developed on Nielsen time and/or resources and not related to the aforementioned current, planned or future Nielsen research or development, products, systems, services, methods or the like, shall be my sole property. I agree to promptly inform the legal department of Nielsen of any such inventions that I believe are not Inventions. I have identified in Attachment B attached hereto all inventions I have discovered, conceived, devised or developed prior to the commencement of my employment with Nielsen and which I believe are not subject to the assignment of this Section 5.

I further agree to cooperate fully with and assist Nielsen in evaluating said Inventions and, should Nielsen so decide in its sole discretion, in applying for and preparing any patent applications, executing any assignment or other documents reasonably necessary to file said patent applications and/or record, perfect or maintain Nielsen’s sole and exclusive ownership of said Inventions, patent applications, and any patents that may issue there from anywhere in the world and all intellectual property rights embodied therein or associated with any of the foregoing.

6. Upon my termination, I shall return all copies and originals of any documents, reports, working papers or other documents which I have in my possession. During or after termination of my employment, I will not publish or cause to be published, release or cause to be released, or otherwise make available or cause to be made available to any third party any information describing any Confidential Information, report, service content, customer list or proprietary information of Nielsen or a client or cooperator of Nielsen without prior specific written authorization of Nielsen.

7. I understand that if there is a breach by me of any duty to Nielsen with respect to any Confidential Information, Developed Work or Invention, Nielsen may sustain irreparable injury and may not have an adequate remedy at law. As a result, I agree that, in the event of any breach of this Agreement, Nielsen may, in addition to any other remedies available to it, bring an action or actions for injunction, specific performance or both, and have entered a temporary restraining order, preliminary or permanent injunction, or order compelling specific performance, and if successful, seek reasonable attorney’s fees and costs.

8. This Agreement shall inure to the benefit of Nielsen, its successors and assigns, and shall supersede all other agreements, written and oral, between Nielsen and myself with respect to invention and confidential information. This Agreement may not be modified or terminated in whole or in part except in writing, signed by an officer of Nielsen.

9. Neither the waiver by Nielsen of any of its rights under this Agreement, nor the invalidity of any provision hereof, shall prevent Nielsen from enforcing any other provision or right created by this Agreement.

10. This Agreement shall be construed and interpreted in accordance with the laws of the State of New York. If any provision of this agreement is declared void and unenforceable, such provision shall be deemed severed from the agreement and the balance of the agreement shall remain in full force and effect.

EMPLOYEE

Signature ____

Name ____

Date ____

ATTACHMENT A

The following is a list of examples of information considered Confidential by Nielsen, its clients, cooperators, vendors, contractors, licensors, joint developers, joint venture partners, or other third parties. This is not a comprehensive list.

Marketing and Sales Plans
Prospect Lists
Customer Lists
Cooperator Lists
Trade Payments
Financial Data including:
- *Cost Information*
- *Pricing Information*
- *Profit & Loss Statements*
- *Budgets*

New Business Proposals
Internal Business Plans
GSR Documents
Report Data
Data Base Designs
Software and Documentation,
including personal
computer software
Passwords
User Numbers
UPC Files
Confidential Client information such as:
- *Marketing Plans*
- *Product R&D*
- *Manufacturing Techniques*

Confidential Cooperator information such as:
- *Store Movement Data*
- *Merchandising Plans*

Attachment B

Complete either A or B (but not both).

A. All inventions discovered, conceived, devised or developed by me (solely or jointly) prior to the commencement of my employment with Nielsen, are:

Title: ____

Document number, Patent Number, etc.: __________________________________

Authors/inventors: ____

Assignee (if any): ____

Title: ____

Document number, Patent Number, etc.: __________________________________

Authors/inventors: ____

Assignee (if any): ____

Title: ____

Document number, Patent Number, etc.: __________________________________

Authors/inventors: ____

Assignee (if any): ____

Title: ____

Document number, Patent Number, etc.: __________________________________

Authors/inventors: ____

Assignee (if any): ____

Title: ____

Document number, Patent Number, etc.: __________________________________

Authors/inventors: ____

Assignee (if any): ____

***B**. There are no* Inventions conceived by me (solely or jointly) prior to the commencement of my employment with Nielsen.

Initial: ________

Note: attach additional copies of this page if needed.

Employment Development Department
State of California

This form can be used to manually compute your withholding allowances, or you can electronically compute them at **www.taxes.ca.gov/de4.pdf.**

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD
City, State, and ZIP Code	

1. Number of allowances for Regular Withholding Allowances, Worksheet A ____________
   Number of allowances from the Estimated Deductions, Worksheet B ____________
   Total Number of Allowances (A + B) when using the California Withholding Schedules for 2015 ____________

   OR
2. Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C ____________

   OR
3. I certify under penalty of perjury that I am not subject to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Signature ________________________________ Date ____________

Employer's Name and Address	California Employer Account Number

- - - - - - - - - - - - - - - - cut here - - - - - - - - - - - - - - - -

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME TAX MAY BE UNDERWITHHELD IF YOU DO NOT FILE THIS DE 4 FORM.

IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

You should complete this form if either:

(1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,

(2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. **If you rely on the number of withholding allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld.** This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your Form W-4 and/or DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption is good for one year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted by February 15 each year to continue your exemption. If you are not having federal income tax withheld this year but expect to have a tax liability next year, you are reuired to give your employer a new Form W-4 by December 1.

EXEMPTION FROM WITHHOLDING (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD (FTB).

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES	800-852-5711 (voice) 800-822-6268 (TTY)
IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free)	916-845-6500

The *California Employer's Guide* (DE 44) provides the income tax withholding tables. This publication may be found on the Employment Development Department (EDD) website at **www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm**. To assist you in calculating your tax liability, please visit the Franchise Tax Board website at **www.ftb.ca.gov/individuals/index.shtml**.

NOTIFICATION: Your employer is required to send a copy of your DE 4 to the FTB if it meets either of the following two conditions:

- You claim more than 10 withholding allowances.
- You claim exemption from state or federal income tax withholding and your employer expects your usual weekly wages to exceed $200 per week.

IF THE IRS INSTRUCTS YOUR EMPLOYER TO WITHHOLD FEDERAL INCOME TAX BASED ON A CERTAIN WITHHOLDING STATUS, YOUR EMPLOYER IS REQUIRED TO USE THE SAME WITHHOLDING STATUS FOR STATE INCOME TAX WITHHOLDING IF YOUR WITHHOLDING ALLOWANCES FOR STATE PURPOSES MEET THE REQUIREMENTS LISTED UNDER "NOTIFICATION." IF YOU FEEL THAT THE FEDERAL DETERMINATION IS NOT CORRECT FOR STATE WITHHOLDING PURPOSES, YOU MAY REQUEST A REVIEW.

To do so, write to:

W-4 Unit
Franchise Tax Board MS F180
P.O. Box 2952
Sacramento, CA 95812-2952
Fax: 916-843-1094

Your letter should contain the basis of your request for review. You will have the burden of showing that the federal determination is incorrect for state withholding purposes. The FTB will limit its review to that issue. The FTB will notify both you and your employer of its findings. Your employer is then required to withhold state income tax as instructed by the FTB. In the event the FTB or the IRS finds there is no reasonable basis for the number of withholding exemptions that you claimed on your Form W-4/DE 4, you may be subject to a penalty.

PENALTY: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided for by Section 13101 of the California Unemployment Insurance Code.

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

TWO-EARNER/TWO-JOBS: When earnings are derived from more than one source, underwithholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with one employer. Do not claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 or Form W-4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you at any time during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; and
(3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the entire year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A — REGULAR WITHHOLDING ALLOWANCES

(A) Allowance for yourself — enter 1 . . . . . (A) ______

(B) Allowance for your spouse (if not separately claimed by your spouse) — enter 1 . . . . . (B) ______

(C) Allowance for blindness — yourself — enter 1 . . . . . (C) ______

(D) Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1 . . . . . (D) ______

(E) Allowance(s) for dependent(s) — do not include yourself or your spouse . . . . . (E) ______

(F) Total — add lines (A) through (E) above . . . . . (F) ______

INSTRUCTIONS — 2 — ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim one or more additional withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

WORKSHEET B — ESTIMATED DEDUCTIONS

1. Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540 . . . . . 1. ______
2. Enter $7,984 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $3,992 if single or married filing separately, dual income married, or married with multiple employers . . . . . − 2. ______
3. Subtract line 2 from line 1, enter difference . . . . . = 3. ______
4. Enter an estimate of your adjustments to income (alimony payments, IRA deposits) . . . . . + 4. ______
5. Add line 4 to line 3, enter sum . . . . . = 5. ______
6. Enter an estimate of your nonwage income (dividends, interest income, alimony receipts) . . . . . − 6. ______
7. If line 5 is greater than line 6 (if less, see below);
   Subtract line 6 from line 5, enter difference . . . . . = 7. ______
8. Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number . . . . . 8. ______
   Enter this number on line 1 of the DE 4. Complete Worksheet C, if needed.
9. If line 6 is greater than line 5;
   Enter amount from line 6 (nonwage income) . . . . . 9. ______
10. Enter amount from line 5 (deductions) . . . . . 10. ______
11. Subtract line 10 from line 9, enter difference . . . . . 11. ______
    Complete Worksheet C

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California Personal Income Tax (PIT) withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of Section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 888-745-3886.

WORKSHEET C **TAX WITHHOLDING AND ESTIMATED TAX**

1. Enter estimate of total wages for tax year 2015 . . . . 1. ____________
2. Enter estimate of nonwage income (line 6 of Worksheet B) . . . . 2. ____________
3. Add line 1 and line 2. Enter sum . . . . 3. ____________
4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest) . . . . . . 4. ____________
5. Enter adjustments to income (line 4 of Worksheet B) . . . . 5. ____________
6. Add line 4 and line 5. Enter sum . . . . 6. ____________
7. Subtract line 6 from line 3. Enter difference . . . . 7. ____________
8. Figure your tax liability for the amount on line 7 by using the 2015 tax rate schedules below . . . . 8. ____________
9. Enter personal exemptions (line F of Worksheet A x $118.80) . . . . 9. ____________
10. Subtract line 9 from line 8. Enter difference . . . . 10. ____________
11. Enter any tax credits. (See FTB Form 540) . . . . 11. ____________
12. Subtract line 11 from line 10. Enter difference. This is your total tax liability . . . . 12. ____________
13. Calculate the tax withheld and estimated to be withheld during 2015. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2015. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2015 . . . . 13. ____________
14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld . . . . 14. ____________
15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4 . . . 15. ____________

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2015 ONLY

SINGLE OR MARRIED WITH DUAL EMPLOYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER		OF AMOUNT OVER . . .	PLUS*
$0	$7,749 ...	1.100%	$0	$0.00
$7,749	$18,371 ...	2.200%	$7,749	$85.24
$18,371	$28,995 ...	4.400%	$18,371	$318.92
$28,995	$40,250 ...	6.600%	$28,995	$786.38
$40,250	$50,869 ...	8.800%	$40,250	$1,529.21
$50,869	$259,844 ...	10.230%	$50,869	$2,463.68
$259,844	$311,812 ...	11.330%	$259,844	$23,841.82
$311,812	$519,687 ...	12.430%	$311,812	$29,729.79
$519,687	$1,000,000 ...	13.530%	$519,687	$55,568.65
$1,000,000	and over	14.630%	$1,000,000	$120,555.00

MARRIED FILING JOINT OR QUALIFYING WIDOW(ER) TAXPAYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER		OF AMOUNT OVER . . .	PLUS*
$0	$15,498 ...	1.100%	$0	$0.00
$15,498	$36,742 ...	2.200%	$15,498	$170.48
$36,742	$57,990 ...	4.400%	$36,742	$637.85
$57,990	$80,500 ...	6.600%	$57,990	$1,572.76
$80,500	$101,738 ...	8.800%	$80,500	$3,058.42
$101,738	$519,688 ...	10.230%	$101,738	$4,927.36
$519,688	$623,624 ...	11.330%	$519,688	$47,683.65
$623,624	$1,000,000 ...	12.430%	$623,624	$59,459.60
$1,000,000	$1,039,374 ...	13.530%	$1,000,000	$106,243.14
$1,039,374	and over	14.630%	$1,039,374	$111,570.44

UNMARRIED HEAD OF HOUSEHOLD TAXPAYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER		OF AMOUNT OVER . . .	PLUS*
$0	$15,508 ...	1.100%	$0	$0.00
$15,508	$36,743 ...	2.200%	$15,508	$170.59
$36,743	$47,366 ...	4.400%	$36,743	$637.76
$47,366	$58,621 ...	6.600%	$47,366	$1,105.17
$58,621	$69,242 ...	8.800%	$58,621	$1,848.00
$69,242	$353,387 ...	10.230%	$69,242	$2,782.65
$353,387	$424,065 ...	11.330%	$353,387	$31,850.68
$424,065	$706,774 ...	12.430%	$424,065	$39,858.50
$706,774	$1,000,000 ...	13.530%	$706,774	$74,999.23
$1,000,000	and over	14.630%	$1,000,000	$114,672.71

*marginal tax

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FTB:

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES 800-852-5711 (voice)
800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) 916-845-6500

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, California Code of Regulations, and the Revenue and Taxation Code, including Section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California income tax return.

EMPLEADOR: TNC Holdings
NÚM. DE IDENTICACIÓN DE LA MPN: # 2323 NOMBRE DE LA MPN: Sedgwick/Harbor MPN

Información Importante sobre el Cuidado Médico si tiene una Lesión o Enfermedad Relacionada con el Trabajo
Notificación Escrita Completa de la MPN al Empleado

(Titulo 8, Código de Regulaciones de California, Sección 9767.12)

La ley de California requiere que su empleador le proporcione y pague el tratamiento médico si usted se lesiona en el trabajo. Su empleador le proporciona este cuidado médico utilizando la red de médicos de Compensación de Trabajadores llamada la Red de Proveedores Médicos (con sus siglas en inglés, MPN). Esta Red de Proveedores Médicos es administrada por el Harbor Health Systems. Esta notificación le indica lo que necesita conocer sobre el programa de la MPN y describe sus derechos al escoger el cuidado médico para lesiones y enfermedades relacionadas con el trabajo.

¿Qué es la MPN?
La Red de Proveedores Médicos (MPN) es el grupo de proveedores de cuidados de la salud (médicos y otros proveedores médicos) utilizados por su empleador para tratar trabajadores lesionados en el trabajo. Cada MPN debe incluir una mezcla de médicos especializados en lesiones relacionadas con el trabajo y médicos con experiencias en áreas generales en la medicina. Las Redes de Proveedores Médicos deben permitir a los empleados tener opciones con el/ los proveedor(es).

¿Cómo puedo saber que médicos se encuentran en mi Red de Proveedores Médicos (MPN)?
El Contacto de la MPN y del Asistente de Acceso Médico que se encuentra al final de esta notificación será capaz de contestar sus preguntas sobre la MPN y le ayudará a obtener una lista de todos los médicos regionales de la MPN en su área o una lista de todos los médicos en la MPN. Como mínimo, la lista regional debe incluir un listado de todos los proveedores de la MPN que se encuentren dentro de quince (15) millas de su lugar de trabajo y/o residencia, o una lista de todos los proveedores dentro del condado donde usted vive y/o trabaja. Usted puede escoger cual de las listas desea recibir. Usted puede obtener la lista de los proveedores de la MPN llamando al contacto de la MPN o puede ir al sitio de búsqueda en la red que se encuentra al final de esta notificación. También, tiene derecho a un listado completo de todos los proveedores de la MPN una vez lo solicite. La MPN es responsable de actualizar los listados de los proveedores de la MPN, como mínimo, en una base trimestral.

¿Cómo revisar, recibir, o tener acceso al directorio de proveedores de la Red de Proveedores Médicos (MPN)?
El empleador, asegurador, o entidad que proporciona los servicios a la red de médicos garantizarán que los empleados cubiertos tengan acceso a, como mínimo, al listado de proveedores del área regional de la Red de Proveedores Médicos (MPN); además de mantener y tener disponible su directorio completo de la lista de proveedores por escrito y/o en el sitio web de la MPN. La dirección del sitio web de la MPN deberá estar claramente indicada. Si el empleado solicita el directorio electrónico de la lista de proveedores, se proporcionará electrónicamente en un disco compacto (CD), dispositivo portátil ("flash drive"), a través del correo electrónico, o en el sitio web. La dirección del URL del directorio de proveedores se registrará con cualquier información adicional que se necesite para tener acceso al directorio en línea, incluyendo todas las instrucciones o códigos de accesos necesarios. Los solicitantes de la MPN son responsables de la actualización del listado de los proveedores de la MPN, como mínimo, en una base trimestral con la fecha de la última actualización proporcionada en el listado brindado al empleado. Cada proveedor en la lista del directorio incluirá el número de teléfono y la dirección de correo electrónico para reportar inexactitudes en la lista de los proveedores. Si un proveedor que se encuentra en la lista fallece o no se encuentra por más tiempo tratando pacientes de compensación de trabajadores en la dirección indicada, el proveedor será removido del directorio de proveedores dentro de cuarenta y cinco (45) días de la notificación a la MPN, a través del método de contacto indicado en el directorio de la lista de proveedores de reportar inexactitudes.

EMPLEADOR: TNC Holdings
NÚM. DE IDENTICACIÓN DE LA MPN: # 2323 NOMBRE DE LA MPN: Sedgwick/Harbor MPN

¿Qué sucede si me lesiono en el trabajo?
En caso de una emergencia, llame al 911 o diríjase a la sala de emergencias más cercana.
Si se lesiona en el trabajo, notifíquelo a su empleador lo más pronto posible. Su empleador le proporcionará el formulario del reclamo. Cuando le notifique al empleador que ha tenido una lesión relacionada con el trabajo, su empleador o asegurador le hará una cita inicial con un médico de la Red de Proveedores Médicos (MPN).

¿Cómo escojo un proveedor?
Después de la primera visita médica, usted puede continuar siendo tratado por este médico, o puede escoger otro médico de la Red de Proveedores Médicos (MPN). Usted puede continuar escogiendo médicos dentro de la MPN para todos sus cuidados médicos de esta lesión. Si es apropiado, usted puede escoger un especialista o solicitarle al médico tratante un referido a un especialista. Si necesita ayuda para escoger un médico puede llamar al Contacto de la MPN o al Asistente de Acceso Médico, que se encuentra en la última página de esta notificación.

¿Puedo cambiar de proveedores?
Si. Usted puede cambiar de proveedores dentro de la Red de Proveedores Médicos (MPN) por cualquier motivo, pero los proveedores que escoja deberán ser apropiados para tratar su lesión. Si necesita ayuda escogiendo al médico, puede llamar al Contacto de la MPN o al Asistente de Acceso Médico de la MPN, que se encuentran en la última página de esta notificación.

¿Cuáles son los estándares que la Red de Proveedores Médicos (MPN) tiene que cumplir?
La Red de Proveedores Médicos (MPN) tiene proveedores en el Estado completo de California.
La MPN debe proporcionarle una lista de proveedores regionales que incluya al menos tres (3) médicos de cada especialidad comúnmente utilizados para tratar lesiones/enfermedades relacionadas con el trabajo, en su industria. La MPN debe proveer acceso a médicos primarios que se encuentren dentro de quince (15) millas y a especialistas que se encuentren dentro de treinta (30) millas. Si usted vive en un área rural puede haber diferentes estándares. El contacto de la MPN que se encuentra al final de esta notificación tiene más información sobre los estándares de accesos rurales. La MPN debe proporcionar el tratamiento inicial dentro de tres (3) días. Usted debe recibir el tratamiento de un especialista dentro de veinte (20) días de su solicitud. Si tiene problemas haciendo su cita, comuníquese con el contacto de la MPN, o con el Asistente de Acceso Médico de la MPN.

¿Qué sucede si no hay proveedores de la Red de Proveedores Médicos (MPN) donde me encuentro localizado?
Si usted es un empleado actual que se encuentra trabajando temporalmente o que vive fuera del área de servicio de la Red de Proveedores Médicos (MPN), o es un ex empleado viviendo permanentemente fuera del área de servicio de la MPN, la MPN o su médico tratante le brindará una lista de al menos tres (3) médicos que lo pueden tratar. También, la MPN le puede permitir escoger su propio médico fuera de la red de la MPN. Comuníquese con el examinador de su reclamo, el Asistente de Acceso Médico, o el contacto de la MPN para asistencia en encontrar un médico o para información adicional.

¿Qué sucede si necesito un especialista que no se encuentra en la Red de Proveedores Médicos (MPN)?
Si necesita ver un tipo de especialista que no se encuentra disponible en la MPN, usted tiene derecho a ver un especialista fuera de la MPN. Comuníquese con el examinador de reclamos, el Asistente de Acceso Médico de la MPN, o el Contacto de la MPN para asistencia en encontrar un médico o para información adicional.

¿Qué sucede si no estoy de acuerdo con mi médico con respecto a mi tratamiento médico?
Si no está de acuerdo con su médico o desea cambiar su médico por cualquier motivo, usted puede escoger otro médico dentro de la Red de Proveedores Médicos (MPN). Si no está de acuerdo con el diagnostico o el tratamiento prescrito por su médico, usted puede solicitar una segunda opinión de otro médico dentro de la MPN. Si desea una segunda opinión, debe comunicarse con la MPN e indicarles que desea una segunda opinión. La MPN deberá brindarle al menos una lista de los proveedores regionales de la MPN con los que puede escoger el médico para la segunda opinión. Para obtener la segunda opinión, debe escoger un médico de la lista de la MPN y hacer la cita dentro de los próximos sesenta (60) días. Usted debe decirle al Contacto de la MPN la fecha de su cita, y la MPN le enviará al médico una copia de su expediente médico. Usted puede solicitar una copia de sus expedientes médicos que serán enviados al médico.

- Si no hace la cita dentro de sesenta (60) días después de recibir la lista de proveedores regionales, a usted no se le permitirá tener una segunda o tercera opinión con relación a este diagnostico o tratamiento disputado de este médico tratante.
- Si el médico de la segunda opinión siente que su lesión se encuentra fuera del tipo de lesión que él o ella normalmente trata, la oficina del médico se lo notificará a su empleador o asegurador. Se le brindará otra lista de médicos o especialistas de la MPN para que pueda hacer otra selección.
- Si no se encuentra de acuerdo con la segunda opinión, usted puede solicitar una tercera opinión. Si solicita una tercera opinión, irá a través del mismo proceso que fue durante la segunda opinión.
- Recuerde, si no hace la cita dentro de sesenta (60) días de haber obtenido la otra lista de proveedores de la MPN, a usted no se le permitirá tener una tercera opinión con relación a este diagnostico o tratamiento disputado de este médico tratante.
- Si no está de acuerdo con el médico de la tercera opinión, usted puede solicitar una Revisión Médica Independiente (con sus siglas en ingles, IMR) de la MPN. Su empleador o la persona de contacto de la MPN le proporcionará información para solicitar la Revisión Médica Independiente de la MPN y el formulario, en el momento en que solicite la tercera opinión.
- Si el médico de la segunda o tercera opinión está de acuerdo con la necesidad de su tratamiento o prueba, a usted se le permitirá recibir el servicio médico de un proveedor fuera de la MPN, incluyendo el médico de la segunda o tercera opinión.
- Si el Revisor Médico Independiente de la MPN respalda la necesidad de su tratamiento o prueba, usted puede recibir ese cuidado de un médico dentro o fuera de la MPN.

¿Qué sucede si ya he sido tratado por la lesión relacionada con el trabajo antes de que comience la Red de Proveedores Médicos (MPN)?

Su empleador o asegurador tiene una póliza de “Transferencia de Cuidados” la cual determinará si puede continuar siendo tratado temporalmente por una lesión existente relacionada con el trabajo por un médico fuera de la Red de Proveedores Médicos (MPN), antes de que su cuidado sea transferido a la MPN.

Si ha pre-designado apropiadamente un médico tratante primario, usted no puede ser transferido a la MPN. (Si tiene preguntas sobre la pre-designación, pregunte a su supervisor). Si su médico actual no es o no va a ser miembro de la MPN, a usted se le puede requerir ver a un médico de la MPN.

Si su empleador decide transferirlo a la MPN, usted y su médico tratante primario deben recibir una carta donde se les notifique la transferencia. Si cumple con ciertas condiciones, usted puede cualificar para continuar tratándose con un médico que no se encuentre en la MPN por hasta un (1) año, antes de que sea transferido a la MPN. Las condiciones de cualificación para posponer la transferencia de su cuidado se encuentran en la tabla de Condiciones de Cualificación y aparecen como puntos marcados en la tabla a continuación.

Usted puede estar en desacuerdo con la decisión de su empleador de transferir su cuidado a la MPN. Si usted cree que tiene una (1) de las cuatro (4) condiciones de cualificación que podría impedir la transferencia de su cuidado en este momento, usted debe solicitar un reporte de su médico tratante primario. El reporte médico debe describir cual de las cuatro (4) condiciones usted tiene, la cual puede cualificar para posponer su transferencia a la MPN. Su médico tratante primario tiene veinte (20) días desde la fecha de su solicitud para brindarle una copia del reporte de su condición. Si su médico tratante primario no le entrega el reporte dentro de veinte (20) días de su solicitud, el empleador puede transferir su cuidado a la MPN y a usted se le requerirá utiliza el médico de la MPN. Si usted o su empleador no están de acuerdo con el reporte del médico sobre su condición, usted o su empleador pueden disputarlo. Vea la póliza completa de Transferencia de Cuidados para más detalles del proceso de resolución de disputas. Para una copia de la póliza completa de Transferencia de Cuidados, pregunte a su Contacto en la MPN.

¿Qué sucede si estoy siendo tratado por un médico de la MPN y éste decide dejar la Red de Proveedores Médicos (MPN)?

Su empleador o asegurador tienen una póliza por escrito de "Continuidad de los Cuidados" que determinará si puede continuar temporalmente su tratamiento para la lesión existente relacionada con el trabajo con su médico si su médico no continúa participando por más tiempo en la Red de Proveedores Médicos (MPN).

- Si su empleador decide que usted no cualifica para continuar sus cuidados con un proveedor que no se encuentre en la MPN, usted y su médico tratante primario deben recibir una carta de notificación.
- Si usted cumple con ciertas condiciones, usted puede cualificar para continuar tratándose con este médico por hasta un (1) año antes de que deba cambiar a los médicos de la MPN. Estas condiciones se indican en la tabla de condiciones de cualificación a continuación.
- Usted puede estar en desacuerdo con la decisión del empleador de denegar su Continuidad de los Cuidados con el proveedor terminado de la MPN. Si usted desea continuar tratándose con el médico terminado, solicítele a su médico tratante un reporte médico en el que presente que usted tiene una (1) de las cuatro (4) condiciones indicadas en la tabla de Condiciones de Cualificación que aparecen como puntos marcados a continuación para que vea si cualifica en continuar tratándose temporalmente con su médico actual.
- Su médico tratante primario tiene veinte (20) días desde la fecha de la solicitud para brindarle una copia del reporte médico de su condición. Si su médico tratante primario no le proporciona el reporte dentro de veinte (20) días de su solicitud, el empleador puede transferir su cuidado a la MPN y a usted se le requerirá utilizar un médico de la MPN.
- Si su empleador no está de acuerdo con el reporte de su médico sobre su condición, usted o su empleador pueden disputarlo. Vea la póliza completa de Continuidad de los Cuidados para más detalles del proceso de resolución de disputas.

Para una copia de la póliza entera de la Continuidad de los Cuidados, pregunte a su Contacto de la MPN.

Condiciones de Cualificación
• (Agudo) El tratamiento para su lesión o enfermedad será completado en menos de noventa (90) días. • (Serio o crónico) Su lesión o enfermedad es una que es seria y continúa por al menos noventa (90) días sin una cura completa o empeora, y requiere tratamiento en lo subsiguiente. A usted se le puede permitir el ser tratado por su médico tratante actual por hasta un (1) año, hasta que una transferencia segura del cuidado pueda ser realizada. • (Terminal) Usted tiene una enfermedad incurable o una condición irreversible que es probable que cause la muerte dentro de un (1) año o menos. • (Cirugía Pendiente) Usted ya tiene una cirugía u otro procedimiento que ha sido autorizado por su empleador o asegurador que ocurrirá dentro de ciento ochenta (180) días a partir de la fecha de efectividad de la MPN, o la terminación de la fecha de contrato entre la MPN y su médico.

¿Qué sucede si tengo preguntas, quejas o necesito ayuda?

Contacto de la MPN

Usted siempre puede comunicarse con el Contacto de la MPN, si necesita ayuda o una explicación sobre su tratamiento médico para su lesión o enfermedad relacionada con el trabajo. El Contacto de la MPN estará disponible para ayudarle con cualquier pregunta o queja.
Sedgwick MPN Contact: Sedgwick MPN Coordinator
10690 White Rock Road, Ste. 100
Rancho Cordova, CA 95670
(800) 625-6588
Email: MPNCoordinators@Sedgwickcms.com
Sitio web de la MPN (para información y las Listas de todos los médicos tratantes de la MPN): www.harborsys.com/Sedgwick2
Número de la Línea Gratuita del Asistente de Acceso Médico de la MPN: (877) 334-9425

Asistente de Acceso Médico de la Red de Proveedores Médicos de la MPN (MPN)

Los Asistentes Médicos de la MPN están localizados en los Estados Unidos y están disponibles de lunes a sábados de 7 am a 8 pm, Hora Pacifico, (excluyendo los domingos y los días feriados), para proveer ayuda a los empleados con el acceso al cuidado médico bajo la MPN. La ayuda al empleado estará disponible en inglés y español. La ayuda incluirá ponerse en contacto con las oficinas de proveedores durante horas regulares de oficina y la programación de citas médicas para los empleados cubiertos. El número de la línea gratuita se encuentra en la última página de esta notificación, para tener acceso al Asistente de Acceso Médico de la MPN, incluyendo los médicos de la MPN que se encuentran disponibles para su elección, y para la programación y confirmación de citas con los médicos.
Sitio web de la MPN (para información y las Listas de todos los médicos tratantes de la MPN): www.harborsys.com/Sedgwick2
Número de la Línea Gratuita del Asistente de Acceso Médico de la MPN: (877) 334-9425

División de Compensación de Trabajadores (DWC)
Si tiene dudas, quejas o preguntas relacionadas a la Red de Proveedores Médicos (MPN), el proceso de notificación o su tratamiento médico después de una lesión o enfermedad relacionada con el trabajo, usted puede llamar a la Oficina de Información y Asistencia de la DWC al (800) 736-7401. También puede ir sitio web de la DWC en www.dir.ca.gov/dwc y hacer clic en "las redes de proveedores médicos" para más información sobre las redes de proveedores médicos (MPN).

Revisión Médica Independiente de la Red de Proveedores Médicos (MPN)
Si tiene preguntas sobre el proceso de la Revisión Médica Independiente de la MPN comuníquese con la Unidad Médica de la División de Compensación de Trabajadores en:
DWC Medical Unit
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 o (800) 794-6900

Mantenga esta información en caso de que tenga una lesión o enfermedad relacionada con el trabajo

EMPLOYER: TNC Holdings
MPN IDENTIFICATION NUMBER: # 2323 MPN NAME: Sedgwick/Harbor MPN

Important Information about Medical Care if you have a Work-Related Injury or Illness
Complete Written MPN Employee Notification

(Title 8, California Code of Regulations, section 9767.12)

California law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer is providing this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). This MPN is administered by Harbor Health Systems. This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work-related injuries and illnesses.

What is a MPN?
A Medical Provider Network (MPN) is group of health care providers (physicians and other medical providers) used by your employer to treat workers injured on the job. Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. MPNs must allow employees to have a choice of provider(s).

How do I find out which doctors are in my MPN?
The MPN Contact and Medical Access Assistant listed at the end of this notification will be able to answer your questions about the MPN and will help you obtain a regional list of all MPN doctors in your area or a roster of all treating physicians in the MPN. At minimum, the regional listing must include a list of all MPN providers within 15 miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive. You can get the list of MPN providers by calling the MPN contact or by going to the network search site listed at the end of this notice. You also have the right to a complete listing of all of the MPN providers upon request. The MPN is responsible for updating an MPN's provider listings, at minimum, on a quarterly basis.

How to review, receive or access the MPN provider directory?
An employer, insurer, or entity that provides physician network services shall ensure covered employees have access to, at minimum, a regional area listing of MPN providers in addition to maintaining and making available its complete provider directory listing in writing and/or on the MPN's website. The MPN's website address shall be clearly listed. If an employee requests an electronic provider directory listing, it shall be provided electronically on a CD, flash drive, via email or on a website. The URL address for the provider directory shall be listed with any additional information needed to access the directory online including any necessary instructions and passcodes. MPN applicants are responsible for updating an MPN's provider listings, at minimum, on a quarterly basis with the date of the last update provided on the listing given to the employee. Each provider directory listing shall include a phone number and an email address for reporting of provider listing inaccuracies. If a listed provider becomes deceased or is no longer treating workers' compensation patients at the listed address, the provider shall be taken off the provider directory within 45 days of notice to the MPN through the contact method stated on the provider directory listing to report inaccuracies.

What happens if I get injured at work?
<u>In case of an emergency, you should call 911 or go to the closest emergency room.</u>
If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer that you have had a work-related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

How do I choose a provider?
After the first medical visit, you may continue to be treated by this doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury. If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. If you need help in choosing a doctor you may call the MPN Contact or MPN Medical Access Assistant, listed on the last page of this notice.

Can I change providers?
Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. If you need help in choosing a doctor you may call the MPN Contact or MPN Medical Access Assistant, listed on the last page of this notice.

What standards does the MPN have to meet?
The MPN has providers in the entire State of California.

The MPN must give you a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The MPN must provide access to primary physicians within 15 miles and specialists within 30 miles. If you live in a rural area there may be a different standard. The MPN contact listed at the end of this notice has more information about the rural access standard. The MPN must provide initial treatment within 3 days. You must receive specialist treatment within 20 days of your request. If you have trouble getting an appointment, contact the MPN Contact, or MPN Medical Access Assistant.

What if there are no MPN providers where I am located?
If you are a current employee temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area, the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your own doctor outside of the MPN network. Contact your claims examiner, MPN Medical Access Assistant, or MPN contact for assistance in finding a physician or for additional information.

What if I need a specialist not in the MPN?
If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside the MPN. Contact your claims examiner, MPN Medical Access Assistant, or MPN Contact for assistance in finding a physician or for additional information.

What if I disagree with my doctor about medical treatment?
If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN. If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN and tell them you want a second opinion. The MPN should give you at least a regional MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within 60 days. You must tell the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

- If you do not make an appointment within 60 days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.
- If the second opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer. You will get another list of MPN doctors or specialists so you can make another selection.
- If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.
- Remember, if you do not make an appointment within 60 days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.
- If you disagree with the third opinion doctor, you may ask for an MPN Independent Medical Review (IMR). Your employer or MPN contact person will give you information on requesting an MPN Independent Medical Review and a form at the time you request a third opinion.

- If either the second or third opinion doctor agrees with your need for a treatment or test, you will be allowed to receive that medical service from a provider inside the MPN, including the second or third opinion physician.
- If the MPN Independent Medical Reviewer supports your need for a treatment or test you may receive that care from a doctor inside or outside of the MPN.

What if I am already being treated for a work-related injury before the MPN begins?
Your employer or insurer has a "Transfer of Care" policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

If you have properly predesignated a primary treating physician, you cannot be transferred into the MPN. (If you have questions about predesignation, ask your supervisor.) If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician.
If your employer decides to transfer you into the MPN, you and your primary treating physician must receive a letter notifying you of the transfer. If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the MPN. The qualifying conditions to postpone the transfer of your care are in the Qualifying Conditions chart listed as bullet points in the table below.

You can disagree with your employer's decision to transfer your care into the MPN. If you believe you have one of the four qualifying conditions that would preclude your transfer of care at this time, you should request a report from your primary treating physician. The medical report should describe which one of the four conditions you have, which may qualify for a postponement of your transfer into the MPN. Your primary treating physician has 20 days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within 20 days of your request, the employer can transfer your care into the MPN and you will be required to use a MPN physician. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Transfer of Care policy for more details on the dispute resolution process. For a copy of the entire transfer of care policy, ask your MPN Contact.

What if I am being treated by a MPN doctor who decides to leave the MPN?
Your employer or insurer has a written "Continuity of Care" policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

- If your employer decides that you do not qualify to continuing your care with the non-MPN provider, you and your primary treating physician must receive a letter of notification.
- If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must switch to MPN physicians. These conditions are set forth in the qualifying conditions table below.
- You can disagree with your employer's decision to deny your Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the Qualifying Conditions chart listed as bullet points below to see if you qualify to continue treating with your current doctor temporarily.
- Your primary treating physician has 20 days from the date of your request to give you a copy of his/her medical report on your condition. If your primary treating physician does not give you the report within 20 days of your request, the employer can transfer your care into the MPN and you will be required to use a MPN physician.
- If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Continuity of Care policy for more details on the dispute resolution process.

For a copy of the entire Continuity of Care policy, ask your MPN Contact.

EMPLOYER: TNC Holdings
MPN IDENTIFICATION NUMBER: # 2323 MPN NAME: Sedgwick/Harbor MPN

Qualifying Conditions
• (Acute) The treatment for your injury or illness will be completed in less than 90 days. • (Serious or chronic) Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made. • (Terminal) You have an incurable illness or irreversible condition that is likely to cause death within one year or less. • (Pending Surgery) You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

What if I have questions, complaints or need help?

MPN Contact

You may always contact the MPN Contact, if you need help or an explanation about your medical treatment for your work-related injury or illness. The MPN Contact shall be available to assist with any questions or complaints.
Sedgwick MPN Contact: Sedgwick MPN Coordinator
10690 White Rock Road, Ste. 100
Rancho Cordova, CA 95670
(800) 625-6588
Email: MPNCoordinators@Sedgwickcms.com
MPN website (for information and Rosters of all treating physicians in the MPN): www.harborsys.com/Sedgwick2
MPN Medical Access Assistant Toll-Free Number: (877) 334-9425

MPN Medical Provider Network (MPN) Medical Access Assistant

MPN Medical Access Assistants are located in the United States and are available, from Monday through Saturday from 7 am to 8 pm, Pacific Time, (excluding Sundays and Holidays), to provide employee assistance with access to medical care under the MPN. The employee assistance shall be available in English and Spanish. The assistance shall include contacting provider offices during regular business hours and scheduling medical appointments for covered employees. A toll-free number is listed on the last page of this notice, for the MPN Medical Access Assistant, including finding available MPN physicians of your choice, scheduling and confirming physician appointments.

MPN website (for information and Rosters of all treating physicians in the MPN): www.harborsys.com/Sedgwick2
MPN Medical Access Assistant Toll-Free Number: (877) 334-9425

Division of Workers' Compensation (DWC)

If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call DWC's Information and Assistance at (800) 736-7401. You can also go to DWC's website at www.dir.ca.gov/dwc and click on "medical provider networks" for more information about MPNs.

MPN Independent Medical Review

If you have questions about the MPN Independent Medical Review process contact the Division of Workers' Compensation's Medical Unit at:
DWC Medical Unit
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

Keep this information in case you have a work-related injury or illness