



PLEASE PRINT

WE CAN NOT PROCESS A PAYCHECK WITHOUT THIS INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____

STATE & ZIP CODE: _____

PHONE NUMBER: home: _____

cell: _____

SS #: _____

SEX: _____

RACE: _____

BIRTH DATE: _____

DATE HIRED: _____

UNION LOCAL # : _____

ARE YOU AN APPRENTICE: Y N IF YES WHAT %: _____

IN CASE OF EMERGENCY, NOTIFY:

NAME: _____

ADDRESS: _____

PHONE #: _____

THIS FORM TO BE ATTACHED TO W-4 AND I-9

NAME OF JOB

OFFICE USE ONLY: IN SYSTEM _____
DOR _____
SS CHECK _____
OSHA _____



58 Mellen St. Hopedale Ma. 01747
Voice 1-508-634-6600 • Fax 1-508-634-3611

As a new hire, you have provided Front Line with a copy of the following to receive a check:

- Drivers license or State issued picture ID
- INS – Alien Card
- Social Security Card or Birth Certificate
- 10 – hour OSHA card
- Union Book

You must also provide a completed W-4, I-9 and employee packet cover sheet. Without this information a check will not be cut.

Do you have a vehicle to get to work? YES NO

Are you physically able to do laboring work? YES NO

I am aware of the Front Line safety procedures, and agree that I will wear my hardhat and safety glasses at all time on the jobsite!

NAME (PRINT)

SIGNATURE

DATE

I give permission and consent for Frontline, Inc to take my photograph. I further give permission and consent that any such photographs may be published and used by Frontline, Inc.

Signed _____



58 Mellen St. Hopedale Ma. 01747
Phone 508-634-6600 * Fax 508-634-3611

FRONT LINE, INC.

Safety Requirements:

- Must wear safety goggles at all times.
- Must wear gloves.
- Must wear hard hat at all times.
- Must wear work boots.
- Must wear long pants.
- All ladders other than step ladders must be footed at all times.

Injury Policy:

In the event that a Front Line employee is injured on the job, the employee is required to immediately notify the foreman (if there is one) and project manager of the injury. Either the foreman or project manager will accompany the injured employee to the nearest recommended medical facility. Unless the employee has a "911" injury, meaning an ambulance needs to be called for an emergency, the employee must be accompanied by either a foreman or project manager to the care center of Front Line's choice (the nearest Concentra Urgent Care Center. Please note that in the event of an injury, Front Line reserves the right to have the employee engage in both a drug and alcohol test immediately following the injury.

Front Line has a light duty policy. If an employee is injured on the job and released for modified duty, they are required to come to Front Line's home office for light duty work.

In signing the below, the employee recognizes and agrees to abide by Front Line's injury and light duty policies.

EMPLOYEE _____

DATE _____



58 Mellen St. Hopedale Ma. 01747

Voice 1-508-634-6600 • Fax 1-508-634-3611

Dues Deduction Authorization

To all Employers by whom I am employed during the terms of the present or future Collective Bargaining Agreements either by and between signatory Contractor Associations and the Massachusetts & Northern New England Laborers' District Council of the Laborers' International Union of North America, AFL-CIO and its Affiliates, or by an Employer, not a member of said Associations, which has an individual collective Bargaining Agreement with the Council and its affiliates.

I, _____ / _____
(Print Member Name) (Social Security Number)

of Local # _____ hereby authorize my Employer to deduct from my wages each week one dollar and fifty-two cents (\$1.56) per hour for each hour worked, or the amount of dues specified in any future collective bargaining agreement covering my employment, all of said amounts constitute what are known as the hourly deductions as part of my membership dues for said week owing by me to the Union. Such deduction shall be made from my earned pay on each regularly-scheduled pay day and shall be remitted to the designated depository at the same time and along with the Health & Welfare Pension, Legal, Annuity, Training, New England Laborers' Labor-Management Cooperation Trust, New England Laborers' Health & Safety Fund and Massachusetts & Northern New England Laborers' Unified Trust contributions.

This authorization shall become operative upon the effective date of each Collective Bargaining Agreement entered into between my Employer and the Union or upon the date that I execute this card, whichever is sooner. This authorization shall remain in effect during the terms of the currents and all future Collective Bargaining Agreements entered into between my Employer and the Union unless it is specifically revoked in writing, bearing the date and my signature, and delivered to the Office of the Local Union of which I am a member and to the Employer to whom I am currently employed.

Laborers' Political League LIUNA PAC & LIUNA LPL Education Fund

This is to certify that _____ / _____
(Print Member Name) (Social Security Number)

Of Local # _____ has made a voluntary contribution of seven cents (\$.07) per hour for each hour worked. Foreign nationals may not contribute. I understand that this voluntary payment is not a condition of membership in the union and that the union cannot favor or disadvantage me because of the amount of my contribution or my decision not to contribute. The money received will be used to make political expenditures and contributions in connection with federal, state and local elections as outline herein. While specific amounts may be mentioned, these are merely suggestions, and you are free to contribute more or less than the suggestion.

I hereby authorize my Employer to deduct from my wages each week, seven cents (\$.07) per hour for each hour worked as a voluntary contribution.

Four cents (\$.04) shall be contributed to the Laborers' Political League (LPL), which I understand constitutes a separate segregated fund used for the purposes allowed under Massachusetts Campaign Finance Laws.

Three cents (\$.03) shall be contributed to the LIUNA PAC and the LIUNA LPL Education Fund, which I understand constitutes separate segregated funds for the purposes allowed under Federal Election Campaign Act, 2 U.S.C. Sec. 441(b).

Such authorization shall be remitted to the designated depository at the same time and along with the Health & Welfare, Pension, Legal, Annuity, Training, New England Laborers' Labor-Management Cooperation Trust, New England Laborers' Health & Safety Fund and Massachusetts Laborers' Unified Trust contributions.

Any revocation of the above must be in writing, bear the date and my signature, and will be delivered to the Offices of the Local Union of which I am a member and to the Employer to whom I am then currently employed.

Any and all contributions to the Laborers' Political League are not deductible as charitable contributions for Federal income tax purposes.

Signature: _____

Date: _____

Employee's Withholding Certificate

OMB No. 1545-0074

2021

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

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**
 (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**
 (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

Multiply the number of other dependents by \$500 ▶ \$

Add the amounts above and enter the total here **3** \$

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
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General Instructions

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 and you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

Step 4(b)—Deductions Worksheet (Keep for your records.)

- 1** Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$24,800 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,650 \text{ if you're head of household} \\ \bullet \$12,400 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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 with no other entries on the form; 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.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

Employer Notice to W2 Employee

Covered Entities with 25 or more Workers

Rights and Obligations under the Massachusetts Family and Medical Leave Law, M.G.L. c. 175M

Front Line, Inc.
(Employer Name)
58 Mellen Street
(Employer Street Address)
Hopedale, MA 01747
(Employer City, State, Zip)
04-3425068
(Federal Employer ID Number) (FEIN)

Explanation of Benefits

- **Beginning January 1, 2021**, you may be entitled to up to
 - 12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child, or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces;
 - 20 weeks of paid medical leave in a benefit year if they have a serious health condition that incapacitates them from work
 - 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member's military service.
- **Beginning July 1, 2021**, you may be entitled to up to
 - 12 weeks of paid family leave in a benefit year to care for a family member with a serious health condition.
 - 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year.
- **Your weekly benefit amount** will be based on the employee's earnings, with a maximum benefit of \$850 per week.

Job Protection, Continuation of Health Insurance, No Retaliation

- **Job Protection:** Generally, if you take family or medical leave under the law you must be restored to your previous position or to an equivalent position, with the same status, pay, employment benefits, length-of-service credit and seniority as of the date of leave.
- **Continuation of Health Insurance:** Your employer must continue to provide for and contribute to your employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if you had continued working continuously for the duration of such leave.
- **No Retaliation:** It is unlawful for any employer to discriminate or retaliate against you for exercising any right to which you're entitled under the paid family and medical leave law. An employee or former employee who is discriminated or retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court.

Contributions to the DFML Family and Employment Security Trust Fund

On October 1, 2019, contributions to the Department of Family and Medical Leave (DFML) Employment Security Trust Fund will begin. An employer will be responsible for sending contributions to the DFML for all employees, though they may deduct a portion from employee pay. The contribution rate may be adjusted annually and can be found in the attached effective rate notice.

How to File a Claim

Employees must file claims for paid family and medical leave benefits with the DFML using the Department's forms. Forms and claim instructions will be available on the Department's website www.mass.gov/DFML before January 2021.

Employees are required to provide at least 30 days' notice to their employer of the anticipated starting date of any leave, the anticipated length of the leave and the expected date of return. An employee who is unable to provide 30 days' notice due to circumstances beyond his or her control is required to provide notice as soon as practicable.

Payment for Concurrent Leave

Any paid leave provided under a collective bargaining agreement or employer policy and paid at the same or higher rate than paid leave available under this law shall count against the allotment of leave benefits available under this law.

Private Plan Exemption

An employer that offers paid leave with benefits that are at least as generous as those provided under the law may apply for an exemption from paying the Department of Family and Medical Leave Family and Employment Security Trust Fund contribution. An employer may apply for an exemption from the medical leave contribution, family leave contribution, or both.

The details of any private plan must be provided to employees by an employer at the same time as this Notice.

Employees enjoy rights to job-protected leave and from discrimination and retaliation under the law even if their employer is approved to provide leave benefits through a private plan.

<u>Front Line, Inc.</u> (Employer Name)	<input checked="" type="checkbox"/> Does not have an approved private plan; <input type="checkbox"/> Has an approved private plan for both family and medical leave; <input type="checkbox"/> Has an approved private plan for family leave only; <input type="checkbox"/> Has an approved private plan for medical leave only.
--	--

Department of Family and Medical Leave (DFML) Contact Information

The Massachusetts Department of Family and Medical Leave
Charles F. Hurley Building
19 Staniford Street, 1st Floor
Boston, MA 02114
(617) 626-6565
www.mass.gov/DFML

More Information is Available

For more detailed information, please consult the Department's website: www.mass.gov/DFML.

ACKNOWLEDGMENT

Your signature below acknowledges your receipt of the information above within 30 days from the start date of your employment or prior to October 1, 2019, whichever is later.

Signature

Date

Name (Print)

Your signed acknowledgement will be retained by your employer. Please retain a copy for your own reference.

Effective Rates: 2019

For employers with 25 or more employees

Family Leave Contribution	Medical Leave Contribution	Total Contribution Amount
.13%	.62%	.75%

On October 1, 2019, contributions to the Department of Family and Medical Leave (DFML) Employment Security Trust Fund will begin. An employer will be responsible for sending contributions to the DFML for all employees.

Currently, the total contribution amount is 00.75% of wages. Of that 00.75% total contribution amount, there is a split: 17.3% is a family leave contribution and 82.7% is a medical leave contribution.

Under the law, employers are responsible for a minimum of 60% of the medical leave contribution (.372% of wages), but are permitted to deduct from employees' wages up to 40% of the medical leave contribution (.248% of wages) and up to 100% of the family leave contribution (.13% of wages).

Medical Leave	Total Required Contribution: .62%		
	<u>Front Line, Inc.</u> (Employer Name)	will contribute	<u>40</u> % of the medical leave contribution
		and the remaining	<u>40</u> % will be deducted from your earnings

Family Leave	Total Required Contribution: .13%		
	<u>Front Line, Inc.</u> (Employer Name)	will contribute	<u>0</u> % of the family leave contribution
		and the remaining	<u>100</u> % will be deducted from your earnings

Initial _____



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (See instructions)
<p>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>
<p>QR Code - Section 1 Do Not Write in This Space</p>

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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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		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
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	Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative		
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	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)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing 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	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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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	OR LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. 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. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)		
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.	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
	4. Voter's registration card	
	5. U.S. Military card or draft record	4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
	6. Military dependent's ID card	
	7. U.S. Coast Guard Merchant Mariner Card	5. Native American tribal document
	8. Native American tribal document	
6. 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	9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above:	6. U.S. Citizen ID Card (Form I-197)
		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	10. School record or report card	
	11. Clinic, doctor, or hospital record	8. Employment authorization document issued by the Department of Homeland Security
	12. Day-care or nursery school record	

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

Refer to the instructions for more information about acceptable receipts.



58 Mellen Street
Hopedale, MA 01747
Phone (508) 634-6600 Fax (508) 634-3611

Memo

To: All field employees

From: Kim Harney

Date: 2/23/2009

Re: State taxes / Union dues

As of March 1, 2009 all payroll taxes and union benefits will follow the state where the work was performed per state regulations. If you have any questions please contact me @ 508-634-6600.

EARNED SICK TIME

Notice of Employee Rights

Beginning July 1, 2015, Massachusetts employees have the right to earn and take sick leave from work.

WHO QUALIFIES?

All employees in Massachusetts can earn sick time.

This includes full-time, part-time, temporary, and seasonal employees.

HOW IS IT EARNED?

- ☐ Employees earn 1 hour of sick time for every 30 hours they work.
- ☐ Employees can earn and use up to **40 hours per year** if they work enough hours.
- ☐ Employees with unused earned sick time at the end of the year can **rollover up to 40 hours**.
- ☐ Employees **begin earning** sick time on their first day of work and **may begin using** earned sick time 90 days after starting work.

WILL IT BE PAID?

- ☐ If an employer has 11 or more employees, sick time must be paid.
- ☐ For employers with 10 or fewer employees, sick time may be unpaid.
- ☐ Paid sick time must be paid on the same schedule and at the same rate as regular wages.

WHEN CAN IT BE USED?

- ☐ An employee can use sick time when the employee or the employee's child, spouse, parent, or parent of a spouse is sick, has a medical appointment, or has to address the effects of domestic violence.
- ☐ The smallest amount of sick time an employee can take is one hour.
- ☐ Sick time cannot be used as an excuse to be late for work without advance notice of a proper use.
- ☐ Use of sick time for other purposes is not allowed and may result in an employee being disciplined.

CAN AN EMPLOYER HAVE A DIFFERENT POLICY?

Yes. Employers may have their own sick leave or paid time off policy, so long as employees can use at least the same amount of time, for the same reasons, and with the same job-protections as under the Earned Sick Time Law.

RETALIATION

- ☐ Employees using earned sick time cannot be fired or otherwise retaliated against for exercising or attempting to exercise rights under the law.
- ☐ Examples of retaliation include: denying use or delaying payment of earned sick time, firing an employee, taking away work hours, or giving the employee undesirable assignments.

NOTICE & VERIFICATION

- ☐ Employees must **notify** their employer before they use sick time, except in an emergency.
- ☐ Employers may require employees to **use a reasonable notification system** the employer creates.
- ☐ Employees out of work for 3 consecutive days **OR** using sick time within 2 weeks prior to leaving their jobs, may be required by their employer to provide documentation from a medical provider.

DO YOU HAVE QUESTIONS?

Call the Fair Labor Division at 617-727-3465 ☐ E-Mail us at EarnedSickTime@state.ma.us

Visit www.mass.gov/ago/earnedsicktime



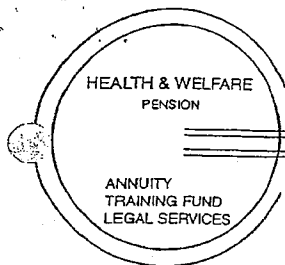
Commonwealth of Massachusetts
Office of the Attorney General

The Attorney General enforces the Earned Sick Time Law and regulations.

It is unlawful to violate any provision of the Earned Sick Time Law. Violations of any provision of the Earned Sick time law, M.G.L. c. 149, §148C, or these regulations, 940 CMR 33.00 shall be subject to paragraphs (1), (2), (4), (6) and (7) of subsection (b) of M.G.L. c. 149, §27C(b) and to §150.

This notice is intended to inform.

Full text of the law and regulations are available at www.mass.gov/ago/earnedsicktime.



MASSACHUSETTS LABORERS' BENEFIT FUNDS

14 NEW ENGLAND EXECUTIVE PARK • SUITE 200
P.O. BOX 4000, BURLINGTON, MASSACHUSETTS 01803-0900
TELEPHONE (781) 272-1000 OR (800) 342-3792 FAX (781) 272-2226

IMPORTANT – IF YOU ARE A LABORER AND WORK IN CONNECTICUT OR RHODE ISLAND

NEW ENGLAND LABORERS' RECIPROCAL AGREEMENT

TO ALL MASSACHUSETTS LABORERS BENEFIT PLAN PARTICIPANTS:


We are pleased to announce that effective for work performed on and after July 1, 2005, should you work in the states of Connecticut or Rhode Island, your contractor must pay all fringe benefit contributions and dues to conform to the collective bargaining agreement provisions in the jurisdiction in which you work. For example, should you work in Rhode Island the wage rate and other contribution rates established by the Rhode Island collective bargaining agreement must be remitted by your contractor to the Rhode Island Laborers' Funds. Once the Rhode Island Laborers' Funds have received your contributions from your employer, the contributions paid to those Funds, namely health and welfare, pension and annuity, will be reciprocated back to Massachusetts on your behalf. Contributions for work in Connecticut or Rhode Island are no longer permitted to be directly remitted by your contractor to the Massachusetts Laborers' Benefit Funds. This process is accomplished by the Massachusetts, Rhode Island and Connecticut Laborers' Funds signing a "money-follows-the-man" reciprocal agreement that requires the transfer of your fringe benefit contributions back to your "Home Funds" in Massachusetts.

In order to have contributions exchanged in a timely manner, **WHEN EVER YOU WORK OUTSIDE THE STATE OF MASSACHUSETTS YOU MUST CONTACT THE FUND OFFICE.** This will enable this office to follow up with the Fund Office in the state in which you are working to reciprocate the contributions received by those Funds on your behalf.

The Reciprocal Agreements provide that should you wish contributions for your work in Connecticut or Rhode Island to stay with those Funds, you have the options to elect **NOT** to have your contributions reciprocated. Please contact the Fund Offices in Massachusetts and the state you are working in and advise them that you do not authorize the transfer of contributions to your Home Fund in Massachusetts for that particular job assignment.

Should you have any questions regarding the "money-follow-the-man" reciprocal agreements, please contact the Fund Office.

Sincerely,

 Board of Trustees

E-Verify™



This employer will provide the Social Security Administration (SSA) and, if necessary, the Department of Homeland Security (DHS), with information from each new employee's Form I-9 to confirm work authorization.

IMPORTANT: If the Government cannot confirm that you are authorized to work, this employer is required to provide you written instructions and an opportunity to contact SSA and/or DHS before taking adverse action against you, including terminating your employment.

Employers may not use E-Verify to pre-screen job applicants or to re-verify current employees and may not limit or influence the choice of documents presented for use on the Form I-9.

In order to determine whether Form I-9 documentation is valid, this employer uses E-Verify's photo screening tool to match

the photograph appearing on some permanent resident and employment authorization cards with the official U.S. Citizenship and Immigration Services' (USCIS) photograph.

If you believe that your employer has violated its responsibilities under this program or has discriminated against you during the verification process based upon your national origin or

citizenship status, please call the Office of Special Counsel at 1-800-255-7688 (TDD: 1-800-237-2515).

N O T I C E:

**Federal law requires
all employers
to verify the identity and
employment eligibility
of all persons hired to work
in the United States.**





New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Massachusetts Laborers' Health and Welfare Fund (781) 272-1000.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name <i>Front Line, Inc.</i>		4. Employer Identification Number (EIN) <i>04-3425068</i>	
5. Employer address <i>58 Melten Street</i>		6. Employer phone number <i>508-634-6600</i>	
7. City <i>Hopedale</i>	8. State <i>MA</i>	9. ZIP code <i>01747</i>	
10. Who can we contact about employee health coverage at this job? <i>Massachusetts Laborers' Health & Welfare Fund, Eligibility Department</i>			
11. Phone number (if different from above) <i>781-272-1000</i>		12. Email address <i>www.mlb.org</i>	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees.

☒ Some employees. Eligible employees are:

Union Laborers who have met all eligibility requirements including hours worked. Coverage is provided thru The Massachusetts Laborers' Health & Welfare - 781-272-1000, or, www.mlb.org

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Your legally married spouse, and your children up to age 26. Children include: natural children, legally adopted children, children placed with you for adoption, and children, including step children for whom you have legal guardianship (provided he or she is also the member's federal income tax dependent).

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.**

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Time Sheet Front Line Inc

email: kharney@frontlineinc.info

Fax 1-508-634-3611 OR 1-508-473-0735

Name: _____

Telephone# _____

Week Ending: _____

		circle one	REG	OT	DT
SUN	GC:	slip			
		contract			
	Job:				
MON	GC:	slip			
		contract			
	Job:				
TUE	GC:	slip			
		contract			
	Job:				
WED	GC:	slip			
		contract			
	Job:				
THUR	GC:	slip			
		contract			
	Job:				
FRI	GC:	slip			
		contract			
	Job:				
SAT	GC:	slip			
		contract			
	Job:				

Total Reg Hours _____

Total OT Hours _____

Total DT Hours _____

Time sheets MUST be submitted online, faxed or emailed by midnight on Sunday