APPLICATION FOR EMPLOYMENT

Reynolds Asphalt & Construction Company is an Equal Opportunity Employer

PERSONAL INFORMATION DATE _____

APPLICANT NAME _____
LAST FIRST MIDDLE

SOCIAL SECURITY# _____

PRESENT ADDRESS _____
STREET CITY STATE ZIP

PERMANENT ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE# _____ Are you 18 years or older? **(Y) (N)**
CELL PHONE# _____

You are subject to medical & drug testing at any time with this company.
Explain "Yes" answers to any of the following questions.

1. Have you used any drugs that would indicate a *"Positive"* result on a drug test? **(Y) (N)**
2. Do you have any violations on your driving record? **(Y) (N)** (This will be verified.)
3. Have you ever been convicted of a crime (other than a minor traffic citation)? **(Y) (N)**
   If yes, please explain fully on a separate sheet of paper. Conviction of a crime is not an automatic bar to employment-all circumstances will be considered.

Position Desired_____ Date you are available to begin work_____

Are you employed now? **(Y) (N)** If so, may we contact your employer? **(Y) (N)**

Have you applied with this company before? **(Y) (N)** Where and When?_____

How did you hear about this position?_____

EDUCATION

	NAME & LOCATION	YEARS ATTENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
Grammar School				
High School				
College				
Trade, Business or Correspondence School				

FORMER EMPLOYER (LIST LAST FOUR EMPLOYERS, STARTING WITH LAST ONE FIRST).

DATE MONTH/YR	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				
FROM				
TO				
FROM				
TO				

REFERENCES: GIVE THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR

NAME	ADDRESS	BUSINESS	YEARS KNOWN
1.			
2.			
3.			

PHYSICAL RECORD:

DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT PRECLUDE YOU FROM PERFORMING ANY WORK FOR WHICH YOU ARE BEING CONSIDERED? **(Y) (N)**

IF YES, WHAT CAN BE DONE TO ACCOMMODATE YOUR LIMITATION? _____

PLEASE DESCRIBE:

In case of emergency notify: _____

NAME ADDRESS PHONE#

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result form furnishing same to you.

I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time without any prior notice."

DATE SIGNATURE

INTERVIEWED BY			DATE	
HIRED (Y) (N)	POSITION		DEPT.	
SALARY/WAGE		DATE REPORTING TO WORK		
APPROVED	1.	2.	3.	
	EMPLOYMENT MANAGER	DEPT HEAD	GENERAL MANAGER	

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

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

What Is the Purpose of This Form?

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

When Should Form I-9 Be Used?

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

Filling Out Form I-9

Section 1, Employee

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

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

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

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

Section 2, Employer

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

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

Employers must record in Section 2:

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

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

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

Section 3, Updating and Reverification

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

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

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

What Is the Filing Fee?

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

USCIS Forms and Information

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

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

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

Photocopying and Retaining Form I-9

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

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

Privacy Act Notice

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

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

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

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

Paperwork Reduction Act

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

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

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

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

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

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

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

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

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

Employee's Signature — Date *(month/day/year)*

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

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

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

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

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

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*		Date *(month/day/year)*

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

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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

Signature of Employer or Authorized Representative	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

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.** Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)				**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
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		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**3.** School ID card with a photograph		
		4. Voter's registration card		**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. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		**5.** U.S. Military card or draft record		
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		**5.** Native American tribal document
		8. Native American tribal document		**6.** U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
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		**10.** School record or report card		**8.** Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

EMPLOYEE DRIVING RECORD AUTHORIZATION

It is the policy of **REYNOLDS ASPHALT & CONSTRUCTION COMPANY** to check the driving record of employees who may operate a company motor vehicle. You are being asked to consent to a DRIVING RECORD check and periodic checks in the future. By signing the following statement you are giving your consent to the periodic checks.

I do hereby appoint and / or assign REYNOLDS ASPHALT & CONSTRUCTION COMPANY to conduct or commission periodic checks of my driving record. I agree to indemnify and release REYNOLDS ASPHALT & CONSTRUCTION COMPANY and its agents from any and all liability for claims, damages, losses or actions resulting from or arising from its investigation, except as such may be caused by or arise out of the gross negligence or unauthorized act of either party. I understand that an adverse driving record may be grounds for reassignment or termination of employment.

I have read the above statement and accept the same as a condition of my employment with REYNOLDS ASPHALT & CONSTRUCTION COMPANY.

Texas Drivers License # Date of Birth (Month/Day/Year)

Signature Date

Printed Name

Witness

Form W-4 (2010)

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 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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 $1,800 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 $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children.

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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $18,000 ($32,000 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.

Cut 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

2010

1 Type or print your first name and middle initial.	Last name	**2** Your social security number	
Home address (number and street or rural route)		**3** ☐ 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 2010, 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
(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 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: $11,400 if married filing jointly or qualifying widow(er) $8,400 if head of household $5,700 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 2010 adjustments to income and any additional standard deduction. (Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.)	5	$
6	Enter an estimate of your 2010 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 $3,650 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 4–9 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 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. 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		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $6,000	0
7,001 - 10,000	1	6,001 - 12,000	1
10,001 - 16,000	2	12,001 - 19,000	2
16,001 - 22,000	3	19,001 - 26,000	3
22,001 - 27,000	4	26,001 - 35,000	4
27,001 - 35,000	5	35,001 - 50,000	5
35,001 - 44,000	6	50,001 - 65,000	6
44,001 - 50,000	7	65,001 - 80,000	7
50,001 - 55,000	8	80,001 - 90,000	8
55,001 - 65,000	9	90,001 -120,000	9
65,001 - 72,000	10	120,001 and over	10
72,001 - 85,000	11		
85,001 -105,000	12		
105,001 -115,000	13		
115,001 -130,000	14		
130,001 - and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$550	$0 - $35,000	$550
65,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 165,000	1,020
185,001 - 330,000	1,200	165,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

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 using it 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.

REYNOLDS ASPHALT AND CONSTRUCTION CO.
PO Box 370 Euless, Texas 76039
Metro (817) 267-3131
FAX (817) 267-1878

DEAR EMPLOYEE AND ELIGIBLE DEPENDENTS:

PLEASE READ THE ATTACHED FORMS AND FILE WITH YOUR INSURANCE PAPERS.

PLEASE SIGN AND DATE THIS ACKNOWLEDGEMENT OF RECEIPT AND RETURN TO MELANI MARTIN AT THE MAIN OFFICE.

ENCLOSED:

1. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)
2. NEW HIRE NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
3. NEW HIRE NOTICE OF SPECIAL ENROLLMENT RIGHTS
4. NEW HIRE NOTICE OF PRE-EXISTING CONDITIONS LIMITATIONS
5. NEW HIRE NOTICE OF NEWBORN'S AND MOTHER'S PROTECTION ACT OF 1996
6. MODEL NOTICE OF EMPLOYEE'S RIGHTS TO CONTINUE GROUP HEALTH COVERAGE

THANK YOU,

BILL EVANS
HEALTH AND LIFE INSURANCE REPRESENTATIVE

BCBS

_____ _____
NAME DATE

TRAVELERS

First Health®

Workers' Compensation Health Care Network
Employee Acknowledgment Form

I have received information that tells me how to get medical care under workers' compensation insurance. I understand that my employer uses the **First Health/Travelers Health Care Network (HCN)**.

If I have a work-related injury or illness and I live in the Network Service Area described in this information, then I understand that:

1. I am required to choose a treating doctor from the list of doctors in the HCN.

   Note: There is only one exception to this requirement, which applies if I am covered by an HMO for my Group Health benefits. In that case, I may choose my HMO Primary Care Physician (PCP) to serve as my treating doctor. My PCP must agree to all the requirements of the HCN. I must check one of the following boxes:

   - ❑ I choose my HMO PCP to provide any medical care related to a work-related injury or illness. I will call the HCN at 1-866-245-6472 and tell the HCN the name of my PCP, or,
   - ❑ I do not choose my HMO PCP to provide any medical care related to a work-related injury or illness.

2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.

3. The insurance carrier will pay the treating doctor and other network providers.

4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.

_____ _____
(Employee Signature) (Date)

_____
(Printed Name)

I live at _____
(Street Address)

_____
(City) (State) (ZIP Code)

Name of Employer: _____

Name of Network: First Health/Travelers HCN

The Network Service Area is subject to change.
If you need a treating provider call the HCN at: 1- 866-245-6472.
PLEASE RETURN THE COMPLETED FORM TO YOUR EMPLOYER

Formulario de Acuse de Recibo por el Empleado de Información sobre la Red de Cuidado de Salud (HCN) de Compensación por Lesiones de Trabajo

He recibido información que me notifica cómo obtener cuidado médico bajo el seguro de compensación por lesiones de trabajo ("Workers' Compensation" por su nombre en inglés). Entiendo que mi empleador utiliza **la Red de Cuidado Médico First Health Travelers**.

Si me lesiono en el trabajo y vivo en el área de servicio descrita en esta información, entiendo que:

1. Debo escoger un médico tratante de la lista de médicos de la red del HCN.

   Nota: Hay solamente una excepción a este requisito que se aplica si estoy cubierto por un HMO en mi grupo de beneficios médicos. En ese caso, puedo elegir a mi médico primario del cuidado de HMO (PCP) que sirva como mi doctor de tratamiento. Mi PCP debe adherir a todos los requisitos del HCN. Debo escoger una de las siguientes:

   - ❑ Elijo a mi HMO PCP para que proporcione cualquier asistencia médica relacionada con una lesión o enfermedad relacionada con el trabajo. Llamaré al HCN al 1-866-245-6472 y le diré a HCN el nombre de mi PCP (médico primario del cuidado) o,
   - ❑ No elijo a mi HMO PCP para que proporcione ninguna asistencia médica relacionada con una lesión o una enfermedad relacionada con el trabajo.

2. Debo acudir a mi médico tratante para recibir cualquier y toda atención médica por mi lesión. En caso de necesitar un especialista, mi médico tratante me derivará. Si necesito cuidado de urgencia, puedo buscar atención médica en cualquier lugar.
3. La compañía de seguro pagará al médico tratante y a los otros profesionales de la red.
4. Es posible que yo tenga que pagar la factura si recibo atención médica de personas ajenas a la red sin aprobación previa de la HCN.

_____ _____

(Firma) (Fecha)

_____

(Nombre y apellido en letra de molde)

Vivo en _____

(Domicilio)

_____

(Ciudad) (Estado) (Código postal)

Nombre de la compañía: _____

Nombre de la Red: First Health/Travelers HCN

El área de servicio de la red está sujeta a cambios.
Si usted necesita un profesional médico tratante llame a la HCN al: 1-866-245-6472.
DEVUELVA ESTE FORMULARIO COMPLETADO A SU COMPAÑÍ

Mạng Lưới Chăm Sóc Sức Khỏe Bồi Thường Tai Nạn Lao Động
Mẫu Xác Nhận Của Nhân Viên

Tôi đã nhận được hướng dẫn cách có được dịch vụ chữa trị theo diện bảo hiểm bồi thường tai nạn lao động. Tôi biết là hãng sở của tôi sử dụng **First Health/Travelers Health Care Network (HCN).**

Nếu tôi gặp một thương tích hay căn bệnh liên quan tới công việc và tôi cư ngụ trong Khu Vực Phục Vụ của Mạng Lưới như trình bày trong tờ thông tin này, thì tôi hiểu rằng:

1. Tôi phải lựa chọn một bác sĩ điều trị trong danh sách các bác sĩ của HCN.
   Lưu ý: Chỉ có một trường hợp ngoại lệ đối với yêu cầu này, và ngoại lệ này sẽ áp dụng nếu tôi nhận bảo hiểm Sức Khỏe Theo Nhóm qua HMO. Trong trường hợp đó, tôi có thể chọn Bác Sĩ Chăm Sóc Chính HMO của tôi (PCP) là bác sĩ điều trị. PCP của tôi phải đồng ý với tất cả các yêu cầu của HCN. Tôi phải đánh dấu vào một trong các ô sau đây:
   - ❑ Tôi chọn PCP trong HMO của tôi cho các dịch vụ điều trị liên quan tới một thương tích hoặc căn bệnh liên quan tới công việc. Tôi sẽ gọi HCN tại số 1-866-245-6472 để thông báo tên PCP của tôi, hoặc,
   - ❑ Tôi không chọn PCP trong HMO của tôi cho các dịch vụ điều trị liên quan tới một thương tích hoặc căn bệnh liên quan tới công việc.

2. Tôi phải nhận toàn bộ dịch vụ chữa trị cho thương tích của tôi qua bác sĩ điều trị. Nếu tôi cần bác sĩ chuyên khoa, bác sĩ điều trị của tôi sẽ giới thiệu tôi. Nếu tôi cần chăm sóc cấp cứu, tôi có thể tới bất kỳ đâu.

3. Hãng bảo hiểm sẽ trả tiền cho bác sĩ điều trị và các nhà cung cấp dịch vụ khác trong mạng lưới.

4. Tôi có thể phải trả chi phí nếu chữa trị qua người khác không phải là bác sĩ trong mạng lưới khi chưa được mạng lưới cho phép.

_____ _____
(Chữ Ký Của Nhân Viên) (Ngày)

_____
(Tên Viết Bằng Chữ In)

Tôi cư ngụ tại

_____
(Địa Chỉ Đường Phố)

_____
(Thành Phố) (Tiểu Bang) (Số ZIP Code)

Tên của Hãng Sở: _____

Tên của Mạng Lưới: First Health/Travelers HCN_____

Khu Vực Phục Vụ của Mạng Lưới có thể thay đổi.
Nếu bạn cần bác sĩ điều trị, xin gọi HCN tại: 1- 866-245-6472.
VUI LÒNG GỬI LẠI MẪU ĐƠN ĐÃ ĐIỀN CHO HÃNG SỞ CỦA BẠN

REYNOLDS ASPHALT AND CONSTRUCTION CO.
PO Box 370 Euless, Texas 76039
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NOTIFICATION OF DRUG AND ALCOHOL POLICY

EFFECTIVE DATE: January 1, 2003

Because of growing concern regarding the effects of alcohol and drug abuse in the workplace, the potential adverse impact of such abuse on employees, the safety of employees and to comply with federal laws such as the Department of Transportation's Federal Highway Administration Substance Abuse policy, Reynolds Asphalt and Construction Company (RAC) has developed a Substance Abuse Policy for our employees.

Use and misuse of alcohol or drugs can and does impair the ability of an employee to perform their duties. Such abusive activity may endanger the employee, his/her co-workers, company property, and the public at large. Reynolds Asphalt and Construction Company will try to prevent the use, misuse, and or abuse of substances which impair the employee's ability to perform their duties.

Therefore, in the interest of safety for the employee and their fellow co-workers, it is the policy of RAC to require urine drug testing and alcohol testing under the circumstances outlined in RAC's Substance Abuse Policy.

Each employee and candidate for employment is hereby notified of the following:

Safety and efficiency make enforcement of the Substance Abuse Policy a pre-requisite to providing a safe and productive workplace for all employees and our customers.

Drug and alcohol testing is part of RAC's Substance Abuse Policy, as are possible searches. Drug and alcohol testing will begin as of the effective date of this policy. The testing program was designed as a deterrent to continued abuse, and encouragement to seek help before personal problems affect job performance, and to help overcome an individual's natural tendency to deny there is a problem.

RAC has taken the necessary precautions to ensure the accuracy of all tests.

RAC will test all candidates for new hire and rehire. All applicants who fail to pass a drug test will have their employment offers revoked by RAC.

ALL OFFERS OF EMPLOYMENT ARE EXPRESSLY CONTINGENT UPON NEGATIVE DRUG TEST RESULTS.

Employees who are suspected of a violation of the Substance Abuse Policy will be tested. Any individual involved in either an on-the-job accident that causes injury to a person, including themselves, or destruction of property will be tested.

ANY EMPLOYEE WHO REFUSES A DRUG OR ALCOHOL TEST WILL BE TERMINATED.

This is only a notice and does not contain all the provisions of the Substance Abuse Policy adapted by RAC. All employees are expected to educate themselves on the policy and must agree to abide by the policy as a condition of continued employment with RAC. A complete copy of RAC's Substance Abuse Policy is attached for personnel reference and is on file with the Substance Abuse Program Manager (Bill Evans). RAC retains the privilege to make changes or revisions to any part or parts of this policy without further notice and at any time which are binding on all current employees.

Gary E. Reynolds December 2, 2002
Gary E. Reynolds, President

EMPLOYEE ACKNOWLEDGMENT FOR FHWA/DOT & NON-DOT

I acknowledge that I have received a copy of the RAC Drug and Alcohol Policy. I also acknowledge that the provisions of the policy are part of the terms and conditions of my employment and that I agree to abide by them. In addition, my signature below constitutes voluntary consent to RAC's request for me to provide urine, breath and blood samples for Department of Transportation testing under 49CFR Part 382 and 40 and/or under RAC's Substance Abuse Program. I fully understand that failure to cooperate will result in termination or the offer of employment being withdrawn.

THIS COPY TO BE MAINTAINED IN THE PERSONNEL FILE

Signature of Employee	**RAC Witness**
Print Name	**Date**
Employee Social Security #	