**Dalrada Financial Corporation** | 9449 Balboa Avenue, Suite 210 San Diego, CA 92123
P: 858.427.8700 F. 858.277.3448 www.dalrada.com

# NEW EMPLOYEE CHECKLIST

Employee Name______________________________ Date of Hire ___________________

| Form, Information or Action | Date Issued | Date Completed |
|---|---|---|
| Emergency Information | | |
| Employee Handbook (*in revision, to be distributed shortly)* | | |
| **Workers' Compensation Statement** | | ----- |
| **Form DE2515: Disability Insurance Pamphlet (CA Only)** | | ----- |
| **Form I-9: Employment Eligibility Verification (INS)** | | |
| **Form W-4: Employee Withholding** | | |
| Health Insurance and Benefits Information | | |
| ● Initial Notice of COBRA Rights | | |
| **Sexual Harassment Information** | | ----- |
| Other: | | |
| | | |
| | | |
| | | |
| | | |

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# APPLICATION FOR EMPLOYMENT

Client Company: ________________________ Date:___________

## PERSONAL INFORMATION

Name_______________________________________________Social Security Number - -
Last First Middle

Present Address_____________________________________________________________
Street City State Zip

Home Phone Number (___)_____________________________ Do you have the legal right to work in the U.S.? ☐ Yes ☐No

Position Applying For_______________________ Shift_______________________ Email ______________________________

Have you ever been employed by Dalrada Financial? If yes, when and where? ___________________________________________

**Dalrada Financial offers equal employment opportunities regardless of sex, age, race, color, religious creed, national origin, ancestry, medical status, medical condition, physical or mental disability, pregnancy or sexual orientation.**

Do you have a current Driver's License? ☐ Yes ☐ No Name of issuing state.______________________________
Driver's License Number______________________ Has your Driver's License ever been revoked or suspended? ☐ Yes ☐ No
If yes, state reasons, date of revocation or suspension and date of reinstatement. ____________________________________

Have you ever been convicted of a felony in relation to the position for which you are applying? ☐Yes ☐No
If yes, state date, location and disposition of the case.______________________________________________
(Disclosure will not necessarily bar employment.)

If hired, can you provide written evidence that you are authorized to work in the U.S.? ☐Yes ☐No

Are you eligible to perform the essential functions of the position for which you are applying either with or without reasonable accommodations? ________
If necessary, please describe what types of reasonable accommodations are needed. ____________________________________
________________________________________________________________________________

Emergency Contact:_________________________________________________________________
Name Address

____________________________________________(___)___________________________
City State Zip Telephone Relationship

***PLEASE REVIEW THE FOLLOWING BEFORE SIGNING THIS APPLICATION FOR EMPLOYMENT.***

I authorize any representative of Dalrada Financial to investigate my background, including but not limited to, references, education and work history. I authorize the above and any other individual or entity that may posses information about my background to provide full disclosure without prior notice to me. I release all of the above from any and all liability for damage of any kind which may at any time result to me because of compliance with this authorization to release information.

I understand that any falsification of this or any Dalrada Financial document may result in failure to receive an offer or if hired, dismissal from employment. I understand that any offer may be conditional on the successful completion of medical or drug testing.

**Signature of Applicant**:_______________________________________________**Date:**______________

## IMPORTANT THIS SECTION MUST BE FULLY COMPLETED BY CLIENT TO BE PROCESSED

Date of Hire:_______________ Job Position Title:___________________________ W/C Code: ______________________

Salary ☐ Rate of Pay: _____________________ Full Time ☐ Part Time ☐ Exempt ☐ Non-exempt ☐

Hourly ☐ Rate of Pay: _____________________ Full Time ☐ Part Time ☐ Exempt ☐ Non-exempt ☐

**DALRADA FINANCIAL OFFICE USE ONLY-**

DOB:____________________ W4: _____________________ AUTHORIZED: _______________________ DATE: ________

## FORMER EMPLOYERS

List below the last three employers, starting with the most recent one first.

Name of Present or Last Employer:______________________________________________

Address:______________________________City__________________State__________Zip__________

Starting Date:_______________Leaving Date:__________________Job Title:______________________________

Weekly Starting Salary:__________________Weekly Final Salary______________May we contact your Supervisor:__________

Name of Supervisor:____________________Title:_________________________Phone:(     )__________________________

Description of Work:______________________________________________

Reason for Leaving:______________________________________________

Name of Present or Last Employer:______________________________________________

Address:______________________________City__________________State__________Zip__________

Starting Date:_______________Leaving Date:__________________Job Title:______________________________

Weekly Starting Salary:__________________Weekly Final Salary______________May we contact your Supervisor:__________

Name of Supervisor:____________________Title:_________________________Phone:(     )__________________________

Description of Work:______________________________________________

Reason for Leaving:______________________________________________

Name of Present or Last Employer:______________________________________________

Address:______________________________City__________________State__________Zip__________

Starting Date:_______________Leaving Date:__________________Job Title:______________________________

Weekly Starting Salary:__________________Weekly Final Salary______________May we contact your Supervisor:__________

Name of Supervisor:____________________Title:_________________________Phone:(     )__________________________

Description of Work:______________________________________________

Reason for Leaving:______________________________________________

**References: Names of three persons you are not related to, whom you have known at least one year.**

| NAME | ADDRESS | BUSINESS | YEARS ACQUAINTED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

# INITIAL NOTICE OF COBRA RIGHTS

To be given to employees at the time of hire.

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage in certain instances where coverage under the plan would otherwise end. This is commonly called COBRA. You do not have to show that you are insurable to elect continuation coverage. However, you may have to pay all or part of the premium for your continuation coverage. At the end of the maximum coverage period (described below), you must be allowed to enroll in an individual conversion health plan if it is otherwise available under the plan.

The purpose of this letter is to summarize your and your dependents' rights. Both you and your spouse should read this summary carefully.

- **QUALIFYING EVENTS**

If you lose coverage under a qualified medical plan for any on of the following two "qualifying events" you have a right to elect continuation of coverage:

1) Termination of your employment (for reasons other than your gross misconduct); or
2) Reduction of the hours of your employment, if such reduction causes you to no longer be eligible for coverage under the plan.

If you are the spouse of an employee covered by the plan you have the right to elect continuation coverage if you lost coverage under the plan for any of the following "qualifying events":

1) The death of your spouse.
2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the employer which causes a loss of plan coverage;
3) Divorce or legal separation from your spouse; or
4) Your spouse becomes entitled to Medicare benefits.

In the case of a dependent child of an employee covered by the plan, he or she has the right to elect continuation coverage if group health coverage under the plan is lost for any of the following "qualifying events":

1) The death of the employee parent;
2) The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment with the employer, causing that employee to lose coverage under the plan;
3) Parents' divorce or legal separation;
4) The employee parent becomes entitled to Medicare benefits; or
5) The dependent ceases to be a "dependent child" under the plan.

- **NOTICES AND ELECTION**

The employee or a family member has the responsibility to notify the employer of a divorce, legal separation or a child losing dependent status under the plan. You or your family member must give this notice no later than 60 days after the day you would lose coverage because of one of the above events. If you fail to give this notice during the 60-day period, you will be offered the option to elect continuation coverage.

After the employer has been notified that one of the events has occurred, you will be notified that you have the right to elect continuation coverage. Under the law, you must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the date of the notice of your right to elect continuation coverage. If you do not elect continuation coverage within the 60-day period, you will lose your right to elect continuation coverage.

A covered employee or the spouse of the covered employee may elect continuation coverage for all family members. The covered employee, his or her spouse and dependent children, however, each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered employee does not elect it.

- **TYPE OF COVERAGE; PREMIUM PAYMENTS**

If you elect coverage, the employer must give you coverage that, as of the time coverage is provided, is identical to the coverage provided under the employer's plan to similarly situated employees or family member. This means that if the coverage for similarly situation employees of family members is modified, your coverage will be modified.

You must pay the premium payments for your "initial premium months" by the 45th day after you elect continuation coverage. Your initial premium months are the months that end on or before the 45th day after you elect continuation coverage. All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period.

- **MAXIMUM COVERAGE PERIODS**

If you (spouse or dependent child) lose group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lost your status as a dependent under the plan, the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

If you (employee, spouse or dependent child) lost group health coverage because of a termination or reduction in hours of the employee's employment, the maximum continuation coverage period (for the employee, spouse and dependent child) is 18 months from the date of termination or reduction in hours. There are two exceptions to this rule:

1. For an employee or family member who is disabled on the date of termination or reduction in hours, the continuation coverage period is 29 months from the date of termination or reduction in hours. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided by the disabled individual to the employer within the 18-month coverage period and within 60 days after the date of the determination.

2. If a second qualifying event occurs (for example, the employee dies or becomes divorced) within the 18-month or 29-month coverage period, the maximum coverage period becomes three years from the date of the termination or reduction in hours.

- **ENTITLEMENT TO MEDICARE BENEFITS**

If you are the spouse or dependent of an employee who becomes entitled to Medicare (either before or after that qualifying event), your maximum coverage period ends three years from the date the employee became entitled to Medicare, or, if later, on the last day of the maximum coverage period for which you were eligible due to the qualifying event.

- **TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD**

Your continuation coverage automatically terminates (even before the end of the maximum coverage period) when any one of the following events occurs:

1) The employer no longer provides group health coverage to any of its employees;
2) The premium for your continuation coverage is not timely paid;
3) You become covered under another group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any preexisting condition of you;
4) You become entitled to Medicare benefits;
5) If you become entitled to a 29-month maximum coverage period, but then there is a final determination under Title II or XVI of the Social Security Act that you are no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination.

**Please notify Dalrada Financial Corporation promptly of any changes in your or your dependent's status related to marital status or address.**

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# Employee Emergency Information

**Client** ______________________________________________

**Employee Name** ____________________ **S.S. #** __________________

**Address** ______________________________________________

**Phone Number** (______) ________________________

**In case of an emergency, please contact:**

**1. Name** ________________________ **Relationship** ______________

**Address** ______________________________________________

**Phone Number** (______) ________________________

**2. Name** ________________________ **Relationship** ______________

**Address** ______________________________________________

**Phone Number** (______) ________________________

**I authorize** ____________________ **to seek emergency treatment for me. I am allergic to the following medications:**

__________________________ __________________________

__________________________ __________________________

**Signed** ______________________ **Date** ______________________

**This form is to be retained at the client site for referral in case of an emergency.**

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# EMPLOYEE ACKNOWLEDGMENT FOR WORKERS' COMPENSATION PROCEDURES

Dalrada Financial Corporation is involved with a wide variety of Medical Providers for Workers' Compensation. This helps provide the most timely and suitable, quality medical care in the event of an injury on the job. Dalrada Financial Corporation requires post-accidents drug testing. If an employee is clinically tested and the results are positive, disciplinary action will be taken up to and including termination.

**The following procedures must be followed for all work related injures and illnesses.**

1) Report promptly all work-related injuries to your supervisor. Your supervisor will direct you to the nearest authorized Occupational Medical Provider.
2) If it is a medical emergency, get medical care immediately, then notify your supervisor.
3) Complete a Workers' Compensation Injured Employee Packet within 24 hours of the time of the injury.
4) Take post injury drug screen at the clinic.
5) After treatment, you must bring back to your supervisor the paperwork given to you at the clinic. This will normally include the Doctor's Report with any Work Restrictions and Documentation that you did take a Drug Test. Understand that in almost every case "Modified Work Will be Offered to You".
6) You may choose to inform your employer that you wish to pre-designate your personal medical doctor by filling out a pre-designation form. Please see your supervisor for this form.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury.

__________________________________ ____________________
Employee Name Social Security Number

__________________________________ ____________________
Employee Signature Date

__________________________________
Company Name

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# Non-Harassment Policy

We believe that people are our most important asset and expect *Dalrada Financial's* employees to observe the highest standards of conduct. In keeping with those values, *Dalrada Financial* has long been committed to assisting our employees in maintaining a work environment that is free of harassment on the basis of any legally protected status. Accordingly, all *Dalrada Financial* employees are expected to avoid any behavior or conduct that could reasonably be interpreted as unlawful harassment. All *Dalrada Financial* employees are also expected to make known promptly, through the avenues identified below, whenever they experience or witness such behavior.

The conduct prohibited by this policy includes all unwelcome conduct, whether verbal, physical, or visual, that is based upon protected status, such as sex, color, race, ancestry, religion, national origin, age, disability, medical condition, marital status, veteran status, citizenship, sexual orientation, or other protected group status.

The conduct forbidden by this policy specifically includes, but is not limited to: (a) epithets, slurs, negative stereotyping, or intimidating acts that are based on a person's protected status; and (b) written or graphic material circulated within or posted within the workplace that shows hostility toward a person because of his or her protected status.

Sexual Harassment is a problem that deserves special mention. Sexual harassment includes unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature not only when the conduct is made as a condition of employment, or a basis for employment decisions, but also when the conduct creates an intimidating, hostile, or offensive work environment. Sexual harassment also affects third parties. An employee may file a complaint if they feel that sexual harassment between other employees is affecting their work environment, even if the harassment is not directed towards them.

Sexual harassment includes unwanted sexual advances, offering employment benefits in exchange for sexual favors, and making or threatening reprisals after a negative response of sexual advances. Sexual harassment is not limited to explicit demands for sexual favors. It may also include such actions as (1) sex-oriented verbal kidding, teasing, or jokes; (2) repeated offensive sexual flirtations, advances, or propositions; (3) continued or repeated verbal abuse of a sexual nature; (4) graphic or degrading comments about an individual or his or her appearance or sexual activity; (5) visual conduct, including leering, making sexual gestures, the display of sexually suggestive objects or pictures, cartoons or posters; (6) subtle pressure for sexual activity; (7) suggestive or obscene letters, notes, or invitations; or (8) physical contact such as patting, hugging, pinching, or brushing against another's body.

If you experience or witness any conduct you feel may be inconsistent with this policy, *Dalrada Financial* encourages and expects you to immediately notify your supervisor and/ or Human Resources. If you are reluctant to do this for any reason, you may notify another member of senior management instead. Please take every step you can to make sure your concern is known to management. Employees are also expected and encouraged to inform others in the workplace whenever their conduct is unwelcome, offensive, in poor taste, or inappropriate.

All reports that you make will be fully investigated. In investigating complaints of harassment under this policy, *Dalrada Financial* may impose discipline for inappropriate conduct that comes to *Dalrada Financial's* attention, up to and including termination, without regard to whether the conduct constitutes a violation of law or even a violation of this policy. In the event of harassment by an individual who is not employed by *Dalrada Financial*, *Dalrada Financial* will take whatever corrective action is appropriate under the circumstances.

Any employee who reports unlawful harassment or cooperates in the investigation of a complaint will be protected from retaliatory action. *Dalrada Financial* will preserve confidentiality to the extent the needs of the investigation permit.

All employees have a personal responsibility to conduct themselves in compliance with this policy and to report any observations of harassment. (Employees in some states can be held personally liable for sexual harassment.)

If you have any questions regarding this policy, please contact the Human Resources.

*I have received a copy of Dalrada Financial Corporation's Non-Harassment policy which addresses Sexual Harassment specifically.*

________________________________ ________________________

*Employee Signature* *Date*

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# Equal Opportunity Policy Statement

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It is the policy of Dalrada Financial Corporation to base all decisions concerning employment so as to promote the principle of Equal Opportunity Employment. Accordingly, the employment policies and practices of Dalrada Financial Corporation, are to recruit and hire employees without discrimination because of race, sex, color, religion, national origin, ancestry, citizenship, pregnancy, age, marital status, sexual orientation, medical condition, or mental or physical disability as defined by law, and to treat employees without discrimination with respect to compensation and opportunity for advancement and promotion. Reasonable accommodation of otherwise qualified mentally or physically disabled persons and disabled or Vietnam Era Veterans will be made that does not result in undue hardship.

Dalrada Financial Corporation is committed to the continuation of employment policies and practices which are based upon merit, qualifications and competence, Dalrada Financial Corporation is also committed to the recruitment of qualified minority and women candidates.

Dalrada Financial Corporation has established this Equal Opportunity Employment Policy to reaffirm its continued commitment to equal opportunity employment, and to assure present and future compliance with Executive Order No. 11246, as well as applicable state and federal legislation.