Leon Jones Feed and Grain, Inc.
4880 Leland Drive
Cumming, Georgia 30041
(770) 887-6117

LEON JONES FEED AND GRAIN, INC. EMPLOYEE PACKET

The Leon Jones Feed and Grain, Inc. Employee Packet includes all of the following documents: This page, The LJFG Safe Working Practices Acknowledgement Form, Post Accident Drug Testing Acknowledgement Form, Georgia Employee Beneficiary Notification Form, Leon Jones Feed and Grain Workers' Compensation Panel of Physicians Acknowledgement Form, Payroll Deduction Authorization Form, Benefits Payroll Deduction Authorization Form, Direct Deposit Authorization From, The W-4 Form, The G-4 Form, and the I-9 Form.

PLEASE COMPLETE ALL ATTACHED FORMS

Employee Name: _____
LAST FIRST Middle Int.

SSN: _____-_____-_____ Date of Birth: _____

Current Address: _____
Number and Street Apartment or Lot #

_____
City State Zip Code

Phone Number: (_____)_____-_____ (_____)_____-_____
Home Cell

Email Address: _____ Marital Status: _____

Job Description: (Check One) ☐ Driver ☐ Mechanic ☐ Wash Bay ☐ Office

_____ _____
Employee Signature Date

OFFICE USE ONLY: Date of Hire _____ **Employee Number** _____

LEON JONES FEED AND GRAIN, INC.
SAFE WORKING PRACTICES ACKNOWLEDGEMENT

As a condition of employment with Leon Jones Feed and Grain, Inc. located at 4880 Leland Drive Cumming, Georgia 30041, I

_____ do hereby agree to comply
(Please Print Full Name)

with the following safe working practices.

1. I agree to follow all safety requirements, procedures and practices, including but not limited to those impose or recommended by: Leon Jones Feed and Grain management, dispatchers, or safety supervisors, any government entity, OSHA, or any other entity whatsoever without exception.
2. I agree to report any work-related accident, or injury, to my supervisor as well as the safety director, Nathan Bottoms, as soon as it occurs, without any hesitations or exceptions.
3. If I need treatment for a work related injury, I agree to:

    a. Notify my supervisor and safety director with Leon Jones Feed and Grain of the need for treatment.
    b. Only go to a Leon Jones Feed and Grain directed physician for the initial treatment.
    c. On the initial visit, hand carries a Medical Authorization for Treatment Form to the authorized treating facility (provided by the HR or Safety Dept.)
    d. Notify the safety director and the Workers Compensation carrier when I am referred to any specialist for treatment.
    e. Only go to Leon Jones Feed and Grain Workers Compensation direct specialists for care.

I understand that failure on my part, to follow the above procedures, could result in disciplinary action, not to exclude termination.

I agree to inform Leon Jones Feed and Grain supervisors of any safety violations I encounter in the workplace.

I understand if I do not report my accident or injury to Leon Jones Feed and Grain, Inc. management within 30 days, my claim will be denied for lack of notice.

_____ _____
Employee Signature Date

LEON JONES FEED AND GRAIN, INC.
ACKNOWLEDGMENT OF THE POST ACCIDENT PROGRAM

I understand that Leon Jones Feed and Grain, Inc. maintains a Post Accident Program requiring all employees to report to work in a substance free condition.

I have read, or had read to me, a copy of this policy and I understand the consequences of violating the policy, including my obligations under the Post-Accident Policy. If I did not understand the policy, I have asked for and have received an explanation. I specifically understand that if I am injured on the job and have a confirmed positive test result; refuse to consent or submit to a drug or alcohol test; tamper with or adulterate a drug or alcohol specimen, or otherwise violate this policy I may forfeit all benefits under workers compensation and unemployment compensation laws.

Leon Jones is in agreement with Federal Government that marijuana is a controlled substance and will recognize medical marijuana as a legitimate prescription. A positive test result for marijuana will be treated the same as any other positive test result, even if an employee has a medical marijuana prescription.

I understand that as a condition of my continued employment, where reasonable suspicion of drug and alcohol use exists, Leon Jones will require me to undergo substance screening by urinalysis for drugs and blood for alcohol. I hereby agree to submit to such test including follow up to rehabilitation testing and the required post-accident testing.

I further consent to the results of any such drug and alcohol test being released to Leon Jones authorized representative by the Medical Review Officer. I understand that I am legally authorized to receive a copy of this consent form if requested. The results will not be released to any additional parties without written authorization.

I release any testing facility personnel and/or any physicians who have tested me from any liability arising from a release or use of any and all test results, written reports, medical records, and data concerning my test to the appropriate Leon Jones officials. I further release all Leon Jones officials from liability arising from the release or use of these test results.

I also understand that the Post-Accident Policy and related documents are not intended to constitute a contract between Leon Jones Feed and Grain, INC. and me.

I acknowledge receipt of a copy of this policy.

Employee Signature	Printed Name	Date

LEON JONES FEED AND GRAIN, INC.
WORKERS COMPENSATION PANEL OF PHSYCICANS
ACKNOWLEDGMENT FORM

This is to certify that I have reviewed the official notice of the Panel of Physicians. I understand that when I am involved in an on-the-job injury and emergency treatment is not necessary, I must choose the services of a physician from the Panel. The physician selected from the Panel may arrange for appropriate consultations, referrals, and other specialized medical services, as the nature of the injury requires. If I am dissatisfied with the physician selected, I may make one change without permission to a second physician also listed on the Panel. However, any further changes require the permission of Leon Jones Feed and Grain, Inc, claims office or the State Board of Workers' Compensation. If I desire to obtain medical services from a physician not listed on the Panel, I may do so; however, I will be liable for those medical expenses.

In the case of an emergency, I should be taken to the nearest emergency room. However, all follow-up care must, thereafter, be rendered by a physician from the Panel, or a Panel Physician's referral. I further understand that I must notify my supervisor as soon as an injury occurs, regardless of the extent of the injury. Delay in notification may result in denial of payment for medical services rendered.

Employee Signature	Printed Name	Date

Witness Signature	Date

LEON JONES FEED AND GRAIN, INC.
GEORGIA EMPLOYEE BENEFICIARY NOTIFICATION

Pursuant to Georgia Law, Leon Jones Feed and Grain, Inc. is required to obtain contact information for the employee's beneficiary in the event the employee passes away and unpaid wages are due.

In the space provided below provide name, address, phone number, and email address (if known) for your selected beneficiary.

Beneficiary Printed Name _____ Phone Number _____

Street Address _____ City, State, Zip _____

Email Address (if known) _____

Employee Signature _____ Printed Name _____ Date _____

Form W-4 (2015)

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 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

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

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

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

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E ____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
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 $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G ____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H ____

For accuracy, complete all worksheets that apply.

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2015

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

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

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

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

Form G-4 (Rev. 1/13)

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: Enter 0 or 1 .....[ ]

B. Married Filing Joint, both spouses working:
Enter 0 or 1 .....[ ]

C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 .....[ ]

D. Married Filing Separate:
Enter 0 or 1 .....[ ]

E. Head of Household:
Enter 0 or 1 .....[ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
   Yourself: ☐ Age 65 or over ☐ Blind
   Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300.....$_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:
   A. Federal Estimated Itemized Deductions.....$_____
   B. Georgia Standard Deduction (enter one): Single/Head of Household $2,300
      Each Spouse $1,500 $_____
   C. Subtract Line B from Line A.....$_____
   D. Allowable Deductions to Federal Adjusted Gross Income.....$_____
   E. Add the Amounts on Lines 1, 2C, and 2D.....$_____
   F. Estimate of Taxable Income not Subject to Withholding.....$_____
   G. Subtract Line F from Line E (if zero or less, stop here).....$_____
   H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above..... _____

(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in the Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**

a) I claim exemption from withholding because I incurred no Georgia income tax liability last year **and** I do not expect to have a Georgia income tax liability this year. **Check here** ☐

b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is _____ My spouse's (servicemember) state of residence is _____ The states of residence must be the same to be exempt. **Check here** ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature_____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, P. O. Box 49432, Atlanta, GA 30359.

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN:_____

EMPLOYER'S WH#:_____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

Employment Eligibility Verification

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

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

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	☐☐☐-☐☐-☐☐☐☐		

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

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

☐ A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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

3-D Barcode
Do Not Write In This Space

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

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write In This Space

Certification

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

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

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		HR MGR

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
DANIEL	MALINDA	LEON JONES FEED & GRAIN, INC

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
4880 LELAND DRIVE	CUMMING	GA	30041

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

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

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

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

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

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

LEON JONES FEED AND GRAIN, INC.
PAYROLL DEDUCTION AUTHORIZATION

Employee Name: _____ SSN: ____-____-____

Type of Deduction: (Uniform, Loan, Advance)	Payroll Commencement Date:
Total Amount of Deduction: $	Amount of Deduction per Pay Period: $

Type of Deduction: (Uniform, Loan, Advance)	Payroll Commencement Date:
Total Amount of Deduction: $	Amount of Deduction per Pay Period: $

Type of Deduction: (Uniform, Loan, Advance)	Payroll Commencement Date:
Total Amount of Deduction: $	Amount of Deduction per Pay Period: $

I hereby authorize Leon Jones Feed and Grain, Inc. to make the above deductions from my pay in accordance with the above terms. I understand and agree that I am responsible for satisfying the above amounts. I further understand and agree that deductions will be made after any federal or state requirements as well as for any Leon Jones Feed and Grain, Inc. programs in which I have enrolled, for which I am eligible, or to which I have agreed.

_____ _____ _____

Employee Signature Printed Name Date

LEON JONES FEED AND GRAIN, INC.
BENEFITS PAYROLL DEDUCTION AUTHORIZATION

Employee Name: _____ SSN: _____-_____-_____

Insurance Company Name:	Type of Deduction: (Health, Dental, Etc)
Payroll Commencement Date:	Amount of Deduction per Pay Period: Pre Tax Amount: $ Post Tax Amount: $

Insurance Company Name:	Type of Deduction: (Health, Dental, Etc)
Payroll Commencement Date:	Amount of Deduction per Pay Period: Pre Tax Amount: $ Post Tax Amount: $

Insurance Company Name:	Type of Deduction: (Health, Dental, Etc)
Payroll Commencement Date:	Amount of Deduction per Pay Period: Pre Tax Amount: $ Post Tax Amount: $

I hereby authorize Leon Jones Feed and Grain, Inc. to make the above deductions from my pay in accordance with the above terms. I understand and agree that I am responsible for satisfying the above amounts. I further understand and agree that deductions will be made after any federal or state requirements as well as for any Leon Jones Feed and Grain, Inc. programs in which I have enrolled, for which I am eligible, or to which I have agreed.

_____ _____ _____

Employee Signature Printed Name Date

LEON JONES FEED AND GRAIN, INC.
CHILD SUPPORT PAYROLL DEDUCTION AUTHORIZATION

Employee Name: _____ SSN: ____-____-____

Child Support Case #1 State of Order: _____	Case # _____
Address for Distribution: _____ _____	Amount of Deduction per Pay Period: $_____

Child Support Case #2 State of Order: _____	Case # _____
Address for Distribution: _____ _____	Amount of Deduction per Pay Period: $_____

Child Support Case #3 State of Order: _____	Case # _____
Address for Distribution: _____ _____	Amount of Deduction per Pay Period: $_____

I hereby authorize Leon Jones Feed and Grain, Inc. to make the above deductions from my pay in accordance with the above terms. I understand and agree that I am responsible for satisfying the above amounts. I further understand and agree that deductions will be made after any federal or state requirements as well as for any Leon Jones Feed and Grain, Inc. programs in which I have enrolled, for which I am eligible, or to which I have agreed.

_____ _____ _____

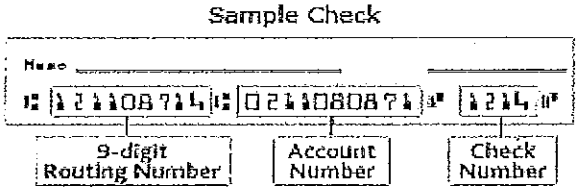
Employee Signature Printed Name Date

LEON JONES FEED AND GRAIN, INC.
DIRECT DEPOSIT AUTHORIZATION

Employee Name: _____ SSN:_____-_____-_____

Name of Banking Facility:	Account Type: Checking Savings (CIRCLE ONE)
Account Number:	Dollar Amount: $
Routing Number:	Percentage:

Name of Banking Facility:	Account Type: Checking Savings (CIRCLE ONE)
Account Number:	Dollar Amount: $
Routing Number:	Percentage:



Attach one of the following for EACH Direct Deposit.

1. **Checking Account:** Copy of a voided check or bank courtesy letter.
2. **Savings Account:** A bank courtesy letter stating: Your name, Routing #, and Account #.
3. The designated account(s) must be in your name.

Please read and sign before submitting: Funds transferred by electronic transmission normally post to an account in two to three business days after the payroll is processed. Employee remains responsible for verifying that the funds are deposited, clear, and available prior to writing checks or debiting the account. Also, please allow one additional business day for direct deposits to be process during a holiday.

I grant my employer the right to correct any electronic fund transfer, resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

_____ _____ _____

Employee Signature Printed Name Date