HAZLEHURST CITY SCHOOL DISTRICT

NEW HIRE PACKET

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ **I did not use a preparer or translator.** ☐ **A preparer(s) and/or translator(s) assisted the employee in completing Section 1.**

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

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

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

STOP *Employer Completes Next Page* STOP

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Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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)*				

Additional Information

QR Code - Sections 2 & 3
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	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

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

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		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)		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. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		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		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
Hazlehurst, MS 39083

Cloyd Garth, Jr., Superintendent

DRUG AND ALCOHOL TESTING POLICY

I understand that it is the Hazlehurst City School District's policy to prohibit the use, possession, transportation, or sale of illegal or non-prescription drugs, and alcoholic beverages on the premises of the district. I understand that it is a violation of the district's policy to be under the influence of drugs and alcohol while on its premises.

My signature below constitutes my consent to provide a sample of my blood, breath, urine, or other related sample for alcohol and drug testing analysis administered in accordance with Mississippi Code Annotated Sections 71-7-1 *et seq.* Supp. (1994).

I understand that failure to cooperate with any testing procedure may result in disciplinary action up to and including discharge.

I confirm that I have reviewed, or have been given the opportunity to review, Hazlehurst City School District's Drug and Alcohol Testing Policy.

EMPLOYEE NAME: _____

SOCIAL SECURITY NUMBER: _____

SIGNATURE: _____

DATE: _____

Mississippi Department of Human Services
Child Abuse/Neglect (CA/N) Common Central Registry Application

To be completed by requesting Agency/Organization

Official Name of Requesting Agency / Organization & License #:

Requesting Agency/Org Mailing Address:

Requestor's Name:

Mailing Address:

City: State Zip Code

Phone: Email:

Requestor's Signature: Date:

Check all That Apply

- ☐ MSA Foster/Adoption Agency
- ☐ Out of State/International Foster/Adoption
- ☐ MS Residential Child Care Facility
- ☐ Mental Health Facility/MH Residential Services
- ☐ MS Non Licensed Child Care
- ☐ MS Mentoring Program
- ☐ MS School District
- ☐ Out of State School District
- ☐ MS Community/Human Resource Agency
- ☐ MS Health Care/Nursing Home/ Hospital
- ☐ MS Youth Court/Non Violent Shelters
- ☐ Law Enforcement/Youth Challenge

To be completed by person being cleared

The Applicant's name & identifying information will provide unsupervised care and supervision of children as an:

☐ Employee ☐ Foster Resource Parent ☐ Adoption Resource Parent
☐ Relative Resource ☐ Volunteer/Internship ☐ Other (Please Specify)

This person's job/role is or will be:

Applicant Name:

Date of Birth: SSN: ☐ Male ☐ Female

(Requesting Agency should verify by viewing the applicant's Drivers License and Social Security card)

Phone Number(s) where applicant can be reached

Current Address:

City: State Zip Code

By signing this form, I give the above named agency/organization permission to request a MDHS Child Abuse/Neglect Central Registry background check. I understand, that this information will be used to determine my suitability in working with children and/or to be a foster/adoption resource for children. This information will **not be** re-disseminated to other persons or used for other purposes.

Applicant's Signature: _____ Date:

Witness' Signature: _____ Date:

To be completed by MDHS/DFCS Protection Unit State Office Central Registry Staff

A search of the Mississippi Child Abuse/Neglect Central Registry has been completed. MDHS releases only that information which is necessary to discover or prevent child abuse or neglect.

☐ No Felony Information Found ☐ Felony Information Found ☐ MDHS Licensure Policy Violation Found

☐ Substantiated Report Type: ☐ Physical Abuse ☐ Neglect ☐ Sexual Abuse ☐ Mental Abuse/Neglect

Substantiated Report Dates: Signature Stamp:

HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
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Cloyd Garth, Jr., Superintendent

EMERGENCY CONTACT INFORMATION

YOUR NAME _____
(Please print)

DATE OF BIRTH _____SOCIAL SECURITY # _____

HOME PHONE _____ CELL _____

SCHOOL LOCATION _____

CONTACT PERSON #1

NAME _____

RELATIONSHIP TO EMPLOYEE _____

HOME PHONE NUMBER _____

WORK PHONE NUMBER _____

CELL PHONE NUMBER _____

CONTACT PERSON #2

NAME _____

RELATIONSHIP TO EMPLOYEE _____

HOME PHONE NUMBER _____

WORK PHONE NUMBER _____

CELL PHONE NUMBER _____

HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
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Cloyd Garth, Jr., Superintendent

BACKGROUND CHECK AUTHORIZATION

Date _____

I give my permission for the Hazlehurst City School District to conduct a background screening check with the law enforcement, Child Abuse Registry, previous employers, and any other persons to determine my suitability in working with or around children. I understand that this permission is a part of my application for a position with Hazlehurst City School district. I further understand that this information will only be used in regard to the above application.

_____
Signature

PLEASE PRINT CLEARLY

_____ _____ _____ _____
Last Name/Surname First Name Middle Name Suffix

Sex: _____ ____/____/____ _____
Date of Birth Social Security Number

Race: _____

Eye Color: _____

Hair Color: _____

Height: _____

Weight: _____

HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
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Cloyd Garth, Jr., Superintendent

OFFENSE FORM

This document is part of the Hazlehurst City School District's application for employment.

Applicant Name (**Please Print**) _____

Social Security Number _____Date of Birth _____

In connection with your application for employment, please answer the following questions:

1. Have you ever pled guilty to an offense other than a minor traffic violation?

   YES ____ NO ____

2. Have you ever pled "no contest" to an offense other than a minor traffic violation?

   YES ____ NO ____

3. Have you ever been convicted of an offense other than a minor traffic violation?

   YES ____ NO ____

If you answered **"YES"** to any of the above questions, please list (explain) the particular circumstances below:

DATE	LOCATION	CHARGE	COURT	DISPOSITION of CASE

I understand that the Hazlehurst City School District reserves the right to verify all information on this application and that any false statements or any failure to disclose information may be sufficient grounds to disqualify me from employment, or if employed, may result in a dismissal from employment.

_____ _____

Applicant's Signature Date

HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
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Cloyd Garth, Jr., Superintendent

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS

_____ New Employee _____ Change _____ Cancel

I hereby authorize Hazlehurst City School District to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my ___checking or ___ savings account (**select one**) indicated below and the depository named below to credit and/or debit the same to such account.

Bank Name (or other Depository) _____

Bank Address _____
City **State** **ZIP Code**

Routing Number _____ Account Number _____

This authorization is to remain in full force and effect until Hazlehurst City School District has received written notification from me of its termination in such time and in such manner as to afford Hazlehurst City School District and Depository a reasonable opportunity to act on it. <u>All requests for changes to Direct Deposit must be in Payroll two weeks prior to the upcoming pay period.</u>

Name _____ Social Security No. _____
(Please print or type name as it appears on bank account)

School/Office _____
(Hazlehurst Elementary, Hazlehurst Middle, Hazlehurst High, District Office)

_____ _____
Applicant's Signature Date

Please attach a voided check for the account to be credited.

HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
Hazlehurst, MS 39083

Cloyd Garth, Jr., Superintendent

CONFIDENTIALITY NOTICE

TO: Hazlehurst City School District Employees

FROM: Department of Human Resources

SUBJECT: Acknowledgement of Confidentiality Notice

I, _____, acknowledge and understand that I am in a position that requires information of employees and students to be kept **confidential**. I understand that I am required not to discuss salaries, insurance, or personal and confidential information such as terminations, employee reprimands and other actions, and student information and actions.

I acknowledge that such information must be kept **confidential** and further acknowledge that by violating the confidence of such information, I may be subject to termination from Hazlehurst City School District.

_____ _____

Signature of Employee Date

HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
Hazlehurst, MS 39083

Cloyd Garth, Jr., Superintendent

STAFF INTERNET USE CONTRACT

(This is a legally binding document)

STAFF CONTRACT AGREEMENT

Carefully read the attached Hazlehurst City School District Acceptable Use Policy. If you have any questions as to what will be expected of you when you are using the district's Internet access or school network or computer equipment, ask a technology department person, your supervisor, or someone in the office to help you with anything you do not understand.

When you feel that you understand the rules, sign the contract below so that you will be able to access the school's network and utilize the available technology.

CONTRACT

I have read the Hazlehurst City School District's Acceptable Use Policy. I understand the rules that I am to follow while using the Internet or the technology equipment owned by the Hazlehurst City School District. I understand that the equipment in my classroom/office belongs to the Hazlehurst City School District; not to me. Its use is therefore governed entirely by the policies and regulations of the Hazlehurst City School District.

I understand that if I violate district regulations regarding the use of its equipment, I will be subject to disciplinary action by the Hazlehurst City School District, which includes suspension as well as employment termination. The disciplinary action will be based on the type and severity of the violation. I further understand that if I break a law while using the Hazlehurst City School District facilities, the courts and law enforcement officials will determine the disciplinary action that I receive.

Staff Member's Name (Please Print): _____

Staff Member's Signature: _____

Date: _____

HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
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Cloyd Garth, Jr., Superintendent

PERMISSION TO RELEASE EMPLOYMENT HISTORY

I, _____, hereby give permission to release my employment history to Hazlehurst City School District.

_____ _____
Signature Date

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

► _____ ► _____

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

Employers Only

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

General Instructions

Future Developments

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

Purpose of Form

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

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

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

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

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

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

Single or Married Filing Separately

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

Head of Household

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

Form 89-350-15-8-1-000 (Rev. 05/15)

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Mississippi Department of Revenue
P.O. Box 960
Jackson, MS 39205

Employee's Name _____ **SSN** _____

Employee's Residence Address _____ (Number and Street) _____ (City or Town) _____ (State) _____ (Zip Code)

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION

	Marital Status	Personal Exemption Allowed	Amount Claimed
EMPLOYEE:	1. **Single**	☐ Enter $6,000 as exemption . . . . ▶	$
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	2. **Marital Status** (Check One)	(a) ☐ Spouse **NOT** employed: Enter $12,000 ▶	$
		(b) ☐ Spouse **IS** employed: Enter that part of $12,000 claimed by you in multiples of $500. See instructions 2(b) below . ▶	$
	3. **Head of Family**	☐ Enter $9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d) below . . . . . ▶	$
EMPLOYER: **Keep this certificate with your records.** If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	4. **Dependents** Number Claimed	You may claim $1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim $1,500 for each dependents excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by $1,500. Enter amount claimed... ▶	$
	5. **Age and Blindness**	• Age 65 or older ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ Single Multiply the number of blocks checked by $1,500. Enter the amount claimed . . . . . ▶ * **Note:** No exemption allowed for age or blindness for dependents.	$
	6. **TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5...** ▶		$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer . . . . . ▶		$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write "**Exempt**" on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▶		_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ **Date:** _____

INSTRUCTIONS

1. **The personal exemptions allowed:**

(a) Single Individuals	$6,000	(d) Dependents	$1,500
(b) Married Individuals (Jointly)	$12,000	(e) Age 65 and Over	$1,500
(c) Head of family	$9,500	(f) Blindness	$1,500

2. **Claiming personal exemptions:**

(a) Single Individuals enter $6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of $12,000.

If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of $500. For example, the taxpayer may claim $6,500 and the spouse claims $5,500; or the taxpayer may claim $8,000 and the spouse claims $4,000. The total claimed by the taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter $9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind.** No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. **Total Exemption Claimed:**
Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. **A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.**

5. **PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION**

6. **IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENEFIT OF EXEMPTION..**

7. To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.

LIFE INSURANCE RATES

EFFECTIVE JANUARY 1, 2014

SALARY	LIFE INS PREM	SALARY	LIFE INS PREM
30,000.00	$ 5.40	66,000.00	$ 11.88
31,000.00	$ 5.58	67,000.00	$ 12.06
32,000.00	$ 5.76	68,000.00	$ 12.24
33,000.00	$ 5.94	69,000.00	$ 12.42
34,000.00	$ 6.12	70,000.00	$ 12.60
35,000.00	$ 6.30	71,000.00	$ 12.78
36,000.00	$ 6.48	72,000.00	$ 12.96
37,000.00	$ 6.66	73,000.00	$ 13.14
38,000.00	$ 6.84	74,000.00	$ 13.32
39,000.00	$ 7.02	75,000.00	$ 13.50
40,000.00	$ 7.20	76,000.00	$ 13.68
41,000.00	$ 7.38	77,000.00	$ 13.86
42,000.00	$ 7.56	78,000.00	$ 14.04
43,000.00	$ 7.74	79,000.00	$ 14.22
44,000.00	$ 7.92	80,000.00	$ 14.40
45,000.00	$ 8.10	81,000.00	$ 14.58
46,000.00	$ 8.28	82,000.00	$ 14.76
47,000.00	$ 8.46	83,000.00	$ 14.94
48,000.00	$ 8.64	84,000.00	$ 15.12
49,000.00	$ 8.82	85,000.00	$ 15.30
50,000.00	$ 9.00	86,000.00	$ 15.48
51,000.00	$ 9.18	87,000.00	$ 15.66
52,000.00	$ 9.36	88,000.00	$ 15.84
53,000.00	$ 9.54	89,000.00	$ 16.02
54,000.00	$ 9.72	90,000.00	$ 16.20
55,000.00	$ 9.90	91,000.00	$ 16.38
56,000.00	$ 10.08	92,000.00	$ 16.56
57,000.00	$ 10.26	93,000.00	$ 16.74
58,000.00	$ 10.44	94,000.00	$ 16.92
59,000.00	$ 10.62	95,000.00	$ 17.10
60,000.00	$ 10.80	96,000.00	$ 17.28
61,000.00	$ 10.98	97,000.00	$ 17.46
62,000.00	$ 11.16	98,000.00	$ 17.64
63,000.00	$ 11.34	99,000.00	$ 17.82
64,000.00	$ 11.52	100,000.00	$ 18.00
65,000.00	$ 11.70		

STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.

Policy 33683-G

SECTION A: Employee/Employer Information

Employee/Retiree Last Name:	First Name:	MI:	Social Security Number:	Birthdate: (MM/DD/YYYY):
Employee/Retiree Home Address:			Email Address:	Home Phone: Alternate Phone:
Employer Name:				Employer Phone:
Employer Address:				

SECTION B: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)

ACTIVE FULL-TIME EMPLOYEE: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of $30,000 and a maximum of $100,000. The employee and employer each pay 50 percent of the monthly premium.

☐ New Employee – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.

☐ Late Enrollee Applicant – Applications made after initial 31 days of employment will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life. **(Employee must also complete the Minnesota Life *GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY* form.)**

Date of Employment: _____

☐ RETIRED EMPLOYEE: Life benefit amounts are limited to $5,000, $10,000 or $20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

Date of Retirement: _____ **COVERAGE AMOUNT REQUESTED:** ☐ **$5,000** ☐ **$10,000** ☐ **$20,000**

☐ **DISABLED EMPLOYEE:** Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months.
(Employee must also complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

NOTE: You cannot designate your life insurance beneficiary on this form. To designate your life insurance beneficiary, please follow the instructions below:

1. Log in to your *my*Blue site, **https://myblue.bcbsms.com**, and click on the My Benefits tab.
2. Scroll down to the Life Benefits section below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on the site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through the *my*Blue portal.

If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the policy.

If you do not have Internet access, contact Minnesota Life toll free at 877-348-9217 to request a paper beneficiary designation form.

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone

SECTION D: Authorization and Certification

I am applying for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Insurance Company, Group Policy #33683-G, and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee/Retiree Signature (Required) **Date**

SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)

☐ **Waiver of Coverage – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.**

☐ **Cancellation of Coverage – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.**

SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.

Employee/Retiree Signature **Date**

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT http://KnowYourBenefits.dfa.ms.gov/ OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	GROUP NUMBER:	INFORMATION VERIFIED: (INITIAL AND DATE)

Beneficiary Designation and Change Request

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Group Administration Department • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Employer	Policy number
Mississippi State and School Employees' Life Insurance Plan	33683

Policyowner name and address (notify employer of any change in address)

Call 1-877-348-9217 with questions.

Employee name		Last four digits of Social Security number
Employee's date of birth	Policyowner (if different than the insured)	Policyowner's telephone number ( )

INSTRUCTIONS:

1. Print or type in the space below, the full name, address, relationship to the insured, and share % of each beneficiary to be named. If identifying a class of beneficiaries, such as children, identify each person currently included in that class.
2. **Sign and date the completed form.**
3. Return to Minnesota Life using the address above or fax to 651-665-4827.

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive death proceeds. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children", without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by Minnesota Life, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive death proceeds, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death proceeds will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the proceeds

Beneficiary Full Name & Address	Relationship	Share % (for primary beneficiaries must total 100%)

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name & Address	Relationship	Share % (for contingent beneficiaries must total 100%)

Total = 100%

SIGNATURE REQUIRED	
Policyowner's signature X	Date

RETURN TO MINNESOTA LIFE FOR ENDORSEMENT

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
Effective January 1, 2019

Legacy - Initially hired before 1/1/2006
Horizon - Initially hired on or after 1/1/2006

ACTIVE EMPLOYEE	LEGACY EMPLOYEES				HORIZON EMPLOYEES			
	BASE		SELECT		BASE		SELECT	
	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee *	$367	$0	$387	$20	$367	$0	$406	$39
Employee + Spouse	$768	$401	$843	$476	$768	$401	$862	$495
Employee + Spouse & Child(ren)	$978	$611	$1,053	$686	$978	$611	$1,072	$705
Employee + Child	$471	$104	$547	$180	$471	$104	$566	$199
Employee + Children	$633	$266	$708	$341	$633	$266	$727	$360

*The State pays 100% of the employee's premium for Base Coverage. Active employees enrolling in Select Coverage must pay a portion of the employee premium.

RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	LEGACY RETIREES		HORIZON RETIREES	
	BASE	SELECT	BASE	SELECT
Retiree	$421	$445	$673	$696
Retiree + Spouse (Non-Medicare)	$881	$969	$1,349	$1,436
Retiree + Spouse & Child(ren) (Non-Medicare)	$1,123	$1,211	$1,508	$1,595
Retiree + Child	$540	$605	$792	$856
Retiree + Children	$727	$766	$979	$1,017
Retiree + Spouse (Medicare)	N/A	$633	N/A	$884
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$793	N/A	$1,044

RETIRED EMPLOYEE - MEDICARE ELIGIBLE	BASE	SELECT	BASE	SELECT
Retiree	N/A	$188	N/A	$188
Retiree + Spouse (Non-Medicare)	N/A	$712	N/A	$928
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	$954	N/A	$1,087
Retiree + Child	N/A	$348	N/A	$348
Retiree + Children	N/A	$509	N/A	$509
Retiree + Spouse (Medicare)	N/A	$376	N/A	$376
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$536	N/A	$536

COBRA	BASE	SELECT	BASE	SELECT
Participant	$374	$394	$374	$414
Participant + Spouse	$783	$859	$783	$879
Participant + Spouse & Child(ren)	$997	$1,074	$997	$1,093
Participant + Child	$480	$557	$480	$577
Participant + Children	$645	$722	$645	$741

COBRA DISABILITY EXTENSION	BASE	SELECT	BASE	SELECT
Participant	$550	$580	$550	$609
Participant + Spouse	$1,152	$1,264	$1,152	$1,293
Participant + Spouse & Child(ren)	$1,467	$1,579	$1,467	$1,608
Participant + Child	$706	$820	$706	$849
Participant + Children	$949	$1,062	$949	$1,090

STATE OF MISSISSIPPI
STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
APPLICATION FOR COVERAGE

PLEASE PRINT **Section A: Enrollee Information (all fields are required)**		**Employer Name**		
Social Security Number	**First Name**	**MI**	**Last Name**	
Home Address		**City**	**State**	**ZIP**
Primary Telephone Number	**Secondary Telephone Number**	**Personal Email Address**		
Marital Status ☐ Single ☐ Married	**Gender** ☐ Male ☐ Female	**Date of Birth (mm/dd/yyyy)**	**Date of Employment/Retirement**	

Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? ☐ No (Horizon) ☐ Yes (Legacy)

If yes, please list your most recent (pre-1/1/06) employer and dates of employment: _____

If married, is your spouse a Plan participant? ☐ Yes ☐ No If yes, Spouse Name and SSN: _____

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

◯ **I hereby apply to ADD, CONTINUE AND/OR CHANGE COVERAGE** for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the *Plan Document*. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

◯ **I hereby WAIVE COVERAGE in the State and School Employees' Health Insurance Plan.** I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. **If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.**

Enrollee Signature: _____ Date: _____

Section C: Coverage

Enrollee Type:	**Coverage Type:**	**Coverage Option:** (Choose Only One)	**Do you have Medicare?** ☐ Yes ☐ No
☐ Employee - Legacy	☐ Enrollee Only	◯ Select	**Medicare Number:** _____
☐ Employee - Horizon	☐ Enrollee + Spouse	◯ Base (HIGH DEDUCTIBLE)	☐ "A" Effective Date: _____
☐ Retiree	☐ Enrollee + Child		☐ "B" Effective Date: _____
☐ COBRA	☐ Enrollee + Children		**Reason for Entitlement:**
☐ Surviving Spouse	☐ Enrollee + Spouse & Child(ren)		☐ Age ☐ ESRD ☐ Disability

Are you a tobacco user? ☐ Yes ☐ No If yes, are you interested in participating in the Plan's free cessation program? ☐ Yes ☐ No

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? ☐ Yes ☐ No If yes, please provide the following:

	1.	2.	3.	4.
Name of Individual Covered:				
Policyholder's Name:				
Policyholder's Date of Birth:				
Policyholder's Insurance Effective Date:				
Policy Number:				
Policyholder's Employment Status:	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐
Insurance Company Name address & phone #:				
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:

Section E: Dependents

Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security Number	Date of Birth (mm/dd/yyyy)	Address (if different from Enrollee)	Current Status
1.	Spouse ☐ Male ☐ Female				Employed? ☐ Yes ☐ No
2.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
3.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
4.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? ☐ Yes ☐ No
If yes, please provide the following:

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason

Section F: Change Information

☐ **Add Enrollee:** ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of Coverage due to Divorce
☐ Other: _____ Requested Effective Date: _____

☐ **Add Dependent(s):** ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Other: _____
(List all dependents in Section E.) Qualifying Event/ Effective Date: _____

☐ **Change Coverage:** ☐ Base Coverage ☐ Select Coverage

☐ **Drop Dependent(s):** ☐ Divorce ☐ Deceased ☐ Other: _____
Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date

☐ **Other Changes** (Explain):

FOR EMPLOYER / ADMINISTRATOR USE ONLY: **GROUP NUMBER:** _____

New Legacy Employee, Requested Effective Date: _____
New Horizon Employee, Requested Effective Date: _____
Retiree, Requested Effective Date: _____
COBRA, Requested Effective Date: _____
Surviving Spouse, Requested Effective Date: _____
Change(s), Requested Effective Date: _____

ENTERED BY: _____
DATE: _____

VERIFIED BY: _____
DATE: _____

Print

unum

Unum Dental℠

A smile-worthy dental plan

Hazlehurst City School District
Effective date: 01/01/2019
Elite Education Platinum Plan

Plan features:

- 100% coverage for preventive services
- No waiting period on Class B services
- See any dentist or maximize your benefits by utilizing our national network of more than 323,000+ dental access points[1] with discounted fees for in-network services
- **Find an in-network provider at unumdentalcare.com**
- Manage benefits online with AlwaysAssist.com and on-the-go with the AlwaysAssist mobile app.

AlwaysAssist.com
Online benefits management

AlwaysAssist App
Available on the App Store | Google play

Monthly Premium Rates*:

*Rates reflect 10% agent commission and are guaranteed 24 months from the effective date.

Employee Only	$30.46
Employee & Spouse	$60.92
Employee & Children	$67.02
Employee & Family	$97.36

Overview:

Deductible:
Maximum 3 per family. Applies to Basic (Class B) and Major (Class C) Services.

$50 per benefit year

Coinsurance:
The plan pays the following percentages of maximum allowable charges for each class:

Class A	Preventive	100%
Class B	Basic	80%
Class C	Major	50%
Class D	Orthodontics	50%

Benefit Maximums:
(Class A, B, and C benefits).

$2000 per benefit year

Carryover Benefit:

Takeover of carryover not included but is available at an additional 4% load to the rates. Prior carrier report must be provided.

Covered procedures and waiting periods:

Preventive Services (Class A):
- No waiting period
  - Routine exams (2 per 12 months)
  - Prophylaxis (2 per 12 months)
    - (1 additional cleaning or periodontal maintenance per 12 months if member is in 2nd or 3rd trimester of pregnancy)
  - Bitewing x-rays (maximum of 4 films; 1 per 12 months)
  - Fluoride treatment for children up to age 16 (1 per 12 months)
  - Sealants for children up to age 16 (permanent molars 1 per 36 months)
  - Space maintainers for children up to age 16 (1 per 24 months)
  - Adjunctive pre-diagnostic oral cancer screening (1 per 12 months for age 40+)

Basic Services (Class B):
No waiting period
- Full mouth / panoramic x-rays (1 per 24 months)
- Emergency treatment (1 per 12 months)
- Simple restorative services (fillings; benefit allowed for amalgam restorations on posterior teeth)
- Simple extractions
- Oral surgery (extractions and impacted teeth) & anesthesia (subject to review, covered with complex oral surgery)
- Repair of crown, denture, or bridge

Major Services (Class C):
12-month waiting period
(Subject to takeover benefits for existing enrollees)
- Periodontics
- Endodontics (root canals)
- Inlays and onlays
- Crowns, bridges, dentures and endosteal implants (in lieu of an approved 3-unit bridge)

Orthodontics (Class D):
12-month waiting period
(Subject to takeover benefits for existing enrollees.)
- Maximum annual benefit: $500
- Maximum lifetime benefit: $1,000
- Up to 25% of lifetime allowance may be payable on initial banding.
- Dependent children to age 19 only
- Class D maximums are separate from $2000 benefit year maximum

UNUM

Unum Vision℠

Quality eye care meets convenience

Hazlehurst City School District
Effective date: 01/01/2019
Elite Education Vision Plan

Plan features:

- Our network offers members access to convenient, quality care with more than 40,000 vision access points[1], including independent optometrists and retail stores like Walmart, Sam's Club, JCPenney, Sear's Optical, America's Best and many more!
- **Find an in-network provider at unumvisioncare.com**
- Manage benefits online with AlwaysAssist.com and on-the-go with the AlwaysAssist mobile app.

AlwaysAssist.com | **Always**Assist App

Monthly Premium Rates[2]:		
Rates reflect 10% agent commission and are guaranteed 24 months from the effective date.	Employee Only	$7.88
	Employee & Spouse	$16.10
	Employee & Child(ren)	$14.20
	Employee & Family	$22.08

Covered benefits:

Exam: Each member is entitled to a comprehensive vision exam. An exam co-pay applies and is outlined in the grid below.

Materials: Each member may purchase eyewear in the form of an eyeglass frame and lenses, or contact lenses. Purchases are subject to benefit frequencies and co-pays. Plan features include:

- **Frame benefit:** You may choose any frame within a provider's collection, subject to the retail frame allowance listed below. If the cost is greater than the plan's benefits, you are responsible for the difference.
- **Eyeglass lens benefit:** Standard plastic (CR-39 Plastic Material) single vision, bifocal and trifocal lenses are generally covered after any applicable materials copay. Plan allowances are listed below for specialty lenses. If the cost is greater than the plan's benefits, you are responsible for the difference.
- **Contact lens benefit:** Members electing contact lenses instead of glasses may apply the contact lens allowance to any lenses in the provider's collection. If the cost is greater than the plan's benefits, you are responsible for the difference. The contact allowance will apply to the retail cost of contact lenses and to any professional fitting fee charged by the provider. Some providers, operating independently of the optical store, may charge separately for the fit and evaluation, permitting the contact lens benefit to be used fully for materials.

Laser vision correction: Discounts are available with participating surgery providers across the country (not an insured benefit)

Overview:

Vision Care Services	All Participating Providers	Out-of-Network
Exam (1 per 12 month)	$10 Co-pay	Up to $35
Materials	$10 Co-pay	See Below
Standard Plastic Lenses: (1 per 12 month)		
Single Vision	Covered by Co-pay	Up to $25
Bifocal	Covered by Co-pay	Up to $40
Trifocal	Covered by Co-pay	Up to $50
Lenticular	$80 allowance	Up to $50
Progressive	$70 allowance	Up to $40
Lens Options:		
Scratch resistant coating	Covered in full	N/A
Frames: (1 per 24 months) Members choose from any frame available at provider locations.	Up to $120 allowance	Up to $50 retail
Contact Lenses[3]: (1 per 12 months) (Includes fit[4], follow-up and materials)	$0 Co-pay	
Elective	Up to $130 allowance	Up to $100
Medically Necessary	Up to $210 allowance	Up to $210

1. Starmount internal data, 2017. Access points are sites where network providers see patients. Some providers may be available at more than one access point.
2. Final rates subject to home office underwriting verification of participation and other factors. Members must enroll for a minimum of 12 months.
3. Contact lenses are in lieu of eyeglass lenses and frames.
4. Some providers, such as Walmart, may charge for a contact lens fit and evaluation separately from your contact lens allowance, leaving the entire allowance for materials.

Administered by: AlwaysCare a member of the Unum Group family of licensed insurer

Enrollment Form for Group Insurance

Underwritten by: Starmount Life Insurance Company

Administered by: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
P.O. Box 98100 Baton Rouge, LA 70898-9100, (225)926-2888 or 1-888-729-5433

1. MEMBER INFORMATION ☐ A: Add (Enroll) ☐ T: Terminate ☐ C: Change (change of name or coverage)

Group/Policyholder Name	Group Number	Location	Effective Date
Hazelhurst City School District			

Gender	Last Name (Member or subscriber)	First Name	M.I.	Birth Date mm / dd / yyyy	Social Security Number
☐ M ☐ F				Birth City:	
				Birth State:	
				U.S. Citizen: ☐ Yes ☐ No	

Home Street Address	City/State/Zip	Home Phone	Work Phone	Cell Phone
			Email:	

Please include me in future communications regarding product offerings. ☐ Yes ☐ No
You may opt out at any time by contacting Customer Service.

COMPLETED BY EMPLOYER

Date of Hire	☐ Full time ☐ Part-time ☐ Retiree If part time: Hrs worked per week: ________	Occupation	Class

Salary $: ______________ ☐ Yearly ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly ☐ hourly

2. FAMILY INFORMATION (Only those eligible may be enrolled. Use additional paper if needed) (Relationship – If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.) Please include an email address for each dependent over Age 18.

	Gender	Relationship	Last Name, First Name, MI, Email Address	Social Security #, Child Handicap Status	Date of Birth (mm/dd/yyyy)	Place of Birth (City and State)
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Husband ☐ Wife Legally recognized ☐ Civil Union Partner ☐ Domestic Partner	(Spouse) Email Address:	SS#	U.S. Citizen: ☐ Yes ☐ No	
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other__________	(Dependent) Email Address:	SS# Handicapped: ☐ Yes ☐ No Age when Handicap began: ____	Date of Birth (mm/dd/yyyy) U.S. Citizen: ☐ Yes ☐ No Married: ☐ Yes ☐ No	Place of Birth (City and State)
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other__________	(Dependent) Email Address:	SS# Handicapped: ☐ Yes ☐ No Age when Handicap began: ____	Date of Birth (mm/dd/yyyy) U.S. Citizen: ☐ Yes ☐ No Married: ☐ Yes ☐ No	Place of Birth (City and State)
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other__________	(Dependent) Email Address:	SS# Handicapped: ☐ Yes ☐ No Age when Handicap began: ____	Date of Birth (mm/dd/yyyy) U.S. Citizen: ☐ Yes ☐ No Married: ☐ Yes ☐ No	Place of Birth (City and State)

3. BENEFIT ELECTIONS (Employer determines benefits available for election):
(Dental and Vision Underwritten by Starmount Life Insurance Company.)

☐ **Dental**	☐ **Member Only**	☐ **Member/ Spouse**	☐ **Member/Child(ren)**	☐ **Member/Family**	☐ Waive
☐ **Vision**	☐ **Member Only**	☐ **Member/Spouse**	☐ **Member/Child(ren)**	☐ **Member/Family**	☐ Waive

DV – 10/16

PERS of MISSISSIPPI

Membership Application

Form 1 – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member Information – 📎 *Attach a copy of the member's Social Security card.*

First Name: _____ MI: _____ Last Name: _____ Gender: ☐ M ☐ F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

Have you previously served on active duty in the U.S. Armed Forces? *If yes,* 📎 *attach Form(s) DD214* ..... ☐ Yes ☐ No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? ..... ☐ Yes ☐ No

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Family Information – *Use additional* Membership Applications *if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B,* Beneficiary Designation, *to officially designate any and all beneficiaries.*

Marital Status – *Select one. Add date for last three.* ☐ Single ☐ Married ☐ Divorced ☐ Widowed Effective Date *mm/dd/ccyy*: _____

Spouse's Full Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Wedding Date** *mm/dd/ccyy*	**Gender**
				☐ M ☐ F

Dependent Child's Full Name – *Up to age 19, or 23 if unmarried and a full-time student*	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Gender**
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

❹ Member Certification – *If an authorized representative signs this form,* 📎 *attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

Member's Signature: _____ Date *mm/dd/ccyy*: _____

❺ Employer Certification – *This section must be completed by an authorized employer representative, not the member.*

Member's Position Held/Job Title: _____ **Member's Hire Date** *mm/dd/ccyy*: _____

Member's Status: Elected Official: ☐ Yes ☐ No Fee Paid Official: ☐ Yes ☐ No Public Safety Employee: ☐ Yes ☐ No

Employer Name: _____ Employer No.: _____ - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, *Eligibility of Part-time Employees for State Retirement Annuity Service Credit*, and PERS Board of Trustees Regulation 36, *Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS)*.

Employer Representative's Signature: _____ Date *mm/dd/ccyy*: _____

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, *fax* www.pers.ms.gov

PERS of MISSISSIPPI

Beneficiary Designation

Form 1B – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ ☐ Member ☐ Retiree

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ Gender: ☐ M ☐ F

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Beneficiary Information – *Use additional Form 1B,* Beneficiary Designation, *to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary and secondary beneficiary percentages must equal 100 percent.*

Beneficiary Name	Social Security No.	Birth Date *mm/dd/ccyy*	Relationship	Beneficiary Percentage *P=Primary, S=Secondary Use whole numbers*	Gender
				☐P ☐S _____ %	☐M ☐F
				☐P ☐S _____ %	☐M ☐F
				☐P ☐S _____ %	☐M ☐F
				☐P ☐S _____ %	☐M ☐F
				☐P ☐S _____ %	☐M ☐F

❹ Member/Retiree Certification – *Check applicable acknowledgement then sign. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

☐ **Member** – I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).

☐ **Retiree** – I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date *mm/dd/ccyy*: _____

❺ Employer Certification – *This section must be completed by an authorized employer representative, not the member. Only complete for active members.*

Employer Name: _____ Employer No.: _____ - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

Employer Representative's Signature: _____ Date *mm/dd/ccyy*: _____

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, *fax* www.pers.ms.gov

PERS of MISSISSIPPI

Reemployment of PERS Service Retiree Certification/Acknowledgement

Form 4B – Revised 11/17/2017

Please print or type in black ink. A Form 4B, Reemployment of PERS Service Retiree Certification/Acknowledgement, should be submitted each fiscal year (July 1 – June 30) of reemployment. ***See Regulation 34,*** **Reemployment after Retirement,** ***for rules governing reemployment.*** *Completed form should be mailed or faxed to PERS. See bottom of form for contact information.*

❶ Retiree Information

First Name: _____ MI:_____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ E-Mail: _____

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

Position/Agency from which Retired: _____ Retirement Date *mm/dd/ccyy*: _____

❷ Annual Retiree Acknowledgement and Election – *Please check one.*

I hereby acknowledge that I have read, understand, and agree to comply with the provisions for reemployment as outlined in PERS Board Regulation 34, *Reemployment after Retirement*, which stipulates that I must be retired at least 90 days or I forfeit my retirement benefit. With that understanding, I make the following annual election in accordance with Miss. Code Ann § 25-11-127 (1972, as amended):

A. ____ I hereby elect to be employed by a covered employer for a period of time not to exceed one-half of the normal working days or hours for the full-time equivalent position during the state fiscal year indicated in Section 3, and I will receive no more than one-half of the salary in effect for the position at the time of employment. The normal working days or hours for the full–time equivalent position are _____ days or _____ hours and I will work no more than _____ days or _____ hours during the state fiscal year indicated in Section 3. The full-time annual salary authorized for this position is $_____ and I will earn no more than $_____ during the state fiscal year indicated in Section 3.

B. ____ I hereby elect to earn an annual salary that will not exceed 25 percent of the final average compensation used in calculating my service retirement allowance. My final average compensation at retirement was $_____ and I will earn no more than $_____ from all PERS-covered employers during the state fiscal year indicated below.

Retiree's Signature: _____ Date *mm/dd/ccyy*: _____

❸ Employer Certification – *This section should be completed by an authorized employer representative, not the retiree.*

I hereby certify that the above-named individual, who is a service retiree receiving benefits from PERS, is employed in the below-named position in accordance with the reemployment provisions as authorized in Miss Code Ann. § 25-11-127 (1972 as amended) and in accordance with the provisions of PERS Regulation 34, *Reemployment after Retirement*. I understand that wages earned and paid to the above-named individual during this period of employment will be reported in accordance with reporting requirements prescribed by PERS and **the applicable employer contributions on the wages actually paid must be submitted**. I further understand that any person who makes a false statement or shall falsify or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution, and with that understanding, I certify that the below information is true and correct.

Retiree's Position /Job Title: _____ **Fiscal Year of Reemployment** *(July 1 - June 30)*: _____

Retiree's Hire Date *mm/dd/ccyy*: _____ **Termination Date** *mm/dd/ccyy*: _____

Retiree Employed through Third Party: ☐ No ☐ Yes **Name of Third Party**: _____

Employer Name: _____ Employer No.: _____ - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

Employer Representative's Signature: _____ Date *mm/dd/ccyy*: _____

Public Employees' Retirement System of Mississippi
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