Application for Classified Personnel
District OR 1 Public Schools
An Equal Opportunity/Affirmative Action Employer

425 F St.
Palmyra, NE 68418
Phone: (402)780-5327
Fax: (402)780-5349

Please type or print your responses in ink.

I. PERSONAL & CONTACT INFORMATION

Name _____
First *Middle* *Last* *(Maiden)*

Present Address _____ Telephone (___) _____
Street *City* *State* *Zip*

Permanent Address _____ Telephone (___) _____
(If different from present address.) *Street* *City* *State* *Zip*

Social Security Number ___/___/_____ E-mail address _____

___Yes ___No. Are you a former District OR 1 Public Schools employee? Date of separation _____
Date available to work with District OR 1 Public Schools _____

II. POSITION DESIRED

For what position(s) are you applying? If more than one area, mark first choice 1, second choice 2, etc.:

_____ _____ _____

III. EDUCATION

A. SECONDARY SCHOOL(S) ATTENDED and GED: ____ Yes ____ No

Name of School	Grades Attended	Special Honors or Recognition

B. COLLEGE or UNIVERSITIES ATTENDED and OTHER POST-SECONDARY EDUCATIONAL PROGRAMS

Name of Institution (City, State)	Major	Hrs	Minor	Hrs	Year Graduated	Degree	GPA (4.0 scale) & Special Honors or Recognition

IV. WORK EXPERIENCE

Include all of your last five employers, and all employers for the last 15 years, starting with your current or most recent employer. Omission of prior employment or false reasons for leaving may be considered falsification of information.

Start Date	End Date	Position (also state if full or part-time)	Duties	Name, Mailing Address and Telephone of Employer	Reason for Leaving

Work Experience Continued:

Start Date	End Date	Position (also state if full or part-time)	Duties	Name, Mailing Address and Telephone of Employer	Reason for Leaving

V. SKILLS

List technical skills, clerical skills, trade skills relevant to the Position(s) for which you have applied. Identify other credentials, licenses, professional affiliations, etc. relevant to the Position(s)

If required for the Position, do you have a valid driver's license? ___Yes ___No

VI. REFERENCES

List names and addresses of persons who are qualified to answer questions concerning your fitness for the position you seek.

Name	Relationship (e.g. supervisor, friend)	Contact Info: Telephone & Complete Mailing Address

VII. VETERAN PREFERENCE

If you wish to be considered for a Veterans Preference please indicate ___ Yes ___ No, and submit the appropriate documentation with your application. Note: This section is optional; you need to request a Veterans Preference even if you are eligible, and if you do not request the preference, you need not submit information about your veteran status.

1. **Applicant Veteran?** ___ Yes ___ No. If yes, submit DD Form 214.
2. **Disabled Veteran?** ___ Yes ___ No. If yes, submit DD Form 214 and Veteran's disability verification.
3. **Spouse of 100% Disabled Veteran?** ___ Yes ___ No. If yes, submit DD Form 214, veteran's disability verification and proof of marriage.
4. **Spouse of Veteran on active duty at this time or within 180 days of the spouse's discharge or separation of service.** ___ Yes ___ No.

VIII. QUESTIONS

Directions: Please answer each of the questions below as best you can. If more space is needed, please attach additional pages. If you are typing your answers, please respond to at least one question in your own handwriting.

1. **Eligibility for hire:**
   - Are you currently employed? ___Yes ___No.
   If yes, give name of employer & why do you wish to leave your current position? _____
   _____
   - Are you eligible to work in the United States? ___Yes ___No. - Are you 18 years of age or older? ___Yes ___No.
   - Do you have any condition (physical, mental, or otherwise) which prevents you from performing the essential functions of any of the positions for which you have applied, with or without accommodation? (Note: regular, dependable attendance is an essential function of positions at District OR 1 Public Schools.) ___Yes ___No.
   If yes, describe: _____
2. **Interest in District OR 1 Public Schools:**
   - Have you previously filed a written application for employment with District OR 1 Public Schools? ___Yes ___No.
   If yes, give date(s) and position for which you applied: _____
   - Why do you want to be employed at District OR 1 Public Schools? _____
   _____
   - What experiences have you had with District OR 1 Public Schools or the community of District OR-1? _____
   _____
3. **Prior History:**
   - Have you ever had failed or refused to fulfill a contract of employment with any employer? ___Yes ___No. If yes, describe:
   _____
   - Have you ever had a certificate or license for work purposes denied or revoked? ___Yes ___No.

If yes, describe: _____

_____

4. **Self-Evaluation:**

- Describe your employment strengths and abilities and personal characteristics which will apply to your position: _____

_____

- Describe your weakness/areas in which you feel you need to improve: _____

_____

- Describe your future plans and goals in employment & your plans for remaining at our school if hired: _____

_____

IX. PERSONAL DISCLOSURE

Respond to EACH item. If there is no response to any item, or if the required attachments do not accompany your application, your application WILL BE REMOVED FROM CONSIDERATION. Information provided in this disclosure will not automatically bar you from employment but will be considered in view of all relevant circumstances.

1. Have you ever received a ticket, been charged with, or been convicted of, a criminal offense relating to sexual or physical abuse?
   Yes____ No ____

2. If you answered "Yes" to Question #1 above, you must explain each situation including location(s), date(s), agency(ies) involved, and the outcome of each ticket, charge, or arrest (use an attachment if needed):
   _____

   _____

   _____

3. Have you ever had any license, permit, or certificate terminated, revoked, suspended, received a private or public reprimand or admonishment from a licensing agency or been subject to a judicial restraining or contempt order?
   Yes____ No ____

4. If you answered "Yes" to Question #3 above, you must attach an explanation of each situation including location(s), date(s), agency(ies) involved, and the outcome of each situation (use an attachment if needed):
   _____

   _____

5. Have you ever been involuntarily terminated or asked to resign, or resigned in lieu of termination from employment?
   Yes____ No____

6. If you answered "Yes" to Question #5 above, you must explain each situation including the name of the employer(s), the date(s) and reason(s) for the resignation or termination.
   _____

   _____

Note: School policy requires that a criminal history record information check be completed prior to employment.

X. VERIFICATION

I certify that I have made true, correct and complete answers and statements on this application in the knowledge that they may be relied upon in considering my application. I understand it is my responsibility to immediately provide updated, correct information if any of the information changes at any time. I understand that any omission, falsification or misrepresentation made by me on this application or any supplement will be sufficient grounds for failure to employ me or for my discharge should I become employed with the school district. I understand that disclosure of social security number is optional. It will be used to conduct background checks for employment purposes and for personnel and payroll processing and required reporting if I am employed. I further understand that employment in a classified position would be on an at will basis, terminable at will.

_____

Legal Signature of Applicant

Date: _____, 20__

It is the policy of District OR 1 Public Schools to not discriminate on the basis of sex, handicap or disability, race, color, religion, marital status, veteran status, or national or ethnic origin, or on the basis of genetic information, in its educational programs, admission policies, employment policies or other administered programs. This position is subject to a veteran's preference. Persons requiring accommodations to apply and/or be considered for positions with District OR 1 Public Schools are asked to make their request to the Superintendent.

FOR CDL REQUIRED POSITIONS ONLY

APPLICANT'S CONSENT
TO OBTAIN PAST DRUG AND ALCOHOL TEST RESULTS
Required by Federal Law

I, _____ *(insert applicant's name),* understand that as a condition of hire with District OR 1 Public Schools *(School District)* I must give the District OR 1 Written Consent to obtain the results of all DOT-required drug and/or alcohol tests (including my refusals to be tested) from all of the companies for which I worked as a driver, or for which I took a pre-employment drug and/or alcohol test during the past two (2) years. I also understand that the School District requires me to consent to access to the same information concerning any non-DOT driver drug and/or alcohol tests which I took during this same period of time. I have also been advised and understand that my signing of this consent does not guarantee me a job or guarantee that I will be offered a position with the School District.

Below I have listed all of the companies for which I worked as a driver, or for which I took a pre-employment driver position drug and/or alcohol test during the past two (2) years. I hereby consent to the School District obtaining from those companies, and I hereby consent to those companies furnishing to the School District, all requested information concerning my drug and alcohol tests, including:

(i) all DOT and non-DOT alcohol test results of 0.04 or greater during the past two (2) years;
(ii) all verified positive DOT and non-DOT drug test results during the past two (2) years;
(iii) all instances in which I refused to submit to a DOT-required drug and/or alcohol test during the past two (2) years
(iv) any other violations of DOT agency drug and alcohol testing regulations during the past two (2) years; and
(v) documentation of successful completion of DOT return-to-duty requirements (including follow-up tests) in the event of a violation of a DOT drug and alcohol testing regulations during the past two (2) years.

I specifically authorize the companies to fully complete the School District's Report of Past Drug and/or Alcohol Test Results form.

The following is a list of all of the companies for which I worked as a driver, or for which I took a pre-employment driver position drug and/or alcohol test, during the past two (2) years;

Company name	**Dates worked for/took pre-employment test**
_____	_____
_____	_____
_____	_____
_____	_____

APPLICANT CERIFICATION

I have carefully read and fully understand this Consent to release my past drug and alcohol test results. In authorizing the release of my test results, I consent and agree to waive any physician-patient privilege that may otherwise exist with respect to the confidentiality of my drug and alcohol test results. I further release the Company and its medical review officer, and any officer, employee or agent of the Company whose disclosure of the results is in accordance with this release from any and all claims or causes of actions which may result from the disclosure of such test results to the person or persons identified on this release form.

I signing below, I certify that all of the information which I have furnished on this form is true and complete, and that I have identified all of the companies for which I have either worked, or for which I took a pre-employment drug and/or alcohol test, as a driver during the past two years. I understand that this information is material to my hiring and that my failure to provide true and complete information will automatically disqualify me for a position with the School District or, in the event that I am hired, subject me to immediate termination. Further, I understand that in the event of a receipt of a report of past drug and/or alcohol violation, any conditional offer of employment will be revoked and in the event I have been hired, any employment will be automatically ended.

_____	_____	_____
Signature of Applicant	*Print Name*	*Date*

FOR CDL REQUIRED POSITIONS ONLY

APPLICANT'S CERTIFICATION OF PAST DRUG AND ALCOHOL TEST RESULTS

Required by Federal Law

During the past two years before this application, I:

___ Did __ Did not *(check applicable blank)* **TEST POSITIVE OR REFUSE TO SUBMIT** to any pre-employment drug or alcohol test administered by an employer to which I applied for, but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol testing rules.

If I did test positive or refuse to submit, then I further certify that I:

___ Did __ Did not __ N/A *(check applicable blank)* complete the return-to-duty process of the DOT agency drug and alcohol testing rules. I agree that it is my responsibility to provide the School District with documents establishing completion of such process before I may perform safety-sensitive functions for the School District.

APPLICANT CERTIFICATION

In signing below, I certify that all of the information which I have furnished on this form is true and complete. I understand that this information is material to my hiring and that my failure to provide true and complete information concerning the time period in question will automatically disqualify me for a position with the School District or in the event that I am hired, subject me to immediate termination.

Signature of Applicant *Print Name* *Date*

Personnel - All Employees

Drug and Substance Use and Abuse

It is the policy of the Palmyra District OR-1 Public School District to eliminate the influence of drugs, alcohol and other chemicals within the school environment and to educate students against the usage of drugs, alcohol and illegal substances. The District will implement regulations and practices which will insure compliance with laws relating to drugs and alcohol, including: the Drug-Free Workplace Act and the Omnibus Transportation Employee Testing Act of 1991, and all regulations and rules promulgated pursuant thereto.

Section 1 Drug-Free Workplace

The District has established the school as a drug-free workplace. The drug-free workplace for this purpose includes school grounds, school utilized vehicles, and places in which school activities are held. The school district recognizes that the use, possession, or being under the influence of illicit drugs or alcohol constitutes a hazard to the positive development of students and employees and a substantial interference with school purposes.

1. The unlawful manufacture, distribution, disposition, possession, or use of a controlled substance is prohibited in the work place. Employees are also prohibited from possessing, using or distributing illicit drugs or alcohol, or being under the influence of illicit drugs or alcohol, on any district property or district sponsored event. Any level of impairment from illicit drugs, alcohol, or inhalants, and the presence of any odor of illicit drugs (such as marijuana) or alcohol in the work place or on duty time shall be a violation of the drug-free workplace.

2. The possession or distribution of a look-alike drug or look-alike controlled substance is prohibited. In addition, employees are expected to serve as role models for students and will be considered to have violated the District's expectations in the event the employee commits a criminal drug or alcohol offense off the work place or off duty time.

3. As a condition of employment, employees will abide by the District's drug-free workplace policies and notify the Superintendent or designee of any criminal drug statute conviction for a violation occurring in the workplace no later than 5 days after such conviction.

4. Disciplinary sanctions, up to and including termination of employment and referral for prosecution, will be imposed upon employees who violate the aforementioned standards of conduct. Sanctions for violation thereof may include the requirement that the employee complete an appropriate rehabilitation program, reprimands, and non-renewal, cancellation, or termination of contract of employment.

5. Employees shall be advised through employee publications about drug and alcohol counseling and rehabilitation and reentry programs that are available.

6. Employees shall be furnished with a paper or digital copy of this policy.

This policy supplements and is in addition to all other policies, regulations, practices, procedures and contractual provisions regarding or related to the improper or unlawful possession, use, or distribution of illicit drugs and alcohol.

Section 2 Alcohol and Drug Testing

The District will implement regulations and practices which will insure compliance with the Omnibus Transportation Employee Testing Act of 1991, and all regulations and rules promulgated pursuant thereto. Employees in "safety-sensitive" positions, as defined by the Act and regulations promulgated thereunder, including employees whose position requires a commercial driver's license (CDL), shall be tested for alcohol and controlled substances as required by law. (See attached Appendix "1"). Refusal to submit to such pre-employment testing, or testing positive, shall disqualify an applicant from employment. Reasonable suspicion, random, post-accident, return-to-duty, and follow-up testing shall also be conducted. Employees who test positive shall be immediately removed from safety-sensitive positions and shall be removed from employment.

Legal Reference: 41 U.S.C. §§701 to 707
49 U.S.C. §31306 and 49 CFR Part 382

Document No. 1

APPLICANT'S CONSENT
TO OBTAIN PAST DRUG AND ALCOHOL TEST RESULTS

I, _____ *[insert applicant's name]*, understand that as a condition of hire with Palmyra District OR-1 Public Schools (*"School District"*) I must give written Consent to obtain the results of all DOT-required drug and/or alcohol tests (including any refusals to be tested) from all of the companies for which I worked as a driver, or for which I took a pre-employment drug and/or alcohol test during the past two (2) years. I also understand that the School District requires me to consent to access to the same information concerning any non-DOT driver drug and/or alcohol tests which I took during this same period of time. I have also been advised and understand that my signing of this consent does not guarantee me a job or guarantee that I will be offered a position with the School District.

Below I have listed all of the companies for which I worked as a driver, or for which I took a pre-employment driver position drug and/or alcohol test during the past two (2) years. I hereby consent to the School District obtaining from those companies, and I hereby consent to those companies furnishing to the School District, all requested information concerning my drug and alcohol tests, including:

(i) all DOT and non-DOT alcohol test results of 0.04 or greater during the past two (2) years;
(ii) all verified positive DOT and non-DOT drug test results during the past two (2) years;
(iii) all instances in which I refused to submit to a DOT-required drug and/or alcohol test during the past two (2) years;
(iv) any other violations of DOT agency drug and alcohol testing regulations during the past two (2) years; and
(v) documentation of successful completion of DOT return-to-duty requirements (including follow-up tests) in the event of a violation of a DOT drug and alcohol testing regulations during the past two (2) years.

I specifically authorize the companies to fully complete the School District's Report of Past Drug and/or Alcohol Test Results form.

The following is a list of all of the companies for which I worked as a driver, or for which I took a pre-employment driver position drug and/or alcohol test, during the past two (2) years:

Company name	Dates worked for/took pre-employment test
_____	_____
_____	_____
_____	_____
_____	_____

APPLICANT CERTIFICATION

I have carefully read and fully understand this Consent to release my past drug and alcohol test results. In authorizing the release of my test results, I consent and agree to waive any physician-patient privilege that may otherwise exist with respect to the confidentiality of my drug and alcohol test results. I further release the Company and its medical review officer, and any officer, employee or agent of the Company or medical review officer whose disclosure of the results is in accordance with this release from any and all claims or causes of actions which may result from the disclosure of such test results to the person or persons identified on this release form.

In signing below, I certify that all of the information which I have furnished on this form is true and complete, and that I have identified all of the companies for which I have either worked, or for which I took a pre-employment drug and/or alcohol test, as a driver during the past two years. I understand that this information is material to my hiring and that my failure to provide true and complete information will automatically disqualify me for a position with the School District or, in the event that I am hired, subject me to immediate termination. Further, I understand that in the event of receipt of a report of past drug and/or alcohol violation, any conditional offer of employment will be revoked and in the event I have been hired, any employment will be automatically ended.

_____ Signature of Applicant

_____ Print Name

_____ Date

Document No. 3

REQUEST FOR PAST TEST RESULTS

To: _____ *[Insert name of previous employer]*

From: _____ *[Insert name and title of school representative]*

Subject: Request to obtain past drug and alcohol test results

Date: _____ *[Insert date]*

_____ *[Insert applicant's name]* has advised us that he/she ☐ worked for your company as a driver or that he/she ☐ applied to work as a driver for you, during the previous two (2) years.

Regulations of the Department of Transportation (DOT) (49 C.F.R. § 40.25) require us to obtain from you, and **require you to provide** to us, information concerning the above-named driver's past drug and alcohol test results (including refusals to be tested).

In accordance with DOT's regulations, therefore, we are providing you with the driver's written consent directing you to provide us with the past drug and alcohol testing results, as set forth in the consent. A Report form to provide the requested information is also enclosed for your convenience.

Please send this information to

Palmyra District OR-1 Public Schools
425 F Street
PO Box 130
Palmyra, NE 68418

as soon as possible, either by facsimile (402)780-5328 or by mail. As required by the DOT, the information which you furnish will be treated as strictly confidential.

Enclosures:

Document No. 1. Applicant's Consent to Obtain Past Drug and Alcohol Test Results.
Document No. 4. Report of Past Drug and Alcohol Test Results.

ACKNOWLEDGEMENT AND RECEIPT

I, the undersigned, herewith acknowledge that I have received a copy of the District OR-1 Public Schools Substance-Free Workplace policy, have read the policy and understand it, and by affixing my signature hereto in the presence of a witness indicate that I agree to be bound by the terms and conditions of the said policy and recognize it as a material term of my employment with the District OR-1 Public Schools. The signature of the undersigned acknowledges the permission of the undersigned to place a copy of this Acknowledgment and Receipt in the personnel file of the undersigned.

Dated this _____ day of _____, 2_____

_____ Employee

_____ Witness

DIRECT DEPOSIT AUTHORIZATION FORM

Fill in the boxes below and sign the form.

Last Name

First Name

MI

Social Security Number

Work Phone

Action

New

Change

Cancel

Effective Date

Month

Day

Year

Name of Financial Institution

Account Number

(Include hyphens but omit spaces and special symbols.)

Type of Account

Checking

Savings

Routing Transit Number

(All 9 boxes must be filled. The first two numbers must be 01 through 12 or 21 through 32.)

Ownership of Account

Self

Joint

Other

By signing this agreement, I authorize _____ to initiate credit entries to the account indicated above for the purpose of expense and/or payroll. I also authorize _____ to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Signature _____ Date _____

If the account is a joint account or in someone else's name, that individual must also agree to the terms stated above by signing below.

Signature _____ Date _____

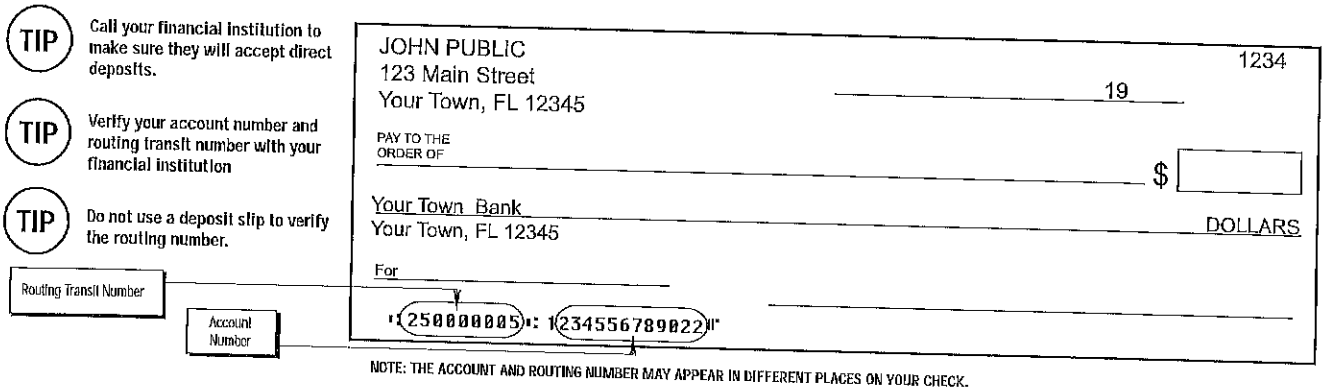
HOW TO COMPLETE THIS FORM

1. Fill in all boxes above.
2. Sign and date the form.

TIP Call your financial institution to make sure they will accept direct deposits.

TIP Verify your account number and routing transit number with your financial institution

TIP Do not use a deposit slip to verify the routing number.



NOTE: THE ACCOUNT AND ROUTING NUMBER MAY APPEAR IN DIFFERENT PLACES ON YOUR CHECK.

DISTRICT OR-1
PALMYRA JUNIOR-SENIOR HIGH SCHOOL--BENNET ELEMENTARY
P.O. BOX 130 PALMYRA, NE 68418 402-780-5327 www.districtor1.org

Robert Hanger	David Bottrell	Linde Walter	Aaron Hoeft
Superintendent	Secondary Principal	Elementary Principal	Activities Director

DISTRICT OR-1 PUBLIC SCHOOLS
HEALTH INSURANCE OFFER

To: Classified Staff
From: Robert L. Hanger
Date: July 20, 2017

This document summarizes the offer of health insurance the district is making to you for the 2017-2018 year. It provides a summary of the district's contribution and available insurance options, and if accepted it will entitle you to participate in the Educator's Health Alliance (EHA) plan sponsored by the district. The EHA plan year for which this offer is effective begins September 1, 2017 and runs through August 31, 2018 ("Plan Year"). This is not a guarantee of continued employment and does not affect any other employment agreement or your status as an at-will employee.

Attached to this Summary is an EHA Enrollment Application. Blue Cross Blue Shield of Nebraska (BCBS) is the provider for all EHA plans, including the plan sponsored by the district. If you elect to accept this offer and elect to apply to enroll, you must complete the Application and turn it in to Mr. Hanger on or before August 15, 2017. Failure to complete the Application on time will constitute a denial of the offer of coverage. Whether you elect to enroll or decline the offer of insurance, you must return this form to Mr. Hanger on or before August 15, 2017.

Offer of Coverage

You are receiving this offer of coverage because you meet the district's requirements for enrollment for the upcoming Plan Year. The offer for the Plan Year is as follows:

Available Plan. The following EHA plan is available to you. Information about the plan is available online at www.ehaplan.org/plan-documents:

1. "$4,000 Deductible HSA-Eligible"

District's Contribution Amount.

The district will pay for 75% of the cost of the single $4,000 deductible plan including single dental, and by signing below you agree to pay the difference through payroll deduction. This amount will be deducted from your pay in equal amounts during the district's regular pay periods in September through May.

Together we prepare our students to successfully meet the challenges of the future.

DISTRICT OR-1

PALMYRA JUNIOR-SENIOR HIGH SCHOOL--BENNET ELEMENTARY
P.O. BOX 130 PALMYRA, NE 68418 402-780-5327 www.districtor1.org

Robert Hanger	David Bottrell	Linde Walter	Aaron Hoeft
Superintendent	Secondary Principal	Elementary Principal	Activities Director

$4,000 deductible, single-only, EHA dual option plan with a yearly premium of $5,744.76. District contribution would be 75% of the annual yearly single-only premium ($4,308.57). The employee would be responsible for the remainder of the single ($1,436.19) and single dental ($344. 04) which is required by BC/BS) through payroll deduction. The employee is eligible to purchase additional coverage for their dependents and spouse at the employee's expense.

Ability to Enroll Dependents and Spouse. You may also elect to enroll your spouse, dependents, and any other person so long as they are eligible for enrollment pursuant to the EHA/BCBS enrollment rules. *You will bear the cost of insuring your spouse and/or dependents*, and by signing below you agree to pay the cost of any additional enrollees through payroll deduction. This amount will be deducted from your pay in equal amounts during the district's regular pay periods in September through May. In the event your gross income is insufficient to cover the costs, you must provide the district with funds sufficient to cover you're the costs for which you are responsible under this offer. Failure to pay any of the amounts required based on your enrollment selections will be grounds to terminate your coverage as permitted by law.

_____ I intend to fill out an EHA Enrollment Application and enroll.

_____ I decline the district's offer.

_____	_____	_____
Print Name	Signature	Date

Together we prepare our students to successfully meet the challenges of the future.

BlueCross BlueShield Nebraska

Blue Cross and Blue Shield of Nebraska
PO Box 3248
Omaha, Nebraska 68180-0001

Group Health and Dental Enrollment Form (With Multiple Plan Options)

Instructions:
1. Complete the enrollment form with black pen. Be sure to complete all questions in full. Incomplete forms cause unnecessary delays.
2. If you need more space for any answers, you can use a separate piece of paper. Please include your name and social security number.
3. Please Print.

☐ New Application (Complete all sections except Section C. Complete Section H, if applicable.)

☐ Change (Complete all sections except Section B. Complete Section H, if applicable.)

Section A: Applicant Information

Social Security Number	Name (Last) (First) (MI) (Title)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Address (Street, PO Box) (City) (State) (Zip+4 Code) (County)			
Home Phone Number	Work Phone Number	Cell Phone Number	Marital Status: ☐ Single ☐ Married ☐ Divorced
Group Name (Employer or Organization)	Group Number	Job Title	Date Employed with Group / Hours Worked per Week

Are you, your spouse or your dependent(s) current or former Blue Cross and Blue Shield insureds or applicants? If Yes, please give name(s) & ID number(s). ☐ Yes ☐ No

Are you or your spouse terminating other Blue Cross and Blue Shield coverage? If Yes, please complete Section E. Loss of Coverage ☐ Yes ☐ No

Are you a member of a federally-recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

Section B: Health and Dental Election(s) for Newly Eligible Employees

I Hereby Apply For:

HEALTH PLAN OPTION
(Not all options may be available to you under your Plan)
Select one and indicate Deductible:
☐ PPO Option..... $_____
☐ High Deductible (HSA-eligible) Option $_____

☐ HEALTH
☐ One Person
☐ Family
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ _____

(If applicable to your plan)
☐ DENTAL
☐ One Person
☐ Family
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ _____

(If applicable)
☐ MEDICARE SUPPLEMENT
(Not available to active employees or their spouses age 65 and older unless the group has fewer than 20 full and/or part-time employees.)

(If applicable to your plan)
HEALTH NETWORK OPTION
(not all options may be available to you under your Plan)
☐ NEtwork BLUE
☐ Premier Select BlueChoice

Section C: Coverage Change Election(s) For Current Members

I Hereby Apply For The Following Changes In Coverage: ☐ Health Only ☐ Dental Only ☐ Both

☐ Change To: ☐ One Person Coverage ☐ Employee and Spouse Coverage ☐ Employee and Child(ren) Coverage ☐ Family Coverage

Change Reason: ☐ Marriage ☐ Divorce ☐ Spouse Deceased ☐ Other: _____ Date: _____

☐ Add New Dependent(s): _____ Date Dependent(s) joined your household: _____ (Complete Section D.)

_____ Date Dependent(s) joined your household: _____ (Complete Section D.)

☐ Change Network Options (if applicable) ☐ NEtwork BLUE ☐ Premier Select BlueChoice ☐ Other - Network Name: _____

☐ Other Changes: _____

Section D: Personal Data

List below spouse and other dependent(s) to be covered including eligible children under age 26. List In Order Of Age – Oldest First.

Full Name (Last, First, MI)	Social Security Number	Date of Birth (MM/DD/YYYY)	M	F	Relation to Employee

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

Name (Last)	(First)	(MI)	Social Security Number

Section E. Loss of Coverage - Special Enrollment

Are You or Dependent terminating (or losing) other health coverage? ☐ Yes ☐ No If YES, please complete the following:

1) Give us the reason for loss of other health coverage:

☐ Employment terminated ☐ Death, divorce, or legal separation ☐ I/we voluntarily chose to drop other insurance

☐ Spouse employment terminated ☐ I/we have reached the end of COBRA coverage ☐ Other: _____

2) Coverage termination date: _____

3) Please provide the notice of termination, or loss of eligibility documentation from the other insurance company.

Section F. Medicare Secondary Payor Information

Are you, your spouse, or dependent(s) enrolled in Medicare? ☐ Yes ☐ No If the answer is "Yes," please fill in requested information below:

If Medicare: Name of Beneficiary _____

Medicare HIC #: _____

Part A effective date: _____

Part B effective date: _____

Reason for entitlement (check all applicable boxes): ☐ Age ☐ Disability ☐ End stage renal disease

Section G. Acknowledgement and Authorization

I represent that my answers and statements in this enrollment form are true and complete to the best of my knowledge and belief. I understand that any intentional misrepresentation in this enrollment form may cause the coverage to be void. I further understand that Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this enrollment form and that no right whatever is created by it. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for processing claims. I authorize my employer to deduct from my earnings any required premiums.

By providing your telephone numbers you agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless number, using an automatic telephone dialing system and/or prerecorded message. Without limit, these calls may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you are declining coverage for yourself or your dependents because of coverage under Medicaid or a State Child Health Insurance Program (SCHIP), you may be able to enroll yourself or your dependents in this plan if that coverage terminates due to a loss of eligibility. You must request enrollment in the plan no later than 60 days after the termination of coverage.

Additionally, if you decline coverage and you or your dependents become eligible for premium assistance for this group health plan under Medicaid or SCHIP, you or your dependents may be able to enroll in the plan at that time. You must request enrollment no later than 60 days after the date you are determined to be eligible for the premium assistance.

To request special enrollment or obtain more information contact our Member Services Department at 402-390-1820 or toll free 800-642-8980.

Signature of Applicant: _____ Date: _____

Section H. Declination Of Coverage. Complete only if you elect not to participate in the group insurance offered.

The group health/dental program has been offered to me and after seriously considering its benefits, I have decided:

☐ not to enroll myself in the health/dental plan.

☐ not to enroll myself and my dependents in the health/dental plan.

☐ not to enroll my dependents in the health/dental plan.

Coverage in the health/dental plan is declined because:

☐ I am enrolled and/or ☐ My dependents are enrolled, under my spouse's health coverage.

My spouse is employed by (name of firm) _____

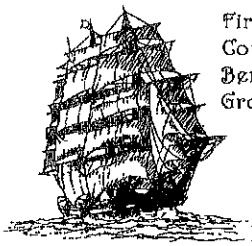
☐ I am enrolled and/or ☐ My dependents are enrolled, under a COBRA continuation or state continuation coverage.

☐ I have and/or ☐ My dependents have, individual coverage through ☐ Medicare ☐ Medicaid ☐ SCHIP ☐ another insurance company

☐ Other reason(s) _____

If you decline enrollment for yourself and your dependents, a request for enrollment at a later date may be subject to late enrollment restrictions. See "Special Enrollment Notice" above.

Signature of Applicant: _____ Date: _____



First
Concord
Benefits
Group

www.firstconcord.com
Phone: 402-423-4454
Fax: 402-423-4549
www.ezflexplan.com/fcbg

I.R.C. Section 125 Enrollment Form

School: District OR-1 PALMYRA

Plan Year: Sep 1, 2017 to Aug 31, 2018 No.Payrolls 12

LastName _____ FirstName _____ Date of Birth _____ SocSecNo. _____

Home Address _____ City _____ State _____ Zip _____

DEBIT CARD REQUEST/ CONTINUATION

I understand that the take care debit card is available to pay only qualified expenses. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by law). www.myflexonline.com

☐ **YES** I want the convenience of using the take care debit card to pay for qualified expenses.

E-MAIL (required-if YES): _____

☐ **NO** At this time, I do NOT want to use the take care debit card.

Flexible Spending Account (FSA)

Allows you to use pre-tax dollars to pay for expenses which are not covered, or are not eligible for payment through any group health care plan(s), under which you or your spouse are covered.

_____ **YES, I elect to participate:** $_____ **Per Pay** $_____ **Annual Amount**

$2,600 maximum election

Dependent Care Spending Account

The Dependent Care Spending Account allows you to use pre-tax dollars to pay for eligible Dependent Care Expenses which allow you or your spouse (if applicable) to work, look for work, or attend school on a full-time basis.

_____ **YES, I elect to participate:** $_____ **Per Pay** $_____ **Annual Amount**

$5,000 maximum election

Group Premium Payment Plan

The Premium Payment Plan allows you to pay for your portion and your dependent(s) portion of employer-provided benefits on a pre-tax basis. I understand that my share of these insurance benefits will be paid with pre-tax dollars.

_____ **YES, I elect to participate:** $_____ **Per Pay** $_____ **Annual Amount**

_____ **NO, I WAIVE my right to participate and understand that I will lose all tax savings I may have received as a participant.**

My employer and I agree that my taxable income will be reduced each pay period by the amount set forth in this agreement. I understand that I may only change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year or after termination of employment or benefits will be forfeited and will *not* be paid to me in cash or used in a later plan year.

Employee Signature: _____ **Date:** _____

NPERS Nebraska Public Employees Retirement Systems

1526 K St., Ste. 400 PO Box 94816 Lincoln, NE 68509-4816 PHONE 402-471-2053 TOLL FREE 800-245-5712
npers.ne.gov

Name (Last / First / Middle / Maiden)		Date of Birth - -	Plan Type (check all that apply)
Social Security Number - -	Retirement Number		☐ School ☐ State ☐ County ☐ Judges ☐ Patrol ☐ DCP
Address	City	State Zip	
Home Phone	Work Phone	Employer	

Beneficiary Designation Form

READ CAREFULLY BEFORE COMPLETING: Use this form to designate or change your beneficiaries for the Retirement Plan indicated above. Benefits will be paid to your survivors exactly as you provide on this form. This form supersedes prior beneficiary designation forms. If you name a trust or other legal entity as your beneficiary, include the name of both the trust and the trustee. Submit the original document only; **photocopies and faxes will not be accepted.** If you wish to designate more than three beneficiaries in either the Primary or Contingent category, you must attach a supplemental form(s) and indicate the number of additional pages here. _____

PRIMARY BENEFICIARY(IES): I designate the following person(s) to be my Primary Beneficiary(ies) for the Retirement Plan noted above. All Primary Beneficiaries designated will share equally in the benefit unless I have included a percentage (%) amount on the line following the date of birth below. **(The shares of all Primary Beneficiaries must total 100%.) PLEASE PRINT.**

Name of Beneficiary _____ Spouse/Child/Other _____ M / F Gender _____ Social Security Number _____ Date of Birth _____ %

Address _____ City _____ State _____ Zip _____

Name of Beneficiary _____ Spouse/Child/Other _____ M / F Gender _____ Social Security Number _____ Date of Birth _____ %

Address _____ City _____ State _____ Zip _____

Name of Beneficiary _____ Spouse/Child/Other _____ M / F Gender _____ Social Security Number _____ Date of Birth _____ %

Address _____ City _____ State _____ Zip _____

CONTINGENT BENEFICIARY(IES): I designate the following person(s) to be my Contingent Beneficiary(ies) for the Retirement Plan noted above. I understand my Contingent Beneficiary(ies) will receive a share of my benefit if all Primary Beneficiaries pre-decease me or refuse their shares of the benefit. All Contingent Beneficiaries designated will share equally in the benefit unless I have included a percentage (%) amount on the line following the date of birth below. **(The shares of all Contingent Beneficiaries must total 100%.) PLEASE PRINT.**

Name of Beneficiary _____ Spouse/Child/Other _____ M / F Gender _____ Social Security Number _____ Date of Birth _____ %

Address _____ City _____ State _____ Zip _____

Name of Beneficiary _____ Spouse/Child/Other _____ M / F Gender _____ Social Security Number _____ Date of Birth _____ %

Address _____ City _____ State _____ Zip _____

Name of Beneficiary _____ Spouse/Child/Other _____ M / F Gender _____ Social Security Number _____ Date of Birth _____ %

Address _____ City _____ State _____ Zip _____

SIGNATURE OF MEMBER _____ **Date** _____

I hereby certify that the above member, whose identity I have established to my own satisfaction, freely and voluntarily signed this beneficiary designation form in my presence.

State of _____

County of _____

STAMP HERE

Subscribed and sworn before me this _____ day of _____, _____.

NOTARY PUBLIC SIGNATURE _____ My commission expires: _____.

BAR CODE

Nebraska Public Employees Retirement Systems
1221 N Street, Suite 325
P.O. Box 94816
Lincoln, NE 68509

402-471-2053
800-245-5712
Fax: 402-471-9493

Name (Last / First / Middle)		Date of Birth	Plan Type (Check One)
Social Security Number	Retirement Number		☐ School ☐ State ☐ County ☐ Judges ☐ Patrol ☐ DCP
Address	City	State / Zip	
Home Phone	Work Phone	Employer	

Application for Vesting Credit/Prior Service Credit

You must use a separate form for each past Retirement Plan.
See reverse side for complete instructions.

Current Place of Employment _____ Date of Hire _____ FT / PT

LIST ALL NEBRASKA PUBLIC EMPLOYMENT

The following should be completed by you.
Please include all past participation with another Nebraska Governmental Entity as well as any past participation with your current employer.

BELOW SHOULD REFLECT DATES YOU PARTICIPATED IN ANOTHER NEBRASKA GOVERNMENTAL PENSION PLAN.

Place of Employment	Circle One	Dates of Participation	
	Full Time / Part Time	From	To
	Full Time / Part Time	From	To
	Full Time / Part Time	From	To

Identify person to contact with the Government Plan:

Name _____ Department _____

Address _____ Phone Number _____

This form must be completed and received by the Retirement Office no later than 30 days after your date of hire.

I hereby certify and warrant that, to the best of my knowledge and belief, the foregoing is true and correct.

Signature of Member _____ Date _____

NPERS2100 Rev. 09/05

BAR CODE

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Children and Family Services (CFS)
Nebraska Child Abuse and Neglect Central Registry (CAN Registry)/
Nebraska Adult Protective Services Central Registry (APS Registry)

All designated fields must be completed or the request will be returned and not processed. Please type or print legibly. For information on how to register your organization go to: http://dhhs.ne.gov/CFSCentralRegistry

ORGANIZATION INFORMATION

Registered Organization ID Number	Registered Organization Name
1022	OneSource

APPLICANT INFORMATION

First	Middle	Last Name

Date of Birth	Age	Social Security Number

Current Address

City	State	Zip Code

Applicant's E-Mail Address (Please leave the E-Mail field blank if you prefer to receive correspondence by U.S. Mail).

Other names, such as a maiden name, former married name, or nickname

Names and birthdates of your children and children who lived with you:

All previous addresses at which you have resided (minimum City & State):

Please release the following information to the Organization listed above: (Check all that apply): .

☐ Nebraska Child Abuse and Neglect Central Registry (CAN Registry)
1. Whether or not I am listed on the CAN Registry, and the following information regarding that listing:
   a. Date of the alleged child abuse or neglect; and
   b. The classification of the case pursuant to Neb. Rev. Stat. 28-720. (i.e., Agency Substantiated or Court Substantiated).

☐ Nebraska Adult Protective Services Registry (APS Registry)
1. Whether or not I am listed on the APS Registry, and the following information regarding that listing:
   a. Date of the alleged adult abuse or neglect; and
   b. The classification of the case pursuant to Neb. Rev. Stat. 28-376. (i.e., Agency Substantiated or Court Substantiated).

This authorization is valid for a period of 6 months from the date of signature.

Signature of Applicant _____ Date _____

(NOTE: If Applicant is less than 19 years of age the notarized signature of Applicant's Legal Guardian is also required below in Section C).

Section A - Verification of Identity of Applicant: Section A or B must be completed.

STATE OF_____)
COUNTY OF_____) ss.

The foregoing instrument was acknowledged before me this_____day of _____, 20_____ by:

_____
(Printed Name of Applicant) .

Affix Official Notary seal here _____
Notary Public

Section B - Verification of Identity of Applicant: Section A or B must be completed.

The undersigned Organization employee hereby certifies that he or she has verified the identity of the Applicant by examining the Applicant's identification documents.

_____ _____
Signature of Organization Employee Date

_____
Printed Name of Organization Employee

_____ _____
Signature of Applicant's Legal Guardian Date
(NOTE: This signature is necessary only if Applicant is less than 19 years of age).

Section C - Verification of Identity of Applicant's Legal Guardian (If applicable)

STATE OF_____)
COUNTY OF_____) ss.

The foregoing instrument was acknowledged before me this_____day of _____, 20_____ by:

_____
(Printed name of Applicant's Legal Guardian) .

Affix Official Notary seal here _____
Notary Public

Registered Organization ID Number
1022

Onesource
The Background Check Company

APPLICANT DISCLOSURE AND AUTHORIZATION FORM

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

[Employer] ("The Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history including current position, worker's compensation injuries, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by [One Source The Background Check Company, PO Box 24148 Omaha, NE 68124, 1.800.608.3645] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing [Employer] to obtain from any outside organization all manners of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by [One Source The Background Check Company, PO Box 24148 Omaha, NE 68124, 1.800.608.3645], another outside organization acting on behalf of [Employer], and/or [Employer] itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by [Employer] by contacting the consumer reporting agency identified above directly.
Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐
California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Last Name _____ First _____ Middle _____

Other Names/Alias _____

Social Security* # _____ Date of Birth* _____

Driver's License # _____ State of Driver's License _____

Present Address _____ Phone Number _____

City/State/Zip _____

All Previous Addresses In the Last Seven Years _____

_____

_____

Signature: _____ Date: _____

*This information will be used for background screening purposes only and will not be used as hiring criteria.

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

- You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if: (a) a person has taken adverse action against you because of information in your credit report; (b) you are the victim of identity theft and place a fraud alert in your file; (c) your file contains inaccurate information as a result of fraud; (d) you are on public assistance; (e) you are unemployed but expect to apply for employment within 60 days. In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.
- You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- You may limit "prescreened" offers of credit and insurance you get based on information in your credit report. Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- Identity theft victims and active duty military personnel have additional rights. For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General.

For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates. b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau:	a. Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20552 b. Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Ave, Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street SW, Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 406 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357

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

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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 report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
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. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
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. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		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		
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				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2018)

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

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. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

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

Employee's Withholding Allowance Certificate

OMB No. 1545-0074

2018

▶ **Whether you're 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.**

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 filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, 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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/programs/css/employers***.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	
B	Enter "1" if you will file as married filing jointly	B	
C	Enter "1" if you will file as head of household	C	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E	
F	**Credit for other dependents.** • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-"	F	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here	G	
H	Add lines A through G and enter the total here ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details	1	$
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	$
5	**Add** lines 3 and 4 and enter the total	5	$
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	$
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H above	9	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 $ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ _____

9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and 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 aren't required to provide the information requested on a form that's 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.