Print Form

Millard PUBLIC SCHOOLS
Human Resources, Don Stroh Administration Center, 5606 So. 147 St., Omaha, NE 68137
(402)715-8582 FAX (402)715-8409 e-mail: mlellis@mpsomaha.org

Congratulations! We are excited to have you become part of the Millard Public Schools.

We would appreciate your help in having these forms completed when you come in to sign your contract. We will go over all your benefits and answer any questions you may have concerning the forms you completed.

The forms included are:

- Demographic Form
- I-9 Form
- Criminal Background Check
- W-4
- Direct Deposit (Bring a voided Check)
- Payflex Enrollment Form
- HIPPA Privacy Notice
- Health, Dental, and LTD Enrollment Form
- Life Insurance Enrollment Form
- Nebraska School Employees Retirement System Enrollment/Beneficiary Form
- 403b Form
- Personnel Handbook Form

Items to bring with you:

- Voided Check
- Driver's License
- Social Security Card
- Birth Certificate

If you have any questions please call Human Resources 402-715-8200

BENEFIT ELIGIBILITY LIST 2010-11: CUSTODIAN 10 MONTH

BENEFIT	DISTRICT PAYS: 19 PAY PERIODS	EMPLOYEE PAYS: 19 PAY PERIODS
SINGLE HEALTH	$143.77	$95.85
FAMILY HEALTH	$393.73	$262.48
SINGLE DENTAL	$9.06	$6.04
FAMILY DENTAL	$9.06	$32.43
$50,000 TERM LIFE	$2.21	$0.00
$25,000 - $300,000 Supplemental Life, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$5.13 to $51.25
$12,500 - $150,000 Spouse Supplemental Life, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$2.25 to $22.50
Dependent Child Life $10,000 Coverage, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$2.05
Section 125 Medical Plan	$0.00	$25 to $368.43
Section 125 Child/Elder Care Plan	$0.00	$25 to $263.16
403(b) Tax Deferred Savings, Employee must complete the salary reduction agreement	$0.00	$25.00 to IRS maximum
Nebraska Public Employees Retirement (required)	8.3628%	8.2800%
Social Security (required)	7.6500%	7.6500%

BENEFIT ELIGIBILITY LIST 2010-11: CUSTODIAN 12 MONTH

BENEFIT	DISTRICT PAYS: 24 PAY PERIODS	EMPLOYEE PAYS: 24 PAY PERIODS
SINGLE HEALTH	$189.70	$0.00
FAMILY HEALTH	$519.50	$0.00
CASH OPTION	Only Available for Employees Continously employed by the Distirct from 1996-97 who do not elect Health Insurance	
SINGLE DENTAL	$11.95	$0.00
FAMILY DENTAL	$11.95	$20.90
$50,000 TERM LIFE	$1.75	$0.00
$25,000 - $300,000 Supplemental Life, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$2.56 to $25.63
$12,500 - $150,000 Spouse Supplemental Life, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$1.13 to $11.25
Dependent Child Life $10,000 Coverage, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$1.63
Long Term Disability Premium (required)	0.2100%	0.0000%
Section 125 Medical Plan	$0.00	$25 to $291.67
Section 125 Child/Elder Care Plan	$0.00	$25 to $208.34
403(b) Tax Deferred Savings, Employee must complete the salary reduction agreement	$0.00	$25.00 to IRS maximum
Nebraska Public Employees Retirement (required)	8.3628%	8.2800%
Social Security (required)	7.6500%	7.6500%

BENEFIT ELIGIBILITY LIST 2010-11: CUSTODIAN 12 MONTH PART-TIME

BENEFIT	DISTRICT PAYS: 24 PAY PERIODS	EMPLOYEE PAYS: 24 PAY PERIODS
SINGLE HEALTH	$94.85	$94.85
FAMILY HEALTH	$259.75	$259.75
CASH OPTION	Only Available for Employees Continously employed by the Distirct from 1996-97 who do not elect Health Insurance	
SINGLE DENTAL	$7.17	$4.78
FAMILY DENTAL	$5.98	$33.94
$50,000 TERM LIFE	$1.75	$0.00
$25,000 - $300,000 Supplemental Life, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$2.56 to $25.63
$12,500 - $150,000 Spouse Supplemental Life, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$1.13 to $11.25
Dependent Child Life $10,000 Coverage, any request for an increase requires Evidence of Insurability form to be completed and returned to Human Resources	$0.00	$1.63
Long Term Disability Premium (required)	0.2100%	0.0000%
Section 125 Medical Plan	$0.00	$25 to $368.43
Section 125 Child/Elder Care Plan	$0.00	$25 to $263.16
403(b) Tax Deferred Savings, Employee must complete the salary reduction agreement	$0.00	$25.00 to IRS maximum
Nebraska Public Employees Retirement (required)	8.3628%	8.2800%
Social Security (required)	7.6500%	7.6500%

NEW EMPLOYEE DEMOGRAPHIC INFORMATION FORM

Please complete the following:

Legal Name (as it appears on your Social Security Card):

Last Name _____ First Name _____ Middle Initial ____

Social Security Number

Marital Status (circle the number)
- ☐ = single
- ☐ = single with dependents
- ☐ = married

Sex (circle the letter)
- ☐ = female
- ☐ = male

Ethnic Code (circle the number)
- ☐ = Hispanic or Latino or Spanish Origin
- ☐ = Not Hispanic or Latino or Spanish Origin

Race Code (circle the number)
- ☐ = American Indian or Alaska Native
- ☐ = Asian
- ☐ = Black or African American
- ☐ = Native Hawaiian or Other Pacific Islander
- ☐ = White

Citizenship (check one)
- ☐ United States Citizen
- ☐ Non-Citizen

Birth Date _____

Address _____
Street

_____
City State ZIP

Phone Number _____ _____ _____

Employee's Emergency Contact _____
Name Phone #

FOR HR USE ONLY
ID# _____
[ ] I-9
[ ] PH
[ ] W4 _____
[ ] CBC

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

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

Form I-9, Employment Eligibility Verification

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

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

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

Print Name: Last | First | Middle Initial | Maiden Name

Address *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

City | State | Zip Code | Social Security #

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

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

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

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

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

Preparer's/Translator's Signature | Print Name

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

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

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

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

Signature of Employer or Authorized Representative | Print Name | Title: **Human Resources**

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*: **Millard Public Schools, 5606 S 147th St., Omaha, NE 68137** | Date *(month/day/year)*

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

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

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

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

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

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

Print Form

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)				**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**3.** School ID card with a photograph		
		4. Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		**5.** U.S. Military card or draft record		
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		**5.** Native American tribal document
		8. Native American tribal document		**6.** U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		**8.** Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Department of Health & Human Services

DHHS

NEBRASKA

Division of Children and Family Services

State of Nebraska
Dave Heineman, Governor

AGENCY REQUEST FOR INFORMATION FROM THE NEBRASKA ADULT AND CHILD ABUSE AND NEGLECT REGISTER/REGISTRY

The State of Nebraska approved this form, any alteration will invalidate it.

I hereby request information from the Nebraska Adult and Child Abuse and Neglect Registry. I agree to use the requested information to determine whether to hire or retain the individual to provide care, custody, treatment, transportation or supervision of children or vulnerable adults.

Agency Name/ Fax: **One Source, The Background Check Company –Fax 1-800-929-8117**

Please do not use abbreviations

Address and Phone Number: **P.O. Box 24148, Omaha, NE 68124—Attn Nick Jasa**

I hereby authorize the Division of Children and Family Services to disclose whether I have an Adult and/or Child Abuse and Neglect Register/Registry record to the above-named agency.

Print Full Legal Name: (applicant)_____

_____ _____
Signature (applicant) **Date**

Current Address: _____
(Street/City/State/Zip)

_____ _____
Applicant Date of Birth **Applicant Social Security Number**

Other names previously used such as former married names, maiden name and nick names. Please Print.

Names and birth dates of your children and children who have lived with you. Please Print.

Any Address at which you have resided during the past 20 years. Please Print.

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, 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.

Print Form

SUMMARY OF RIGHTS UNDER THE FCRA

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every consumer reporting agency (CRA). You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commissions web site (http://www.ftc.gov). The FCRA gives you specific rights, as outlined below. You may have additional rights under the state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

1. You must be told if information in your file has been used against you. Anyone who uses information from a CRA to take action against you--such as denying an application for credit, insurance or employment must tell you and give you the name, address, and phone number of the CRA that provided the consumer report.

2. You can find out what is in your file. At your request, a CRA must give you the information in your file and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You are also entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.

3. You can dispute inaccurate information with the CRA. If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs--to which it has provided the data, of any error.) The CRA must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the CRAs investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.

4. Inaccurate information must be corrected or deleted. A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified. If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.

5. You can dispute inaccurate items with the source of the information. If you tell anyone--such as a creditor who reports to the CRA--that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you*ve notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.

6. Outdated information may not be reported. In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.

7. Access to your file is limited. A CRA may provide information about you only to people with a need recognized by the FCRA, usually to consider an application with a creditor, insurer, employer, landlord, or other business.

8. Your consent is required for reports that are provided to employers or reports that contain medical information. A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.

9. You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers. Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.

10. You may seek damages from violators. If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.
The FCRA gives several different federal agencies authority to enforce the FCRA. For questions or concerns regarding:

CRAs, creditors and others not listed below, please contact:

Federal Trade Commission
Bureau of Consumer Protection-FCRA,
Washington, DC 20580 (202) 326-3761

National banks, federal branches/agencies of foreign banks, please contact:

Office of the Controller of the Currency
Compliance Management, Mail Stop 6-6
Washington, DC 20219 (800) 613-6743

Federal Reserve System member banks, please contact:

Federal Reserve Board
Division of Consumer & Community Affairs
Washington, DC 20551 (202) 452-3693

Savings associations and federally chartered savings banks, please contact:

Office of Thrift Supervision
Consumer Programs
Washington, DC 20552
(800) 842-6929

Federal credit unions, please contact:

National Credit Union Administration
775 Duke Street
Alexandria, VA 22314
(703) 518-6360

Federal Deposit Insurance Corporation

Division of Compliance & Consumer Affairs
Washington, DC 20429
(800) 934-FDIC

Air, surface or rail common carriers regulated by former Civil Aeronautics Board of Interstate Commerce Commission, please contact:

Department of Transportation
Office of Financial Management
Washington, DC 20590
(202) 366-1306

Activities subject to the Packers and Stockyards Act, 1921, please contact:

Department of Agriculture
Office of Deputy Administrator-GIPSA
Washington, DC 20250
(202) 720-7051

Form W-4 (2010)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** _____

F Enter "1" if you have at least $1,800 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children.

G _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** _____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $18,000 ($32,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2010

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

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2010, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	**7**

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

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

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

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: { $11,400 if married filing jointly or qualifying widow(er); $8,400 if head of household; $5,700 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.)	5	$
6	Enter an estimate of your 2010 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,650 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3."	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

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

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $6,000	0
7,001 - 10,000	1	6,001 - 12,000	1
10,001 - 16,000	2	12,001 - 19,000	2
16,001 - 22,000	3	19,001 - 26,000	3
22,001 - 27,000	4	26,001 - 35,000	4
27,001 - 35,000	5	35,001 - 50,000	5
35,001 - 44,000	6	50,001 - 65,000	6
44,001 - 50,000	7	65,001 - 80,000	7
50,001 - 55,000	8	80,001 - 90,000	8
55,001 - 65,000	9	90,001 -120,000	9
65,001 - 72,000	10	120,001 and over	10
72,001 - 85,000	11		
85,001 -105,000	12		
105,001 -115,000	13		
115,001 -130,000	14		
130,001 - and over	15		

Table 2

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

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

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

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

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

MILLARD PUBLIC SCHOOLS
DIRECT DEPOSIT – ENROLLMENT/CHANGE

I, _____, request that Millard Public Schools directly deposit my paycheck in the Referenced account(s). I further authorize Millard Public Schools to request my bank to debit my account for any direct deposit made in error.

Signed: _____ Dated: _____

Social Security Number: _____

Attach a voided check.

Note: all new direct deposits and changes must be pre-noted. During the month of pre-noting, a paycheck will be mailed. Direct Deposit requests must be received by the Business Office by the 10th of the month in which pre-noting will occur. If you close your accounts, please notify the Payroll Department immediately. We are not responsible for deposits made to closed accounts.

PRIMARY BANK ACCOUNT:

BANK NAME: _____ Account type: _____
(C=Checking, S=Savings)

Bank Routing Number:
Bank Account Number:

SECONDARY BANK ACCOUNT:

BANK NAME: _____ Account type: _____
(C=Checking, S=Savings)

Bank Routing Number:
Bank Account Number: _____

SECONDARY BANK ACCOUNT:

BANK NAME: _____ Account type: _____
(C=Checking, S=Savings)

Bank Routing Number: _____
Bank Account Number: _____

SECONDARY BANK ACCOUNT:

BANK NAME: _____ Account type: _____
(C=Checking, S=Savings)

Bank Routing Number: _____
Bank Account Number: _____

Health/Dependent Care Flexible Spending Accounts-FSA Enrollment Form

Employer Use Only

Re-enrollment __ New __ Change __
Effective Date _____
1st Deduction Date _____
Payroll Mode W B S M Q
Division Code _____

I. Personal Information (Please print clearly and provide complete and accurate information.)

Your Employer _____

SSN _____ _____ _____ **Your Name** _ _____
(Last) (First) (MI)

Address_ __**City** _____ **State** _____ **Zip** _____ _____

☐ *Check if this address is new within last year.* **Date of Birth** _____ _____ _____ **Hire Date** _____ _____ _____

II. Election Information (Please check the appropriate box to indicate if you wish to enroll, or do not wish to enroll, and sign below.)

☐ Yes, I wish to participate in the flexible spending account plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ I have been offered the opportunity to enroll in the flexible spending account plan and do not wish to enroll at this time. However, my employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

BENEFIT CHOICES	PER PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		PLAN YEAR AMOUNT
Health Care Reimbursement Account	$_____ ____	X	_____	=	$_____ ____
Dependent Day Care Reimbursement Account (If married, this amount is less than my spouse's earned income)	$_____ ____	X	_____	=	$_____ ____

I understand that:

- This election can only be changed or revoked during the Plan Year if I have a change in status as defined in the Plan or if I am no longer eligible to participate. The new election must be consistent with my change in status, must be applied for within 30 days of the change, and is subject to final approval by my employer.
- This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required employer-sponsored benefit contributions increase or decrease.
- The maximum exclusion under a Dependent Care Reimbursement Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- Any amounts remaining in my reimbursement accounts at the end of the Plan Year will be forfeited.
- Salary contributed into one reimbursement account cannot be transferred and used for expenses in any other account.
- A new Enrollment Form must be completed each Plan Year. If I do not complete and return an Enrollment Form during Open Enrollment, I forfeit the opportunity to participate in the Benefit Choices outlined above.
- Social Security and Medicare taxes are not being withheld on the amount of my salary reduction under this election.
- The amount of salary reductions may not be claimed on my or my spouse's income tax returns.
- If my employment terminates, only medical expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- I understand all claims submitted for reimbursement are subject to substantiation requirements and I am required to, and agree to, provide documentation as requested.
- If using the Flex Convenience® Card, I agree to use the card for eligible expenses only and retain all itemized receipts/statements. I agree to read and adhere to the cardholder statement I receive with the card and I understand the card is subject to inactivation if I do not comply with the provisions or upon termination of employment.
- Any expenses I pay for with the Flex Convenience® Card or for which I claim reimbursement will not have been nor will I seek to have reimbursed elsewhere.

III. Pre-Authorization for Direct Deposit (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

☐ I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements. This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement.
A "VOIDED" CHECK MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

Employee Signature _____ ***Date*** _____

Rev.9/2004

Confirmation of Receipt

You are required to sign and return this copy to the Millard Public Schools to confirm that you have received a copy of this Notice. You will be provided with a copy for your records as well. The Notice with your signature will be maintained as a part of your employment record.

I _____ acknowledge receipt of this HIPAA Privacy Notice.

Date: _____

Millard Public Schools
Benefit Enrollment Form

Event(s) or Reason(s) for Changing Contract

- ☐ New Hire
- ☐ Birth/Adoption
- ☐ Marriage
- ☐ Change of Spouse's Employment
- ☐ Death
- ☐ Add/Delete Dependent
- ☐ Divorce
- Date of Event:_____

A. EMPLOYEE INFORMATION

First Name	M.I.	Last Name	Social Security Number	Gender	Birthdate

Street Address	Apt. No.	City	State	ZIP Code	County

Home Phone	Work phone	Marital Status

Hire Date	Effective Date

Occupational / Job Title	# Hours Worked Each Week

B. BENEFIT SELECTION

MEDICAL BENEFITS (Administered by Coventry Health Care)

- ☐ Employee Only
- ☐ Employee + Family
- ☐ Decline Medical Benefits

DENTAL BENEFITS (Insured and administered by United Concordia)

- ☐ Employee Only
- ☐ Employee + Family
- ☐ Decline Dental Benefits

- ☐ **LONG TERM DISABILITY**

C. FAMILY INFORMATION

- List all family members to be covered. Write name as it should appear on I.D. card.
- Student status information will be required for all family members who exceed the age stated for dependents in the Master Group Contract or Policy. (Please attach)
- Indicate dependent address (if different) in the space provided below.
- Attach additional enrollment form if enrolling more than 5 members.

	First Name M.I. Last Name	**Social Security Number**	**Relationship**	**Sex**	**Birthdate**	Full-Time College Student
01	Spouse's Employer:		**SPOUSE**			
02						
03						
04						
05						
06						

D. OTHER HEALTH INSURANCE INFORMATION (*THIS SECTION MUST BE COMPLETED)*

HAVE YOU (OR YOUR FAMILY MEMBERS) HAD ANY OTHER HEALTH CARE COVERAGE DURING THE PREVIOUS 12 MONTHS? ☐ Yes ☐ No **IF YES, FILL OUT THIS SECTION:**

Company (Companies)	Start Date of Prior Coverage(s)	End Date of Prior Coverage(s)

ON THE DAY YOUR COVERAGE BEGINS, WILL ANY FAMILY MEMBER (INCLUDING THOSE NOT LISTED IN SECTION C) BE COVERED BY OTHER HEALTH OR DENTAL INSURANCE OR MEDICARE? ☐ Yes ☐ No **IF YES, FILL OUT THIS SECTION:**

Coverage Type	Insurance Company Name, Address and Phone Number	Policy Number
☐ Medical Insurance ☐ Dental Insurance ☐ Medicare		

Policy Coverage Date	Name of Policyholder	Policyholder's Birthdate	Family Members Covered

Policyholder's Employer: Name	Address	Phone Number

Names of family members covered by Medicare	Medicare Claim Number	Part A Effective Date	Part B Effective Date	**Is Medicare eligibility due to:**
				☐ Kidney Failure ☐ Disability

E. SIGNATURE (*THIS FORM MUST BE SIGNED)*

The information provided on this application is accurate and complete. I declare that I am actively at work on the date of this enrollment form. I understand and agree that any omission or incorrect statements knowingly made by us on this application may invalidate my and / or my dependents coverage. If contributions are required, I authorize my employer to deduct premiums from my salary. No insurance is in force until this application is accepted by the home office.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give Coventry Health Care, or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and /or my dependents' coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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's Signature Date

F. FOR EMPLOYER USE ONLY

Company Name	Plan / Reporting Code	
Millard Public Schools		
Hire Date / Effective Date	☐ Open Enrol ment ☐ Special Enrollment _____ (date) Explanation _____ ☐ New Hire ☐ Other _____ (date) Explanation _____	☐ Admin. ☐ All Other
Approved By (Signature)		Date

Group Benefits from The Hartford

Income Protection Benefits

Millard Public Schools
Policy Number 398481
Benefits Enrollment Form for All Other Employees

Information About You

Name:	**Social Security Number / Employee ID Number:**
Date of Birth:	**Date of Hire:**

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*
- **Step 2:** Please **sign, date and return** this form to Human Resources

Employee Basic Life Insurance

Millard Public Schools provides, at no cost to you, Basic Life Insurance in an amount equal to $50,000.

Supplemental Life and AD&D Insurance

You can purchase Supplemental Life and AD&D Insurance in increments of $25,000. The maximum amount you can purchase cannot be more than $300,000. If you elect an amount that exceeds the guaranteed issue amount of $150,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

Employee Supplemental Life and AD&D Insurance			
☐ **$25,000** ($5.13/month)	☐ **100,000** ($20.50/month)	☐ $175,000 ($35.88/month)	☐ $250,000 ($51.25/month
☐ **$50,000** ($10.25/month)	☐ **$125,000** ($25.63/month)	☐ $200,000 ($41.00/month)	☐ **$**275,000 ($56.38/month)
☐ **$75,000** ($15.38/month)	☐ **$150,000** ($30.75/month)	☐ $225,000 ($46.13/month)	☐ $300,000 ($61.50/month)
☐ I **decline** to purchase Supplemental Life and AD&D Insurance coverage			

Supplemental Dependent Life Insurance

If you purchase Supplemental Life and AD&D for yourself, you can purchase Supplemental Life Insurance for your Spouse and Supplemental Life and AD&D for your Dependent Child(en). You can purchase coverage for your Spouse in increments of $12,500. The maximum amount you can purchase cannot be more than the lesser of $150,000 or 50% of your Supplemental Life and AD&D Insurance. If you elect an amount that exceeds the guaranteed issue amount of $25,000, your Spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. You can purchase coverage for your Dependent Child(ren) between the ages of Birth and 23 years in the amount(s) of $10,000.

Spouse Supplemental Life Insurance			
☐ **$12,500** ($2.25/month)	☐ **$50,000** ($9.00/month)	☐ **$87,500** ($15.75/month)	☐ **$125,000** ($22.50/month)
☐ **$25,000** ($4.50/month)	☐ **$62,500** ($11.25/month)	☐ **$100,000** ($18.00/month)	☐ **$137,500** ($24.75/month)
☐ **$37,500** ($6.75/month)	☐ **$75,000** ($13.50/month)	☐ **$112,500** ($20.25/month)	☐ **$150,000** ($27.00/month)
☐ I **decline** to purchase Supplemental Life Insurance coverage for my Spouse			
Child(ren) Supplemental Life and AD&D Insurance			
☐ I **elect** to purchase Supplemental Dependent Life and AD&D Insurance coverage for my Child(ren) at a cost of $3.25 per month		☐ I **decline** to purchase Supplemental Dependent Life and AD&D Insurance coverage for my Child(ren).	

Expertise without equal.
Benefits without burden.℠

Name: _____

Spouse First Name	Spouse Last Name	Gender	Date of Birth	Date of Marriage

Child First Name	Child Last Name	Date of Birth	Gender

Beneficiary Designation

You must select your beneficiary the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percent-age
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life and Accident insurance coverage described in the Benefit Highlight Sheets and offered through Millard Public Schools.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

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

402-471-2053
800-245-5712

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 Millard Public Schools		

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 equal 100%.)**

Name of Beneficiary	Spouse/Child/Other	Social Security Number	Date of Birth	%
Address	City	State	Zip	
Name of Beneficiary	Spouse/Child/Other	Social Security Number	Date of Birth	%
Address	City	State	Zip	
Name of Beneficiary	Spouse/Child/Other	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%.)**

Name of Beneficiary	Spouse/Child/Other	Social Security Number	Date of Birth	%
Address	City	State	Zip	
Name of Beneficiary	Spouse/Child/Other	Social Security Number	Date of Birth	%
Address	City	State	Zip	
Name of Beneficiary	Spouse/Child/Other	Social Security Number	Date of Birth	%
Address	City	State	Zip	

Signature of Member_____Date_____

I hereby certify that the undersigned 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_____ } Subscribed and sworn before me this _____ day of _____ , _____

Notary Public Signature_____ My commission expires: _____

NPERS1300 Rev. 08/05

BAR CODE

Beneficiary Designation Supplemental Form

IMPORTANT: This form is to be used as a supplement to the Beneficiary Designation Form only if you wish to designate more than three Primary or Contingent Beneficiaries. You may use as many Supplemental forms as needed. This form will not be accepted without the original notarized Beneficiary Designation form.

Name _____

Social Security Number _____ _____ _____ **Retirement Number**_____

Primary Beneficiary(ies) (Continued)

Fill in a percentage amount (%), for all persons designated below **(the shares of all primary beneficiaries must equal 100 %, including those listed on page 1.)**. If all beneficiaries are to share equally no percentage needs to be listed.

Name of Beneficiary | Spouse/Child/Other | Social Security Number | Date of Birth | %

Address | City | State | Zip

Name of Beneficiary | Spouse/Child/Other | Social Security Number | Date of Birth | %

Address | City | State | Zip

Name of Beneficiary | Spouse/Child/Other | Social Security Number | Date of Birth | %

Address | City | State | Zip

Name of Beneficiary | Spouse/Child/Other | Social Security Number | Date of Birth | %

Address | City | State | Zip

Contingent Beneficiary(ies) (Continued)

Fill in a percentage amount (%), for all persons designated below **(the shares of all contingent beneficiaries must equal 100%, including those listed on page 1.)**. If all beneficiaries are to share equally no percentage needs to be listed.

Name of Beneficiary | Spouse/Child/Other | Social Security Number | Date of Birth | %

Address | City | State | Zip

Name of Beneficiary | Spouse/Child/Other | Social Security Number | Date of Birth | %

Address | City | State | Zip

Name of Beneficiary | Spouse/Child/Other | Social Security Number | Date of Birth | %

Address | City | State | Zip

Name of Beneficiary | Spouse/Child/Other | Social Security Number | Date of Birth | %

Address | City | State | Zip

Signature of Member _____ Date _____

BAR CODE

Notice
Of The 403(b) Plan
Offered By Your Employer

_____

Employer

_____ _____

Printed Name SSN

_____ _____

Signature Date

By signing, I hereby acknowledge I have received a Retirement Plan Benefits Overview and have been informed of my eligibility to participate in the Plan.

Please check the box below that applies to your situation.

☐ I am a current participant in the 403(b) Plan and I must complete a *Salary Reduction Agreement & Investment Company Selection Form* to continue participation.

☐ I am interested in participating in the 403(b) Plan and I would like a 403(b) Enrollment Kit to learn more.

☐ I am not interested in participating in the plan at this time.

I understand my choice is completely voluntary and I may change my choice to participate at any time, subject to our specific provisions.

Tear Here

I hereby acknowledge that I have been informed of the Millard Public Schools Board Polices and Rules found at:

http://mps.schoolfusion.us/modules/cms/pages.phtml?pageid=97377&sessionid=0aa9f2217c6791c85fcdfe8e37f11910

I further acknowledge that it is my responsibility to know and abide by all Polices and Rules of the Millard Public Schools Board of Education including but not limited to the Polices and Rules on:

Smoking and use of tobacco (4172); drug and alcohol, (4173); grievances (4325); harassment (4327); written curriculum (6110); taught curriculum (6200, 6203, 6240); Millard Education Program (6315); and mentor and new staff induction (6440).

I understand and acknowledge the Millard Public Schools Board Polices and Rules are amended from time to time and recognize that it is my responsibility to remain aware of all changes to Board Policies and Rules as may be posted on the Millard Public Schools Board of education website.

_____ _____

Print Name Building Name

_____ _____

Signature Here Date

Please sign and return to your building secretary today.