Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.™

Human Resources
2100 Mack Boulevard
Allentown, PA 18103
Phone 610-402-LVHR
Fax 484-884-0153

Welcome and congratulations on being selected to join Lehigh Valley Health Network (LVHN). This packet will provide you with information regarding your employment with LVHN. Please ensure all of the following steps and forms are completed. The checklist and notes below are for your convenience:

☐ **Paperwork** (Please complete prior to your meeting with Human Resources and your pre-employment medical assessment with Employee Health Services).

- Please visit www.lvhn.org/newhire to access our electronic briefing presentation to learn more about your benefits and new hire paperwork.

☐ **Documentation for Meeting with Human Resources** (Please bring the following documentation):

- **Background Check Documents – LVHN incurs all costs** associated with these background checks.
  ☐ Child Abuse History Clearance Application (Do not purchase money order. Submission of application with payment will be handled by Human Resources)
  ☐ Consent/Release for Child Abuse History Clearance
  ☐ LVHN Affidavit – CPSL (Allows provisional hire into LVHN pending results of Child Abuse & FBI.)

- **Hiring Documents –** You must bring a state or federal issued Photo ID as well as a signed Social Security Card for payroll purposes. (Note: the name on your SS Card will be the name used for all LVHN documentation.)
  ☐ I-9 (Employment Eligibility Verification)
  ☐ W-4 (Payroll/Tax information)
  ☐ Employee New Hire Information Sheet
  ☐ Direct Deposit Form (You must **bring a voided check**)
  ☐ PA Residency Certification Form (for Local Earned Tax Withholding) – ***PA Residents only***
  ☐ Employment EEO Data Form (Optional confidential document used for reporting purposes only.)
  NOTE: If you will be driving a company owned or leased vehicle you will need to sign a Driver's Abstract and present a valid Driver's License.

- **Benefits Documents**
  ☐ Dependent Eligibility Documentation (i.e., marriage license or birth certificate for enrolled dependents)
  ☐ Benefit Action Form (Enrollment form for medical and dental plan)
  ☐ Vision Benefits of America Enrollment Form
  ☐ Flexible Spending Form
  NOTE: Please bring Social Security numbers for any dependents and/or Life Insurance beneficiaries.

☐ **Fingerprinting** (To be completed by the Thursday at noon prior to Orientation)

- **Cogent Systems** – LVHN incurs all costs for fingerprinting. *Cogent Systems* is used to process the FBI fingerprints for all new hires.
  ☐ Visit *Cogent Systems*' web site www.pa.cogentid.com/dpw/ and click on "Department of Public Welfare" then "Print Locations & Hours" to locate a convenient fingerprinting location.
  ☐ Bring the registration # from your emailed Offer Letter and a government issued photo ID to the *Cogent Systems* fingerprint location.
  ☐ The Department of Public Welfare will send your FBI fingerprint results directly to your home address. Immediately upon receipt, it is required that you provide Human Resources with the original results. Please bring the original FBI results with you to Orientation or send to Human Resources, 2100 Mack Blvd, Attn: Jo-Anne Ehritz (484-884-3094).

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☐ **Pre-Employment Medical Assessment** (To be completed by the Tuesday prior to Orientation)

- Bring this completed paperwork with you to your Pre-Employment Medical Assessment (physical). This paperwork can be printed from the electronic briefing presentation if you have not printed the forms.

☐ **New Hire Orientation "Connections"**

- Orientation takes place at the location specified in you offer letter (see *Driving Directions* within the electronic briefing presentation for directions).
- *Connections* is a full day from 8:00-3:30. Please arrive no later than 7:45AM for registration.
- Attire for the day is **business casual/professional**. Please do not wear jeans, sneakers or flip flops. You may want to bring a light sweater or jacket as the temperature tends to fluctuate in the room.
- LVHN will provide you with lunch.

☐ **Tasks to perform within the first 30 days of employment**

☐ **FBI Fingerprint Results** – You will receive your FBI fingerprint results at your home address. Your FBI results must be received in Human Resources within 30 days of your start date.

☐ **Retirement Matched Savings Plan** – Enroll by visiting www.valic.com/lvhhn. If you do not take any action you will be defaulted into a 2% contribution. You can, however, change your contribution at any time in the future.

☐ **The Learning Curve New Employee Core Curriculum (NECC)** – Complete required modules **within 30-days** of employment. During your orientation you will be responsible for completing the required NECC. The curriculum will require 2-4 hours of computer time depending on the employee's clinical or non-clinical status. Topics may include but are not limited to Bloodborne pathogens, Corporate Compliance, HIPPA, Cultural Awareness, Hand Hygiene, TJC, and OSHA.

☐ **Tasks to perform within the first 60 days of employment**

☐ **Department Specific Checklist** – Complete required sections to meet The Joint Commission, OSHA and Dept. of Health requirements **within 60 days** of employment.

If you have further questions, please call the HR Department at 610-402-LVHR. Thank you for choosing Lehigh Valley Health Network. We are excited to have you join the organization!

PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE

COMPLETE SECTION I ONLY. PRINT CLEARLY IN INK. ENCLOSE $10.00 MONEY ORDER ONLY. PAYABLE TO DEPARTMENT OF PUBLIC WELFARE. DO NOT SEND CASH OR PERSONAL CHECK.

SEND TO CHILDLINE AND ABUSE REGISTRY, DEPARTMENT OF PUBLIC WELFARE, P.O. BOX 8170 HARRISBURG, PA 17105-8170

APPLICATIONS THAT ARE INCOMPLETE ILLEGIBLE OR RECEIVED WITHOUT FEE WILL BE RETURNED UNPROCESSED. IF YOU HAVE QUESTIONS CALL 717-783-6211

CHILDLINE USE ONLY

DATE RECEIVED BY CHILDLINE

SECTION I — APPLICANT IDENTIFICATION

IN THIS SPACE PRINT APPLICANTS FULL NAME AND ADDRESS (DO NOT USE INITIALS)

NAME

STREET

CITY, STATE
ZIP CODE

SOCIAL SECURITY NUMBER

AGE	DATE *OF* BIRTH	DAYTIME PHONE NO.

SEX ☐ M ☐ F

COUNTY YOU LIVE IN

PREVIOUS NAMES USED SINCE 1975 (Include Maiden Name, Nicknames, Aliases)

(FIRST, MIDDLE, LAST)		(FIRST, MIDDLE, LAST)

PURPOSE OF CLEARANCE (Check ONE block ONLY)

☐ CHILD CARE
☐ FOSTER CARE
☐ ADOPTION
☐ SCHOOL

☐ VOLUNTEERS-A copy of your PROCESSED 'Request for Criminal Record" (Form SP4-164) must be attached. Out-of-state residents must also attach a copy of their PROCESSED FBI clearance (Form FID-258).

☐ CWEP (Community Work Experience Program Participant)

SIGNATURE OF CAO REP — CAO PHONE NO

PREVIOUS ADDRESSES SINCE 1975 (Attach additional pages if necessary)

1.
2.
3.
4.

HOUSEHOLD MEMBERS (List everyone who lived with you at anytime since 1975 to the present).

NAME (First, Middle, Last) Do not use initials.	RELATIONSHIP	PRESENT AGE	SEX
1.			
2.			
3.			
4.			
5.			
6.			

I certify that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code).

Applicants are required to show the Administrator the original document. Administrators are required to keep a copy of this child abuse history record on file. Any person altering the contents of this document may be subject to civil, criminal or administrative action.

APPLICANT'S SIGNATURE — DATE

DO NOT WRITE IN THIS SECTION - CHILDLINE USE ONLY

SECTION II — RESULTS OF HISTORY CHECK

☐ APPLICANT IS **NOT** LISTED IN A REPORT OF CHILD ABUSE OR A REPORT FOR SCHOOL EMPLOYEE.

☐ APPLICANT **IS** LISTED IN A REPORT OF CHILD ABUSE OR A REPORT FOR SCHOOL EMPLOYEE (SEE BELOW).

STATUS OF REPORT	DATE OF INCIDENT	STATUS OF REPORT	DATE OF INCIDENT
1.		3.	
2.		4.	

VERIFIER — DATE

VERIFIER'S SUPERVISOR — DATE

DO NOT WRITE IN THIS SECTION - CHILDLINE USE ONLY

SECTION III

VOLUNTARY CERTIFICATION FOR CHILD CARE SERVICES

_____ **has requested a certification which includes a clearance of his/her name against the child abuse, school employee, and criminal history reports.**

The results of the child abuse and school employee report clearances are listed in Section II on the reverse side. The results of the criminal history reports are listed below. Out-of-state residents must have criminal history clearance from both the Pennsylvania State Police and the FBI. The voluntary certification may be obtained every two years.

It is the responsibility of **parents** and **guardians to review this information to determine the suitability of the applicant as a substitute caregiver.**

PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE

- ☐ **Applicant is named as the perpetrator of a "Founded" child abuse or school employee report which occurred in the last five years.**
- ☐ **Applicant is named as the perpetrator of a "Founded" child abuse or school employee report which occurred over five years ago.**
- ☐ **Applicant is named as the perpetrator of an "Indicated" child abuse or school employee report.**
- ☐ **Applicant is not named as the perpetrator of any child abuse or school employee report contained in the Statewide Central Register.**

PENNSYLVANIA STATE POLICE CLEARANCE

- ☐ **Record exists and contains convictions which prohibit hire in a child care position. Report attached.**
- ☐ **Record exists, but convictions do not prohibit hire in a child care position. Report attached.**
- ☐ **Record exists, but no convictions are shown. This does not prohibit hire in a child care position. Report attached.**
- ☐ **No record exists. Report attached.**

FBI CLEARANCE

- ☐ **Record exists and contains convictions which prohibit hire in a child care position. Report attached.**
- ☐ **Record exists, but convictions do not prohibit hire in a child care position. Report attached.**
- ☐ **Record exists, but no convictions are shown. This may not prohibit hire in a child care position. Report attached.**
- ☐ **No record exists. Report attached.**
- ☐ **No FBI clearance required.**

VERIFIER	DATE	VERIFIER'S SUPERVISOR	DATE

CONSENT/RELEASE OF INFORMATION AUTHORIZATION FORM
FOR THE PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE

I, _____ (Applicant's Name) hereby authorize the Department of Public Welfare, ChildLine to release my Pennsylvania Child Abuse History Clearance information directly to LEHIGH VALLEY HEALTH NETWORK.

I understand that this information is confidential in nature pursuant to §6340 (relating to information in confidential reports) of the Child Protective Services Law (CPSL) (23 Pa.C.S Chapter 63) and will not otherwise be released by the LEHIGH VALLEY HEALTH NETWORK without my express authorization or pursuant to authorization by Title 55 of the Pennsylvania Code. I understand that the aforementioned information will not be released directly to me _____ (Applicant's Name) as stated in the Pennsylvania Child Abuse History Clearance application.

I understand that I will not receive a copy of my Pennsylvania Child Abuse History Clearance directly from ChildLine; however, I may request a copy of my Pennsylvania Child Abuse History Clearance from LEHIGH VALLEY HEALTH NETWORK upon written request.

I have read this Consent/Release of Information Authorization form and fully understand and agree to its content. I further understand and agree to all information and ramifications of the Pennsylvania Child Abuse History Clearance application as it otherwise relates to this consent.

_____ _____

Date Applicant's Signature

Name of Requesting Agency's Mailing Address:

LVHN – HUMAN RESOURCES
ATTN: JO-ANNE EHRITZ
2100 MACK BLVD
ALLENTOWN, PA 18103

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CANDIDATE'S AFFIDAVIT FOR PROVISIONAL EMPLOYMENT - CPSL

I, _____, hereby depose and say as follows:
(Please print full name)

1. I have applied for a position with Lehigh Valley Health Network (LVHN) and have been advised that as a condition of employment with LVHN, all applicants are required to satisfy the requirements of the Pennsylvania Child Protective Services Law (CPSL).

2. I acknowledge that CPSL requires a Pennsylvania State Police Criminal History Report, Pennsylvania Department of Public Welfare Child Abuse History Clearance and a Federal Bureau of Investigation Criminal History Report.

3. I further acknowledge that I will provide a copy of the Child Abuse History Clearance report to LVHN.

4. I understand that LVHN is prohibited from hiring me if I have been identified as the perpetrator of a founded report of child abuse committed within the past five years.

5. I affirm that I have not been identified as the perpetrator of a founded report of child abuse committed within the past five years.

6. I understand that LVHN is prohibited by CPSL from hiring me if I have been convicted of one or more of the crimes listed on Exhibit A to my Affidavit.

7. I affirm that I have not been convicted of one or more of the crimes listed on Exhibit A to my Affidavit.

8. I acknowledge that CPSL permits LVHN to hire me on a provisional basis for a set period of time.

9. I understand and agree that during the period of provisional employment, I will not be permitted to work alone with children and must work in the immediate vicinity of a permanent LVHN employee.

10. I understand and agree that LVHN will immediately terminate my provisional employment if I am identified as the perpetrator of a founded report of child abuse committed within the past five years or have been convicted of one or more of the crimes listed on Exhibit A to my Affidavit.

11. I further understand and agree that LVHN may immediately terminate my provisional employment should the Pennsylvania State Police, Pennsylvania Department of Public Welfare and/or the Federal Bureau of Investigation be unable to timely provide the required reports.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Witness Date

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EXHIBIT A TO

CANDIDATE'S AFFIDAVIT FOR PROVISIONAL EMPLOYMENT

Lehigh Valley Health Network and its subsidiaries (hereinafter referred to as LVHN) may be prohibited by the Pennsylvania Child Protective Services Law from hiring a candidate who has been:

1. Convicted of one or more of the following crimes under Title 18 of the Pennsylvania Consolidated Statutes (Crimes Code), an equivalent crime under Federal law or an equivalent crime under the law of another state:

- Chapter 25 (relating to Criminal Homicide including, criminal homicide, murder, voluntary manslaughter, manslaughter, causing or aiding suicide, and drug delivery resulting in death).
- Section 2702 (relating to Aggravated Assault).
- Section 2709.1 (relating to Stalking).
- Section 2901 (relating to Kidnapping).
- Section 2902 (relating to Unlawful Restraint).
- Section 3121 (relating to Rape).
- Section 3122.1 (relating to Statutory Sexual Assault).
- Section 3123 (relating to Involuntary Deviate Sexual Intercourse).
- Section 3124.1 (relating to Sexual Assault).
- Section 3125 (relating to Aggravated Indecent Assault).
- Section 3126 (relating to Indecent Assault).
- Section 3127 (relating to Indecent Exposure).
- Section 4302 (relating to Incest).
- Section 4303 (relating to Concealing Death of Child).
- Section 4304 (relating to Endangering Welfare of Children).
- Section 4305 (relating to Dealing in Infant Children).
- A felony offense under section 5902(b) (relating to Prostitution and Related Offenses).
- Section 5903(c) or (d) (relating to Obscene and Other Sexual Materials and Performances).
- Section 6301 (relating to Corruption of Minors).
- Section 6312 (relating to Sexual Abuse of Children).

2. Convicted of the attempt, solicitation or conspiracy to commit any of the offenses set forth in Paragraph 1 above; or,

3. Convicted of a felony offense under The Controlled Substance, Drug, Device and Cosmetic Act, committed within the five-year period immediately preceding candidate's application.

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

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

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
		HR Technician

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*
LVHN, 2100 Mack Boulevard, Allentown, PA 18103	

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)*

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

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

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. 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 presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1.** For employees who indicate an employment authorization expiration date in **Section 1,** employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2.** Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A or C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

EMPLOYERS MUST RETAIN COMPLETED FORM I-9
DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

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)

Form W-4 (2012)

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 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at *www.irs.gov/w4*. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

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 $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight 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	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2012

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6	Additional amount, if any, you want withheld from each paycheck		**6** $
7	I claim exemption from withholding for 2012, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		**7**

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

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

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

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 2012 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: { $11,900 if married filing jointly or qualifying widow(er); $8,700 if head of household; $5,950 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 2012 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2012 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2012 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 $3,800 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 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 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. 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 - $8,000	0
5,001 - 12,000	1	8,001 - 15,000	1
12,001 - 22,000	2	15,001 - 25,000	2
22,001 - 25,000	3	25,001 - 30,000	3
25,001 - 30,000	4	30,001 - 40,000	4
30,001 - 40,000	5	40,001 - 50,000	5
40,001 - 48,000	6	50,001 - 65,000	6
48,001 - 55,000	7	65,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 72,000	9	95,001 - 120,000	9
72,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 - 110,000	12		
110,001 - 120,000	13		
120,001 - 135,000	14		
135,001 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 - $70,000	$570	$0 - $35,000	$570
70,001 - 125,000	950	35,001 - 90,000	950
125,001 - 190,000	1,060	90,001 - 170,000	1,060
190,001 - 340,000	1,250	170,001 - 375,000	1,250
340,001 and over	1,330	375,001 and over	1,330

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 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.

CLGS-32-6 (8-11)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS (**No** PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (**No** PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

Lehigh Valley Health Network
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Employee New Hire Information Sheet

Personal Information

Last Name	First Name	Middle Initial
Street Address		Resident County
City, State ZIP		Nickname for Photo ID (Optional)
Maiden Name (If Applicable)	SS#	Highest degree for Photo ID (Optional)
Main Phone #	Alternate Phone #	Date of Birth (MM/DD/YY)
Were you previously employed by Lehigh Valley Health Network or Health Network Laboratory? ☐ Yes ☐ No		If yes, please provide approximate dates:

Emergency Contact Information *Signature and Initial Verification*

Last Name	First Name	Relationship	**Printed** Employee Name
Street Address		City, State ZIP	Employee Signature
Phone (Cell)	Phone (Home)	Phone (Work)	Initials (FML)

Receipt of Acknowledgement

I have received the following in the Policies Document via the New Hires Webpage (http://www.lvh.org/newhires):

- Code of Conduct
- Corporate Compliance
- Sexual Harassment
- COBRA Notification
- Workers' Compensation Panel Physicians
- Unlawful Discrimination
- Americans with Disabilities Act
- Acknowledgement Of Rights And Responsibilities Under Pennsylvania Workers' Compensation Act
- Information Systems Acceptable Computer Use
- Trial Period
- Dress Code
- Attendance
- Counseling and Discipline
- Issue Resolution Procedure (IRP)
- Leave of Absence (LOA)
- Solicitation and Distribution
- HIPAA – Confidentiality
- Overtime
- FMLA Posting

In addition, the Lehigh Valley Health Network (LVHN) Human Resources policies webpage, which outline my privileges and obligations as an employee of LVHN, are available on the LVHN Intranet website, www.lvh.com. I will familiarize myself with the information in the Human Resources policies webpage and understand that:

1. The Human Resources Policies webpage contains the present personnel policies of LVHN and I am governed by it
2. I am employed at will, and the policies are meant to be a guideline
3. It is my responsibility to remain current on the contents of these and other LVHN policies
4. The information contained in the policies are subject to change by action of LVHN and all such changes will supersede previous policies
5. Failure to abide by these and other LVHN policies could result in discipline up to and including termination

I have had the opportunity to ask and have answered all my questions regarding the information contained in this acknowledgement. I am aware that my signature acknowledges that I will abide by the policies set-forth by LVHN. In the event I have difficulty accessing the Intranet website, I can contact the Information Services Help Desk at 610-402-8303 once I am employed.

_____ _____

Signature of Employee Date

Lehigh Valley Health Network

Authorization Agreement for Direct Deposit

PLEASE PRINT

Employee Name: _____ Employee ID #: _____
(Print Last, First, Middle Initial)

I hereby authorize Lehigh Valley Health Network to initiate credit entries and, if necessary, debit entries (adjustment for credit entries in error) to my account indicated below:

Banking Institution - **Please list each bank and percentage to be deposited**

Primary Bank Name _____
Primary Routing # _____ % _____ Flat Amt. _____
Account Number: _____ ☐ Checking ☐ Savings

Secondary Bank Name _____
Secondary Routing # _____ Remainder of Pay
Account Number: _____ ☐ Checking ☐ Savings

This authority is to remain in full force and effect until Lehigh Valley Health Network receives another authorization agreement from me modifying or canceling this authority in such time to afford the company a reasonable opportunity to comply with my request.

☐ New Authorization ☐ Cancel Existing Authorization ☐ Modify Existing Authorization

Date: _____ Signature: _____

Instructions:

Print your name and employee ID in the spaces provided.
Print the name of the banking institution you want your deposit made to.
List the routing number for your banking institution enter your account number.
Check the account type you wish your deposit to be made to (checking/savings).

You must include either a voided check or a letter from your bank identifying both your account number and the correct Routing number.

Date and sign this form. Forward it to the Payroll Department, 2100 Mack Boulevard, Allentown, PA 18103.

NOTE: For new authorizations or changes to an existing authorization, automatic deposits normally begin two or three pay cycles after this form reaches payroll. Regular paychecks are issued in the interim before the new authorization takes effect. This time and procedure are necessary to allow your bank to verify that an open account exists for you.

For authorization cancellations, regular paychecks will be issued within one or two pay cycles after this form reaches payroll.
In the case of unrecoverable funds posted to this account beyond the control of the employer, the employee will be responsible for the posting of such funds to this account.

Lehigh Valley Health Network
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CONFIDENTIAL - EMPLOYMENT EEO DATA FORM

Last Name: _____ **First Name:** _____ **MI:** __

Position: _____ **Facility:** _____

Gender

☐ Female

☐ Male

US Citizen

☐ Yes

☐ No

Veteran

Are you a veteran?*

☐ Yes

☐ No

2. If Yes to question 1 please select an option below.

☐ Vietnam Era Veteran

☐ Special Disabled Veteran

☐ Other Protected Veteran

☐ Recently Separated Veteran

RACE OR ETHNIC GROUP: (Please check ALL that apply)

☐ White (Not Hispanic or Latino origin). A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ Black or African-American (Not Hispanic or Latino origin). A person having origins in any of the black racial groups of Africa.

☐ Asian or Pacific Islanders (Not Hispanic or Latino origin). A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino origin). A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ American Indian or Alaskan Native (Not Hispanic or Latino origin). A person having origins in any of the original peoples of North and South American (including Central America), and who maintain tribal affiliation or community attachment.

☐ Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Date Completed: _____ Employee Signature: _____

Lehigh Valley Health Network

DEPENDENT ELIGIBILITY

General Guidelines

Effective January 1, 2010, Lehigh Valley Health Network will require verification of health, dental and vision plan eligibility for dependents of newly hired employees, dependents added to a current employee's coverage as a result of a life event change, and full time student or disability status for dependent children over the age of 18. This practice will ensure that all covered members of the health, dental and vision plans are eligible under the rules of the plan(s).

- Proof of plan eligibility may be requested by the Plan Sponsor, Lehigh Valley Health Network (LVHN) human resources staff or Spectrum Administrators at any time. When a request is received to add a dependent family member or, under certain circumstances an enrollee requests a dependent be removed from the plan, documentation will be required. Failure to provide documentation by the date requested will result in ineligibility for plan benefits for the plan year. You will not be able to make any changes until open enrollment the following year unless you experience a qualifying event.

- Proof of the full-time student status will be required for any child over the age of 18 added or maintained on the plan. Failure to provide documentation will result in ineligibility for plan benefits.

- Refer to plan documentation for definitions of eligible dependents. The term eligible dependent may be used herein to describe a spouse or same-sex domestic partner.

- The term "qualifying event" is used to describe any life event that changes the plan eligibility of an enrollee, spouse, same-sex domestic partner or dependent. Examples of qualifying events include new hire or new eligibility for benefits, birth, marriage, divorce, full-time enrollment in school for dependents over age 18.

- Notice of a change in the qualifying status of an enrollee or dependent must be reported to human resources within 30 days of the date of the event. Required documentation must be provided within 90 days of the date of hire or other qualifying event with the exception of incapacitated dependent children, which requires the documentation to be returned within 31 days. Failure to meet the submission requirements will result in the dependent's removal from coverage retroactive to the date of the life event or denial of eligibility for coverage until the required documentation is submitted. Failure to meet deadlines may result in a lapse of coverage and ineligibility for enrollment until the next open enrollment period.

- For incapacitated dependent children, documentation must be returned within 31 days.

- If claims were incurred and paid for a dependent ultimately deemed ineligible, restitution will be sought retroactive to the date on which termination should have occurred.

- Any enrollee falsifying documents or otherwise enrolling or attempting to enroll an ineligible dependent will be subject to disciplinary action up to and including termination of employment.

LEHIGH VALLEY HEALTH NETWORK
DOCUMENTATION REQUIRED TO SUBSTANTIATE DEPENDENT ELIGIBILITY

DEPENDENT	REQUIRED DOCUMENTATION	POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION

Spouse	• Marriage License (this is not the certificate provided from the official conducting the ceremony);
	  ○ Original or clear copy
	  ○ May be in the form of an Online Marriage Record if available from state or county of record showing the names of spouse and enrollee and the date of marriage; **or,**
		• County courthouse that issued original marriage license. A list of Pennsylvania County Courthouses can be found at www.health.state.pa.us under Health Statistics and Vital Records (www.vitalcheck.com)

	• Valid Military ID for the spouse of the armed services member. Must show both spouse and enrollee's name and SSN; **or,**	• In accordance with military procedures established by the applicable branch of service
	• If a foreign marriage, documentation confirming existence of marriage; **or,**	• Location where marriage was performed
	• Divorce decree (when removing spouse from plan).	• Clerk of county in which divorce was finalized (www.vitalcheck.com)

Same-Sex Domestic Partner	• LVHN Affidavit—Same Sex Domestic Partnership; **and,**
	• Three of the following (original documents for review):
	  ○ Joint Deed
	  ○ Joint Mortgage or residential lease
	  ○ Designation of domestic partner as primary beneficiary for a life insurance policy
	  ○ Durable property and health care powers of attorney
	  ○ Joint ownership of an automobile
	  ○ Joint bank account or credit account; **and,**
	• If applicable, complete the LVHN Declaration of Tax Status Form.
		• LVHN Human Resources

DEPENDENT	REQUIRED DOCUMENTATION	POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION

Child(ren) by birth	• Birth Certificate
	  ○ Original
	  ○ Certified copy; **and,**
		• For Pennsylvania births, birth certificates are available from the PA Department of Health, Division of Vital Records and can be requested by fax, mail or online at www.health.state.pa.us - Fee is $10.
		
		(Many states allow you to order a new birth certificate from their website. Access to other state websites can be linked through www.health.state.pa.us or www.vitalcheck.com or www.usbirthcertificate.net)

	• If dependent child is full-time student over age 18 – age 23, you also provide an official class schedule or tuition invoice showing at least 12 units of learning from an institution of higher learning.	• Available from Bursar or Registrar's offices

Child(ren) by adoption	• Certificates and court documents showing legal responsibility for the child(ren)
	  ○ Court approved adoption Order
	  ○ Placement letter from court/adoption agency for pending adoptions; **and,**
		• County courthouse that issued final adoption order
		
		• County court/adoption agency that issued placement letter

	• If dependent child is full-time student over age 18 – age 23, you also provide an official class schedule or tuition invoice showing at least 12 units of learning from an institution of higher learning.	• Available from Bursar or Registrar's offices

Child(ren) by legal guardianship	• Certificates and court documents showing legal responsibility for the child(ren)
	  ○ Court or agency Order establishing guardianship; **and,**
	  ○ Affidavit of Dependency of Children; **and,**
		• County courthouse/agency that issued guardianship order
		
		• LVHN Human Resources

	• If dependent child is full-time student over age 18 – age 23, you also provide an official class schedule or tuition invoice showing at least 12 units of learning from an institution of higher learning.	• Available from Bursar or Registrar's offices

DEPENDENT	REQUIRED DOCUMENTATION	POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION
Stepchildren	• The following documents o Birth certificate of stepchild listing employee's current spouse as the parent of the step-child(ren); **and,** o The first 2 pages of your latest IRS Federal Tax Return; **and,** o Marriage license; **and,** o Affidavit of Dependency for Children; **and,**	• See Possible Resources for Birth and Marriage Licenses noted above. • LVHN Human Resources
	• If dependent child is full-time student over age 18 – age 23, you also provide an official class schedule or tuition invoice showing at least 12 units of learning from an institution of higher learning.	• Available from Bursar or Registrar's offices
Foster Child(ren)	• Certificates and court documents showing legal responsibility for the child(ren) o Court or agency Order establishing foster child status; **and,** o Affidavit of Dependency of Children; **and,**	• County courthouse/agency establishing foster child status • LVHN Human Resources
	• Documentation reflecting the need to provide medical coverage; **and,**	• County courthouse/agency establishing foster child status
	• If dependent child is full-time student over age 18 – age 23, you also provide an official class schedule or tuition invoice showing at least 12 units of learning from an institution of higher learning.	• Available from Bursar or Registrar's offices
Same-Sex Domestic Partner's child(ren) by birth	• Birth Certificate o Original o Certified copy; **and,**	• For Pennsylvania births, birth certificates are available from the PA Department of Health, Division of Vital Records and can be requested by fax, mail or online at www.health.state.pa.us - Fee is $10. *(Many states allow you to order a new birth certificate from their website. Access to other state websites can be linked through www.health.state.pa.us or www.vitalcheck.com or www.usbirthcertificate.net)*
	• LVHN-acceptable Proof of Same Sex Domestic partnership; **and,**	• LVHN Human Resources
	• If dependent child is full-time student over age 18 – age 23, you also provide an official class schedule or tuition invoice showing at least 12 units of learning from an institution of higher learning.	• Available from Bursar or Registrar's offices

DEPENDENT	REQUIRED DOCUMENTATION	POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION
Same-Sex Domestic Partner's child(ren) by adoption	• Certificates and court documents showing legal responsibility for the child(ren) o Court approved adoption order o Placement letter from court/adoption agency for pending adoptions; **and**	• County courthouse that issued final adoption order • County court/adoption agency that issued placement letter
	• LVHN-acceptable Proof of Same-Sex Domestic partnership; **and,**	• LVHN Human Resources
	• If dependent child is full-time student over age 18 – age 23, you also provide an official class schedule or tuition invoice showing at least 12 units of learning from an institution of higher learning.	• Available from Bursar or Registrar's offices
Same-Sex Domestic Partner's child(ren) by legal guardianship	• Certificates and court documents showing legal responsibility for the child(ren) o Court or agency order establishing guardianship; **and,** o Affidavit of Dependency for Children; **and,**	• County courthouse/agency that issued guardianship order
	• LVHN-acceptable Proof of Same-Sex Domestic partnership; **and,**	• LVHN Human Resources
	• If dependent child is full-time student over age 18 – age 23, you also provide an official class schedule or tuition invoice showing at least 12 units of learning from an institution of higher learning.	• Available from Bursar or Registrar's offices
Incapacitated Adult Child	• Application for Extended Coverage Due to Incapacitation/Disability (including employee and physician information).	• LVHN Human Resources or Spectrum Administrators

Updated January 1, 2010

Lehigh Valley Health Network

Affidavit of Dependency for Children

New Hire ☐	Open Enrollment ☐	Life Status Change ☐	Coverage Effective _____

I, _____, submit this Affidavit of
(Employee Name)

Dependency to establish _____ as
(Child's Name)

a dependent child (as defined below) in order to obtain benefits that Lehigh Valley Health Network, Inc. may extend to employees' dependent children through guardianship or marriage.

1. I declare that the dependent child is eligible for benefits because (you must check **one** of these):

   ☐ I have been appointed guardian of the child (attach copy of Court Order).

   ☐ The child is my foster child (attach copy of Court/Agency Order).

   ☐ The child is my step-child and resides with me (attach proof of child's residency).

2. I agree to notify Lehigh Valley Health Network, Inc. within (30) days of any change in the circumstances attested to in this affidavit.

3. I understand I may be responsible for payment of income taxes as a result of Lehigh Valley Health Network, Inc. providing benefits to the identified dependent child.

4. I will provide to the designated Human Resource Representative documents to verify the dependent child's eligibility as per the policy.

5. Annual enrollment may be required.

6. I understand that providing false or misleading information in the Affidavit may result in any or all of the following actions by Lehigh Valley Health Network, Inc.

   a) a requirement that I reimburse Lehigh Valley Health Network, Inc. for all expenses
   b) termination of my employment
   c) other legal action against me

I affirm that the assertions in this affidavit are true to the best of my knowledge.

_____ _____ _____

Employee Signature **Social Security #** **Date**

_____

Employee/Dependent Child's Home Address

_____ _____

Benefits Counselor Signature **Date**

Lehigh Valley Health Network

The benefit elections made on this form are binding for the plans specified and can only be changed due to a qualifying life event during the plan year.

Empl ID# _____

Benefit Action Form

Reason(s) for submitting this form: ❑ Enrollment ❑ Status Change _____ DATE ❑ Marriage _____ DATE ❑ Divorce _____ DATE ❑ Birth _____ DATE

❑ Death _____ DATE ❑ Dependent Child No Longer Eligible _____ DATE ❑ Other _____ DATE _____ REASON

Employee Name: _____ Last (Please Print) First M.I. Soc. Sec. No.: _____ Sex: ❑ Male ❑ Female Birthdate: _____

Address: _____ Street City State Zip Code Home Phone: _____

❑ Full Time ❑ Part Time: _____ Hours/week Work Phone: _____ Dept: _____ Hire Date: _____ Marital Status: ❑ Single ❑ Married

LVHN COMPREHENSIVE HEALTH PLAN, INC.

	Employee	*Employee + 1 dependent*	*Family (Employee + 2 or more dependents)*
❑ Status Changes (existing employees)	❑	❑	❑
❑ Full Time Coverage Upon Employment	❑	❑	❑
❑ Full Time Coverage Delayed Until Reduced Cost	❑	❑	❑
❑ Part Time Coverage Upon Employment	❑	❑	❑

Effective Date _____

LVHN DENTAL PLAN

	Employee	*Employee + 1 dependent*	*Family (Employee + 2 or more dependents)*
❑ Basic and Preventive	❑	❑	❑
❑ Basic, Preventive, Major & Orthodontic	❑	❑	❑

Effective Date _____

DEPENDENT INFORMATION

Delete/Add	Last Name	First	M.I.	SSN	Relationship	Sex	Birthdate	Full-Time Student	If dependent residence is different, please specify address below
❑ Delete ❑ Add								❑ Yes ❑ No	Address
❑ Delete ❑ Add								❑ Yes ❑ No	Address
❑ Delete ❑ Add								❑ Yes ❑ No	Address
❑ Delete ❑ Add								❑ Yes ❑ No	Address
❑ Delete ❑ Add								❑ Yes ❑ No	Address
❑ Delete ❑ Add								❑ Yes ❑ No	Address

Changes to coverage as a result of a life status change must be submitted to Human Resources within 31 days of the qualifying event. Depending on your life event, you may only be permitted to change your deductions, not enroll, as a result of your life status change according to the plan document and IRS regulations.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFICIARY DESIGNATION

Effective Date _____

MY BENEFICIARY: _____ (Please Print)

Last Name	First Name	M.I.	S.S. #	%	Relationship

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the insured, settlement will be made to the estate of the Insured unless otherwise provided in the Group Policy.

STATEMENT OF AUTHORIZATION

I understand this application is subject to approval by the Plans and any coverage will be subject to the terms of the Plan Documents. I authorize any hospital, physician, dentist or health care provider to furnish Lehigh Valley Health Network, Inc., or its assignee, with medical or dental information about the enrollees as may be required by the Plans. I authorize appropriate payroll deduction(s), if applicable:

Any person who knowingly defrauds any insurance company by filing an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent act. This is a crime and could subject such person to criminal and civil penalties.

Signature: _____ Date: _____

HUMAN RESOURCES VERIFICATION

(To be completed by Human Resources) Benefits Counselor: _____

RETURN COMPLETED FORM TO HUMAN RESOURCES

VISION BENEFITS OF AMERICA VBA# 1741 SUBGROUP#_____
ENROLLMENT FORM

COVERAGE EFFECTIVE DATE _____/_____/_____

INSTRUCTIONS FOR EMPLOYEE:
1. COMPLETE SECTION BELOW AND SIGN.
2. RETURN COMPLETED FORM TO YOUR BENEFITS OFFICE.

EMPLOYEE SOCIAL SECURITY NUMBER _____

EMPLOYEE NAME _____ BIRTHDATE ____|_____|_____

ADDRESS _____

CITY _____ STATE_____ZIP CODE _____-_____

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

	FIRST NAME	**MIDDLE INITIAL**	**LAST NAME**	**BIRTHDATE**
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED **AS FULL-TIME COLLEGE STUDENTS**.)

STUDENTS NAME	NAME OF SCHOOL OR UNIVERSITY	

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME		

EMPLOYEE SIGNATURE _____ DATE _____/_____/_____

Lehigh Valley Health Network

The benefit elections made on this form are binding for the plans specified and can only be changed due to a qualifying life event during the plan year.

_____
Empl ID#

Flexible Spending Form

Reason(s) for submitting this form: ❑ Enrollment ❑ Marriage _____ DATE ❑ Divorce _____ DATE ❑ Birth _____ DATE

❑ Death _____ DATE ❑ Dependent Child No Longer Eligible _____ DATE ❑ Status Change _____ DATE

❑ Other _____ DATE _____ REASON

Employee Name: _____ Soc. Sec. No.: _____
Last (Please Print) First M.I.

Sex: ❑ Male ❑ Female Birthdate: _____ Home Phone: _____

Address: _____
Street City State Zip Code

❑ Full Time ❑ Part Time: _____ Hours/week

Work Phone: _____ Dept: _____ Hire Date: _____ Marital Status: ❑ Single ❑ Married

All health and dependent FSA claims need to be submitted for reimbursement by March 31st of the following calendar year, any unused money remaining in your account(s) will be forfeited. Upon employment employees enrolling in an FSA can submit eligible expenses from their date of hire only. Estimate carefully - use it or lose it dollars!

HEALTH CARE FLEXIBLE SPENDING

❑ Health Care FSA $ _____ per year Effective Date _____

You will automatically be defaulted to auto interface. To change this, please contact Spectrum Administrators.

CHANGES (Do not complete if you are enrolling for the first time)

Date of life status change: _____ Type of life status change _____

❑ Cancel ❑ Change

Current Amount $ _____ per year New Amount $ _____ to be deducted per year

HEALTH CARE FSA: The minimum annual participation is $100; maximum is $4,000. You will be allowed to claim reimbursement under the Health FSA for qualifying services incurred up to 2 1/2 months after the end of the calendar year. Please note that any premiums you are paying for health, dental, and/or vision coverage will be deducted on a pre-tax basis and should **NOT** be included in the amount you elect to contribute to your health FSA.

CHILD/ELDER CARE FLEXIBLE SPENDING

❑ Child/Elder Care FSA $ _____ per year Effective Date _____

CHANGES (Do not complete if you are enrolling for the first time)

Date of life status change: _____ Type of life status change _____

❑ Cancel ❑ Change

Current Amount $ _____ per year New Amount $ _____ to be deducted per year

CHILD/ELDER CARE FSA: The maximum annual participation is $5,000 per family. You may only be reimbursed for qualifying expenses that you incur during the calendar year.

STATEMENT OF AUTHORIZATION I understand this application is subject to approval by the Plans and any coverage will be subject to the terms of the Plan Documents. I authorize any hospital, physician, dentist or health care provider to furnish Lehigh Valley Health Network, Inc., or its assignee, with medical or dental information about the enrollees as may be required by the Plans. I authorize appropriate payroll deduction(s), if applicable:

Any person who knowingly defrauds any insurance company by filing an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent act. This is a crime and could subject such person to criminal and civil penalties.

Signature: _____ Date: _____

HUMAN RESOURCES VERIFICATION (To be completed by Human Resources) Division #:_____ Benefits Counselor: _____

RETURN COMPLETED FORM TO HUMAN RESOURCES

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

ABOUT YOUR 403(b) RETIREMENT PLAN

As an eligible employee of Lehigh Valley Health Network, you are permitted to participate in a 403(b) tax deferred retirement program.

What is a 403(b) plan?

A 403(b) plan is a tax-deferred retirement plan available to employees of educational institutions and certain non-profit organizations. In this plan, you can make pre-tax contributions for retirement savings. Distributions generally are only available when you reach age 59 ½ or experience a severance of employment. However, distributions can also be available in the event of financial hardship, death, or disability. Short-term needs also can sometimes be met by non-taxable loans.

Why contribute to a 403(b)?

Participating in your plan can provide a number of benefits, including:

- **LOWER TAXES TODAY.** Your 403(b) contributions are made on a pre-tax basis which can greatly reduce your current income tax bill. For example, if your federal marginal income tax rate is 25%, and if you contribute $100 a month to a 403(b) plan, you've reduced your federal income taxes by roughly $25 (assuming a 25% tax bracket). In effect, your $100 contribution costs you only $75. The tax savings can grow with the size of your 403(b) contribution.

- **TAX-DEFERRED GROWTH.** Your account in the 403(b) plan are tax-deferred. This means that your account can grow tax-free until time of withdrawal.

- **ENHANCED RETIREMENT.** Other sources of retirement income, including state pension plans and, if applicable, Social Security, often do not adequately replace a person's salary upon retirement. A 403(b) plan can provide a healthy supplement to an employee's retirement income.

How do I get more information?

To obtain more information, including information about how to participate, and about the savings products made available under the plan, contact the following VALIC advisors:

Michael Ryan – (610) 644-9497
Kevin Gertz – (610) 392-9912
Richard Silva, Sr. – (610) 349-3616
Tim Schroyer – (717) 379-1920

◆ ❑ ◆

Not intended as tax or legal advice. Neither your employer nor the investment providers offering savings products under the plan can provide you with tax or legal advice.