Checklist for Substitute/Part-Time Employees

EMPLOYEE NAME: ____

The following items must be on file in the Central Office of the Sinton Independent School District prior to employment by said District:

______	1	Application/Letter of Interest
______	2	Criminal History Record Information
______	3	Employment Eligibility Verification
______	4	Drug Free Schools Notification Form
______	5	Input Sheet
______	6	Income tax withholdings Form W-4
______	7	Salary Reduction Agreement
______	8	MetLife Skeletal Account Update
______	9	Workers Compensation Rights
______	10	Ethnicity Form
______	11	TB- a negative intra-dermal tuberculin test or negative X-Ray
______	12	Employee Handbook Receipt
______	13	Letter of Reasonable Assurance
______	14	Driver's License
______	15	Social Security Card
______	16	High School Diploma/GED for Substitutes **OR**
______	17	Official college transcript(s) bearing seal of the college and signature of the registrar (if applicable)

==

COPIES SUBMITTED TO PAYROLL:

______ Income tax withholdings Form W-4
______ Input Sheet
______ Tax Annuity Plan
______ Workers Comp.

SINTON INDEPENDENT SCHOOL DISTRICT
Sinton, Texas

Dear Substitute Teacher:

In an effort to compile our list of substitute teachers for the coming year, we would appreciate you completing the application below and returning it to us as soon as possible.

New employees or employees entering the state school system for the first time will be required to be examined for the disease of tuberculosis.

Each Principal is given a list of the available substitutes and arranges for those whose services are needed for this building(s).

SISD Substitute Pay

Position	Pay
Teacher	$70.00/day
Aide	$60.00/day
Game Worker	$10.00/hr
Bus Monitor	$8.92/hr
Custodian/Food Services	$8.00/hr

SUBSTITUTE TEACHER

SCHOOL YEAR: ____________________

NAME: ____________________ SOC SEC NO: ____________________

PHONE NO: ____________________ EXPERIENCE: ____________________

ADDRESS: ____________________ DEGREE/COLLEGE HRS: ____________________

CITY/ST/ZIP: ____________________ AREAS OF SPECIALIZATION: ____________________

____________________ ____

____________________ ____

WILL ACCEPT ASSIGNMENT AT:

WELDER (PK-2ND)	☐	SIN. ELM. (3rd – 5th)	☐	MIDDLE SCHOOL (6th – 8th)	☐
HIGH	☐	SPEC. ED	☐	DAEP	☐
JDC	☐	PE (WE/SE/LM Only)	☐	Office/Clerical	☐
Game Worker	☐	Custodian	☐	Food Services	☐
Bus Monitor	☐	Bus Driver	☐		

LETTER OF REASONABLE ASSURANCE

Dear Substitute Employee:

This letter provides notice of reasonable assurance of continued employment with the district when each school term resumes after a scheduled school break. By virtue of this notice, please understand that you may not be eligible for unemployment insurance benefits drawn on school district wages during any scheduled school breaks including, but not limited to, the summer, winter, and spring breaks. This assurance is contingent upon continued school operations and will not apply in the event of any disruption that is beyond the control of the district (e.g., lack of school funding, natural disasters, court orders, public insurrections, war, etc.).

Nothing contained herein constitutes an employment contract. Your continued employment is on an at-will basis. At-will employers may terminate employees at any time for any reason or for no reason, except for legally impermissible reasons. At-will employees are free to resign at any time for any reason or for no reason.

Your services on behalf of the children of the district are appreciated, and we hope that you will be able to continue your association with the district. **Failure to sign and return this letter by the date below will be treated as a voluntary resignation.**

Human Resources Department

....

Please complete the following information and return the original to the Human Resources Department.

Date	Street Address
Name (Print)	City, State ZIP Code
Signature	Telephone
Social Security No.	Email Address

Please check the campuses you are interested in substituting:

WELDER (PK-2ND)	☐	SIN. ELM. (3rd – 5th)	☐	MIDDLE SCHOOL (6th – 8th)	☐
HIGH	☐	SPEC. ED	☐	DAEP	☐
JDC	☐	PE (WE/SE/LM Only)	☐	Office/Clerical	☐
Game Worker	☐	Custodian	☐	Food Services	☐
Bus Monitor	☐	Bus Driver	☐		

Confidential

The **Sinton Independent School District** is required by Texas Education Code Chapter 22, Subchapter C to review the criminal history of applicants, employees, independent contractors, student teachers, and certain volunteers. The information requested below is necessary to obtain criminal history record information.

Please print.

Name ____
Last *First* *Middle*

Mailing Address ____
Street *City* *State* *Zip*

Home Phone:___________________ Date of birth ____________________________________

Driver's License ______________________ Social Security Number __________________
State and Number

Sex: ❑ Male ❑ Female Height: ___________ Weight:_______________

Race: ❑ America Indian ❑ Asian ❑ Black ❑ Hispanic ❑ White/Other

Hair Color: ____________ Eye Color: ____________ State of Birth: ___________

I understand that the information I am providing about age, sex, and ethnicity will not be used to determine eligibility for employment but will be used *solely* for the purpose of obtaining criminal history record information.*

____
Signature

____
Date

____

*This form will be removed from the application and filed separately in the HR office.

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

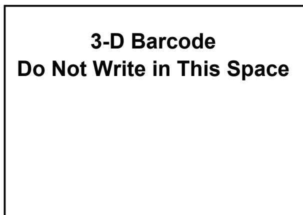
2. Form I-94 Admission Number: ____________

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

Foreign Passport Number: ____________

Country of Issuance: ____________

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



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

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

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

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

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

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

Employer Completes Next Page

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	**OR** **List B** Identity	**AND** **List C** Employment Authorization
Document Title:	Document Title:	Document Title:
Issuing Authority:	Issuing Authority:	Issuing Authority:
Document Number:	Document Number:	Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		**3-D Barcode Do Not Write in This Space**
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		

Certification

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Sanchez	Elia Veronica	Sinton ISD

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
322 S. Archer	Sinton	TX	78387

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A — Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   - **a.** Foreign passport; and
   - **b.** Form I-94 or Form I-94A that has the following:
     - (1) The same name as the passport; and
     - (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
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

OR

LIST B — Documents that Establish Identity

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
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. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C — Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   - (1) NOT VALID FOR EMPLOYMENT
   - (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   - (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
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. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

ACKNOWLEDGEMENT OF ELECTRONIC DISTRIBUTION OF EMPLOYEE HANDBOOK & ACCEPTABLE USE POLICY

Employee Name______________________________________

Campus/Department__________________________________

Employee ID Number_________________________________

I hereby acknowledge my ability to access the Sinton ISD Employee Handbook & Acceptable Use Policy at my discretion located on the district website at www.sintonisd.net. I understand that I may print the entirety of this online handbook if I so desire and if I am unable to print this document that I may request a copy be printed for me. I agree to read the handbook and abide by the standards, policies, and procedures defined or referenced in this document.

The information in this handbook is subject to change. I understand that the changes in District policies may supersede, modify, or eliminate the information summarized in this booklet. As the District provides updated policy information, I accept responsibility for reading and abiding by the changes. I understand that no modifications to employment or contractual relationships are intended by this handbook.

I understand that I have an obligation to inform my supervisor or department head and the Human Resources Department of any changes in personal information, such as phone number, address, etc. I also accept responsibility for contacting my supervisor or Human Resources if I have questions or concerns or need further explanation on any information contained in this handbook or Board policy.

______________________________ ______________________

Signature of Employee Date

SINTON ISD DRUG-FREE SCHOOLS AND COMMUNITIES PROGRAM

EMPLOYEE NAME:____

SOCIAL SECURITY NUMBER:____________________________________

DEPARTMENT OR CAMPUS:______________________________________

I have read notification of Sinton Independent School District's Drug-Free Schools requirements. I understand that compliance with these requirements and prohibitions is mandatory and is a condition of employment.

Signature:____

Date:____

(Please return immediately to your Supervisor or Campus Principal)

DRUG-FREE WORKPLACE NOTICE

The District prohibits the unlawful manufacture, distribution, dispensation, possession, or use of controlled substances, illegal drugs, inhalants, and alcohol in the workplace.

Employees who violate this prohibition shall be subject to disciplinary sanctions. Sanctions may include:

- Referral to drug and alcohol counseling or rehabilitation programs;
- Referral to employee assistance programs;
- Termination from employment with the District; and
- Referral to appropriate law enforcement officials for prosecution.

As a condition of employment, an employee shall:

- Abide by the terms of this notice; and
- Notify the Superintendent, in writing, if the employee is convicted for a violation of a criminal drug statute occurring in the workplace. The employee must provide the notice in accordance with DH(LOCAL).

[This notice complies with the requirements of the federal Drug-Free Workplace Act (41 U.S.C. 702).]

EMPLOYEE MASTER INPUT SHEET

1. EMPLOYEE NUMBER ______________________

NAME
2. FIRST ______ 3. MIDDLE ______ 4. LAST NAME ______ 5. SUFFIX ______

6. MAIDEN NAME ______________________

7. MAILING ADDRESS ______________________

8. PHYSICAL ADDRESS ______________________

9. CITY ______ STATE ______ 10. ZIP ______

11. HOME TELEPHONE NUMBER ______ CELL PHONE NUMBER ______

12. SOCIAL SECURITY # ______ 13. PREV SSN ______

14. MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

15. NUMBER OF DEPENDENTS ______________________

16. HISPANIC/LATINO ☐ YES ☐ NO

17. RACE ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK ☐ PACIFIC ISLANDER ☐ WHITE

18. SPOUSE'S NAME ______________________

19. SPOUSE'S OCCUPATION ______________________

20. SPOUSE'S PHONE ______________________

21. EMPLOYEE BIRTHDATE ______________________

22. EMPLOYEE PLACE OF BIRTH ______________________

23. U.S. CITIZEN? (EMPLOYEE) ☐ YES ☐ NO

24. EMPLOYEE SEX CODE ☐ MALE ☐ FEMALE

25. RELEASE INFO? ☐ YES ☐ NO

______________________ ______________________
Employee Signature Date

Form W-4 (2015)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

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

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

. . . **B** ______

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

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

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

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **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 $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . . . **G** ______

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

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2015

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

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . . **6** $ ______

7 I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ **7** ______

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

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

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

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 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details . . . . **1** $
2. Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 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 2015 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 2015 Form W-4* worksheet in Pub. 505.) . . . . . . **5** $
6. Enter an estimate of your 2015 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 $4,000 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 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. 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 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 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 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

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.

SINTON INDEPENDENT SCHOOL DISTRICT
TAX SHELTER ANNUITY PLAN
FOR PART-TIME EMPLOYEES

SALARY REDUCTION AGREEMENT

Effective _________________, 20 _____, in consideration of the obligations of Sinton Independent School District ("SISD") under the Sinton Independent School District Tax Sheltered Annuity Plan for Part-Time Employees (the "Plan"), I hereby elect to defer ____ __% (at least 7.5%) of my total Compensation (as defined in the Plan) for services rendered for SISD after the date of this Salary Reduction Agreement. I hereby authorize SISD to effect such deferrals by payroll deduction each pay period. In making this election, I understand that my deferrals are being made on a before-tax basis, which means I am agreeing to have my Compensation reduced by the stated percentage and, in turn, SISD will contribute my Compensation reduction amounts to the Plan on my behalf, and such amounts will be applied toward the premiums payable on the annuity contract obtained for me pursuant to the Plan. I also understand that SISD has a right to reduce my elected percentage as may be required in order to comply with section 403 (b) and any and all other sections of the Internal Revenue Code.

Note: I further understand that I may not change my elected percentage nor revoke this Salary Reduction Agreement at any time prior to termination of my employment with SISD or cessation of my status as an Eligible Employee (as defined in the Plan).

____

Signature of Participant (Date)

____

Participant's Name – Please Print (Date)

SINTON INDEPENDENT SCHOOL DISTRICT

By: ______________________________

Agreed to by Employer

MetLife PERC *Plan #* **1008305** ***Skeletal Account Update***

SINTON INDEPENDENT SCHOOL DISTRICT

Program for Extra Retirement Compensation
Participant Set Up

972/246-1662 fax

NAME: ______________________ **SSN #:** ______________________

ADDRESS: ____

CITY: ______________________ **STATE:** ______________ **ZIP:** ______________

DATE OF BIRTH: ______________________ **CITIZENSHIP:** ______________________

PHONE: ______________________ **CELL:** ______________________

SEX: __________ **EMAIL:** ____

PRIMARY BENEFICIARY:

NAME: ____

ADDRESS: ____

CITY: ______________________ **STATE:** ______________ **ZIP:** ______________

PHONE #: ______________________ **SOCIAL SECURITY #:** ______________________

RELATIONSHIP: ______________________ **PERCENTAGE:** ______________________

CONTINGENT BENEFICIARY:

NAME: ____

ADDRESS: ____

CITY: ______________________ **STATE:** ______________ **ZIP:** ______________

PHONE #: ______________________ **SOCIAL SECURITY #:** ______________________

RELATIONSHIP: ______________________ **PERCENTAGE:** ______________________

For additional beneficiaries please list on separate sheet

____ ______________________

PARTICIPANT SIGNATURE **DATE**

______________________________ ______________________________ __________

REPRESENTATIVE'S NAME & DAI # **REPRESENTATIVE'S SIGNATURE** **DATE**

Reference Rule 110.101

(a) In addition to the posted notice required by subsection (e) of this section, employers, as defined by Labor Code Section 406.001, shall notify their employees of workers' compensation insurance coverage status, in writing. This additional notice:

(1) Shall be provided at the time an employee is hired, meaning when the employee is required by federal law to complete both a W-4 form and an I-9 form or when a break in service has occurred and the employee is required by federal law to complete a W-4 form on the first day the employee reports back to duty;

(2) Shall be provided to each employee, by an employer whose workers' compensation insurance coverage is terminated or cancelled, not later than the 15th day after the date on which the termination or cancellation of coverage takes effect;

(3) Shall be provided to each employee, by an employer who obtains workers' compensation insurance coverage, not later than the 15th day after the date on which coverage takes effect, as necessary to allow the employee to elect to retain common law rights under Labor Code Chapter 406;

(4) Shall include the text required in the posted notice (see rule 110.101 (e)(1), (e)(2), (e)(3), (e)(4) for appropriate language); and

(5) If the employer is covered by workers' compensation insurance (subscriber) or becomes covered, whether by commercial insurance or through self-insurance as provided by the Texas Workers' Compensation Act (Act), shall include the following statement:

NOTICE TO NEW EMPLOYEES

"You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained workers' compensation insurance coverage, you notify your employer in writing that you wish to retain your common law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."

Sinton I.S.D. has workers' compensation insurance coverage from Sinton I.S.D. to protect you. You can get more information about your workers' compensation rights from any office of the Texas Workers' Compensation Commission, or by calling 800-252-7031.

You may elect to retain your common law right of action, if, no later than five (5) days after beginning employment, you notify Sinton I.S.D. in writing that you wish to retain your common law right to recover damages for personal injury. If you elect your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured.

I have read the above statement regarding workers' compensation benefits and *DECLINE* my right to workers' compensation benefits.	Signature of Employee: ______________________
OR	
I have read the above statement regarding workers' compensation benefits and *WISH TO BE COVERED* for workers' compensation benefits under the program provided by Sinton I.S.D.	Signature of Employee: ______________________
	Date: ______________________

Sinton ISD

Texas Public School Student/Staff Ethnicity and Race Data Questionnaire

The United States Department of Education (USDE) requires all state and local education institutions to collect data on ethnicity and race for students and staff. This information is used for state and federal accountability reporting as well as for reporting to the Office of Civil Rights (OCR) and the Equal Employment Opportunity Commission (EEOC).

School district staff and parents or guardians of students enrolling in school are requested to provide this information. If you decline to provide this information, *please be aware that the USDE requires school districts to use observer identification as a last resort for collecting the data for federal reporting.*

Please answer both parts of the following questions on the student's or staff member's ethnicity and race. *United States Federal Register (71 FR 44866)*

PART 1. Ethnicity: Is the person Hispanic/Latino? *(Choose only one)*

- ○ Hispanic/Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- ○ Not Hispanic/Latino

PART 2. Race: What is the person's race? *(Choose one or more)*

- ○ American Indian or Alaska Native - A person having origins in any of the original peoples of North and South America (including Central America).
- ○ Asian - 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.
- ○ Black or African American - A person having origins in any of the black racial groups of Africa.
- ○ Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ○ White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

________________________ ________________________

Employee Name (please print) Signature

________________________ ________________________

Employee ID Date

Sinton Independent School District
Payroll Direct Deposit Authorization

Application is hereby made to participate in the Payroll Direct Deposit Plan whereby my wages or salary will be deposited directly into my checking or savings account with the bank named below.

Please Print

EMPLOYEE INFORMATION:

Employee Name: ____

Social Security Number: ____

BANK INFORMATION:

Employee's Bank Account Number: _____________________________

Checking or Savings (Choose One): _____________________________

Bank Routing Number: ____

Bank Name: ____

Bank Address: ____

Bank Telephone Number: _______________________________________

Please write your social security number on a voided check or a copy of a check marked void and return it with this form to the Payroll Office.

Authorization:
I hereby direct my employer to deposit my wages or salary directly to my bank account named above on scheduled payroll dates. I understand I will be furnished with a report showing payroll deductions, net pay, and the date of deposit.

Employee's Signature: ____

Date: ____

Note: Any change in your Bank and/or Account Number must be reported to the SISD Payroll Office immediately so that changes can be made to your direct deposit record. If you fail to notify the Payroll Office and your account is not updated, your direct deposit will be rejected and returned by your bank.

Notice to Employees: Requirements of the Affordable Care Act

As of January 1, 2014, the Affordable Care Act (ACA) requires you to have health insurance for yourself and your dependents. Some people are exempt from this requirement. To learn how to apply for an exemption see *Questions and Answers on the Individual Shared Responsibility Provision*, www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision. If you do not have health insurance and you are not exempt, you may be subject to a penalty (see www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014).

Enrollment in TRS-ActiveCare satisfies the requirement to have health insurance. The TRS-ActiveCare Enrollment Guide explains who is eligible to enroll in ActiveCare.

Enrollment in another plan, such as through a spouse, parent, or association, also satisfies the requirement to have health insurance if the plan provides minimum essential coverage.

As an alternative to ActiveCare or another health insurance program, you may enroll in insurance through the Health Insurance Marketplace. In Texas, the Marketplace is a federal government program that will offer "one-stop shopping" to find and compare private health insurance options. Most individuals are eligible to enroll in insurance through the Marketplace. The Marketplace will begin enrollment in October 2013 for coverage beginning in January 2014. For information on the Marketplace, see www.healthcare.gov.

You may be eligible for a premium tax credit or other assistance toward insurance obtained through the Marketplace, depending on your household income. More information on the premium tax credit and other cost sharing provisions is available at www.healthcare.gov. Please note that the district will not contribute to premium costs if you enroll in insurance through the Marketplace. Also, you will lose the benefit of paying the premium with pre-tax income if you purchase insurance through the Marketplace.

You are encouraged to enroll in ActiveCare during August 2013 open enrollment, if you are eligible. You will not be able to enroll in ActiveCare in January 2014 to avoid the ACA penalty unless you experience a special enrollment event. If you enroll in August 2013, the district's section 125 plan (cafeteria plan) [does/does not] permit you to drop insurance before the end of the plan year.

Additional information. If you have questions or concerns about the health insurance offered through the district, please contact: Esmeralda G. DeLeon. Questions about the Marketplace and how the Affordable Care Act impacts you as an individual should be addressed to www.healthcare.gov or your personal attorney.

Basic Information About Health Care Offered By The District

(*to be completed by the district*)

If you decide to shop for coverage in the Marketplace, below is the employer information you will enter at HealthCare.gov to find out if you are eligible for a premium tax credit.

This information is numbered to correspond to the Marketplace application.

3. Employer name Sinton Independent School District		4. Employer Identification Number (EIN) 74-6002314
5. Employer Address 322 S. Archer St.		6. Employer phone number 361/364-6828
7. City Sinton	8. State Texas	9. Zip code 78387
10. Who can we contact about employee health coverage at this job? Esmeralda G. DeLeon		
11. Phone number (if different from above)		12. Email address edeleon@sintonisd.net

The district offers health coverage through TRS-ActiveCare to all eligible employees and their eligible dependents. Eligibility is described in the ActiveCare Enrollment Guide. The coverage offered by ActiveCare meets the minimum value standard and the cost of this coverage to you is intended to be affordable.

Sinton Independent School District
Sinton, Texas

CERTIFICATION OF EXAMINATION OF SCHOOL PERSONNEL FOR TUBERCULOSIS

This is to certify that ____, was examined for the disease of tuberculosis by the following test(s) and was found to be free of active tuberculosis.

Tuberculin test: **Date**____________

Negative_________ Positive_________

Chest X-Ray: **Date**____________

Negative_________ Positive_________

____
Physician's Signature

(To comply with State Law, Article 4477-12. Section 5, this examination is to be made within 120 days prior to September 1, or first date of employment, by a physician licensed to practice medicine in Texas.)

2014-2015 TRS-ActiveCare Plan Highlights

Effective September 1, 2014 through August 31, 2015 | Network Level of Benefits*

Type of Service	ActiveCare 1-HD	ActiveCare Select	ActiveCare 2
Deductible (per plan year)	$2,500 employee only $5,000 employee and spouse; employee and child(ren); employee and family	$1,200 individual $3,600 family	$1,000 individual $3,000 family
Out-of-Pocket Maximum (per plan year; does include medical deductible/any medical copays/ coinsurance)	$6,350 employee only** $9,200 employee and spouse; employee and child(ren); employee and family**	$6,350 individual $9,200 family	$6,000 per individual $12,000 family
Coinsurance Plan pays (up to allowable amount) Participant pays (after deductible)	80% 20%	80% 20%	80% 20%
Office Visit Copay Participant pays	20% after deductible	$30 copay for primary $60 copay for specialist	$30 copay for primary $50 copay for specialist
Diagnostic Lab	20% after deductible	Plan pays 100% (deductible waived) if performed at a Quest facility; 20% after deductible at other facility	Plan pays 100% (deductible waived) if performed at a Quest facility; 20% after deductible at other facility
Preventive Care See reverse side for a list of services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Teladoc Physician Services	$40 consultation fee (applies to deductible and out-of-pocket maximum)	Plan pays 100%	Plan pays 100%
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	20% after deductible	$100 copay plus 20% after deductible	$100 copay plus 20% after deductible
Inpatient Hospital (preauthorization required) (facility charges) Participant pays	20% after deductible	$150 copay per day plus 20% after deductible ($750 maximum copay per admission)	$150 copay per day plus 20% after deductible ($750 maximum copay per admission; $2,250 maximum copay per plan year)
Emergency Room (true emergency use) Participant pays	20% after deductible	$150 copay plus 20% after deductible (copay waived if admitted)	$150 copay plus 20% after deductible (copay waived if admitted)
Outpatient Surgery Participant pays	20% after deductible	$150 copay per visit plus 20% after deductible	$150 copay per visit plus 20% after deductible
Bariatric Surgery Physician charges (only covered if performed at an IOQ facility) Participant pays	$5,000 copay plus 20% after deductible	Not covered	$5,000 copay (does not apply to out-of-pocket maximum) plus 20% after deductible
Prescription Drugs Drug deductible (per plan year)	Subject to plan year deductible	$0 for generic drugs $200 per person for brand-name drugs	$0 for generic drugs $200 per person for brand-name drugs
Retail Short-Term (up to a 31-day supply) • Generic copay • Brand copay (preferred list) • Brand copay (non-preferred list) Participant pays	20% after deductible	$20 $40*** 50% coinsurance	$20 $40*** $65***
Retail Maintenance (after first fill; up to a 31-day supply) • Generic copay • Brand copay (preferred list) • Brand copay (non-preferred list) Participant pays	20% after deductible	$25 $50*** 50% coinsurance	$25 $50*** $80***
Mail Order and Retail-*Plus* (up to a 90-day supply) • Generic copay • Brand copay (preferred list) • Brand copay (non-preferred list) Participant pays	20% after deductible	$45 $105*** 50% coinsurance	$45 $105*** $180***
Specialty Drugs Participant pays	20% after deductible	20% coinsurance per fill	$200 per fill (up to 31-day supply) $450 per fill (32- to 90-day supply)
Monthly Premium Cost Employee only Employee and spouse Employee and child(ren) Employee and family	$325 $850 $572 $1,145	$450 $1,044 $709 $1,238	$555 $1,287 $875 $1,323

A specialist is any physician other than family practitioner, internist, OB/GYN or pediatrician. *Illustrates benefits when network providers are used. For some plans non-network benefits are also available; see Enrollment Guide for more information. Non-contracting providers may bill for amounts exceeding the allowable amount for covered services. Participants will be responsible for this balance bill amount, which may be considerable. **Includes prescription drug coinsurance ***If the patient obtains a brand-name drug when a generic equivalent is available, the patient will be responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.

2014-2015 TRS-ActiveCare Plan Highlights

TRS-ActiveCare Plans – Preventive Care			
Preventive Care Services	Network Benefits When Using Network Providers (Provider must bill services as "preventive care")		
	ActiveCare 1-HD	ActiveCare Select	ActiveCare 2 Network
Evidence–based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved Evidence–informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents. Additional preventive care and screenings for women, not described above, as provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009). The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. Examples of covered services included are routine annual physicals (one per year); immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for prostate cancer and colorectal cancer (including routine colonoscopies); smoking cessation counseling services and healthy diet counseling; and obesity screening/counseling. Examples of covered services for women with reproductive capacity are female sterilization procedures and specified FDA-approved contraception methods with a written prescription by a health care practitioner, including cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. Prescription contraceptives for women are covered under the pharmacy benefits administered by Caremark. To determine if a specific contraceptive drug or device is included in this benefit, contact Customer Service at **1-800-222-9205**. The list may change as FDA guidelines are modified.	Plan pays 100% (deductible waived)	Plan pays 100% (deductible waived; no copay required)	Plan pays 100% (deductible waived; no copay required)
Annual Vision Examination (one per plan year)	After deductible, plan pays 80%; participant pays 20%	$30 copay for primary $60 copay for specialist	$30 copay for primary $50 copay for specialist
Annual Hearing Examination	After deductible, plan pays 80%; participant pays 20%	$30 copay for primary $60 copay for specialist	$30 copay for primary $50 copay for specialist

Note: Covered services under this benefit must be billed by the provider as "preventive care." If you receive preventive services from a non-network provider, you will be responsible for any applicable deductible and coinsurance under the ActiveCare 1-HD and ActiveCare 2. There is no coverage for non-network services under the ActiveCare Select plan.

TRS-ActiveCare 3 to be discontinued effective September 1, 2014

The Teacher Retirement System of Texas (TRS) regularly reviews the TRS-ActiveCare plan options to ensure the plans meet the health care needs of public school employees and their families. Based on this review, TRS will eliminate the ActiveCare 3 option for the 2014-2015 plan year.

TRS-ActiveCare is administered by Aetna Life Insurance Company. Aetna provides claims payment services only and does not assume any financial risk or obligation with respect to claims. Prescription drug benefits are administered by Caremark.

SUBSTITUTES
TRS-ACTIVECARE RATES
2014-15

		TOTAL PREMIUM
TRS ACTIVECARE 1-HD		
Employee Only		$ 325.00
Employee & Spouse		$ 850.00
Employee & Children		$ 572.00
Employee & Family		$ 1,145.00
Both Spouses employed w/SISD		$ 1,145.00
Deductible $2,500.00/$5,000.00		
TRS ACTIVECARE SELECT		
Employee Only		$ 450.00
Employee & Spouse		$ 1,044.00
Employee & Children		$ 709.00
Employee & Family		$ 1,238.00
Both Spouses employed w/SISD		$ 1,238.00
Deductible $1,200.00/$3,600.00		
Brand Rx deductible $200.00		
TRS ACTIVECARE 2		
Employee Only		$ 555.00
Employee & Spouse		$ 1,287.00
Employee & Children		$ 875.00
Employee & Family		$ 1,323.00
Both Spouses employed w/SISD		$ 1,323.00
Deductible $1,000.00/$3,000.00		
Brand Rx deductible $200.00		