



UNIVERSITY OF LA VERNE

OFFICE OF STUDENT EMPLOYMENT

Job Offer Form

Student Name: _____ Student Id Number: _____

Position Type:

Federal Work Study Student Employment International Student Employment

New Hire Documents Required for Employment:

Only complete and submit documents below if you have never worked on-campus before.

- Employment Application
- I-9 Form with Acceptable Documents
- W-4
- DE-4
- Worker Compensation HR Memo
- Worker Compensation MPN

Rehire:

- I have worked on-campus in the past and do not believe additional paperwork is needed.

I acknowledge that I have been offered and have accepted a position in the below mentioned department. I understand that this form does not grant me the approval to begin my employment. I will only begin working once my supervisor has notified me that they have received an officially hired email from the Office of Student Employment.

Student Signature _____

Supervisor Section Only:

Department of Hire: _____

Supervisor Name: _____

Supervisor Signature: _____

Anticipated Start Date: _____

Hiring Form Submitted: YES NO



UNIVERSITY OF LA VERNE

OFFICE OF STUDENT EMPLOYMENT

APPLICATION FOR EMPLOYMENT

Name: _____ La Verne Student ID #: _____

La Verne email address: _____ Telephone Number: () _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Applying for:

- Federal Work Study
 Student Employment
 International Student Employment

Years worked at La Verne:

- New
 1 Year
 2 Years
 3 Years
 4 Years or more

Previous Work Experience

From (Month/Year)	To (Month/Year)	Employer	Type of Work/Duties

Describe any experience, training, or skills that qualify you for this position. (Be specific)

Licenses/Certificates:	Answer only if position applied for requires driver's license. Do you have a valid California driver's license? [] Yes [] No
Keyboarding WPM:	Computer Programs:
Office Equipment:	
Foreign Language Skills (optional): [] Speak _____ [] Read _____ [] Write _____ [] Interpret and/or translate _____	

*** The University of La Verne is an Equal Opportunity Employer** and does not unlawfully discriminate in employment. No question on this application is used for the purpose of limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Equal access to employment, services, and programs is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify Human Resources.

CERTIFICATION

Important, please read carefully and sign.

I hereby certify that the information on this application and all other information provided by me as part of my employment application is true and correct. I understand that any misrepresentations or omissions will be sufficient cause for cancellation of this application or immediate termination of employment if I am employed, whenever it may be discovered.

I hereby authorize the University of La Verne to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to the University of La Verne any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release the University of La Verne, my former employers, and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

I understand that if I am offered employment, such offer may be and is conditioned upon the successful completion of reference checks, background investigation, pre-employment medical examination (*not applicable for all positions*), and applicable licensure/certification and degree verifications.

If I am employed, I acknowledge that there is no specified length of employment and that this application does not constitute an agreement or contract for employment. Accordingly, either I or the University of La Verne can terminate the relationship at will, with or without cause, at any time with or without prior notice. I further acknowledge that the only manner in which the "at will" nature of the employment relationship can be altered is by means of a specific written agreement signed by me and an authorized representative the University of La Verne.

I understand that should a search of public records (including records documenting an arrest, indictment, conviction, civil judicial action, tax lien or outstanding judgment) be conducted by internal personnel employed by the University of La Verne, I am entitled to copies of any such public records obtained by the University of La Verne unless I mark the check box below. If I am not hired as a result of such information, I am entitled to a copy of any such records even though I have checked the box below.

I waive receipt of a copy of any public record described in the paragraph above.

I represent and warrant that I have read and fully understand the foregoing, and that I seek employment under these conditions.

Applicant's Signature _____ Date: _____

**A copy of the University of La Verne's annual security report can be obtained by contacting the University of La Verne Campus Safety Department or online at www.laverne.edu/security/.



UNIVERSITY OF LA VERNE

THE UNIVERSITY OF LA VERNE RETIREMENT PROGRAM

University of La Verne provides you with the opportunity to save for your retirement through the University of La Verne Defined Contribution Retirement Plan (the “Retirement Plan”). When combined with other retirement programs, a 403(b) defined contribution plan enhances your ability to provide a solid financial foundation for retirement years.

Eligibility

All employees of the University, including students, adjuncts and other part-time workers, are eligible to participate in the Voluntary Employee contributions. Eligible employees that would like to make or change their pre-tax voluntary contributions to the retirement plan can do so by going to www.netbenefits.com/laverne.

Vesting

Voluntary Employee contributions are always fully vested.

Investment Choices

All Plan Contributions shall be invested at the direction of Participants in one or more of the investment options made available. All Plan Contributions that are not subject to a valid Participant direction shall be invested in the default option and then may be transferred at any time by the Participant.

Setting up your Account

Log on to www.netbenefits.com/laverne to defer contributions, choose your provider, select investment options, and designate beneficiaries

Accessing Your Account

You can access your personal account information by visiting the TIAA-CREF Web Center at www.tiaa-cref.org or the Automated Telephone Service (ATS) at 800 842-2252 or Fidelity at www.netbenefits.com/laverne or 1-800-343-0860.

What you can do online:

- Check your account balances
- Make transfers and allocation changes
- Update personal information
- Access financial information and tools

Individual Counseling

TIAA-CREF and Fidelity Investments provide individual counseling sessions at no additional cost to you. This is a great opportunity for you to discuss maximizing your retirement contributions with an experienced financial consultant on a confidential basis.

For a list of the counseling sessions dates, please access <https://myportal.laverne.edu>

Effective January 1, 2014, the IRS limits to qualified retirement plans are listed below.

- ❖ **402(g)(1) Elective Deferrals** – the maximum allowable amount you can contribute towards your voluntary contributions is **\$17,500**.
- ❖ If you are 50 years or older, you are allowed to remit another **\$5,500** under ***Catch-Up Contributions**. Individuals age 50 or older will be permitted to make an “additional” contribution above and beyond the statutory limit. The 403(b) voluntary contribution limit for these individuals is the lesser of 100% of salary or \$23,000.
- Example: \$17,500 (voluntary contributions) + \$5,500 (50 or over “catch up” plan) = **\$23,000**
- ❖ Under the **IRC Section 402(g) 15-Year Rule/Service** there is also an additional special 403(b) *catch-up provision that temporarily increases the voluntary contribution limit (the maximum contribution amount) for eligible employees. This provision raises the maximum contribution amount shown in the chart by as much as **\$3,000** per year. To qualify, you must have completed at least fifteen years of service with the University of La Verne (the years of service need not be consecutive), and you **cannot** have contributed more than an average of \$5,000 per year of elective-deferrals in previous years. The increase in your voluntary contribution limit cannot exceed \$3,000 per year under this provision, up to a **\$15,000** lifetime maximum. If you believe you are eligible for the 15-year rule, you should consult with a tax or financial professional concerning the limits on your contributions.
- Example: \$17,500 (voluntary contributions) + \$3,000.00 (15 yr. rule) = **\$20,500**

OR

- Example: If you meet both criteria (50 or over and 15-year service),: 17,500 (voluntary contributions) + 3,000 (15 yr. rule) + 5,500 (50 or over “catch up” plan) = **\$26,000**
- ❖ The sum of 2014 mandatory contributions, employer contributions, pre-tax voluntary employee contributions, and 15-year catch-up contributions cannot exceed the lesser of **\$52,000** or 100% of the employee’s compensation.

Note: For participants eligible for both the Age 50 Catch-up and the 15 Years of Service provision, the IRS will apply contributions above the 2014 limit of \$17,500 first to the 15 Years of Service provision.

For further details on the Retirement Plan, or if you have questions, please contact:

Office of Human Resources - Benefits

1950 Third St.

La Verne, CA 91750

(909) 448-4076

<https://myportal.laverne.edu>



UNIVERSITY OF LAVERNE

APPLICANT IDENTIFICATION RECORD

To All Applicants: State and federal law requires that we ask you to voluntarily provide the information requested below. If you elect to voluntarily complete this form, the information will be used for statistical purposes only and will in no way be used to determine your qualifications for employment. Failure to provide such information will in no way affect your candidacy or chances of getting a position with the University.

Name: _____ Date: ____/____/____

Student Id Number: _____

1. SEX (Check One):

- Male
- Female

2. ETHNICITY (Check One):

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

3. RACE (*Regardless of your answer to Question 2, you may select one or more of the following categories that apply to you*):

- American Indian or Alaska Native** -- a person having origins in any of the original peoples of North or South America (including Central America), and who maintains tribal affiliation or community attachment.
- 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 Islanders** -- 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.



Instructions
for
MPN NOTIFICATION

Effective 10/8/10, this notice is to be used by all employers who have or are implementing the Travelers MPN.

This notice must be:

1. **POSTED** in a conspicuous location frequented by employees during the hours of the workday and in close proximity to the State workers compensation posting notice (DWC-7). The DWC-7 is available on the State DWC web site:
http://www.dir.ca.gov/dwc/forms/DWCForm7_2010.pdf.

** The Acknowledgement form included in the Notification need not be posted.*

2. Provided to an employee at the time he/she reports an injury. The notice must be given in English, and ALSO in Spanish to Spanish-speaking employees. This should accompany the State DWC-1 Employee Claim Form, also available on the State DWC web site:
<http://www.dir.ca.gov/dwc/forms/ClaimForm2010.pdf>.

** The Acknowledgement form should be included when providing the notification to employees at time of injury. It is recommended that employees be asked to sign the Acknowledgement form, which should then be kept in the employees' personnel file.*

NOTICE OF NEW WORKERS COMPENSATION PROGRAM: Medical Provider Network (MPN) Notification

California Law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer will provide this medical care through a Workers Compensation Medical Provider Network (MPN). This document describes the program and your rights in choosing medical care for work related injuries and illnesses.

What is a Medical Provider Network (MPN)?

A Medical Provider Network is a group of health care providers (physicians and other types of providers) that will manage and direct any medical care you receive if you are injured on the job. The MPN also includes ancillary providers including a pharmacy network and durable medical equipment providers. The providers in the MPN specialize in work related injuries and illnesses and meet CA required access to care standards.

The CA DWC MPN access to care standards require that an MPN plan provide at least three physicians of each specialty expected to treat workers compensation injuries; has primary treating providers within 15 miles or 30 minutes and specialty care providers within 30 miles or 60 minutes from either your work or residence; and that an injured worker will be able to get an appointment for non-emergency services within 3 business days and for specialist services within 20 business days following the insurer's receipt of request for treatment. Further, the regulations require MPN providers to use medical treatment guidelines adopted by the DWC in making any decisions related to medical care or treatment. This MPN plan complies with DWC requirements and in the event that you need medical care in connection with a workers compensation claim, it is likely that you will receive this care from providers within the MPN.

How do I find out which doctors, pharmacies or other medical providers are in the MPN?

You may contact:

Travelers MPN Team
800-287-9682

The MPN Team will be able to answer your questions about the MPN and help you find the names of MPN providers. The Team can also help you if you are having trouble getting an appointment with an MPN provider. There are several methods for locating MPN providers. You may:

- Contact your Case Manager (Claim or Medical)
- Contact the MPN Team above
- Contact your employer
- Log on to the web site at: www.mywcinfo.com
 - Click on "Find a Local Network Provider" link

If you come across any inaccuracies in a provider listing, please report the inaccuracies to the MPN Team by calling 800-287-9682 or by email to CAMPN@travelers.com.

What happens if I get injured at work?

If you incur a work-related injury or illness that is an emergency either call 911 or go to the nearest emergency medical center. You should notify your employer as soon as possible following any emergency treatment. If your injury or illness is not an emergency, notify your employer that you have a work-related injury in a reasonable time following the date of injury. Your employer or insurer will arrange an initial appointment with a doctor within the MPN.

How do I choose a provider?

After your first visit with an MPN provider to treat your work-related injury or illness, you may continue treatment with this doctor or you may choose another MPN provider that is appropriate to treat your injury. If needed, you may choose a specialist or ask the treating doctor to refer you to a specialist for treatment. If you need help in choosing an MPN doctor or have trouble getting an appointment with a doctor within the MPN, contact your Case Manager (Claim or Medical) or the MPN Team for assistance.

What if I have a prescription I need to fill?

If your MPN treating physician prescribes you a medication, Healthsystems our Pharmacy Benefit Manager can process your prescription electronically with no out of pocket expense to you. To access a complete listing of participating pharmacies, please visit their web site at www.healthsystems.com. To assist you and the pharmacists with processing your medication online you will need the following:

- Member ID (Claim Number + TRV)
- Bin Number – 012874
- Healthsystems Pharmacy Help desk – (877) 528-9497

If you have questions or concerns regarding your pharmacy benefits, please contact your case manager (Claim or Medical).

What if there are no providers in my area?

The MPN has providers available within the entire state of California. If you find there is not an appropriate treating physician or specialist available in your area, please contact your Case Manager (Claim or Medical) or the MPN Team for assistance; you may have the right to see a provider or specialist outside of the MPN in this case.

What if I am authorized by my employer to temporarily work or travel for work outside of the MPN geographic service area?

If your employer has authorized you to temporarily work or travel outside the MPN geographic service area and the need for non-emergency medical care arises, you may treat with a provider of your choice. You may also contact the MPN Team or your Case Manager (Claim or Medical). You will be provided with a choice of three physicians who are outside of the MPN geographic service area for care. These providers will be selected by either your primary treating physician, who is participating in the MPN, or by the MPN Team.

If your injury requires emergency care, call 911 or go to the nearest emergency medical treatment center.

What if I decide to temporarily or permanently or reside outside of the MPN geographic service area during my recovery?

If you are a former employee whose employer has ongoing workers compensation obligations and you permanently reside outside of the MPN geographic service area and the need for non-emergency medical care arises, you may treat with a provider of your choice. You may also contact the MPN Team or your Case Manager (Claim or Medical). You will be provided with a choice of three physicians who are outside of the MPN geographic service area to choose from for care. These providers will be selected by your primary treating physician, who is participating in the MPN, or by the MPN Team.

If your injury requires emergency care, call 911 or go to the nearest emergency medical treatment center.

What if I am already being treated for a work-related injury before my MPN coverage begins?

If your current treating doctor is a member of this MPN program, then you may continue to treat with this doctor and your treatment will be provided under the MPN. If your current treating doctor is not, or is not allowed to become, a member of the MPN then you may be required to go to an MPN doctor for treatment instead. If you must go to a new MPN doctor you will be sent an explanation letter as will your doctor.

The MPN “Transfer of Care” policy describes what will happen if you are currently treating for a work-related injury with a physician who is not a member of the MPN. You can request a copy of the “Transfer of Care” policy from the MPN Team or from your Case Manager (Claim or Medical).

You may be able to postpone the transfer of your care if your injury or illness meets any of the following conditions:

- (a) **Acute** - The treatment for your injury or illness is expected to be completed within 90 days.

(b) **Serious chronic** - Your injury or illness is one that is serious in nature and persists without full cure or worsens over 90 days and requires ongoing treatment. Once it has been determined that you have a serious chronic condition, you may be allowed to continue treatment by your current physician for up to one year, until a safe transfer of care can be made. The one year period for the completion of treatment starts from the date you receive notification of determination that you have a serious chronic condition.

(c) **Terminal illness** - You have an incurable or irreversible condition that is likely to cause death within one year or less. If it is determined that you have such an illness, you will be allowed to treat with the current provider for the duration of the terminal illness.

(d) **Pending surgery or other procedure** - You already have a surgery or other procedure that has been authorized by Travelers that will occur within 180 days of the MPN effective date.

If your care is going to be transferred into the MPN you and your physician will be notified in writing. If you disagree with the decision to transfer your care into the MPN, you may ask your treating doctor for a report that states why you should be considered to be in one of the categories listed above. Your treating physician must respond to your request within 20 calendar days. If your treating physician fails to issue the report, then the determination to transfer your care into the MPN shall apply.

If either the MPN or you do not agree with your treating doctor's report, this dispute will be resolved according to Labor Code Section 4062. You must notify your Case Manager (Claim or Medical) if you disagree with this report. If your treating doctor agrees that your condition does not meet one of those listed above, the transfer of care will go forward while you continue to disagree with the decision. If your treating doctor states that your condition does meet one of those listed above, you may continue to treat with him or her until the dispute is resolved.

Until you are transferred into the MPN, your treating physician may make referrals for additional care to providers within or outside the MPN.

If your current treating doctor does become an MPN provider then you and your provider will be notified in writing that your treatment will now be provided under the provisions of the MPN.

Employees who have properly pre-designated a personal physician will not be transferred into the MPN.

What if I am being treated by a MPN provider and the provider leaves the MPN?

If your physician stops participating in the MPN, your Case Manager (Claim or Medical) will advise you on your options for continued treatment based on the approved MPN "Continuity of Care Plan". Please contact your Case Manager (Claim or Medical) for questions or advice on your options. A copy of the "Continuity of Care Plan" will be made available upon request.

If your provider is no longer in the MPN because the MPN terminated his or her contract for issues relating to medical disciplinary cause or reason, fraud, or criminal activity, you will not be allowed to continue treatment with that provider and you will be required to choose a provider within the MPN.

If your provider has been terminated for another reason, the MPN will contact you and your provider in order to determine rights and responsibilities to complete treatment with the terminated provider. If you have one of the following conditions you may qualify to continue treating with your treating provider even though the provider has terminated the MPN:

(a) **Acute** - The treatment for your injury or illness is expected to be completed within 90 days.

(b) **Serious chronic** - Your injury or illness is one that is serious in nature and persists without full cure or worsens over 90 days and requires ongoing treatment. Once it has been determined that you have a serious chronic condition, you may be allowed to continue treatment by your current physician for up to one year, until a safe transfer of care can be made. Completion of treatment shall not exceed 12 months from the contract's termination date.

(c) **Terminal illness** - You have an incurable or irreversible condition that is likely to cause death within one year or less. If it is determined that you have such an illness, you will be allowed to treat with the current provider for the duration of the terminal illness.

(d) **Pending surgery or other procedure** - You already have a surgery or other procedure that has been authorized by Travelers that will occur within 180 days of the contract's termination date.

If you qualify under one of the above listed treatment conditions and request to continue to treat with the terminated provider, the MPN will contact the provider to affirm the provider's willingness and capability to continue treatment under the same contractual terms and conditions that existed prior to termination. If the provider is unwilling or incapable of continuing treatment, the MPN will advise you to seek treatment from another provider within the network. In such circumstances, the MPN will not be obligated to authorize continued services beyond the contract termination date, and will communicate the timeframe they will be authorized to continue treatment with the terminated provider.

If you have chosen to continue treatment with a terminated provider and the provider has agreed to continue to treat, the MPN will be responsible for payment of completion of the medically necessary treatment. The MPN will not be responsible for unauthorized treatment.

If you choose not to continue with the terminated provider, you will be advised of how to choose a new provider within the MPN.

If the MPN has determined that no further treatment will be authorized with the terminated physician and you disagree, you may ask your treating doctor for a report that addresses whether you have one of the conditions listed above. Your treating physician must respond to your request within 20 calendar days. If your treating physician fails to issue the report, then the determination made by the MPN shall apply.

If either the MPN or you do not agree with your treating doctor's report, this dispute will be resolved according to Labor Code Section 4062. If your treating doctor agrees that your condition does not meet one of those medical conditions listed above, you shall choose a new provider from within the MPN until the dispute is resolved. If the treating physician does not agree with the MPN's determination that you do not meet one of the medical conditions listed above, you shall continue to treat with the terminated provider until the dispute is resolved.

What if I disagree with my doctor about medical treatment?

If you disagree with either the diagnosis or treatment prescribed by your treating provider, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact your Case Manager (Claim or Medical) (either orally or in writing) and tell them you want a **second opinion**. Your Case Manager (Claim or Medical) will make sure that you have a regional area listing of MPN providers, based on the specialty or recognized expertise in treating the particular injury or condition in question, for you to choose from. Then you may choose a doctor from the MPN list, make an appointment within 60 days of receipt of the list, and notify your Case Manager (Claim or Medical) of your appointment date. If you do not make an appointment within 60 days of receipt of the list of MPN providers, you will not be allowed to have a second opinion with regard to this disputed diagnosis or treatment by this treating physician.

Upon notification of the appointment date, your Case Manager (Claim or Medical) will contact the physician selected to perform the second opinion and inform them of the nature of the dispute and their role and provide them with any necessary medical records needed for their review. You may request a copy of the medical records that are sent to the second opinion provider. If the second opinion provider that you chose feels that your injury or illness is outside the type of injury or illness he or she normally treats, the provider's office will notify your Case Manager (Claim or Medical) and you will receive an additional list of MPN providers from which to make your selection. During this process, you will be required to continue treatment with your treating physician or with another physician of your choice within the MPN.

After you receive the outcome of the second opinion, if you still disagree with the diagnosis or treatment, you may seek a **third opinion** from another appropriate MPN provider. If you want a third opinion, you must contact your Claim Case Manager (either orally or in writing) and tell them you want a third opinion. Your Claim Case Manager will make sure that you have a regional area listing of MPN providers, based on the specialty or recognized expertise in treating the particular injury or condition in question, for you to choose from. Then you may choose a doctor from the MPN list, make an appointment

within 60 days of receipt of the list and notify your Claim Case Manager of your appointment date. If you do not make an appointment within 60 days of receipt of the list of MPN providers, you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment by this treating physician. During this process, you will be required to continue treatment with your treating physician or with another physician of your choice within the MPN.

Upon notification of the appointment date, your Claim Case Manager will contact the physician selected to perform the third opinion and inform them of the nature of the dispute and their role and provide them with any necessary medical records needed for their review. You may request a copy of the medical records that are sent to the third opinion provider. If the third opinion provider that you chose feels that your injury or illness is outside the type of injury or illness he or she normally treats, the provider's office will notify your Claim Case Manager and you will receive a new list of MPN providers from which to make another selection.

You may obtain any recommended treatment indicated by the second and/or third opinion physician(s) by either changing physicians to the second opinion physician, third opinion physician, or other physician within the MPN.

If after the third opinion, you still disagree with your provider's diagnosis or treatment of your illness or injury, you may ask for an **Independent Medical Review (IMR)**. Your Claim Case Manager will have given you the information on requesting an IMR and provided you with the IMR Application at the time you request a third opinion.

An IMR will be performed by a provider who will be selected by the DWC Administrative Director based upon the specialty of the treating provider and other information submitted with the IMR Application. The provider will be selected to conduct an independent assessment of your dispute.

If the IMR provider agrees with the treating physician, you will be required to continue to receive medical treatment from within the MPN.

If the IMR provider does not agree with your treating provider's diagnosis or treatment of your illness or injury, you can receive treatment from either an MPN provider or a non-MPN provider. If you choose a provider that is outside the MPN, the treatment you receive from that provider can only be for the treatment or diagnostic service recommended by the IMR provider. Once any treatment provided to you related to the disputed diagnosis or treatment is completed, you must seek any further care from an MPN provider.

What if I have questions or need help understanding the MPN?

You may always contact your Case Manager or the MPN Team if you need help or further explanation about your medical treatment if you have a work-related injury or illness. The MPN Team can be reached at 800-287-9682.

DWC Information & Assistance Officer: If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment of a work-related injury or illness, you can call Information and Assistance Officer at the Division of Workers Compensation at 1-800-736-7401.

Independent Medical Review: If you have questions about the Independent Medical Review process or the Independent Medical Reviewer, you may contact the Division of Workers Compensation's Medical Unit at:

P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

Keep this information in case you have a work-related injury or illness.

**ACKNOWLEDGEMENT OF
RECEIPT OF MPN INFORMATION**

I acknowledge that I have received information regarding my employer's use of a Medical Provider Network for Workers Compensation claims.

Employee's Name (please print)

Employee's Signature

Today's Date

Employee: Please return this form to your employer

Employer: Please place in Employee's Personnel file

AVISO DEL NUEVO PROGRAMA DE COMPENSACION PARA EMPLEADOS: CADENA O RED DE PROVEEDORES DE MEDICINA (MPN)

Las leyes de California obligan a su empleador a proporcionar y pagar los gastos del tratamiento médico si usted se lesiona en el trabajo. Su empleador proporcionará atención médica por medio de la Red de Proveedores Médicos ("MPN, por sus siglas en inglés) de Indemnización Laboral. Esta notificación ofrece una descripción del programa y de sus derechos de seleccionar atención médica para lesiones y enfermedades relacionadas con el trabajo.

¿Qué es la Red de Proveedores Médicos ("MPN")?

Una Red de Proveedores Médicos ("MPN") es un grupo de proveedores de atención médica (médicos y otros tipos de proveedores) que estarán a cargo y dirigirán toda atención médica que reciba si usted se lesiona en el trabajo. La Red de Proveedores Médicos ("MPN") también tiene a otros proveedores incluyendo una red de farmacias y una red de proveedores de equipo médico durable. Los profesionales de la Red de Proveedores Médicos ("MPN") se especializan en lesiones relacionadas con el trabajo y satisfacen las normas de acceso a los cuidados convencionales para las lesiones ocupacionales y enfermedades relacionadas con el trabajo.

Las normas de acceso a la Red de Proveedores Médicos ("MPN") requieren que dicha Red de Proveedores Médicos ("MPN") proporcione por lo menos tres médicos de cada especialidad que se ocupan de tratar lesiones en concepto de indemnización laboral. La Red de Proveedores Médicos ("MPN") cuenta con proveedores de atención primaria dentro de un área de 15 millas o a 30 minutos de distancia y con proveedores especialistas dentro de un área de 30 millas o a 60 minutos de distancia de su residencia o trabajo. La Red de Proveedores Médicos ("MPN") también facilita que usted pueda concertar una cita para obtener servicios que no sean de emergencia dentro de un período de 3 días hábiles y para los servicios de especialistas dentro de un período de 20 días hábiles posterior a que la aseguradora reciba el pedido de tratamiento. Además, las regulaciones requieren que la Red de Proveedores Médicos ("MPN") utilicen las pautas de tratamiento médico adoptadas por la Secretaría de Indemnización Laboral ("DWC") al tomar cualquier decisión relacionada con los cuidados o tratamiento médico. Si usted necesita cuidados médicos relacionados con un reclamo de indemnización laboral, es posible que reciba estos cuidados de parte de proveedores que se encuentran dentro de la Red de Proveedores Médicos ("MPN").

¿Cómo hago para saber qué doctores, farmacias y otros proveedores médicos forman parte de la Red de Proveedores Médicos ("MPN")?

Usted podrá comunicarse con:

El Equipo de la Red de Proveedores Médicos de Travelers
800-287-9682

Este equipo podrá responder sus preguntas con respecto a la Red de Proveedores Médicos ("MPN") y ayudarle a encontrar los nombres de proveedores de la Red de Proveedores Médicos ("MPN") o ayudarle si usted está teniendo dificultad para obtener una cita con un proveedor de la Red de Proveedores Médicos ("MPN"). Hay varios medios para localizar a los proveedores de la Red de Proveedores Médicos ("MPN"). Usted podrá:

- Comunicarse con el(la) Administrador(a) de su Caso (Reclamo o Médico)
- Comunicarse con el Equipo de la Red de Proveedores Médicos ("MPN") anteriormente mencionado
- Comunicarse con su empleador
- Dirigirse al sitio en la red: www.myweinfo.com
 - Pulse "Encuentre a un Proveedor Local de la Red de Proveedores."

Si usted encuentra algún error en la lista de proveedores, por favor reporte este error al equipo de MPN llamando al 800-287-9682 or por correo electrónico a CAMPN@travelers.com.

¿Qué sucede si me lastimo en el trabajo?

Si usted resulta lesionado(a) o sufre de una enfermedad relacionada con su trabajo que es de emergencia, llame al 911 o bien diríjase al centro de emergencias médicas más cercano.

Usted deberá notificar a su empleador lo antes posible después de haber recibido tratamiento de emergencia. Si su lesión o enfermedad no es de emergencia, notifique a su empleador que usted ha sufrido una lesión relacionada con su trabajo. Su empleador o asegurador hará los arreglos para una cita inicial con un doctor de la Red de Proveedores Médicos ("MPN").

¿Cómo hago para seleccionar a un proveedor?

Después de la primera visita con un proveedor de la Red de Proveedores Médicos ("MPN") debido a su lesión o enfermedad relacionada con el trabajo, usted podrá continuar recibiendo tratamiento de parte de este doctor o podrá seleccionar a otro proveedor de la Red de Proveedores Médicos que resulte apropiado para tratar su lesión. De ser necesario, usted podrá seleccionar a un especialista o solicitar que el doctor a cargo de su tratamiento le recomiende a un especialista. Si usted necesita ayuda para seleccionar a un doctor o si tiene dificultad para obtener una cita con un doctor de la Red de Proveedores Médicos ("MPN"), comuníquese con su Administrador(a) del Caso o con el equipo de la Red de Proveedores Médicos ("MPN") para que le presten ayuda.

¿Que hago si el médico me da una receta médica?

Si su médico del MPN le da una receta médica, Healthsystems nuestro encargado the beneficios farmacéuticos, puede procesar su receta electrónicamente sin incurrir ningún gasto a su bolsillo. Para tener acceso a un listado completo de farmacias participantes visite el sitio www.healthsystems.com. Para asistirlo a usted y a los farmacéuticos con el proceso de su medicina necesitará lo siguiente:

- Identificación del miembro (número de reclamo y TRV)
- Número de BIN – 012874
- Número de asistencia de Healthsystems – (877) 528-9497

Si tiene alguna pregunta con respecto a sus beneficios farmacéuticos, por favor comuníquese con el encargado de su caso de compensación laboral.

¿Qué sucede si no hay proveedores en mi área?

La Red de Proveedores Médicos ("MPN") cuenta con proveedores disponibles dentro de todo el estado de California. Si usted encuentra que no hay un médico o especialista apropiado disponible para que le proporcione tratamiento en su área, por favor, comuníquese con el(la) Administrador(a) de su Caso o con el Equipo de la Red de Proveedores Médicos para obtener asistencia. Es posible que en este caso, usted tenga derecho a ver a un especialista que no pertenezca a la Red de Proveedores Médicos ("MPN").

¿Qué sucede si estoy trabajando o viajando fuera del área geográfica de servicio de la Red de Proveedores Médicos ("MPN")?

Si su empleador le ha autorizado a trabajar o viajar de forma temporaria fuera del área geográfica de servicio de la Red de Proveedores Médicos ("MPN") por motivos de trabajo y surge la necesidad de obtener cuidados médicos que no son de emergencia, usted puede tratar con un proveedor de su preferencia. Puede también comunicarse con la Red de Proveedores Médicos (MPN) o puede comunicarse con el (la) Administrador (a) de su caso. En dado caso se le proporcionará una opción de tres médicos fuera del área de servicio geográfica del MPN que han sido seleccionados por su médico de tratamiento primario dentro del MPN o que han sido seleccionados por Travelers. Además, usted podrá comunicarse con el(la) Administrador(a) de su caso para que le ayude a obtener los cuidados médicos apropiados dentro de su área. Si su lesión requiere cuidados de emergencia, llame al 911 o diríjase al centro de tratamiento de emergencias médicas más cercano.

¿Qué sucede si yo estoy residiendo de forma temporal o permanente fuera del área geográfica de servicio de la Red de Proveedores Médicos ("MPN")?

Si usted es un(a) empleado(a) lesionado(a) que durante su recuperación decide residir de forma temporal fuera del área geográfica de servicio de la Red de Proveedores Médicos ("MPN") y surge la necesidad de obtener atención médica que no sea de emergencia, usted puede tratar con un proveedor de su preferencia. Pueden también comunicarse con la Red de Proveedores Médicos (MPN) o puede comunicarse con el (la) Administrador (a) de su caso. En dado caso se le proporcionará una opción de tres médicos fuera del área de servicio geográfica del MPN que han sido seleccionados por su médico de tratamiento primario dentro del MPN o que han sido seleccionados por Travelers. Además, usted podrá comunicarse con el(la) Administrador(a) de su caso para que le ayude a obtener los cuidados médicos apropiados dentro de su área. Si su lesión requiere cuidados de emergencia, llame al 911 o diríjase al centro de tratamiento de emergencias médicas más cercano.

Si usted es un ex empleado cuyo empleador todavía tiene obligaciones para con usted de indemnización laboral y usted reside de forma permanente fuera del área geográfica de servicio de la Red de Proveedores Médicos ("MPN") y surge la necesidad de obtener atención médica que no sea de emergencia, se le proporcionará una opción de tres médicos fuera del área de servicio geográfica del MPN que han sido seleccionados por su médico de tratamiento primario dentro del MPN o que han sido seleccionados por Travelers. Además, usted podrá comunicarse con el(la) Administrador(a) de su caso para que le ayude a obtener los cuidados médicos apropiados dentro de su área. Si su lesión requiere cuidados de emergencia, llame al 911 o diríjase al centro de tratamiento de emergencias médicas más cercano.

¿Qué sucede si yo ya estoy recibiendo tratamiento debido a una lesión relacionada con el trabajo antes del inicio de la Red de Proveedores Médicos ("MPN")?

Si el doctor a cargo de su tratamiento actual es miembro del programa de la Red de Proveedores Médicos ("MPN") de Travelers, entonces, usted podrá continuar el tratamiento con este doctor y su tratamiento se encontrará amparado por la Red de Proveedores Médicos ("MPN"). Si el doctor a cargo de su tratamiento actual no es miembro o no se le permite convertirse en miembro de la Red de Proveedores Médicos ("MPN"), entonces, es posible que a usted se le envíe a un doctor de la Red de Proveedores Médicos ("MPN") para que reciba tratamiento. Si este fuera el caso, a usted se le enviará una carta y su doctor también será notificado.

Travelers cuenta con un plan para “Transferencia de Atención Médica” que describe qué es lo que ocurrirá si usted está recibiendo tratamiento en la actualidad debido a una lesión relacionada con el trabajo con un médico que no es miembro de la Red de Proveedores Médicos ("MPN"). Una copia del plan para “Transferencia de Atención Médica” se pondrá a su disposición si usted lo solicita.

Usted puede postponer su transferencia si su lesión o enfermedad reúne cualquiera de las siguientes condiciones:

(a) **Grave** - El tratamiento de una lesión o enfermedad que se anticipa se resolverá dentro de un período de 90 días.

(b) **Crónica Grave** - Su lesión o enfermedad es de índole grave y persiste sin cura total o empeora a lo largo de un período de 90 días y requiere tratamiento continuo. Una vez que se ha determinado que sufre de una condición crónica grave, es posible que a usted se le permita continuar su tratamiento con su médico actual durante un período que no deberá exceder un año, hasta que se pueda realizar una transferencia de cuidados de forma segura. El período de un año para completar el tratamiento se inicia a partir de la fecha en la que recibe notificación que se ha determinado que usted sufre de una condición crónica grave.

(c) **Enfermedad Terminal** - Usted sufre de una enfermedad o lesión incurable o irreversible que probablemente le ocasionará la muerte dentro de un período de un año o menos. Si se determina que sufre de tal enfermedad, a usted se le permitirá recibir tratamiento de parte de su proveedor actual mientras dure dicha enfermedad terminal.

(d) **Cirugía u otro procedimiento pendiente** - Travelers ya le ha dado autorización para una cirugía u otro procedimiento a llevarse a cabo dentro de un período de 180 días contados a partir de la fecha de vigencia de la Red de Proveedores Médicos ("MPN").

Si Travelers va a transferir sus cuidados, usted y su médico recibirán notificación escrita. Si no está de acuerdo con la transferencia de cuidados, usted podrá solicitar que el médico a cargo de su tratamiento le proporcione un informe que indique si usted satisface alguna de las categorías mencionadas anteriormente. El médico a cargo de su tratamiento debe responder a su pedido dentro de un período de 20 días calendarios. Si el médico a cargo de su tratamiento no entrega el informe, será la determinación tomada por Travelers la que regirá.

Si Travelers o usted no está(n) de acuerdo con el informe del doctor a cargo de su tratamiento, esta disputa se resolverá en virtud del artículo 4062 del Código de Trabajo. Usted debe notificar a el(la) Administrador(a) de su Caso si no está de acuerdo con este informe. Si el doctor a cargo de su tratamiento concuerda que su condición no satisface lo mencionado anteriormente, la transferencia de cuidados seguirá adelante mientras usted continúa estando en desacuerdo con la decisión. Si el doctor a cargo de su tratamiento indica que su condición no satisface lo indicado anteriormente, usted podrá continuar recibiendo tratamiento de parte de dicho médico hasta que se resuelva la disputa.

El médico a cargo de su tratamiento lo podrá derivar a proveedores para que le proporcionen cuidados adicionales dentro o fuera de la Red de Proveedores Médicos ("MPN") hasta que a usted se le transfiera a dicha red.

Empleados que han pre-designado apropiadamente un médico personal no serán transferidos a la Red de Proveedores Médicos (MPN)

¿Qué sucede si yo estoy recibiendo tratamiento de un proveedor de la Red de Proveedores Médicos ("MPN") y el proveedor abandona dicha red?

Si su médico deja de participar de la Red de Proveedores Médicos ("MPN"), el(la) Administrador(a) de su Caso le indicará cuáles son sus opciones con respecto a la continuación del tratamiento en base al Plan de Continuidad de Atención Médica aprobado por parte de Travelers. Por favor, comuníquese con el(la) Administrador(a) de su Caso para hacer preguntas con respecto a sus opciones. Una copia del "Plan de Continuidad de Atención Médica" se pondrá a su disposición si usted lo solicita.

Si su proveedor ya no pertenece a la Red de Proveedores Médicos ("MPN") debido a que dicha red ha rescindido su contrato por asuntos relacionados con causas o motivos médicos de índole disciplinaria, fraude o actividad delictiva, a usted no se le permitirá que continúe recibiendo tratamiento de parte de ese proveedor y se le requerirá que elija a un proveedor participante de la Red de Proveedores Médicos ("MPN").

Si su proveedor ha sido rescindido por algún otro motivo, Travelers se comunicará con usted y con su proveedor para poder determinar los derechos y responsabilidades para completar el tratamiento con el proveedor rescindido. Si usted sufre de alguna de las siguientes condiciones, es posible que reúna los requisitos para continuar recibiendo tratamiento del proveedor que está a cargo del mismo, a pesar de que el proveedor ha rescindido su relación laboral con la Red de Proveedores Médicos ("MPN"):

(a) **Grave** - Su dolencia implica el inicio repentino de síntomas ocasionados por una enfermedad, lesión u otro problema médico que requiere atención médica sin demoras y cuya duración es inferior a los 90 días. Travelers autorizará que se complete el tratamiento mientras dure dicha condición de gravedad sujeta a la cooperación del proveedor de acuerdo a lo que se describe a continuación.

(b) **Crónica grave** - Su lesión o enfermedad es de índole grave y persiste sin cura total o empeora durante un período de 90 días y requiere tratamiento continuo. Travelers autorizará que se complete el tratamiento de una condición crónica grave que no exceda los 12 meses contados a partir de la fecha de rescisión del contrato sujeta a la cooperación del proveedor según lo que se indica a continuación.

(c) **Enfermedad terminal** - Usted tiene una condición incurable o irreversible que tiene altas probabilidades de ocasionar la muerte dentro de un período de un año o menos. Travelers autorizará que

se complete el tratamiento mientras dure la enfermedad terminal, sujeto a la cooperación del proveedor, según se describe a continuación.

(d) **Cirugía u otro procedimiento pendiente** - Travelers ya ha autorizado una cirugía u otro procedimiento como parte de un curso de tratamiento documentado y que ha sido recomendado y documentado por parte del proveedor a llevarse a cabo dentro de un período de 180 días contados a partir de la fecha de rescisión del contrato. Travelers reafirmará la autorización para la continuación del tratamiento sujeto a la cooperación del proveedor según lo que se describe a continuación.

Si su caso reúne alguna de las condiciones de tratamiento enumeradas anteriormente y solicita continuar su tratamiento con el proveedor rescindido, Travelers se comunicará con el proveedor para confirmar la intención y capacidad del proveedor de continuar el tratamiento de acuerdo a los mismos términos y condiciones contractuales que existían antes de la rescisión. Si el proveedor no está dispuesto o es incapaz de continuar a cargo del tratamiento, Travelers le aconsejará al trabajador lesionado que solicite tratamiento de parte de otro proveedor dentro de la Red de Proveedores Médicos ("MPN"). En dichas circunstancias, Travelers no estará obligado a autorizar la continuación de servicios más allá de la fecha de rescisión del contrato y le comunicará el período de tiempo durante el cual tendrá autorización para continuar recibiendo tratamiento de parte del proveedor rescindido.

Si usted ha optado por continuar su tratamiento con el proveedor rescindido y el proveedor ha prestado su consentimiento para proporcionar el tratamiento, Travelers será responsable del pago para completar el tratamiento que resulta necesario desde un punto de vista médico. Travelers no será responsable de tratamientos que no hayan sido autorizados.

Si opta por no continuar con el proveedor rescindido, a usted se le indicará el modo de elegir otro proveedor nuevo dentro de la Red de Proveedores Médicos ("MPN").

Si Travelers decide que no se autorizará tratamiento adicional por parte del médico rescindido y usted no está de acuerdo, usted podrá solicitar que su doctor proporcione un informe que indique si usted satisface alguna de las condiciones enumeradas anteriormente. El médico a cargo de su tratamiento debe responder a su solicitud dentro de un período de 20 días calendarios. Si el médico a cargo de su tratamiento no presenta el informe, la decisión de Travelers será la que regirá.

Si Travelers o usted no están de acuerdo con el informe del doctor a cargo del tratamiento, esta disputa se resolverá en virtud del artículo 4062 del Código de Trabajo. Si el doctor a cargo de su tratamiento está de acuerdo con que su condición no satisface alguna de las condiciones médicas indicadas anteriormente, usted deberá elegir a un nuevo proveedor que pertenezca a la Red de Proveedores Médicos ("MPN") hasta la resolución de la disputa. Si el médico a cargo del tratamiento no está de acuerdo con la decisión de Travelers en cuanto a que no satisface ninguna de las condiciones médicas enumeradas anteriormente, usted continuará recibiendo tratamiento de parte del proveedor rescindido hasta que se resuelva la disputa.

¿Qué sucede si yo no estoy de acuerdo con mi doctor acerca del tratamiento médico?

Si usted no está de acuerdo con el diagnóstico o con el tratamiento indicado por el proveedor a cargo del mismo, usted podrá solicitar una segunda opinión de parte de otro doctor que forme parte de la Red de Proveedores Médicos ("MPN"). Si usted desea una segunda opinión, deberá comunicarse con el(la) Administrador(a) de su Caso (tanto verbalmente como por escrito) e indicarle que usted desea una **segunda opinión**. El(la) Administrador(a) del caso se asegurará de que usted tenga una lista de proveedores de la Red de Proveedores Médicos ("MPN") del área de la que elegir en base a la especialidad o experiencia reconocida para tratar la lesión o condición en particular. Luego usted podrá seleccionar a un doctor de la lista de la Red de Proveedores Médicos ("MPN"), hacer una cita dentro de un período de 60 días de haber recibido la lista de proveedores de la MPN y notificar al Administrador(a) de su Caso acerca de la fecha de su cita. Si no hace la cita dentro de un período de 60 días después de haber recibido la lista de proveedores de la Red de Proveedores Médicos ("MPN"), a usted no se le permitirá obtener una segunda opinión con respecto a este diagnóstico o tratamiento disputado del médico que le está proporcionando el tratamiento.

Una vez que se le notifique acerca de la fecha de la cita, el(la) Administrador(a) de su Caso se comunicará con el médico seleccionado para proporcionar la segunda opinión e informarle acerca de la índole de la

disputa y de su papel en la misma, y proporcionarle los archivos médicos necesarios para su consideración. Usted podrá solicitar que se le envíe una copia de los archivos médicos que se le envían al proveedor que proporcionará la segunda opinión. Si el proveedor a cargo de la segunda opinión que usted selecciona considera que la lesión o enfermedad se encuentra fuera del tipo de lesión o enfermedad para la que él o ella proporciona tratamiento, la oficina del proveedor le notificará al Administrador(a) del Caso y usted recibirá una lista nueva de proveedores de la Red de Proveedores Médicos ("MPN") de la cual podrá volver a elegir. Durante este proceso, a usted se le requerirá que continúe con el médico a cargo de su tratamiento o con el médico de su elección que pertenezca a la Red de Proveedores Médicos ("MPN").

Una vez que recibe la segunda opinión, si usted continúa en desacuerdo con el diagnóstico o tratamiento, usted podrá solicitar una **tercera opinión** de parte de otro proveedor apropiado perteneciente a la Red de Proveedores Médicos ("MPN"). Si desea una tercera opinión, usted debe comunicarse con el(la) Administrador(a) de su Caso (tanto de forma verbal como escrita) e informarle que usted desea una tercera opinión. El(la) Administrador(a) de su Caso se asegurará de que tenga una lista de la cual pueda elegir proveedores de la Red de Proveedores Médicos ("MPN") de su área que se base en la especialidad o experiencia reconocida en el tratamiento de la lesión o condición en cuestión. Luego, usted podrá seleccionar a un doctor de la lista de la Red de Proveedores Médicos ("MPN"), hacer una cita dentro de un período de 60 días contados a partir de la fecha en la que se reciba la lista de proveedores de la "MPN" y notificar al Administrador(a) del Caso acerca de la fecha de su cita. Si no hace una cita dentro de los 60 días de haber recibido la lista de proveedores de la Red de Proveedores Médicos ("MPN"), a usted no se le permitirá obtener una tercera opinión con respecto a este diagnóstico o tratamiento disputado de parte de este médico. Durante este proceso, a usted se le requerirá que continúe con el médico a cargo de su tratamiento o con el médico de su elección que pertenezca a la Red de Proveedores Médicos ("MPN").

Cuando reciba notificación de la fecha de la cita, el(la) Administrador(a) de su caso se comunicará con el médico seleccionado para que proporcione la tercera opinión y le informará acerca de la índole de la disputa y de su papel en la misma y le proporcionará todos los archivos médicos necesarios para su consideración. Usted podrá solicitar una copia de los expedientes médicos que se le envíen al proveedor a cargo de la tercera opinión. Si el proveedor a cargo de la tercera opinión que usted elija decide que su lesión o enfermedad se encuentra fuera del tipo de lesión o enfermedad para la que él o ella normalmente proporciona tratamiento, la oficina del proveedor le notificará al Administrador(a) de su Caso y usted recibirá una lista nueva de proveedores de la MPN de la cual podrá volver a elegir.

Usted podrá obtener todo tratamiento recomendado que le haya indicado el o los médicos a cargo de la segunda y/o tercera opinión y cambiar al médico que dio la segunda opinión o la tercera opinión o a cualquier otro médico que se encuentre dentro de la Red de Proveedores Médicos ("MPN").

Si después de la tercera opinión, usted sigue no estando de acuerdo con el diagnóstico o tratamiento de su enfermedad o lesión, usted podrá solicitar una **Revisión Médica Independiente** ("IMR", por sus siglas en inglés). El(la) Administrador(a) de su Caso le proporcionará la información para solicitar la Revisión Médica Independiente y dará la Solicitud en el momento de solicitar una tercera opinión.

La Revisión Médica Independiente ("IMR") será proporcionada por un proveedor seleccionado por parte del Director Administrativo de la Secretaría de Indemnización Laboral ("DWC") en base a la especialidad del proveedor a cargo del tratamiento y de otra información presentada con la Solicitud de la Revisión Médica Independiente ("IMR"). Se seleccionará al proveedor para que lleve a cabo una evaluación independiente de su disputa.

Si La Revisión Médica Independiente (IMR) está de acuerdo con el médico de tratamiento, se le requerirá que continúe el tratamiento médico dentro de la Red de Proveedores Médicos (MPN).

Si el proveedor a cargo de la Revisión Médica Independiente ("IMR") no está de acuerdo con el diagnóstico o tratamiento del proveedor a cargo de su lesión o enfermedad, usted podrá recibir tratamiento de parte de un proveedor de la Red de Proveedores Médicos ("MPN") o de un proveedor que no pertenezca a la "MPN". Si elige a un proveedor que no pertenece a la Red de Proveedores Médicos

("MPN"), el tratamiento que usted reciba de dicho proveedor consistirá solamente del servicio de tratamiento o de diagnóstico recomendado por el proveedor a cargo de la Revisión Médica Independiente ("IMR"). Una vez completado todo tratamiento con respecto a su diagnóstico o tratamiento disputado, usted debe solicitar cuidados adicionales de parte de un proveedor de la Red de Proveedores Médicos ("MPN").

¿Qué sucede si deseo hacer alguna pregunta o necesito ayuda?

Usted podrá comunicarse con el Administrador de su Caso o con el Equipo de la Red de Proveedores Médicos ("MPN") en cualquier momento si necesita ayuda o una explicación adicional con respecto a su tratamiento médico cuando sufre una lesión o enfermedad relacionada con el trabajo. Usted puede comunicarse con el Equipo de la Red de Proveedores Médicos ("MPN") de Travelers llamando al 800-287-9682.

Funcionario de Información y Asistencia de la Secretaría de Indemnización Laboral ("DWC"): Si tiene alguna inquietud, queja o preguntas con respecto a la Red de Proveedores Médicos, el proceso de notificación o su tratamiento médico después de una lesión o enfermedad relacionada con su trabajo, usted puede llamar al Funcionario de Información y Asistencia en la Secretaría de Indemnización Laboral al 1-800-736-7401.

Revisión Médica Independiente ("IMR"): Si tiene preguntas con respecto al proceso de Revisión Médica Independiente, usted podrá comunicarse con la Unidad Médica de la Secretaría de Indemnización Laboral:

P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

Guarde esta información en caso que usted tenga lesión o enfermedad relacionada con su trabajo.

**ACUSE DE RECIBO
DE LA INFORMACIÓN DE LA MPN**

Yo admito haber recibido información relacionada con la utilización por parte de mi empleador de una Red Provedora Médica para reclamos de Indemnizaciones a los Trabajadores.

Nombre del Empleado (escribir con letra imprenta)

Firma del Empleado

Fecha Actual

Empleado: Por favor devuelva este formulario a su empleador
Employee: Please return this form to your employer

Empleador: sírvase incluir en el archivo del personal del empleado
Employer: Please place in Employee's Personnel file



Instructions
for
MPN IMPLEMENTATION NOTICE

This notice is to be used by employers who are implementing the Travelers MPN **60 or more days after** their initial Travelers policy (or CSS contract) effective date. Employers who are implementing the MPN within 60 days of their initial policy effective date are not required to distribute this notice.

1. Fill in the following spots on the notice, in both the English and Spanish sections:
 - **Effective date of new MPN** = the day after the MPN Notification is posted AND all required MPN notices have been distributed.
 - **Policy effective date** = the date the employer's initial Travelers policy (or CSS contract) began. If you are unsure of this date, please check your policy paperwork or contact your Travelers underwriter.
2. Provide the notice to any/all injured employees. The notice must be given in English to all employees, and ALSO in Spanish to Spanish-speaking employees.
3. Provide the notice to any/all new employees at the time of hire. The notice must be given in English to all new employees, and ALSO in Spanish to Spanish-speaking employees.



MEDICAL PROVIDER NETWORK (MPN) IMPLEMENTATION NOTICE

Unless you predesignate a physician or medical group, your new work injuries arising on or after _____ will be treated by providers in a new Medical Provider Network, the **Travelers TCT MPN**.

If you have an existing injury occurring on or after _____, you may be required to change to a provider in the new MPN. Check with your claims adjuster. You may obtain more information about the MPN from the workers' compensation poster or from your employer.

AVISO DE IMPLEMENTACIÓN DE LA RED DE PROVEEDORES MÉDICOS (MPN)

A menos que usted designe con anticipación a un médico o grupo médico, las nuevas lesiones relacionadas con su trabajo que ocurran el _____ o después de esa fecha, serán tratadas por los proveedores que participan en una nueva Red de Proveedores Médicos, la red **Travelers TCT MPN**. Si usted tiene una lesión actual que ocurrió el _____ o después de esa fecha, es posible que deba cambiarse a un proveedor que participe en la nueva MPN. Consulte con su tasador de reclamaciones. Puede obtener más información sobre la MPN en el póster de compensación legal por accidentes de trabajo o hablando con su empleador.

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances
City, State, and ZIP Code	<input type="checkbox"/> SINGLE or MARRIED (with two or more incomes) <input type="checkbox"/> MARRIED (one income) <input type="checkbox"/> HEAD OF HOUSEHOLD

- Number of allowances for Regular Withholding Allowances, Worksheet A _____
 Number of allowances from the Estimated Deductions, Worksheet B _____
 Total Number of Allowances (A + B) when using the California Withholding Schedules for 2013 _____
 OR
- Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C _____
 OR
- I certify under penalty of perjury that I am not subject to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act. (Check box here)

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Signature _____ Date _____

Employer's Name and Address	California Employer Account Number
-----------------------------	------------------------------------

----- cut here -----

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME TAX MAY BE UNDERWITHHELD IF YOU DO NOT FILE THIS DE 4 FORM.

IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

You should complete this form if either:

- You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,
- You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. **If you rely on the number of withholding**

allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld. This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your Form W-4 and/or DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form, and for federal withholding use the Internal Revenue Service (IRS) Publication 919 or federal withholding calculations.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption automatically expires on February 15 of the next year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted before February 15. If you are not having federal income tax withheld this year but expect to have a tax liability next year, the law requires you to give your employer a new Form W-4 by December 1.

EXEMPTION FROM WITHHOLDING (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD.

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES 800-852-5711 (voice)
800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) 916-845-6500

The *California Employer's Guide* (DE 44) provides the income tax withholding tables. This publication may be found on the Employment Development Department (EDD) website at www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm. To assist you in calculating your tax liability, please visit the Franchise Tax Board website at: www.ftb.ca.gov/individuals/index.shtml.

NOTIFICATION: Your employer is required to send a copy of your DE 4 to the Franchise Tax Board (FTB) if it meets either of the following two conditions:

- You claim more than 10 withholding allowances.
- You claim exemption from state or federal income tax withholding and your employer expects your usual weekly wages to exceed \$200 per week.

IF THE IRS INSTRUCTS YOUR EMPLOYER TO WITHHOLD FEDERAL INCOME TAX BASED ON A CERTAIN WITHHOLDING STATUS, YOUR EMPLOYER IS REQUIRED TO USE THE SAME WITHHOLDING STATUS FOR STATE INCOME TAX WITHHOLDING IF YOUR WITHHOLDING ALLOWANCES FOR STATE PURPOSES MEET THE REQUIREMENTS LISTED UNDER "NOTIFICATION." IF YOU FEEL THAT THE FEDERAL DETERMINATION IS NOT CORRECT FOR STATE WITHHOLDING PURPOSES, YOU MAY REQUEST A REVIEW.

To do so, write to:

W-4 Unit
Franchise Tax Board MS F180
P.O. Box 2952
Sacramento, CA 95812-2952
Fax: 916-843-1094

Your letter should contain the basis of your request for review. You will have the burden of showing the federal determination incorrect for state withholding purposes. The FTB will limit its review to that issue. The FTB will notify both you and your employer of its findings. Your employer is then required to withhold state income tax as instructed by FTB. In the event FTB or IRS finds there is no reasonable basis for the number of withholding exemptions that you claimed on your Form W-4/DE 4, you may be subject to a penalty.

PENALTY: You may be fined \$500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided for by Section 19176 of the California Revenue and Taxation Code.

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:

- Do you claim allowances for dependents or blindness?
- Are you going to itemize your deductions?
- Do you have more than one income coming into the household?

TWO-EARNER/TWO-JOBS: When earnings are derived from more than one source, underwithholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with one employer. Do not claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 or Form W-4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet all of the following tests:

- (1) Your spouse will not live with you at any time during the year;
- (2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; and
- (3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the entire year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A

REGULAR WITHHOLDING ALLOWANCES

- | | |
|--|-----------|
| (A) Allowance for yourself — enter 1 | (A) _____ |
| (B) Allowance for your spouse (if not separately claimed by your spouse) — enter 1 | (B) _____ |
| (C) Allowance for blindness — yourself — enter 1 | (C) _____ |
| (D) Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1 | (D) _____ |
| (E) Allowance(s) for dependent(s) — do not include yourself or your spouse | (E) _____ |
| (F) Total — add lines (A) through (E) above | (F) _____ |

INSTRUCTIONS — 2 — ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim one or more additional withholding allowances. Use last year's FTB 540 form as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each \$1,000, or fraction of \$1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

WORKSHEET B

ESTIMATED DEDUCTIONS

- | | | |
|---|------|-------|
| 1. Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB 540 form | 1. | _____ |
| 2. Enter \$7,682 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or \$3,841 if single or married filing separately, dual income married, or married with multiple employers | — 2. | _____ |
| 3. Subtract line 2 from line 1, enter difference | = 3. | _____ |
| 4. Enter an estimate of your adjustments to income (alimony payments, IRA deposits) | + 4. | _____ |
| 5. Add line 4 to line 3, enter sum | = 5. | _____ |
| 6. Enter an estimate of your nonwage income (dividends, interest income, alimony receipts) | — 6. | _____ |
| 7. If line 5 is greater than line 6 (if less, see below);
Subtract line 6 from line 5, enter difference | = 7. | _____ |
| 8. Divide the amount on line 7 by \$1,000, round any fraction to the nearest whole number
Enter this number on line 1 of the DE 4. Complete Worksheet C, if needed. | 8. | _____ |
| 9. If line 6 is greater than line 5;
Enter amount from line 6 (nonwage income) | 9. | _____ |
| 10. Enter amount from line 5 (deductions) | 10. | _____ |
| 11. Subtract line 10 from line 9, enter difference
<u>Complete Worksheet C</u> | 11. | _____ |

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California Personal Income Tax (PIT) withholding and PIT wages. This new law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of Section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 888-745-3886.

WORKSHEET C

TAX WITHHOLDING AND ESTIMATED TAX

1. Enter estimate of total wages for tax year 2013 1. _____
2. Enter estimate of nonwage income (line 6 of Worksheet B) 2. _____
3. Add line 1 and line 2. Enter sum 3. _____
4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest) 4. _____
5. Enter adjustments to income (line 4 of Worksheet B) 5. _____
6. Add line 4 and line 5. Enter sum 6. _____
7. Subtract line 6 from line 3. Enter difference 7. _____
8. Figure your tax liability for the amount on line 7 by using the 2013 tax rate schedules below 8. _____
9. Enter personal exemptions (line F of Worksheet A x \$114.40) 9. _____
10. Subtract line 9 from line 8. Enter difference 10. _____
11. Enter any tax credits. (See FTB Form 540) 11. _____
12. Subtract line 11 from line 10. Enter difference. This is your total tax liability 12. _____
13. Calculate the tax withheld and estimated to be withheld during 2013. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2013. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2013 13. _____
14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld 14. _____
15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4 . . . 15. _____

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2013 ONLY

SINGLE OR MARRIED WITH DUAL EMPLOYERS				
IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .	PLUS*	
\$0	\$7,455 ...	1.100%	\$0	\$0.00
\$7,455	\$17,676 ...	2.200%	\$7,455	\$82.01
\$17,676	\$27,897 ...	4.400%	\$17,676	\$306.87
\$27,897	\$38,726 ...	6.600%	\$27,897	\$756.59
\$38,726	\$48,942 ...	8.800%	\$38,726	\$1,471.30
\$48,942	\$250,000 ...	10.230%	\$48,942	\$2,370.31
\$250,000	\$300,000 ...	11.330%	\$250,000	\$22,938.54
\$300,000	\$500,000 ...	12.430%	\$300,000	\$28,603.54
\$500,000	\$1,000,000 ...	13.530%	\$500,000	\$53,463.54
\$1,000,000	and over	14.630%	\$1,000,000	\$121,113.54

MARRIED FILING JOINT OR QUALIFYING WIDOW(ER) TAXPAYERS				
IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .	PLUS*	
\$0	\$14,910 ...	1.100%	\$0	\$0.00
\$14,910	\$35,352 ...	2.200%	\$14,910	\$164.01
\$35,352	\$55,794 ...	4.400%	\$35,352	\$613.73
\$55,794	\$77,452 ...	6.600%	\$55,794	\$1,513.18
\$77,452	\$97,884 ...	8.800%	\$77,452	\$2,942.61
\$97,884	\$500,000 ...	10.230%	\$97,884	\$4,740.63
\$500,000	\$600,000 ...	11.330%	\$500,000	\$45,877.10
\$600,000	\$1,000,000 ...	12.430%	\$600,000	\$57,207.10
\$1,000,000	and over	14.630%	\$1,000,000	\$106,927.10

UNMARRIED HEAD OF HOUSEHOLD TAXPAYERS				
IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .	PLUS*	
\$0	\$14,920 ...	1.100%	\$0	\$0.00
\$14,920	\$35,351 ...	2.200%	\$14,920	\$164.12
\$35,351	\$45,571 ...	4.400%	\$35,351	\$613.60
\$45,571	\$56,400 ...	6.600%	\$45,571	\$1,063.28
\$56,400	\$66,618 ...	8.800%	\$56,400	\$1,777.99
\$66,618	\$340,000 ...	10.230%	\$66,618	\$2,677.17
\$340,000	\$408,000 ...	11.330%	\$340,000	\$30,644.15
\$408,000	\$680,000 ...	12.430%	\$408,000	\$38,348.55
\$680,000	\$1,000,000 ...	13.530%	\$680,000	\$72,158.15
\$1,000,000	and over	14.630%	\$1,000,000	\$115,454.15

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL FRANCHISE TAX BOARD:

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES 800-852-5711 (voice)
800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) 916-845-6500

*marginal tax

The DE 4 information is collected for purposes of administering the Personal Income Tax law and under the authority of Title 22 of the California Code of Regulations and the Revenue and Taxation Code, including Section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California income tax return.

Form W-4 (2014)

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 2014 expires February 17, 2015. 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 \$1,000 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 2014. 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: <ul style="list-style-type: none"> • 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 (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. <ul style="list-style-type: none"> • If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 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	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ 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.</p>	OMB No. 1545-0074 2014
1 Your first name and middle initial _____ Last name _____		2 Your social security number _____
Home address (number and street or rural route) _____		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. ▶ <input type="checkbox"/>
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 2014, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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)



Instructions for 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

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. 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. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit www.justice.gov/crt/about/osc.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. 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.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. A citizen of the United States

2. A noncitizen national of the United States: 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.

3. A lawful permanent resident: A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

4. An alien authorized to work: If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

If you check this box:

a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CPB).

- (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).
- (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on www.uscis.gov/I-9Central before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include (1) the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and (2) the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

- a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents 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. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at www.uscis.gov/I-9Central for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 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. Also complete the "Signature of Employer or Authorized Representative" block.
3. Complete Block C if:
 - a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
 - b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

To complete Block C:

- a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
 - b. Record the document title, document number, and expiration date (if any).
4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no 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 "**USCIS Privacy Act Statement**" below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)*.

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at I-9Central@dhs.gov, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

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 the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at E-Verify@dhs.gov or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028**.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

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

USCIS Privacy Act Statement

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

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire 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.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: 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 employer will keep this form and make it 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.

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 35 minutes per response, including the time for reviewing instructions and completing and retaining 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 Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**



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 <i>(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.)</i>						
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: _____

**3-D Barcode
Do Not Write in This Space**

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):
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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:		<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>3-D Barcode Do Not Write in This Space</p> </div>		
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
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	
Last Name (Family Name)		First Name (Given Name)	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	Zip Code

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

A. New Name (if applicable) 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):
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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:
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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 		<ol style="list-style-type: none"> 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 <li style="text-align: center;">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 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (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.



Your Workers' Compensation Benefits

CALIFORNIA

This form should be given to all newly hired employees in the State of California. Its content applies to industrial injuries on or after January 1, 2013.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job, or are a victim of a workplace crime. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures to a harmful condition (such as hurting your wrist from doing the same motion over and over).

Workers' compensation benefits include:

Medical Care: Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. Physical therapy, occupational therapy and chiropractic visits may be limited to 24 each.

Temporary Disability Benefits: Payments if you lose wages while recovering. For most injuries after April 18, 2004, temporary disability benefits are limited to 104 weeks within 5 years from your date of injury. Filing a timely Employment Development Department claim may result in additional state disability benefits when TTD benefits are terminated, delayed or denied.

Permanent Disability Benefits: Payments if your injury causes a permanent disability. Once your injury stabilizes, your treating physician may find permanent disability, depending upon your level of recovery. The amount of permanent disability found by your doctor will be rated by your claims administrator according to your age and occupation in order to determine the percentage and corresponding dollar amount of permanent disability due. These amounts are set by state law. You have the right to obtain a state disability rating or appeal a rating.

Return to Work Program: If you experience a permanent earnings loss as a result of your injury and your permanent disability benefits are determined to be disproportionately low, you may qualify for additional monies from the Department of Industrial Relation's Return to Work Fund. Contact the Department of Industrial Relations at: www.dir.ca.gov/ to learn more about this additional benefit.

Supplemental Job Displacement Vouchers: If your injury causes you to miss time from work and results in permanent disability, you may receive a supplemental job displacement voucher if your employer has not offered modified, alternative or regular employment within 60 days of receipt of the doctor's medical report indicating you have made a maximum medical recovery. The voucher is for reimbursement of education-related costs and is capped at \$6,000.00. If you receive a voucher as a result of your injury, you have two years from the date you are furnished the voucher or five years from your date of injury (whichever occurs later), to request reimbursement for qualifying expenditures.

Death Benefits: Paid to dependents of a worker who dies from a work-related injury or illness. Burial expenses are also provided, with the maximum amount allowed dependent upon the date of injury.

Temporary disability, permanent disability, and death benefits are all payable at a rate based on 2/3 of your average weekly wage, and subject to state minimum and maximum amounts in effect on your date of injury. These benefits are paid every two weeks while you are eligible.

Voluntary, off duty, recreational, social or athletic activities may not be covered under workers' compensation.

If you get hurt:

Get Medical Care. If you need first aid, contact your employer. If you need emergency care, call for help immediately.

Report Your Injury. Report the injury immediately to your supervisor. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury, and must also authorize treatment within one working day after you have returned a signed and completed copy of the form. The statute of limitations for filing a workers' compensation claim is one year from the date of injury or, if resulting from repeated exposures, one year from when you realized or should have realized that your job caused the injury.

See Your Treating Physician. Your primary treating physician is the doctor with overall responsibility for treating your injury or illness. He or she is charged with maintaining the continuity of your care, as well as initiating referrals to specialists. If your employer has an approved Medical Provider Network (MPN), they may be able to limit your choices of treating physicians retain medical control, and require you to treat with an MPN physician from the onset. (An MPN is a selected network of healthcare providers who provide treatment to workers injured on the job. See your employer for more information on your MPN.) Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. If your employer does not have an approved MPN and you wish to change doctors in the first 30 days after reporting your claim, your claims administrator must select a new physician within five days of your request.

If you have provided your employer with the name of your personal physician before your injury and have group health insurance at the time of injury, you may see your personal physician for treatment even if your employer has an approved MPN. Your personal physician must be a general practitioner or a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, family practitioner, or multi-specialty medical group of doctors of medicine or osteopathy, and must have treated you and maintained your medical history and records before your work injury and must also agree to treat you for a work-related injury or illness. If your employer does not have an approved MPN and you gave your employer the name of your personal chiropractor or acupuncturist in writing before you were injured, you may switch to the chiropractor or acupuncturist upon request. If you still need medical care after 30 days, you may be able to switch to a doctor of your own choice.

For your convenience, optional forms to predesignate your personal physician or multi-specialty medical group of doctors of medicine or osteopathy are attached to this document. Also attached, are forms to predesignate your personal acupuncturist or chiropractor if your employer does not have a medical provider network in place. By law, chiropractors are not allowed to be the treating physician after 24 visits.

Discrimination: It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If your employer has been found to discriminate, you may be entitled to job reinstatement with back pay, increased compensation, and costs and expenses. You may also have additional rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-3362. You can get free information from a state Division of Workers' Compensation Information & Assistance Officer. Hear recorded information and a list of local offices by calling toll-free **(800) 736-7401** or learn more online at: <http://www.dir.ca.gov> .

If medical care is not being provided by your employer you have several options. First, contact your claims administrator to find out the status of your claim. If you have given your employer a completed and signed claim form but your claim has been delayed for investigation, your employer is still required to authorize treatment, up to \$10,000.00, during the delay. If the claim has not been accepted yet and your medical costs have exceeded the statutory \$10,000.00 cap, you can go to your group health plan for care, find a doctor, clinic or hospital that will bill the claims administrator directly, or use public health services.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it.

Your Workers' Compensation Insurance Company is **The Travelers Indemnity Company**.

You can also look up your insurance carrier at the WCIRB online lookup: <https://www.caworkcompcoverage.com/>

You can obtain free information from an Information and Assistance Officer of the state Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. A list of Information and Assistance offices can be found at the end of this pamphlet to help you locate the I&A office nearest you. You may also go to the DWC web site at: <http://www.dir.ca.gov> for further information.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at: <http://www.californiaspecialist.org>. You may get a list of attorneys from your local information and assistance officer or look in your yellow pages.

Predesignation of personal physician

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) or medical group if:

- you have group health coverage at the time of injury;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

Notice of predesignation of personal physician

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

(Name of Doctor, M.D., D.O., or medical group)

(Street address, city, state, zip code)

(Telephone number)

Employee Name (please print): _____

Employee's Address: _____

Employee's Signature _____ Date: _____

Physician: I agree to this Predesignation.

Signature: _____ Date: _____
(Physician or designated employee of the physician or medical group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Notice of personal chiropractor or personal acupuncturist

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist. By law, chiropractors are not allowed to be the treating physician after 24 visits.

Your Chiropractor or Acupuncturist's Information:

(Name of chiropractor or acupuncturist)

(Street address, city, state, zip code)

(Telephone number)

Employee Name (please print): _____

Employee's Address: _____

Employee's Signature _____ Date: _____

Contact the information & assistance unit

- By phone at 1-800-736-7401: For recorded information that helps injured workers, employers and others understand California's workers' compensation system, and their rights and responsibilities under the law.
- By attending a workshop for injured workers
- By calling or going in person to a local Information & Assistance Unit office:

<p>Anaheim 1065 N. Pacific Center Drive Anaheim 92806 (714) 414-1801</p>	<p>Oakland 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861</p>	<p>San Diego 7575 Metropolitan Drive, Suite 202 San Diego, CA 92102-4424 (619) 767-2082</p>
<p>Bakersfield 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514</p>	<p>Oxnard 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93030 (805) 485-3528</p>	<p>San Francisco 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020</p>
<p>Eureka 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723</p>	<p>Pomona 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568</p>	<p>San Jose 100 Paseo de San Antonio, Room 241 San Jose, CA 95113-1402 (408) 277-1292</p>
<p>Fresno 2550 Mariposa Mall, Room 2035 Fresno, CA 93721-2219 (559) 445-5355</p>	<p>Redding 2115 Civic Center Drive Room 15 Redding, CA 96001-2796 (530) 225-2047</p>	<p>San Luis Obispo 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159</p>
<p>Goleta 6755 Hollister Avenue, Room 100 Goleta, CA 93117-5551 (805) 968-4158</p>	<p>Riverside 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347</p>	<p>Santa Ana 605 W Santa Ana Blvd, Bldg 28 Room 451 Santa Ana, CA 92701 (714) 558-4597</p>
<p>Long Beach 300 Ocean Gate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240</p>	<p>Sacramento 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158</p>	<p>Santa Rosa 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452</p>
<p>Los Angeles 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389</p>	<p>Salinas 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058</p>	<p>Stockton 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980</p>
<p>Marina del Rey 4720 Lincoln Blvd 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820</p>	<p>San Bernardino 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522</p>	<p>Van Nuys 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367</p>



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This form complies with Labor Code requirements §3551, §3553, and Administrative Rule §9880, and has been approved by the Administrative Director of the Division of Workers' Compensation. This form cannot be altered.

CALIFORNIA

Este formulario debe entregarse a todos los empleados recién contratados en el estado de California. Su contenido se aplica a los accidentes de trabajo ocurridos a partir del 1 de enero de 2013.

Cualquier persona que haga o propicie que se haga cualquier declaración sustancial a sabiendas falsa o fraudulenta con el propósito de obtener o denegar beneficios o pagos de compensación laboral es culpable de un delito.

Usted puede tener derecho a beneficios de compensación laboral si resulta lesionado o se enferma a causa de su trabajo, o si es víctima de un delito en el lugar de trabajo. La compensación laboral cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un acontecimiento (como lastimarse la espalda en una caída) o por exposiciones repetidas a una circunstancia perjudicial (como lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Los beneficios de compensación laboral incluyen:

Atención médica: consultas médicas, servicios hospitalarios, fisioterapia, análisis de laboratorio, radiografías y medicamentos que sean razonablemente necesarios para tratar su lesión. No debe recibir nunca una factura. Es posible que las visitas para fisioterapia, terapia ocupacional y al quiropráctico tengan un límite de 24 visitas para cada tipo.

Beneficios por incapacidad temporal: Pagos si usted deja de recibir su salario mientras se recupera. Para la mayoría de las lesiones ocurridas después del 18 de abril de 2004, los beneficios por incapacidad temporal se limitan a 104 semanas dentro del lapso de 5 años a partir de la fecha de la lesión. Presentar de forma oportuna una reclamación en el Departamento de Desarrollo Laboral (*Employment Development Department*) puede conducir a la obtención de beneficios estatales adicionales por incapacidad cuando se terminan los beneficios por incapacidad total temporal (TTD, por sus siglas en inglés), o cuando estos se demoran o los deniegan.

Beneficios por incapacidad permanente: Pagos si su lesión causa una incapacidad permanente. Una vez que su lesión se estabilice, es posible que el médico que lo trata determine que usted tiene una incapacidad permanente, dependiendo de su grado de recuperación. La cantidad de incapacidad permanente que su médico determine será clasificada por su administrador de reclamaciones según su edad y ocupación con el fin de determinar el porcentaje y la cantidad correspondiente en dólares que se le debe a usted a causa de la incapacidad permanente. La ley estatal establece dichas cantidades. Usted tiene derecho a obtener una clasificación estatal de incapacidad o a apelar la clasificación.

Programa para reintegrarse al trabajo: Si usted sufre la pérdida permanente de sus ingresos como resultado de su lesión y se determina que sus beneficios por incapacidad permanente son desproporcionadamente bajos, es posible que usted califique para recibir dinero adicional del Fondo para la reintegración al trabajo del Departamento de Relaciones Laborales (*Department of Industrial Relations*). Comuníquese con el Departamento de Relaciones Laborales en: www.dir.ca.gov/ para conocer más acerca de este beneficio adicional.

Vales suplementarios por destitución laboral: Si su lesión conlleva a que usted falte a su trabajo y le causa una incapacidad permanente, usted puede recibir un vale suplementario por destitución laboral si su empleador no le ofrece un empleo modificado, alternativo o regular dentro de 60 días de haber recibido el informe médico que indique que usted logró una recuperación médica máxima. El vale es para reembolsar los costos educativos y tiene un límite de \$6,000.00. Si usted recibe un vale como consecuencia de su lesión, tiene dos años desde la fecha en que le proporcionen el vale o cinco años desde la fecha de su lesión (lo que ocurra último), para solicitar el reembolso de los gastos que califiquen.

Beneficios por muerte: Se pagan a los dependientes de un trabajador que muere a causa de una lesión o enfermedad laboral. También se cubren los gastos del entierro; la cantidad máxima permitida depende de la fecha de la lesión.

Los beneficios por incapacidad temporal, incapacidad permanente y muerte se pagan a una tasa basada en 2/3 de su salario semanal promedio, y están sujetos a las cantidades mínimas y máximas vigentes en el estado en la fecha de su lesión. Estos beneficios se pagan cada dos semanas mientras usted sea elegible.

Es posible que las actividades como voluntario, en sus horas libres, recreacionales, sociales o atléticas no estén cubiertas bajo la compensación laboral.

Si se lastima:

Obtenga atención médica. Si necesita primeros auxilios, comuníquese con su empleador. Si necesita atención urgente, pida ayuda de inmediato.

Informe sobre su lesión. Informe de inmediato a su supervisor sobre su lesión. No demore en hacerlo; existen límites de tiempo. Si espera demasiado, puede perder los derechos que tiene a recibir beneficios. Su empleador tiene que proporcionarle un formulario de reclamación a más tardar un día laborable después de que esté enterado de su lesión, y también debe autorizar el tratamiento a más tardar un día laborable después de que usted le entregue una copia del formulario lleno y firmado. El plazo de prescripción para presentar una reclamación de compensación laboral es de un año a partir de la fecha de la lesión o, si esta se debe a exposiciones repetidas, un año a partir del momento en que usted se dio cuenta o debió darse cuenta de que su trabajo causó la lesión.

Vea a su médico tratante. Su médico tratante primario es el médico con la responsabilidad global de tratar su lesión o enfermedad. Él o ella están a cargo de mantener la continuidad de su atención, así como de remitirlo a los especialistas. Si su empleador tiene una Red de Proveedores Médicos (MPN, por sus siglas en inglés) aprobada, es posible que ellos puedan limitar sus opciones de médicos tratantes, que retengan el control médico, y que le exijan que se atienda con un médico de la MPN desde el principio. (Una MPN es una red escogida de proveedores de atención médica que proveen tratamiento a los empleados que se lesionan en el trabajo. Consulte con su empleador para obtener más información sobre su MPN). De lo contrario, su empleador tiene el derecho de escoger el médico que lo tratará a usted por los primeros 30 días. Si su empleador no tiene una MPN aprobada y usted desea cambiar de médico en los primeros 30 días después de presentar su reclamación, su administrador de reclamaciones debe escoger un médico nuevo en un lapso de cinco días después de que usted lo solicite.

Si usted le proporcionó a su empleador el nombre de su médico personal antes de sufrir la lesión y tiene seguro médico de grupo al momento de la lesión, usted puede tratarse con su médico personal incluso si su empleador tiene una MPN aprobada. Su médico personal debe ser un médico general o un médico internista, pediatra, ginecobstetra o médico de familia con certificado de especialidad o que haya completado su especialidad, o un grupo médico con múltiples especialidades con doctores o licenciados en medicina, y debe haberlo tratado y tener sus antecedentes médicos y su historia clínica antes de su lesión laboral y también debe estar de acuerdo en tratarlo por una lesión o enfermedad laboral. Si su empleador no tiene una MPN aprobada y usted le dio a su empleador por escrito el nombre de su quiropráctico o acupunturista personal antes de sufrir la lesión, usted puede cambiarse al quiropráctico o acupunturista cuando lo solicite. Si todavía necesita recibir atención médica luego de 30 días, quizás pueda cambiarse a un médico de su propia elección.

Para mayor comodidad, se adjuntan a este documento formularios opcionales para predesignar a su médico personal o a un grupo médico con múltiples especialidades con doctores o licenciados en medicina. También se adjuntan formularios para predesignar a su acupunturista o quiropráctico personal si su empleador no cuenta con una red de proveedores médicos. Por ley, no se permite que los quiroprácticos sean el médico tratante luego de 24 visitas.

Discriminación: Es ilegal que su empleador lo castigue o lo despidan por sufrir una lesión o enfermedad laboral, por presentar una reclamación, o por testificar en el caso de compensación laboral de otra persona. Si se determina que su empleador ha cometido discriminación, usted puede tener derecho a que se le reincorpore a su puesto de trabajo con pagos retroactivos, una mayor compensación, y costos y gastos. Es posible que usted tenga otros derechos bajo la Ley de Protección para Personas Discapacitadas (ADA, por sus siglas en inglés) o la Ley de Igualdad en el Empleo y la Vivienda (FEHA, por sus siglas en inglés). Para obtener más información, comuníquese con FEHA al (800) 884-1684 o con la Comisión de Igualdad de Oportunidades Laborales (EEOC, por sus siglas en inglés) al (800) 669-3362. Puede obtener información gratuita de un funcionario de información y ayuda de la División de Compensación Laboral de su estado. Puede escuchar información grabada y una lista de las oficinas locales llamando sin costo al **(800) 736-7401** o averiguar más en línea en: <http://www.dir.ca.gov>.

Si su empleador no le proporciona atención médica, usted tiene varias opciones. Primero, comuníquese con su administrador de reclamaciones para averiguar el estado de su reclamación. Si le entregó a su empleador un formulario de reclamación lleno y firmado pero su reclamación está retrasada por la investigación, su empleador tiene que autorizar el tratamiento, hasta un máximo de \$10,000.00, durante el retraso. Si todavía no se ha aceptado la reclamación y sus costos médicos sobrepasan el límite reglamentario de \$10,000.00, usted puede acudir a su plan médico de grupo para recibir atención, buscar un médico, una clínica o un hospital que le facture directamente al administrador de reclamaciones, o utilizar los servicios públicos de atención médica.

Usted tiene derecho a estar en desacuerdo con las decisiones que afectan su reclamación. Si está en desacuerdo, comuníquese primero con su administrador de reclamaciones para ver si lo pueden resolver.

Su compañía de seguros de compensación laboral es **The Travelers Indemnity Company**.

También puede buscar su compañía de seguros en el directorio en línea de WCIRB: <https://www.caworkcompcoverage.com/>

Puede obtener información gratuita de un funcionario de Información y Ayuda de la División de Compensación Laboral de su estado, o puede escuchar información grabada y una lista de las oficinas locales llamando al **(800) 736-7401**. Al final de este folleto, encontrará una lista de las oficinas de Información y Ayuda. Esto lo ayudará a localizar la oficina más cerca de usted. Para más información, también puede visitar el sitio web del DWC en: <http://www.dir.ca.gov>.

Puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratuita. Si decide contratar un abogado, es posible que los honorarios se saquen de algunos de sus beneficios. Para obtener los nombres de los abogados especializados en compensación laboral, llame al Colegio de Abogados del estado de California al (415) 538-2120 o visite su sitio web en: <http://www.californiaspecialist.org>. El funcionario local de información y ayuda puede proporcionarle una lista de los abogados o usted puede buscarlos en las páginas amarillas.

Predesignación del médico personal

En caso de que sufra una lesión o enfermedad relacionada con su empleo, su médico (doctor (M.D.) o licenciado (D.O.) en medicina) personal o grupo médico pueden atenderlo si:

- usted tiene cobertura médica de grupo al momento de la lesión;
- el médico es su médico habitual, y debe ser un médico cuyo ejercicio de la medicina se limita a medicina general o que es un médico internista, pediatra, ginecobstetra o médico de familia con certificado de especialidad o que haya completado su especialidad, y que anteriormente haya estado a cargo de su tratamiento médico y tenga en su poder su historia clínica;
- su "médico personal" puede ser un grupo médico si se trata de una corporación con un solo miembro o una sociedad constituida por doctores o licenciados en medicina, que opere un grupo médico integrado con múltiples especialidades que brinde servicios médicos integrales predominantemente para enfermedades y lesiones que no sean de tipo laboral;
- antes de la lesión, su médico acepta tratarlo por lesiones o enfermedades laborales;
- antes de la lesión, usted le proporcionó a su empleador lo siguiente por escrito: (1) notificación de que usted desea que su médico personal lo trate por lesiones o enfermedades laborales, y (2) el nombre y la dirección del consultorio de su médico personal.

Puede usar este formulario para notificar a su empleador si desea que su médico o licenciado en medicina personal lo trate por una lesión o enfermedad laboral, siempre que se cumplan los requisitos anteriores.

Notificación de redesignación del médico personal

Empleado: Llene esta sección.

Para: _____ (nombre del empleador) Si sufro una lesión o enfermedad laboral, escojo ser atendido por:

(Nombre del médico, doctor en medicina, licenciado en medicina o grupo médico)

(Dirección, ciudad, estado, código postal)

(Número de teléfono) _____

Nombre del empleado (en letra de imprenta): _____

Dirección del empleado: _____

Firma del empleado _____ Fecha: _____

Médico: Estoy de acuerdo con esta redesignación.

Firma: _____ Fecha: _____
(Médico o empleado designado del médico o del grupo médico)

No se requiere que el médico firme este formulario, sin embargo, si el médico o el empleado designado del médico o del grupo médico no firma, se necesitará otra documentación de la aceptación del médico a ser redesignado, conforme al Capítulo 8, Código de Disposiciones Reglamentarias de California, apartado 9780.1(a)(3).

Notificación de quiropráctico personal o acupunturista personal

Si su empleador o la compañía de seguros de su empleador no tienen una Red de Proveedores Médicos, usted quizás pueda cambiar su médico tratante a su quiropráctico o acupunturista personal después de una lesión o enfermedad laboral. Para cumplir los requisitos para hacer este cambio, debe proporcionarle a su empleador, por escrito, el nombre y la dirección del consultorio de un quiropráctico o acupunturista personal antes de que ocurra la lesión o enfermedad. Por lo general, su administrador de reclamaciones tiene el derecho de escoger su médico tratante dentro de los primeros 30 días después de que su empleador esté enterado de su lesión o enfermedad. Luego de que su administrador de reclamaciones inicie su tratamiento con otro médico durante este período, usted podrá, previa solicitud, hacer que transfieran su tratamiento a su quiropráctico o acupunturista personal.

Usted puede utilizar este formulario para notificar a su empleador acerca de su quiropráctico o acupunturista personal. Por ley, no se permite que los quiroprácticos sean el médico tratante luego de 24 visitas.

Información de su quiropráctico o acupunturista:

(Nombre del quiropráctico o acupunturista)

(Dirección, ciudad, estado, código postal)

(Número de teléfono)

Nombre del empleado (en letra de imprenta): _____

Dirección del empleado: _____

Firma del empleado _____ Fecha: _____

Comuníquese con la unidad de información y ayuda

- Por teléfono al 1-800-736-7401: Para obtener información grabada que ayuda a los trabajadores lesionados, los empleadores y otras personas a entender el sistema de compensación laboral de California, y sus derechos y responsabilidades conforme a la ley.
- Asistiendo a un taller para trabajadores lesionados
- Llamando o yendo en persona a una oficina local de la Unidad de información y ayuda:

<p>Anaheim 1065 N. PacifiCenter Drive Anaheim 92806 (714) 414-1801</p>	<p>Oakland 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861</p>	<p>San Diego 7575 Metropolitan Drive, Suite 202 San Diego, CA 92102-4424 (619) 767-2082</p>
<p>Bakersfield 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514</p>	<p>Oxnard 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93030 (805) 485-3528</p>	<p>San Francisco 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020</p>
<p>Eureka 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723</p>	<p>Pomona 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568</p>	<p>San Jose 100 Paseo de San Antonio, Room 241 San Jose, CA 95113-1402 (408) 277-1292</p>
<p>Fresno 2550 Mariposa Mall, Room 2035 Fresno, CA 93721-2219 (559) 445-5355</p>	<p>Redding 2115 Civic Center Drive Room 15 Redding, CA 96001-2796 (530) 225-2047</p>	<p>San Luis Obispo 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159</p>
<p>Goleta 6755 Hollister Avenue, Room 100 Goleta, CA 93117-5551 (805) 968-4158</p>	<p>Riverside 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347</p>	<p>Santa Ana 605 W Santa Ana Blvd, Bldg 28 Room 451 Santa Ana, CA 92701 (714) 558-4597</p>
<p>Long Beach 300 OceanGate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240</p>	<p>Sacramento 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158</p>	<p>Santa Rosa 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452</p>
<p>Los Angeles 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389</p>	<p>Salinas 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058</p>	<p>Stockton 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980</p>
<p>Marina del Rey 4720 Lincoln Blvd 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820</p>	<p>San Bernardino 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522</p>	<p>Van Nuys 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367</p>



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Este formulario cumple con los requisitos §3551, §3553, y el Reglamento Administrativo §9880 del Código Laboral, y fue aprobado por el Director Administrativo de la División de Compensación Laboral. Este formulario no puede modificarse.



UNIVERSITY OF LAVERNE

MEMORANDUM

DATE: July 1, 2013
TO: All New ULV Employees
FROM: Human Resources
SUBJECT: Workers' Compensation Benefits

The University of La Verne insures you for job-related injury or illness through the California Workers' Compensation program. If you are injured at work, you should immediately report that injury to your supervisor and the Human Resources Department (909) 593-3511, ext. 4076 so that necessary medical treatment can be arranged and other benefits can be provided as appropriate.

I acknowledge that I have read and understand the above. I understand that I am to report any job-related injury or illness immediately to my supervisor and the Human Resources Department. If medical attention is necessary, I am to request it from my supervisor and/or the Human Resources Department and I will be sent to a physician. I may request to be treated by my private physician for any job-related injury/illness. I understand that this request must be made in writing and on file in the Human Resources Department prior to a job-related injury/illness. If I go to a physician not authorized by the University, it will be at my own expense.

Name: _____ ID#: _____

Signature: _____ Date: _____



UNIVERSITY OF LAVERNE

Work Related Injury/Illness Procedure

For Serious or Life Threatening Injuries CALL 911 Immediately

REPORT INJURY/ILLNESS WITHIN 24 HOURS TO SUPERVISOR & HR

EMPLOYEE

- Report work related injury/illness to Supervisor immediately.
- If injury is during regular work hours contact HR to obtain the Workers' Compensation Claim form (DWC-1). An HR Team member will assist you with filing out the DWC-1 and provide referral to clinic if necessary.
- If injury is after regular work hours contact Campus Safety at 6666 or (909) 608-4903 to report injury/illness and to receive referral to clinic if necessary. Follow up with HR next business day.

SUPERVISOR

- Contact HR at (909) 448-4076 to provide information relating to the injury.
- If injury is during regular work hours send employee to the Office of HR immediately to complete paperwork and receive referral to clinic is necessary.
- If injury is after regular work hours contact Campus Safety at 6666 or (909) 608-4903 to report injury/illness and receive referral to clinic if necessary. Follow up with HR next business day.

Does Employee Want to Seek Medical Treatment?

YES

NO

For serious or life threatening emergencies call 911.

- If injury is during regular work hours please contact HR at (909) 448-4076 to report injury/illness and referral slip to the clinic.
- If injury is after regular work hours please contact Campus Safety at 6666 from a campus phone or (909) 608-4903 for after hour's clinic information.

- Supervisor & Employee will still need to contact HR to fill out proper paperwork for record keeping purposes.
- All claims made to a Supervisor by the Employee will be followed up by an HR Team member.
- Employee will need to sign release of claim.

During Regular Work Hours Clinic:

US HealthWorks
 Hours of Operation: 7:30am- 6:00pm
 801 Corporate Center Dr. Ste 130
 Pomona, Ca 91768
 (909) 623-1954

**Employee will need referral slip from HR*

After Regular Work Hours Clinic Options:

**US HealthWorks
 Medical Group of CA**
 6520 N Irwindale Ave Ste 100
 Irwindale, CA 91702
 (626) 812-0366

**San Antonio
 Community Hospital**
 999 San Bernardino Rd
 Upland, CA 91786
 (909) 985-2811

**Doctors Hospital of
 West Covina**
 725 S Orange Ave
 West Covina, CA 91790
 (626) 338-8481

Office of Human Resources

1950 Third Street* La Verne, California 91750* (909) 448-4076* Fax (909) 392-2791

lavernehr@laverne.edu

UNIVERSITY OF LA VERNE DEFINED CONTRIBUTION RETIREMENT PLAN

Investment Options Comparative Chart

Your plan allows you to direct how your contributions are invested. When making investment decisions, you should keep in mind how long you have until retirement, your tolerance for risk, how this retirement plan fits into your overall financial picture, and the impact of fees. The information on the following pages will help you compare investments that align with your retirement goals.

Part I consists of performance and fee information for plan investment options. This part shows you how well the investments have performed in the past as well as any fees and expenses you will pay if you invest in an option.

Part II contains information about the annuity options available within your employer's retirement plan.

For more information on the impact of fees and expenses to your plan, refer to the Summary of Plan Services and Costs or visit the DOL's website at [dol.gov/ebsa/publications/401k_employee.html](https://www.dol.gov/ebsa/publications/401k_employee.html). Fees are only one of many factors to consider when making an investment decision.



Part I. Performance and Fee Information

The following chart lists your plan's investment options and the performance of these options can vary based on market fluctuations. When evaluating performance of variable investment returns, you should consider comparing the returns of each investment to an appropriate benchmark, which is provided below. A benchmark is a generally accepted unmanaged group of securities whose performance is used as a standard point of reference to measure and compare investment gains or losses for variable return investments. Keep in mind that you may not invest in the benchmark indices which are shown for comparative purposes only. For investments that use a blend of stocks and bonds to limit risk, such as Target Date or Multi-asset funds, a difference from the benchmark may be due to a difference in the proportion of stocks to bonds in the fund when compared to the benchmark. Benchmark information for fixed-return investments is not provided in this chart. Past performance does not indicate how an investment will perform in the future.

TIAA-CREF

Access the most up-to-date information about your investment options online at tiaa-cref.org/planinvestmentoptions, enter your plan ID, 103491, and you'll be directed to plan and investment information.

Visit tiaa-cref.org for information and resources to help you make informed decisions. To request additional plan information or a paper copy of information available online, free of charge, contact TIAA-CREF at 800 842-2252 or write to us at TIAA-CREF, P.O. Box 1259, Charlotte, NC, 28201.

Table 1 – Variable Return Investments as of June 30, 2013

TIAA-CREF				Average Annual Total Returns/Benchmark				Total Annual Operating Expenses				Shareholder Type Fees	Restrictions
								Gross		Net			
Investment Name / Benchmark	Morningstar Category	Ticker Symbol	Inception Date	1 yr.	5 yr.	10 yr.	Since Inception	%	Per \$1000	%	Per \$1000		
Equities													
Variable Annuity													
CREF Equity Index Account	Large Blend	CEQX#	04/29/1994	20.99%	6.87%	7.39%	8.64%	0.42%	\$4.20	0.42%	\$4.20		Round Trip: If a round trip is made within 60 days, exchanges into the same account will be restricted for 90 days.
				<i>Russell 3000 Index</i>	21.46%	7.25%	7.81%	9.00%					
CREF Stock Account	Large Blend	CSTK#	07/31/1952	18.74%	4.73%	7.35%	9.78%	0.49%	\$4.90	0.49%	\$4.90		Round Trip: If a round trip is made within 60 days, exchanges into the same account will be restricted for 90 days.
				<i>Russell 3000 Index</i>	21.46%	7.25%	7.81%	N/A					

TIAA-CREF				Average Annual Total Returns/Benchmark				Total Annual Operating Expenses				Shareholder Type Fees	Restrictions
								Gross		Net			
Investment Name / Benchmark	Morningstar Category	Ticker Symbol	Inception Date	1 yr.	5 yr.	10 yr.	Since Inception	%	Per \$1000	%	Per \$1000		
CREF Growth Account	Large Growth	CGRW#	04/29/1994	16.73%	6.41%	6.79%	7.10%	0.46%	\$4.60	0.46%	\$4.60	Round Trip: If a round trip is made within 60 days, exchanges into the same account will be restricted for 90 days.	
<i>Russell 1000 Growth Index</i>				17.07%	7.47%	7.40%	8.13%						
CREF Global Equities Account	World Stock	CGLB#	05/01/1992	18.64%	2.74%	7.19%	7.24%	0.53%	\$5.30	0.53%	\$5.30	Round Trip: If a round trip is made within 60 days, exchanges into the same account will be restricted for 90 days.	
<i>MSCI World Index</i>				18.58%	2.70%	7.25%	6.98%						
Fixed Income													
Variable Annuity													
CREF Inflation-Linked Bond Account	Inflation-Protected Bond	CILB#	05/01/1997	-5.20%	3.89%	4.69%	6.02%	0.44%	\$4.40	0.44%	\$4.40	Round Trip: If a round trip is made within 60 days, exchanges into the same account will be restricted for 90 days.	
<i>Barclays U.S. Treasury Inflation Protected Securities (TIPS) Index (Series-L)</i>				-4.78%	4.41%	5.19%	6.45%						
CREF Bond Market Account	Intermediate-Term Bond	CBND#	03/01/1990	-0.53%	4.74%	4.05%	6.41%	0.44%	\$4.40	0.44%	\$4.40	Round Trip: If a round trip is made within 60 days, exchanges into the same account will be restricted for 90 days.	
<i>Barclays U.S. Aggregate Bond Index</i>				-0.69%	5.19%	4.52%	6.74%						
Money Market													
Variable Annuity													
CREF Money Market Account	Money Market-Taxable	CMMA#	04/01/1988	0.00%	0.24%	1.63%	3.78%	0.41%	\$4.10	0.41%	\$4.10		
7-day current annualized yield 0.00% as of 25-JUN-13 7-day effective annualized yield 0.00% as of 25-JUN-13 <i>iMoneyNet Money Fund Report Averages-All Taxable</i>				0.02%	0.21%	1.51%	3.50%						
Multi-Asset													
Variable Annuity													

TIAA-CREF				Average Annual Total Returns/Benchmark				Total Annual Operating Expenses				Shareholder Type Fees	Restrictions
								Gross		Net			
Investment Name / Benchmark	Morningstar Category	Ticker Symbol	Inception Date	1 yr.	5 yr.	10 yr.	Since Inception	%	Per \$1000	%	Per \$1000		
CREF Social Choice Account	Moderate Allocation	CSCCL#	03/01/1990	13.03%	6.07%	6.18%	8.46%	0.45%	\$4.50	0.45%	\$4.50		Round Trip: If a round trip is made within 60 days, exchanges into the same account will be restricted for 90 days.
<i>Russell 3000 Index</i>				21.46%	7.25%	7.81%	9.48%						
Real Estate													
Variable Annuity													
TIAA Real Estate Account	N/A	TREA#	10/02/1995	8.61%	-1.96%	4.73%	N/A	0.90%	\$9.00	0.90%	\$9.00		Transfers out: Limit 1 per quarter. Limitations may apply to any transaction resulting in a balance > \$150,000.
<i>S&P 500 Index</i>				20.60%	7.01%	7.30%	N/A						

FIDELITY INVESTMENTS

To request additional plan information from this service provider or a paper copy of information available online, free of charge, contact:

Fidelity Investments

PO Box # 770003

Cincinnati, OH 45277-0065

1 800-343-0860

<http://mv.participantdisclosure.com> (Password: 95482)

Table 1 – Variable Return Investments as of June 30, 2013

FIDELITY INVESTMENTS				Average Annual Total Returns/Benchmark				Total Annual Operating Expenses				Shareholder Type Fees	Restrictions
								Gross		Net			
Investment Name / Benchmark	Morningstar Category	Ticker Symbol	Inception Date	1 yr.	5 yr.	10 yr.	Since Inception	%	Per \$1000	%	Per \$1000		
Allocation													
Mutual Fund													
Janus Balanced I	Moderate Allocation	JBALX	07/06/2009	14.95%	N/A	N/A	11.79%	0.69%	\$6.90	0.69%	\$6.90		

FIDELITY INVESTMENTS				Average Annual Total Returns/Benchmark				Total Annual Operating Expenses				Shareholder Type Fees	Restrictions
								Gross		Net			
Investment Name / Benchmark	Morningstar Category	Ticker Symbol	Inception Date	1 yr.	5 yr.	10 yr.	Since Inception	%	Per \$1000	%	Per \$1000		
S&P 500 TR USD				20.60%	7.01%	7.30%	18.18%						
First Eagle Global A	World Allocation	SGENX	04/28/1970	11.91%	6.66%	11.33%	12.08%	1.15%	\$11.50	1.15%	\$11.50		
MSCI World NR USD				18.58%	2.70%	7.25%	8.79%						
Equities													
Mutual Fund													
DFA Emerging Markets Value Portfolio Institutional	Diversified Emerging Mkts	DFEVX	04/01/1998	2.07%	-0.36%	16.01%	12.01%	0.61%	\$6.10	0.61%	\$6.10		
MSCI Emerging Markets Index				2.87%	-0.43%	13.66%	N/A						
American Funds EuroPacific Growth Fund R4	Foreign Large Blend	RESEX	06/07/2002	15.49%	1.12%	9.54%	7.78%	0.85%	\$8.50	0.85%	\$8.50		
MSCI All Country World Excluding-U.S. Index (GR)				14.14%	-0.34%	9.09%	7.63%						
Oakmark International Fund I	Foreign Large Blend	OAKIX	09/30/1992	34.59%	9.92%	11.08%	10.59%	1.06%	\$10.60	1.06%	\$10.60		
MSCI World Ex-U.S. Index				17.07%	-0.84%	7.86%	6.08%						
Janus Overseas T	Foreign Large Growth	JAOSX	05/02/1994	8.65%	-3.66%	10.76%	9.49%	0.76%	\$7.60	0.76%	\$7.60		
MSCI ACWI Ex USA NR USD				13.63%	-0.80%	8.62%	N/A						
Scout International	Foreign Large Growth	UMBWX	09/14/1993	16.86%	1.80%	9.59%	8.67%	1.00%	\$10.00	1.00%	\$10.00		
MSCI EAFE NR USD				18.62%	-0.63%	7.67%	4.79%						
Parnassus Equity Income - Inv	Large Blend	PRBLX	09/01/1992	23.76%	8.88%	8.74%	10.30%	0.90%	\$9.00	0.90%	\$9.00		
S&P 500 TR USD				20.60%	7.01%	7.30%	8.84%						
Vanguard Dividend Growth Fund Investor	Large Blend	VDIGX	05/15/1992	19.65%	8.64%	9.21%	7.78%	0.29%	\$2.90	0.29%	\$2.90		
Russell 1000 Index				21.24%	7.12%	7.67%	9.02%						
Fidelity Contrafund	Large Growth	FCNTX	05/17/1967	16.79%	5.98%	9.88%	12.28%	0.74%	\$7.40	0.74%	\$7.40		
S&P 500 TR USD				20.60%	7.01%	7.30%	N/A						
American Century Equity Income Fund Investor	Large Value	TWEIX	08/01/1994	18.03%	7.77%	7.69%	10.71%	0.95%	\$9.50	0.95%	\$9.50		
Russell 3000 Value Index				25.28%	6.83%	7.90%	9.53%						
Fidelity Low-Priced Stock	Mid-Cap Blend	FLPSX	12/27/1989	27.05%	9.80%	11.30%	14.35%	0.88%	\$8.80	0.88%	\$8.80	Redemption Fee: 1.50% if held < 90 days	
Russell 2000 TR USD				24.21%	8.77%	9.53%	9.40%						
Meridian Growth	Mid-Cap Growth	MERDX	08/01/1984	15.54%	12.07%	10.66%	12.63%	0.85%	\$8.50	0.85%	\$8.50	Redemption Fee: 2.00% if	

FIDELITY INVESTMENTS				Average Annual Total Returns/Benchmark				Total Annual Operating Expenses				Shareholder Type Fees	Restrictions
								Gross		Net			
Investment Name / Benchmark	Morningstar Category	Ticker Symbol	Inception Date	1 yr.	5 yr.	10 yr.	Since Inception	%	Per \$1000	%	Per \$1000		
<i>Russell 2000 TR USD</i>				24.21%	8.77%	9.53%	10.03%					held < 60 days	
Neuberger Berman Genesis Fund Advisor <i>Russell 2000 Index</i>	Mid-Cap Growth	NBGAX	04/02/1997	19.49%	4.85%	10.90%	11.53%	1.38%	\$13.80	1.38%	\$13.80		
Cohen & Steers Realty Shares <i>FTSE NAREIT All Equity REITs Index</i>	Real Estate	CSRSX	07/02/1991	8.06%	8.11%	11.87%	12.23%	1.00%	\$10.00	1.00%	\$10.00		
Royce Special Equity Fund Investment <i>Russell 2000 Index</i>	Small Blend	RYSEX	05/01/1998	22.34%	11.67%	9.85%	9.69%	1.15%	\$11.50	1.15%	\$11.50	Redemption Fee: 1.00% if held < 180 days	
Vanguard Small-Cap Growth Index Fund Investor <i>CRSP US Small Cap Growth TR USD</i>	Small Growth	VISGX	05/21/1998	24.15%	9.72%	11.13%	8.00%	0.24%	\$2.40	0.24%	\$2.40		
Heartland Value Plus <i>Russell 2000 Value TR USD</i>	Small Value	HRVIX	10/26/1993	16.82%	7.12%	11.05%	11.00%	1.09%	\$10.90	1.09%	\$10.90	Redemption Fee: 2.00% if held < 10 days	
Mutual Global Discovery Fund A <i>S&P 500 Index</i>	World Stock	TEDIX	11/01/1996	19.29%	5.79%	10.19%	9.82%	1.32%	\$13.20	1.32%	\$13.20		
Oakmark Global Fund I <i>MSCI World Index (NR USD)</i>	World Stock	OAKGX	08/04/1999	28.16%	6.23%	10.06%	10.93%	1.16%	\$11.60	1.16%	\$11.60		
Fixed Income													
Mutual Fund													
PIMCO Real Return Fund A <i>Barclays U.S. Treasury Inflation Protected Securit</i>	Inflation-Protected Bond	PRTNX	01/29/1997	-5.27%	4.66%	5.13%	6.58%	0.87%	\$8.70	0.85%	\$8.50		
Fidelity GNMA Fund <i>Barclays GNMA TR USD</i>	Intermediate Government	FGMNX	11/08/1985	-1.74%	5.36%	4.73%	6.75%	0.45%	\$4.50	0.45%	\$4.50		
PIMCO GNMA Fund Institutional <i>Barclays U.S. GNMA Bond Index</i>	Intermediate Government	PDMIX	07/31/1997	-1.52%	5.75%	5.27%	6.30%	0.50%	\$5.00	0.50%	\$5.00		
Metropolitan West Total Return Bond Fund I <i>Barclays U.S. Aggregate Bond Index</i>	Intermediate-Term Bond	MWTIX	03/31/2000	4.76%	8.68%	6.99%	7.15%	0.41%	\$4.10	0.41%	\$4.10		

FIDELITY INVESTMENTS				Average Annual Total Returns/Benchmark				Total Annual Operating Expenses				Shareholder Type Fees	Restrictions
								Gross		Net			
Investment Name / Benchmark	Morningstar Category	Ticker Symbol	Inception Date	1 yr.	5 yr.	10 yr.	Since Inception	%	Per \$1000	%	Per \$1000		
PIMCO Total Return Fund Institutional <i>Barclays U.S. Aggregate Bond Index</i>	Intermediate-Term Bond	PTTRX	05/11/1987	1.20%	7.26%	5.97%	8.06%	0.46%	\$4.60	0.46%	\$4.60		
				-0.69%	5.19%	4.52%	6.97%						
Fidelity Strategic Income <i>BofAML US HY Master II Constnd TR USD</i>	Multisector Bond	FSICX	05/01/1998	3.77%	7.68%	7.13%	7.14%	0.70%	\$7.00	0.70%	\$7.00		
				9.55%	10.70%	8.75%	6.86%						
Oppenheimer International Bond A <i>Citi WGBI NonUSD USD</i>	World Bond	OIBAX	06/15/1995	0.95%	3.99%	7.74%	8.56%	1.02%	\$10.20	1.02%	\$10.20		
				-5.72%	2.55%	4.78%	4.50%						
Templeton Global Bond Fund A <i>Citi World Government Bond Index USD</i>	World Bond	TPINX	09/18/1986	7.66%	9.35%	8.97%	8.25%	0.91%	\$9.10	0.90%	\$9.00		
				-4.50%	3.04%	4.70%	6.74%	Contractual Waiver	Exp: 04/30/2014				
Money Market													
Mutual Fund													
Fidelity Cash Reserves <i>USTREAS T-Bill Auction Ave 3 Mon</i>	Money Market-Taxable	FDRXX	05/10/1979	0.01%	0.39%	1.76%	5.43%	0.38%	\$3.80	0.38%	\$3.80		
				0.09%	0.20%	1.69%	5.31%						
Multi-Asset													
Mutual Fund													
Vanguard Wellington Fund Admiral <i>S&P 500 Index</i>	Moderate Allocation	VWENX	05/14/2001	15.00%	7.31%	8.30%	6.99%	0.17%	\$1.70	0.17%	\$1.70		
				20.60%	7.01%	7.30%	4.12%						

Table 1 shows fee and expense information for the investment options listed including the Total Annual Operating Expenses expressed as a percentage and a dollar amount based upon a \$1,000 accumulation both as net and gross of expenses. Total Annual Operating Expenses is a measure of what it costs to operate an investment, expressed as a percentage of its assets, as a dollar amount or in basis points. These are costs the investor pays through a reduction in the investment's rate of return.

Table 2 – Fixed Return Investments

TIAA-CREF			
Name/Type/Option	Return	Term	Additional Information
Guaranteed Annuity			
TIAA Traditional-Group Retirement Annuity	3.40%	Through 02/28/2014	The current rate shown applies to premiums remitted during the month of July 2013 and will be credited through 2/28/2014. This rate is subject to change in subsequent months. Up to date rate of return information is available on your plan-specific website noted above or at 800 842-2733. TIAA Traditional guarantees your principal and a minimum annual interest rate. The guaranteed minimum interest rate is 3.00%, and is effective while the funds remain in the contract. The account also offers the opportunity for additional amounts in excess of the guaranteed minimum interest rate. When declared, additional amounts remain in effect for the twelve-month period that begins each March 1. Subject to the terms of your plan, lump-sum withdrawals are available within 120 days after termination of employment and are subject to a 2.5% surrender charge. All other withdrawals and transfers must be spread over ten annual installments (over five years for withdrawals after termination of employment).
TIAA Traditional-Retirement Annuity	3.40%	Through 02/28/2014	The current rate shown applies to premiums remitted during the month of July 2013 and will be credited through 2/28/2014. This rate is subject to change in subsequent months. Up to date rate of return information is available on your plan-specific website noted above or at 800 842-2733. TIAA Traditional guarantees your principal and a minimum annual interest rate. The guaranteed minimum interest rate is 3.00%, and is effective while the funds remain in the contract. The account also offers the opportunity for additional amounts in excess of the guaranteed minimum interest rate. When declared, additional amounts remain in effect for the twelve-month period that begins each March 1. Subject to the terms of your plan, once your TIAA Traditional balance exceeds \$2,000 withdrawals and transfers out must be spread out in ten annual installments.

Part II. Annuity Information

The information below focuses on the annuity options under the plan. Annuities are insurance contracts that allow you to receive a guaranteed stream of payments at regular intervals, usually beginning when you retire and lasting for your entire life. Annuities are issued by insurance companies. Guarantees of an insurance company are subject to its long-term financial strength and claims-paying ability.

TIAA-CREF

TIAA Traditional Annuity Lifetime Income Option

Objectives / Goals:

To provide a guaranteed stable stream of income for your life and, if you choose, the life of an annuity partner. A TIAA Traditional Annuity provides income stability by providing a minimum guaranteed interest rate as well as the potential for additional interest. TIAA Traditional can be part of a diversified retirement portfolio that may include stocks (equities), bonds (fixed income), real estate, and money market investments. Electing a life annuity is just one of many payout options available under the TIAA Traditional Annuity.

Pricing Factors:

The amount of your lifetime income is dependent upon many factors including:

- The type of annuity selected (single life, joint life, with or without guaranteed minimum periods), and your selection of either the standard or graded benefit method.
- The amount of accumulations converted to a life annuity.
- Your age and, if applicable, the age of your annuity partner.
- The projected returns of the TIAA Traditional Annuity.

Under no circumstances will you receive less than the guaranteed amount of income required under the annuity contracts. To learn more about investments that offer lifetime annuity income, please access the web link provided in Part I.

Restrictions / Fees:

- You may not begin a one-life annuity after you attain age 90, nor may you begin a two-life annuity after you or your annuity partner attains age 90.
- Subject to contract terms, if your accumulation is less than \$5,000 on your annuity starting date, TIAA may choose instead to pay your accumulations to you in a single sum.

- If your TIAA annuity payment would be less than \$100, TIAA has the right to change the payment frequency which would result in a payment of \$100 or more.
- Once you have elected a lifetime annuity, your election is irrevocable.

TIAA Real Estate and CREF Variable Annuity Lifetime Income Options

Objectives / Goals:

To provide a variable stream of income for your life and, if you choose, the life of an annuity partner. This lifetime annuity provides a variable income that you cannot outlive. A variable annuity can be part of a diversified retirement portfolio that may include guaranteed, stocks (equities), bonds (fixed income), real estate, and money market investments. Electing a life annuity is just one of many payout options available.

Pricing Factors:

The amount of your lifetime income is dependent upon many factors including:

- The type of annuity selected (single life, joint life, with or without guaranteed minimum periods)
- The amount of accumulations converted to a life annuity.
- Your age and, if applicable, the age of your annuity partner.
- The investment performance of the variable annuity account your annuity is based upon.

Variable annuity accounts don't guarantee a minimum income. Income fluctuates based on market performance and is directly tied to the accounts investment returns. A 4% annual investment return is assumed. Generally, if the actual return in a given year is greater than 4% the amount of annuity income will increase; if it is less than 4%, the income will decrease. To learn more about investments that offer lifetime annuity income, please access the web link provided in Part I.

Restrictions / Fees:

- You may not begin a one-life annuity after you attain age 90, nor may you begin a two-life annuity after you or your annuity partner attains age 90.
- Subject to contract terms, if your accumulation is less than \$5,000 on your annuity starting date, TIAA-CREF may choose instead to pay your accumulations to you in a single sum.
- If your annuity payment would be less than \$100, TIAA-CREF has the right to change the payment frequency which would result in a payment of \$100 or more.
- Once you have elected a lifetime annuity, your election is irrevocable.

Please visit tiaa-cref.org/public/support/help/glossary/index.html for a glossary of investment terms relevant to the investment options under this plan.

Fees and expenses are only one of many factors to consider when you decide to invest in an option. You may also want to think about whether an investment in a particular option, along with your other investments, will help you achieve your financial goals. The cumulative effect of fees and expenses can substantially reduce the growth of your retirement savings. Visit the Department of Labor's website for an example showing the long-term effect of fees and expenses at dol.gov/ebsa/publications/401k_employee.html.

The returns quoted represent past performance, which is no guarantee of future results. Returns and the principal value of your investment will fluctuate. Current performance may be higher or lower than that shown, and you may have a gain or a loss when you redeem your investments. Expense ratios shown are based on the most recent information available, but may not reflect all updates. Please consult the most recent prospectus or offering document for more detailed information.

If a variable return investment option includes performance for periods beyond its inception date that performance is based on the performance of an older share class of the investment option. Such performance has not been restated to reflect expense differences between the two classes. If expense differences had been reflected, performance for these periods would be lower or higher than stated.

TIAA-CREF provides information on restrictions on record kept investment options, as well as performance and product information for all proprietary investment options. TIAA-CREF assumes no responsibility for damages or losses arising from the use of such information, and has not independently verified the accuracy or completeness of such information.

Data Provided by Morningstar, Inc. © 2013 Morningstar, Inc. All Rights Reserved. The information contained herein: (1) is proprietary to Morningstar and/or its content providers; (2) may not be copied or distributed; and (3) is not warranted to be accurate, complete or timely. Neither Morningstar nor its content providers are responsible for any damages or losses arising from any use of this information. Neither TIAA nor its affiliates has independently verified the accuracy or completeness of this information.

The Morningstar Category classifies an investment option based on its investment style as measured by underlying portfolio holdings (portfolio statistics and compositions over the past three years). If the investment option is new and has no portfolio, Morningstar estimates where it will fall before assigning a more permanent category. When necessary, Morningstar may change a category assignment based on current information.

There are inherent risks in investing in variable return investments including loss of principal. Please read the prospectus and carefully consider the investment objectives, risks, charges and expenses before investing.

UNIVERSITY OF LA VERNE DEFINED CONTRIBUTION RETIREMENT PLAN

Summary of Plan Services and Costs

This summary provides important information to assist you in making decisions related to your participation in the UNIVERSITY OF LA VERNE DEFINED CONTRIBUTION RETIREMENT PLAN. Your participation in the plan is the first step to ensuring adequate retirement income. Although no action is required at this time, please review this information and refer to it when managing your account.

Your plan allows you to direct how contributions are invested. When making investment decisions, you should keep in mind how long you have until retirement, your tolerance for risk, how this retirement plan fits into your overall financial goals, and the impact of fees. Your plan offers a range of investment options available from the following service providers:

- TIAA-CREF
- Fidelity Investments

TIAA-CREF

Right to Direct Investments

You may specify how your future contributions to the retirement plan are invested or make changes to existing investments in your plan as described in the Summary Plan Document. These changes can be made:

1. Online by visiting tiaa-cref.org
2. By phone at **800 842-2252** available Monday – Friday, 8 a.m. to 10 p.m. and Saturday, 9 a.m. to 6 p.m. (ET)

Restrictions

Changes to existing investments usually take place at the close of the business day if a change is requested prior to 4:00 p.m. (ET). Refer to the Investment Options Comparative Chart for investment-specific restrictions.

Additional Rights and Privileges

Certain investments that you may hold may give you the opportunity to vote on proposals. If and when such opportunities arise, you will receive a notice with the instructions on how to take advantage of what is being offered.

Your Statement of Plan Services and Costs

Investment Options

A variety of investment options are available in the plan. A current list of investment options and detailed descriptions of each one is available online at tiaa-cref.org/planinvestmentoptions, enter your plan ID, 103491, and you'll be directed to plan and investment information. The investment options available as of the date of this summary include:

- CREF Bond Market Account
- CREF Equity Index Account
- CREF Global Equities Account
- CREF Growth Account
- CREF Inflation-Linked Bond Account
- CREF Money Market Account
- CREF Social Choice Account
- CREF Stock Account
- TIAA Real Estate Account
- TIAA Traditional Annuity

Cost of Plan Services

There are three categories of services provided to your plan:

1. General Administrative Services

General administrative services include recordkeeping, legal, accounting, consulting, investment advisory and other plan administration services. Some of the expenses for general administrative services are fixed and other expenses such as legal or accounting may vary from year to year. These costs are allocated to each participant in a uniform way.

Other than your specific investment services fees, your plan has no additional administrative expenses paid to TIAA-CREF.

2. Specific Investment Services

Each investment offered within the plan charges a fee for managing the investment and for associated services. This is referred to as the expense ratio and is paid by all participants in that investment in proportion to the amount of their investment. The specific expense ratio for each plan designated investment option is listed in the Investment Options Comparative Chart.

3. Personalized Services

Personalized services provide access to a number of plan features and investments that you pay for, only if you use them. The personalized services used most often are:

• Retirement plan loan	The cost to you based upon the difference between what you earn on collateral and what you pay in interest
• Qualified domestic relations orders	No charge
• Sales charge for certain investments	None
• Purchase, withdrawal, and redemption fees for certain investments	Varies, see prospectus

Your Statement of Plan Services and Costs

A prospectus for each TIAA-CREF investment offered within the plan is available online at tiaa-cref.org/planinvestmentoptions, enter your plan ID, 103491, and you'll be directed to plan and investment information.

Variable return investments (mutual funds and/or variable annuities) are offered through your plan sponsor's retirement plan. Funds are offered at that day's net asset value (NAV), and the performance is displayed accordingly. Performance at NAV does not reflect sales charges, which are waived through your retirement plan. If included, the sales charges would have reduced the performance as quoted.

There are inherent risks in investing in variable return investments including loss of principal.

Please read the prospectus and carefully consider the investment objectives, risks, charges and expenses before investing.

Fidelity Investments

Right to Direct Investments

You have the right to direct your account balance, and any future contributions, among the Plans investment options, subject to any restrictions. Your rights under the Plan, and any restrictions, are subject to the terms of the Plan.

Restrictions

Any frequent trading restrictions imposed by the Plan and/or by the Plans investment options are listed in Investment Options Comparative Chart Section of this brochure. Keep in mind, restrictions are subject to change.

Additional Rights and Privileges

You have the right to exercise voting, tender, and similar rights related to the following investments you may have in your Plan account:

Mutual Funds

Investment Options

American Century Investments Equity Income Fund Investor Class
American Funds EuroPacific Growth Fund Class R-4
Cohen & Steers Realty Shares Fund
DFA Emerging Markets Value Portfolio Institutional Class
Fidelity Contrafund
Fidelity Low-Priced Stock Fund
Heartland Value Plus Fund
Janus Overseas Fund Class T
Meridian Growth Fund
Mutual Global Discovery Fund Class A
Neuberger Berman Genesis Fund Advisor Class
Oakmark Global Fund Class I
Oakmark International Fund Class I
Parnassus Equity Income Fund Class Investor
Royce Special Equity Fund Investment Class
Scout International Fund
Vanguard Dividend Growth Fund Investor Shares
Vanguard Small Capitalization Growth Index Fund Investor Shares
First Eagle Global Fund Class A
Janus Balanced Fund Class I
Vanguard Wellington Fund Admiral Shares

Your Statement of Plan Services and Costs

Fidelity GNMA Fund
Fidelity Strategic Income Fund
Metropolitan West Total Return Bond Fund Class Institutional
Oppenheimer International Bond Fund Class A
PIMCO GNMA Fund Institutional Class
PIMCO Real Return Fund Class A
PIMCO Total Return Fund Institutional Class
Templeton Global Bond Fund Class A
Fidelity Cash Reserves

Plan Designated Investment Manager

Model Portfolio Recordkeeping Service, an investment management service, is offered under your Plan. The model portfolios in the service are constructed and managed at the discretion of your Plan's named fiduciary. Fidelity is not responsible for the construction or management of the model portfolios, and is not affiliated with the Plan's named fiduciary. Utilizing the investment manager(s) or service(s) identified above may restrict your ability to direct the investment of all or a portion of your account balance.

Cost of Plan Services - General Administrative Services

Asset-based fees reflect an investment options total annual operating expenses and include management and other fees. They are often the largest component of retirement plan costs and are paid by all shareholders of the investment option. Typically, asset-based fees are reflected as a percentage of assets invested in the option and often are referred to as an expense ratio. You may multiply the expense ratio by your balance in the investment option to estimate the annual expenses associated with your holdings. Refer to the Investment Options Comparative Chart Section of this brochure for information about the Plans investment options, including their expense ratios (where applicable). Asset-based fees are deducted from an investment options assets, thereby reducing its investment return. Fee levels can vary widely among investment options, depending in part on the type of investment option, its management (including whether it is active or passive), and the risks and complexities of the options strategy. There is not necessarily a correlation between fees and investment performance, and fees are just one component to consider when determining which investment options are right for you.

Cost of Plan Services - General Administrative Services

Plan Administrative Fees and Expenses

Plan administrative fees may include legal, accounting, trustee, recordkeeping, and other administrative fees and expenses associated with maintaining the Plan. In some instances, they may be deducted from individual accounts in the Plan. Based on the information and direction Fidelity had on file at the time this brochure was prepared, no plan administrative fees were to be deducted from accounts in the Plan. Please keep in mind that fees are subject to change.

If any plan administrative fees are actually deducted from your account, they will be reflected on your Plan account statement.

Cost of Plan Services - General Administrative Services

If you have an account in the Plan, it may be subject to the following types of fees and expenses:

Asset-based fees
Plan administrative fees and expenses
Individual fees and expenses

Cost of Plan Services - Personalized Services

Individual Fees and Expenses

Individual fees and expenses include those associated with a service or transaction that an individual may select. In some instances, they may be deducted from the accounts of those individuals who utilize the service or engage in the transaction. If you have an account in the Plan and you select or execute the following service(s) or transaction(s), the fee(s) outlined below may be deducted from your account based on the information and direction Fidelity had on file at the time this brochure was prepared. As you review this information, please keep in mind that fees are subject to change and that certain individual fees may not be deducted in some circumstances.

Type of Individual Fee Amount

Loan Setup Fee \$50.00 per loan

In-Service Withdrawal Fee \$25.00 per transaction

Loan Maintenance Fee \$25.00 per year per loan

Overnight Mailing Fee \$25.00 per transaction

Qualified Domestic Relations Order (QDRO) Fee up to \$1,800.00 per QDRO

Also please note that you may incur short-term redemption fees, commissions, and similar expenses in connection with transactions associated with your Plans investment options. Please the Investment Options Comparative Chart for details regarding the specific fees that may apply to the investment options available under the Plan.

If any individual fees are actually deducted from your account, they will be reflected on your Plan account statement.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Jackie Cooperstein: (909) 448-4074 or jcooperstein@laverne.edu.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer This

section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name University of La Verne		4. EIN 951644026	
5. Employer address 1950 Third St.		6. Employer phone number 909-593-3511	
7. City La Verne	8. State CA	9. ZIP 91750	
10. Who can we contact about employee health coverage at this job? Jackie Cooperstein			
11. Phone number 909-448-4074		12. Email address jcooperstein@laverne.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees.

Some employees. Eligible employees are: Regular Employees working at least 30 hours per week.

- With respect to dependents:

We do offer coverage. Eligible dependents are: Spouse, Registered Domestic Partner, Child.

We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.**

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

Date of change (8/20/2013):

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)