*Please download this PDF to your desktop.
If you don't it may not save the information that you enter.

Millard PUBLIC SCHOOLS

Don Stroh Administration Center - 5606 So. 147th Street, Omaha, NE 68137 - 402-715-8200 - (Fax) 402-715-8409

Congratulations!

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

We appreciate your help in expediting the hiring process by completing the new hire paperwork prior to your scheduled appointment at the Don Stroh Administration Center.

Please bring **ALL** forms and documents with you to your scheduled appointment at the Don Stroh Administration Center. A check list has been provided below to help you with this process. We will review the forms and answer any questions at that time but please call 402-715-8200 if you have questions prior to your appointment. Thank you!

√ Form check list:

	Forms	Required For:	Exception
	Demographic Form	All Employee Types	
	I-9 Form	All Employee Types	
	OneSource Background Check Forms	All Employee Types	
	W-4 Form	All Employee Types	
	Direct Deposit Enrollment / Change Form	All Employee Types	
	403(b) Plan Notice	All Employee Types	
	Acknowledge of MPS Board Policies & Rules	All Employee Types	Substitutes
	Employee Acknowledgement (HIPPA)	All Employee Types	Substitutes
	Health, Dental, LTD Enrollment Form	All Employee Types	Substitutes
	HSA Savings Account Application	All Employee Types	Substitutes
	Discovery Benefits (FSA) Spending Account	All Employee Types	Substitutes
	Life Insurance Enrollment Form	All Employee Types	Substitutes
	Nebraska Retirement Enrollment Form	All Employee Types	Substitutes

√ 'Must Have' Items to bring with you:

	Document / Item	Required For:	*Please note
	Voided Check for Direct Deposit	All Employee Types	
	Valid Driver's License or Passport	All Employee Types	
	Social Security Card (Original Card - Name on SS card will be the official name with MPS)	All Employee Types	
	State Birth Certificate (Original with Raised Seal)	All Employee Types	
	Official Transcripts	Certificated Staff including Nurses *Excluding Substitutes	*Paraprofessionals may need a copy of their unofficial transcripts
	*Teaching Certificate / Nursing Certification	Certificated Staff	
	Social Security Number for Dependents/Beneficiaries	All Employee Types *Excluding Substitutes	

BENEFIT ELIGIBILITY LIST 2019: PARAPROFESSIONAL
OR FOOD SERVICE Employees
Premium Amounts are per pay check

HEALTH INSURANCE*	19 Pays for Non-Wellness Participant	19 Pays for Non-Wellness Participant	19 Pays for Wellness Participant	19 Pays for Wellness Participant
TRADITIONAL PREFERED PROVIDER OPTION #1	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE PPO HEALTH	$168.49	$205.93	$190.95	$183.47
EMPLOYEE + SPOUSE PPO HEALTH	$353.82	$432.44	$400.99	$385.27
EMPLOYEE + CHILDREN PPO HEALTH	$311.71	$380.98	$353.27	$339.42
EMPLOYEE + FAMILY PPO HEALTH	$475.08	$580.66	$538.43	$517.31
STANDARD HIGH DEDUCTIBLE PLAN OPTION #2	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$169.05	$144.00	$187.83	$125.22
EMPLOYEE + SPOUSE HDHP HEALTH	$355.01	$302.41	$394.45	$262.97
EMPLOYEE + CHILDREN HDHP HEALTH	$312.52	$266.22	$347.24	$231.49
EMPLOYEE + FAMILY HDHP HEALTH	$476.45	$405.87	$529.39	$352.93
CHI NETWORK HIGH DEDUCTIBLE PLAN OPTION #3	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$154.04	$131.22	$171.16	$114.11
EMPLOYEE + SPOUSE HDHP HEALTH	$322.52	$274.74	$358.36	$238.91
EMPLOYEE + CHILDREN HDHP HEALTH	$283.81	$241.77	$315.35	$210.23
EMPLOYEE + FAMILY HDHP HEALTH	$432.94	$368.80	$481.04	$320.69

DENTAL INSURANCE*			District Pays 19 Pays Rate	Employee Pays 19 Pays Rate
SINGLE DENTAL			$10.11	$6.74
EMPLOYEE + SPOUSE DENTAL			$10.11	$27.00
EMPLOYEE + CHILDREN DENTAL			$10.11	$22.47
EMPLOYEE + FAMILY DENTAL			$10.11	$39.74

LIFE INSURANCE			District Pays 19 Pays Rate	Employee Pays 19 Pays Rate
$50,000 TERM LIFE			$2.37	$0.00
Supplemental Life per $50,000 in coverage (any request for an increase requires Evidence of Insurability form)*			$0.00	$6.47
Spouse Supplemental Life per $25,000 in coverage (any request for an increase requires Evidence of Insurability form)*			$0.00	$2.84
Dependent Child Life $10,000 Coverage			$0.00	$2.05

VISION INSURANCE			District Pays 19 Pays Rate	Employee Pays 19 Pays Rate
SINGLE VISION			$0.00	$4.14
EMPLOYEE + SPOUSE VISION			$0.00	$7.87
EMPLOYEE + CHILDREN VISION			$0.00	$8.29
EMPLOYEE + FAMILY VISION			$0.00	$12.18

OTHER BENEFITS			District Pays	Employee Pays
Contributions - Health Savings Accounts for qualifying persons electing Single Coverage - High Deductible Health Plans **			$1,100.00	Employee Election
Contributions - Health Savings Accounts for qualifying persons electing Single+Dependant(s) Coverage - HDHP **			$2,200.00	Employee Election
Employee Contributions - Section 125 Medical Plan for persons electing PPO Health Plan ***			$0.00	Employee Election
Employee Contributions - Section 125 Child/Elder Care Plan ***			$0.00	Employee Election
403(b) or 457 Tax Deferred Savings Retirement Account			$0.00	Employee Election
Nebraska Public Employees Retirement System (required) ****			9.87780%	9.78000%
Social Security / Medicare (required)			7.6500%	7.6500%

* - If you and your spouse both work for the District, contact Human Resources at 402-715-8582 for possible alternate rates.
** - Supplemental employee and spousal life insurance includes premium and coverage reductions at age 70 and 75.
Please contact Human Resources at 402-715-8582 for alternate rates.
*** - Employee contributions are limited by IRS Rules.
(2019 Limits = $2,650 per year for Section 125 Medical and $5,000 per year for Section 125 Child/Elder Care)
(2019 Limits for Health Savings Account = $2,400 per year for Single or $4,800 for three family tiers of coverage after District contributions)
District Contribution: Based on your employment status in January / September, the District contributions are made on the date of your January / September paycheck
**** - Questions about the Nebraska Public Employees Retirement System may be addressed by calling 1-800-245-5712

Benefits FAQs for New Employees

Benefit Start Date for new employees is **the first day of the month following your hire date**
Example: First day worked August 8, Benefits will be effective September 1
Your benefit election as a new hire will be effective through **December 31.**
**New selections can be made during Open Enrollment effective January 1.*

Millard Public Schools Wellness Program

Wellness Program Information may be found on the MPS website
http://hr.mpsomaha.org/home/benefits/wellness

Newly hired employees of Millard Public Schools are not eligible for the wellness incentive. If you choose not to enroll in one of Millard's health plan options but wish to participate in the Wellness Program, please email mpsbenefitsq@mpsomaha.org and request to enroll in the Wellness Program.

- **To receive the Wellness Premium Incentive for the next school year**: Complete both the online health assessment and biometric health screening by **May 31**. If both requirements are met, the incentive discount will start the following school year in September.
- **To complete the Biometric Wellness Screening:** Go to the Quest Diagnostics website (https://my.questforhealth.com/mobile/welcome/home), use ME+your employee number to login (for example "ME1000"). ME is case sensitive. Create your account and register for a biometric wellness screening. Registration Key: **millardps.** Client Name Millard Public Schools FV. If you have problems logging in, please contact Quest Diagnostics at 1-855-623-9355. New employee updates are sent to Quest regularly, but you may have to wait a week or two to be able to register on their portal.
- **To complete the Health Risk Assessment:** Employees enrolling in one of Millard's health plan options can create an account on Aetna Navigator (www.aetnanavigator.com) after benefits become effective. It may take a few weeks to be able to create your account and have the ability to complete the health assessment.

Updating benefits with Millard Public Schools. Benefit changes may be made under the following circumstances:

- During **Open Enrollment** every October/November employees may update benefit selections effective January 1.
- **Event Change:** Qualifying event changes include, change in marital status, birth/adoption, death, change of spouse's employment, loss of coverage. Please request the form from the Benefits Department at mpsbenefitsq@mpsomaha.org. The form **must** be returned within **30 days** of the event change.

For benefit information, visit the MPS Website: http://www.mpsomaha.org/→ Departments→ Human Resources → and then click on the Benefits tile. http://hr.mpsomaha.org/home/benefits

- **Health** - Aetna Health Benefits contains detailed health coverage information, the summary plan description, schedule of benefits and summary of deductibles. If you need to print a card before it arrives in the mail, contact Aetna at 1-888-751-4027.
- **Dental** - Ameritas MPS Dental contains detailed dental coverage information, the summary plan description, schedule of benefits and summary of deductibles. Ameritas: 1-800-487-5553. Press 0 for the operator if you do not have your card.
- **Vision Benefits –** contains information on employee paid Ameritas Vision Benefits. 1-800-487-5553..
- **HSA Savings Accounts –** Includes information on eligibility, maximum contributions, eligible expenses, how to access your account, the District Contribution schedule, and detailed information about your account. HSA Bank 1-800-357-6246.
- **Flex Spending & Dependent Care** contains detailed information on Medical Flex Spending Accounts and Dependent Care/Child Care accounts, including the plan description. DiscoveryBenefits 1-866-451-3399.
- **Long Term Disability (LTD**) – contains an FAQ and certificate of coverage. If approved, allows for you to earn a portion of lost wages in the event that you are disabled.
- **Life Insurance –** New hire guarantee issue amounts: employee requests over $150,000 additional term life insurance must complete the evidence of insurability paperwork. Spouse term life insurance is $25,000, anything above that amount will require evidence of insurability. Contains information for benefit eligible employees and instructions on continuing coverage once employment is termed. Call for more information: 1-800-627-3660.
- **Retirement - Nebraska State Retirement (mandatory) & 403(b) Information –** Here you will find the State of Nebraska Retirement Handbook, beneficiary change form link, Millard Retirement Handbooks and Member Termination Form link (NPERS: 1-800-245-5712) and information on 403(b) accounts administered by Omni (1-877-544-6664).
- **Premiums Per Check** contains Benefit Cost Breakdowns **per paycheck** by job class. Choose the appropriate pdf.
- **Wellness -** contains the Wellness Program requirements and includes information on the Employee Assistance Program.

NEW EMPLOYEE DEMOGRAPHIC INFORMATION FORM

Please complete the following:

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

_____ _____ _____
Last Name First Name Middle Initial

Social Security Number: _____ / _____ /_____ _____
Personal Email Address

Marital Status (select one)
- (•) Single
- ( ) Single with dependents
- ( ) Married

Sex
- (•) Female
- ( ) Male

Ethnic Code (select one)
- ( ) Hispanic or Latino
- (•) Not Hispanic or Latino

Race Code (select one)
- (•) White
- ( ) Black
- ( ) Hispanic
- ( ) Asian/Pacific Islander
- ( ) American Indian/Alaskan
- ( ) Other _____

Citizenship (select one)
- (•) United States Citizen
- ( ) Non-Citizen

Date of Birth: _____ / _____ / _____

Address: _____
Number / Street

_____
City State Zip

Primary Number ( ) _____ ( ) _____
Primary Phone Cell Phone

Emergency Contact_____ ( ) _____
First/Last Name Contact Number

FOR HR USE ONLY

ID# _____

[ ] I-9 [ ] PH [ ] W4 [ ] CBC

Employment Eligibility Verification

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

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

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☑ did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		HR Specialist

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Millard Public Schools

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
5606 S 147 ST	Omaha	NE	68137

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
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		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

Department of Health & Human Services
DHHS
NEBRASKA

Division of Children and Family Services (CFS)
Nebraska Child Abuse and Neglect Central Registry (CAN Registry)/
Nebraska Adult Protective Services Central Registry (APS Registry)
Authorization for Release of Information for Registered Organizations

All designated fields must be completed or the request will be returned and not processed. Please type or print legibly. **This form is for use only by organizations who have registered with CFS to obtain CAN Registry and/or APS Registry information**. For information on how to register your organization go to: http://dhhs.ne.gov/children_family_services/Pages/nea_cr.aspx .

ORGANIZATION INFORMATION

Registered Organization ID Number	Registered Organization Name
1022	One Source The Background Check Company

APPLICANT INFORMATION

First	Middle	Last Name

Date of Birth	Age	Social Security Number
/ /		- -

Current Address

City	State	Zip Code

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

Other names, such as a maiden name, former married name, or nickname, used in the past 20 years:

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

All previous addresses at which you have resided in the past 20 years (minimum City & State):

onesource®
The Background Check Company

APPLICANT DISCLOSURE AND AUTHORIZATION FORM

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

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

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

PLEASE PRINT LEGIBLY

Last Name:_____ First Name_____ Middle_____

Other Names/Alias:_____

*Social Security #:_____ / / *Date of Birth (MM/DD/YYYY):_____

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

Present Address:_____ Phone: ( )_____

City:_____ State:_____ Zip:_____

All Previous Addresses in the Last Seven Years

_____

_____

_____

_____

_____

Signature:_____ Date:_____

**This information will be used for background screening purposes only and will not be used for any other purpose.*

onesource®
The Background Check Company

STATE LAW NOTICES AND DISCLOSURES – BACKGROUND INVESTIGATION

Pursuant to state law, the following disclosures are provided to state residents.

CALIFORNIA applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check the box if you would like to receive a copy of the investigative consumer report or consumer credit report at no charge if one is obtained by the Company. Check box to receive report. ☐
NEW YORK applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting One Source The Background Check Company, PO Box 24148, Omaha, NE 68124, 1.800.608.3645, www.onesourcebackground.com.
NEW YORK applicants or employees only: By signing below, you also acknowledge receipt of a copy of Article 23-A of the New York Correction Law.
WASHINGTON applicants or employees only: You have the right to request from One Source The Background Check Company, PO Box 24148, Omaha, NE 68124, 1.800.608.3645, www.onesourcebackground.com a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.
MASSACHUSETTS, MINNESOTA and OKLAHOMA applicants or employees only: Please check the box if you would like to receive a copy of your consumer report, free of charge, if one is obtained by the Company. Check box to receive report. ☐

Signature: _____

Print Name: _____

Date: _____

Social Security Administration

Form Approved
OMB No. 0960-0760

Authorization for the Social Security Administration (SSA) To Release Social Security Number (SSN) Verification

Printed Name:	Date of Birth:	Social Security Number:
	/ /	/ /

I want this information released because I am conducting the following business transaction:

Background Check for Employment

Reason (s) for using CBSV: (Please select all that apply)

- ☐ Mortgage Service
- ☐ Banking Service
- ☒ Background Check
- ☐ License Requirement
- ☐ Credit Check
- ☐ Other

with the following company ("the Company"):

Company Name: One Source - The Background Check Company

Company Address: 10842 Old Mill Rd, Suite 6, Omaha, NE 68154

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for the purpose I identified.

The name and address of the Company's Agent is:
Computer Information Development LLC
713 W Duarte Rd #106, Arcadia, CA 91007

I am the individual to whom the Social Security number was issued or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to $5,000.

This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature _____ Date Signed _____

Relationship (if not the individual to whom the SSN was issued): _____

Contact information of individual signing authorization:

Address _____

City/State/Zip / /

Phone Number _____

Privacy Act Statement

SSA is authorized to collect the information on this form under Sections 205 and 1106 of the Social Security Act and the Privacy Act of 1974 (5 U.S.C. § 552a). We need this information to provide the verification of your name and SSN to the Company and/or the Company's Agent named on this form. Giving us this information is voluntary. However, we cannot honor your request to release this information without your consent. SSA may also use the information we collect on this form for such purposes authorized by law, including to ensure the Company and/or Company's Agent's appropriate use of the SSN verification service.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U. S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to complete the form. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send to this address only comments relating to our time estimate, not the completed form.***

TEAR OFF

NOTICE TO NUMBER HOLDER

The Company and/or its Agent have entered into an agreement with SSA that, among other things, includes restrictions on the further use and disclosure of SSA's verification of your SSN. To view a copy of the entire model agreement, visit http://www.ssa.gov/cbsv/docs/SampleUserAgreement.pdf

Form W-4 (2019)

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

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

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
2019

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

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▸	**7**	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

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

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

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

Two-Earners/Multiple Jobs Worksheet

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

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

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

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

Instructions for Employer

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself . . . . . **A** _____

B Enter "1" if you will file as married filing jointly . . . . . **B** _____

C Enter "1" if you will file as head of household . . . . . **C** _____

D Enter "1" if:
- You're single, or married filing separately, and have only one job; or
- You're married filing jointly, have only one job, and your spouse doesn't work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

D _____

E **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child.
- If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child.
- If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child.
- If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-" . . . . . **E** _____

F **Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent.
- If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
- If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-" . . . . . **F** _____

G **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F . . . . . **G** _____

H Add lines A through G and enter the total here . . . . . ▸ **H** _____

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1 Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details . . . . . **1** $ _____

2 Enter:
- $24,400 if you're married filing jointly or qualifying widow(er)
- $18,350 if you're head of household
- $12,200 if you're single or married filing separately

. . . . . **2** $ _____

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . **3** $ _____

4 Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) . . **4** $ _____

5 **Add** lines 3 and 4 and enter the total . . . . . **5** $ _____

6 Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest) . **6** $ _____

7 **Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . **7** $ _____

8 **Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction . . . . . **8** _____

9 Enter the number from the **Personal Allowances Worksheet,** line H, above . . . . . **9** _____

10 **Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . . . . . **10** _____

Two-Earners/Multiple Jobs Worksheet

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

1	Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet)		**1**
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3"		**2**
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet		**3**
Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.			
4	Enter the number from line 2 of this worksheet	**4**	
5	Enter the number from line 1 of this worksheet	**5**	
6	**Subtract** line 5 from line 4		**6**
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here		**7** $
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed		**8** $
9	**Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck		**9** $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

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

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

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

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

Print Form

MILLARD PUBLIC SCHOOLS

DIRECT DEPOSIT – ENROLLMENT/CHANGE FORM

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

Signed: _____ Dated: _____

Employee Number: _____ SSN: ___/___/_____

Please attached a voided check or letter from your bank containing your routing information

Please Note: Direct Deposit change requests must be received by the Business Office at least 7 days prior to the next paydate. If you close your account(s), please let the Payroll Department know immediately. We are not responsible for payments made to closed accounts.

PRIMARY BANK ACCOUNT:

Bank Name: _____ **Account Type:** _____
C = Checking, S = Savings

Bank Routing Number: _____

Bank Account Number: _____

SECONDARY BANK ACCOUNT (optional):

Bank Name: _____ **Account Type:** _____
C = Checking, S = Savings

Bank Routing Number: _____

Bank Account Number: _____ **$ Amount to be Deposited:** _____

Bank Name: _____ **Account Type:** _____
C = Checking, S = Savings

Bank Routing Number: _____

Bank Account Number: _____ **$ Amount to be Deposited:** _____

Bank Name: _____ **Account Type:** _____
C = Checking, S = Savings

Bank Routing Number: _____

Bank Account Number: _____ **$ Amount to be Deposited:** _____

Revised 6/2013

403(b) UNIVERSAL AVAILABILITY NOTICE

Employer: Millard Public Schools

How Can I Participate?
You can participate in the Plan with pre-tax contributions by completing and submitting a Salary Reduction Agreement ("SRA") online at http://www.omni403b.com/, or by submitting a completed SRA form, which can be found on the same website, to The OMNI Group either by facsimile to (585) 672-6194 or by mail at 1099 Jay St., Bldg F, Rochester, NY, 14611 ("OMNI").

How Much Can I Contribute Annually?
You may contribute up to $19,000 in 2019; this amount is subject to change annually. If you have at least 15 years of service with your employer or you are at least 50 years old, you may also be able to make additional catch-up contributions. For appropriate limits for your particular circumstances, please contact OMNI's Customer Care Center at 1-877-544-6664. Millard does not match contribution into a 403(b).

What If I Already Have An Account?
If you are already contributing to the Plan, and you want to change your contribution amount or service provider, simply complete and submit a new SRA. See directions above for on-line and paper submission options.

How Can I Get More Information?
You can access further information at www.omni403b.com or www.403bwhyme.com. The Universal Availability notice is posted on the MPS website: http://hr.mpsomaha.org/home/benefits/retirement - then open the 403(b) Information folder.

By signing, I hereby acknowledge that I have received a Retirement Plan Benefits Overview and have been informed of my eligibility to participate in the Plan. I understand my choice is completely voluntary and I may change my choice to participate at any time, subject to our specific provisions.

Employee Printed Name:_____ **SSN:**_____-____ -_____

Signature_____**Date:**_____

- (●) I am a **CURRENT** participant in a 403(b) Plan and I must complete the participation requirements above to continue participation.
- ( ) I **AM** interested in participating in the 403(b) Plan and would like more information.
- ( ) I am **NOT** interested in participating in the Plan at this time.

I hereby acknowledge that I have been informed of the Millard Public Schools Board Policies and Rules found at: https://goo.gl/DNshle

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

1235.1	Conduct on District Property
1315	Gifts to School Personnel
1315.1	Gifts to School Personnel
3131.2	Employee Indemnification/Hold Harmless
4001	Non Discrimination and Sexual Harassment Policy
4001.1	Sexual Harassment
4001.2	Discrimination and Sexual Harassment Complaint and Grievance Procedures
4105	Mentor and New Staff Induction Program
4105.1	Mentor and New Staff Induction Program
4140	Responsibilities and Duties
4140.1	Responsibilities and Duties – Certificated
4140.2	Responsibilities and Duties – Non- Certificated
4155	Code of Ethics
4155.1	Code of Ethics
4163	Remedial Action
4163.1	Remedial Action – Certificated
4163.2	Remedial Action – Non- Certificated
4172	Smoking and Use of Tobacco and E-Cigarette Products
4172.1	Smoking and Use of Tobacco and E-Cigarette Products
4173	Drug-Free Workplace
4173.1	Drug-Free Workplace
4173.2	Drug-Free Workplace: Alcohol
4173.3	Drug-Free Workplace: Drugs
4315	Non-School Employment
4315.1	Non-School Employment
4315.2	Tutoring
4325	Grievances
4325.1	Grievance Procedure
6110	Written Curriculum: Content Standards
6110.1	Written Curriculum: Content Standards
6200	Taught Curriculum: Instructional Delivery
6200.1	Taught Curriculum: Instructional Delivery
6203	Taught Curriculum: Lessons (Instructional) Plans
6240	Taught Curriculum: Controversial Issues
6240.1	Taught Curriculum: Controversial Issues
6315	Millard Education Program: Use of Assessment Data
6315.1	Millard Education Program: Use of Assessment Data

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

Printed Name _____Date_____

Signature_____

Notice of Nondiscrimination

- The District does not discriminate on the basis of race, color, religion, national origin, gender, marital status, disability, or age in admission or access to or treatment of employment, or in its programs and activities.
- The District shall provide an employment, teaching and learning environment free from sexual harassment.
- Personnel violating this Policy shall be subject to disciplinary action.
- The following person has been designated to handle injuries regarding the non-discrimination policies: Superintendent of Schools, 5606 S. 147th Street, Omaha, NE 68137 402-715-8200. The Superintendent may delegate this responsibility as needed.
- Complaints and grievances by school personnel or job applicants regarding discrimination or sexual harassment shall follow the procedures of District Rule 4001.2.

Employee Acknowledgement

You are required to sign and return this form to Millard Public Schools Human Resources to confirm understanding of required notices the District must provide. This Employee Acknowledgement with your signature will be maintained as part of your employment record.

I, (print name) _____, acknowledge I have been provided notice regarding the availability of electronic copies of the Summary of Benefits and Coverage for the Millard Public Schools Health Plans, Marketplace Exchange Notice, as well as an electronic version of the Millard Public Schools Health Plan Notice of Privacy Practices.

All required notices are available on the MPS Human Resources Department website accessible from the following link: http://hr.mpsomaha.org/home/benefits/notices

A hard copy of the Summary of Benefits and Coverage, Marketplace Exchange Notice and Notice of Privacy Practices may be obtained free of charge by contacting the Human Resources Department at: mpsbenefitsq@mpsomaha.org

Additional Notices Made Available Via the District Website Include:

- Medicare Part D Credible Coverage Notice
- Special Enrollment Notice
- Family Medical Leave Act (FMLA) Compliance
- Wellness Program Detail
- Women's Health and Cancer Rights Act (WHCRA)
- Children's Health Insurance Program (CHIP)

Signature: _____

Date_____

millard PUBLIC SCHOOLS

Benefit Enrollment Form 2019

Please enter your hire date

Date of hire:_____

☒New Hire

Welcome to Millard Public Schools

A. EMPLOYEE INFORMATION

First Name	M.I.	Last Name	Social Security No. / /	– Pick One	Birthdate / /
Street Address	Apt. No.	City	State	ZIP	County
Primary Phone ( ) -	Work phone ( ) -	Marital Status			
Effective Date of Change in Benefits	Occupational / Job Title				

☐ **Full-time** ☐ **12 Month**
☐ **Part-time** ☐ **12 Month (less than 1.0 FTE)**

☐ **Full-time** ☐ **10 Month**
☐ **Part-time** ☐ **10 Month (less than 1.0 FTE)**

Hours Scheduled Each Week

B. BENEFIT SELECTION

MEDICAL BENEFITS (Administered by Aetna Health Care) *For detailed information on the health benefits, including medical benefit summaries visit the MPS website. http://hr.mpsomaha.org/home/benefits.*

☒ **Decline Medical Benefits**

TRADITIONAL PPO HEALTH PLAN *Premiums are per paycheck*	**STANDARD HIGH DEDUCTIBLE HEALTH PLAN** *Premiums are per paycheck*	**CHI NETWORK HIGH DEDUCTIBLE HEALTH PLAN** *Premiums are per paycheck*
○ Employee Only	○ Employee Only	○ Employee Only
○ Employee + Spouse	○ Employee + Spouse	○ Employee + Spouse
○ Employee + Child(ren)	○ Employee + Children	○ Employee + Child(ren)
○ Employee + Spouse + Children (Full Family)	○ Employee + Spouse + Children (Full Family)	○ Employee + Spouse + Children (Full Family)

DENTAL BENEFITS (Insured & administered by **Ameritas®**)
For detailed information on the dental benefits http://hr.mpsomaha.org/home/benefits.

- ◉ Decline Dental Benefits
- ○ Employee Only
- ○ Employee + Spouse
- ○ Employee + Child(ren)
- ○ Employee + Spouse + Children (Full Family)

VISION BENEFITS (Insured & administered by **Ameritas®**)
For detailed information on the vision benefits http://hr.mpsomaha.org/home/benefits.

- ◉ Decline Vision Benefits
- ○ Employee Only
- ○ Employee + Spouse
- ○ Employee + Child(ren)
- ○ Employee + Spouse + Children (Full Family)

C. DEPENDENT INFORMATION

- o List all family members to be covered. Write name as it should appear on I.D.card.
- o Indicate dependent address (if different)
- o Attach additional enrollment form if enrolling more than (6) members.

	First Name	M.I.	Last Name	Social Security Number	Relationship	Sex	Birthdate
01				/ /	SPOUSE		

Spouse also works at Millard Public Schools ☐ **YES** **Spouse Employee #** ☐ **NO** (If no, please list spouse's employer)

	First Name M.I. Last Name	Social Security Number	Relationship	Sex	Birthdate
02					
03					
04					
05					
06					

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

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

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

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

Policyholder's Employer: Name	Address	Phone Number

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

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

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. If the reason I lose other coverage is due to fraud or failure to pay premiums, I understand that I will not be entitled to Special Enrollment. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____

Employee's Signature Date

F. FOR EMPLOYER USE ONLY

Millard Public Schools

Notes:

Approved By (Signature)	Date

HEALTH SAVINGS ACCOUNT (HSA)
CONTRIBUTION OPTIONS & SALARY REDUCTION ARRANGEMENT

By my signature below, I certify that I have enrolled, or plan to enroll, in an HSA-compatible health plan and that I am not covered by any other plan that would disqualify me from opening or contributing to my HSA. I understand that this form is provided for convenience purposes and that HSA Bank will not initiate contributions to my HSA, but will allow Millard Public Schools to initiate contributions to my account.

GENERAL RULES

- Eligibility for HSA contributions is determined monthly as of the first day of the month.
- Employees, and not employers, are primarily responsible for determining whether they are HSA-eligible.

ELIGIBILITY CRITERIA

To be HSA-eligible, an individual must:

- Be covered by an HDHP;
- Not be covered by other health coverage that is not an HDHP (with certain exceptions);
- Not be covered by a general-purpose health FSA or HRA, including a spouse's general-purpose FSA or HRA;
- Not be enrolled in Medicare or Tricare
- Not be eligible to be claimed as a dependent on another person's tax return.

HEALTH SAVINGS ACCOUNT ELIGIBILITY

☐ Yes, I am eligible for HSA contributions.

☐ No, I am not eligible for the District to contribute to an HSA account and I do not want to contribute HSA contributions.

DISCONTINUE HSA CONTRIBUTION(S) – *Current Employees Only*

☐ I do not want the District to contribute to an HSA.

☐ I do not want to contribute to an HSA.

EMPLOYEE CONTRIBUTION ELECTION

☐ I elect to contribute to my HSA with a pre-tax salary reduction through my employer's Section 125 Cafeteria Plan, and authorize my employer to deduct the amounts indicated from my salary and forward the funds to HSA Bank to deposit in my HSA. **Effective Date Requested:** _____

**The date must be on or after the first day of your HSA compatible health plan coverage. Leaving the date blank will authorize Millard Public Schools to determine the date on your behalf. Effective dates are typically the first day of the next month depending on the timing of submission.*

Fill out the amount in **one box only** below:

Total Annual Employee Deduction Amount $ _____

Per Pay Check Deduction $ _____

Total Annual Employer Contribution:

Single: $ _____

Family: $ _____

Frequency of Pay Period, Circle Choose One: 19 Pays Bi-Weekly Monthly

Your Total Annual Employee Election along with contributions from any other sources, including employer contributions, may not exceed the Annual Maximum Contribution amount set by the IRS. Contribution Limits can be found: www.hsabank.com, www.irs.gov, or on the Millard Public Schools website HSA Savings Accounts. The District Contribution schedule may also be found on the MPS Website. *Millard Public Schools does not render tax or legal advice. Any HSA contributions and possible tax implications are the responsibility of the employee, including tracking annual IRS limits. Please consult your tax adviser regarding HSA contribution limitations.*

Limits - You can make a contribution to your HSA for each month that you are eligible. For each month that you are eligible, you can contribute one-twelfth of the annual maximum for HSA contributions. The full contribution rule described above for individuals who are eligible on Dec. 1 of a calendar year is an exception to the rule that HSA contributions limits are determined monthly. You can contribute no more than the designated annual maximum. ***For 2019, the maximum is $3,500 for single coverage and $7,000 for family coverage.*** *Individuals who are age 55 and older can also make additional "catch-up" contributions of up to $1,000 annually.* ***Contact HSA Bank for assistance with your contribution amounts, especially if you intend to pro-rate the amount: 1-800-357-6246.***

EMPLOYEE INFORMATION

EMPLOYEE FULL NAME: _____EMPLOYEE ID NUMBER: _____

EMPLOYEE SIGNATURE: _____

Discovery Benefits®

Flexible Spending Account (FSA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. This is an internal document used by your employer for data collection purposes. Worksheets submitted to Discovery Benefits will not be processed.

*= Required Fields

Step 1: Participant Information

MILLARD PUBLIC SCHOOLS	
*Employer Name	*Employee Identifier Number

*Participant Last Name	*Participant First Name,	*MI

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. *Please Note: Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

***Plan Type** (If enrolled in an HSA, you are not eligible to enroll in the Medical FSA. However, you are eligible for both the Limited Medical FSA and Dependent Care FSA if offered through your employer.)	**Medical FSA** Limit set by employer	**Dependent Care Account** Limit set by employer up to IRS maximum
***Annual Election**	$	$
***Number of Pay Periods** (if enrolling mid-year, please enter the number of remaining pay periods within the plan year)	÷	÷
***Per Pay Period Amount** (to be deducted each pay period)	=	=
***Date of First Payroll** (mm/dd/yyyy)		
***Participant Effective Date** (mm/dd/yyyy)		

***Pay Frequency** (please circle one) **Monthly / Bi-Weekly** (12 Month Hourly) **/ 19 Pay** (10 Month Employees)

Step 4: Authorization

I authorize my employer to reduce my pay on a per pay period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

*Participant Signature	*Date

Step 5: Refusal *(**NOTE: only complete this step if you are NOT electing to enroll in a Flexible Spending Account)*

I understand that if I choose not to participate in a Flexible Spending Account (FSA) , I cannot enter the program until the next plan year unless I experience a status change in accordance with Internal Revenue Code Section 125 and submit the change within 30 days of the status change.

*Participant Signature	*Date

Insurance Benefit Enrollment Form

Return to: National Insurance Services, Attn: Billing Department
250 S. Executive Drive, Suite 300 Brookfield, WI 53005-4273
Phone 1.800.627.3660 Fax 262.785.9269

A: Enter your information:

Employer Name: Millard Public Schools				NIS Group Number: 017208	
Full Name (Last name, First name, Middle Initial):				Date of Hire:	
Home Address:		City:	State:	Zip:	
Social Security Number: / /	○ Single ◉ Married	U.S. Citizen? ◉ Yes ○ No*		Date of Birth:	○ Male ◉ Female
Occupation/Title:				Hours worked per week:	Annual Salary:

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Employer-Provided Insurance Benefits:

☑ Basic Life $50,000

B: Optional Insurance benefits: (see rate table)

○ Elect	◉ Decline	Employee Supplemental Life / AD&D Amount $_____ $25,000 increments to a maximum of $300,000 not to exceed 5 times Annual Salary. *Evidence of Insurability is required for amounts over $150,000, late enrollees, or for increases in coverage.*
○ Elect	◉ Decline	Spouse Supplemental Life / AD&D Amount $_____ $12,500 increments to a maximum of $150,000 not to exceed 50% of the Employee's combined Basic and Supplemental Life amounts. If elected, complete spouse information in section D *Evidence of Insurability is required for amounts over $25,000, late enrollees, or for increases in coverage.*
○ Elect	◉ Decline	Child Supplemental Life $10,000 Live birth to age 19, or 23 if a full-time student If elected, **enter** each child's information in section D *Evidence of Insurability is required for late enrollees.*

Full Name:	Employer Name: Millard Public Schools	Date:

Instructions for the employee: Complete, make a copy for your records and return the original form to your Benefits Administrator.
Instructions for assigning a Trust as your beneficiary: To name a trust as a beneficiary, indicate the name and date of the trust and the Trustee (show Name and address). Include a tax identification number if applicable.
Instructions for the Benefits Administrator: Retain a copy of this form for your records. Send the original to National Insurance Services.

C: Enter your Life Insurance Beneficiary information:

1. Primary Beneficiary(ies) Attach additional pages if necessary.

Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	

Total % of Benefit must equal 100%

2. Secondary Beneficiary(ies) Attach additional pages if necessary.

Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	

Total % of Benefit must equal 100%

Full Name:	Employer Name: Millard Public Schools	Date:

D: If Electing Additional Supplemental Life on Spouse/Child:

Full Name	Date of Birth	Social Security Number
Spouse		
Child		
Child		
Child		
Child		

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

NPERS Nebraska Public Employees Retirement Systems

npers.ne.gov

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

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

Beneficiary Designation Form

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

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

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

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

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

SIGNATURE OF MEMBER_____ Date _____

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

State of _____

County of_____ }

STAMP HERE

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

NOTARY PUBLIC SIGNATURE _____ My commission expires: _____.

BAR CODE

Beneficiary Designation Supplemental Form

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

NAME _____

SOCIAL SECURITY NUMBER _____-_____-_____

PRIMARY BENEFICIARY(IES) (continued):

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

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

CONTINGENT BENEFICIARY(IES) (continued):

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

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

SIGNATURE OF MEMBER_____ Date _____.

BAR CODE

NPERS Nebraska Public Employees Retirement Systems

1526 K St., Ste. 400 PO Box 94816 Lincoln, NE 68509-4816 PHONE 402-471-2053 TOLL FREE 800-245-5712 FAX 402-471-9493

npers.ne.gov

Name (Last / First / Middle)	Date of Birth - -	Plan Type (Check One)
Social Security Number - -	Retirement Number	☒ School ☐ Patrol
Address City State Zip		
Home Phone / Work Phone	Employer Millard Public Schools	

Application For Vesting Credit/Prior Service Credit – School & Patrol

SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS

School/Patrol Currently Employed By:	DATE OF HIRE	
Millard Public Schools	/ /	☐ FT ☐ PT

LIST ALL NEBRASKA PUBLIC EMPLOYMENT

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

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

PLACE OF EMPLOYMENT	(CHECK ONE)	DATES OF PARTICIPATION FROM	TO
	☐ Full Time ☐ Part Time	/ /	/ /
	☐ Full Time ☐ Part Time	/ /	/ /
	☐ Full Time ☐ Part Time	/ /	/ /
	☐ Full Time ☐ Part Time	/ /	/ /
	☐ Full Time ☐ Part Time	/ /	/ /

IDENTIFY CONTACT PERSON FOR PREVIOUS GOVERNMENT PLAN:

Name:	Dept.:
Address:	Phone: ( ) -

This form must be completed and received by NPERS within **180 days** of your date of hire.

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

Signature of Member: _____ Date: / /

BAR CODE

Instructions for Completing the Application for Vesting Credit

As a new employee you have 180 days to make application for vesting credit.

"Vesting means to qualify for the employer contributions made on your behalf. In the school and state patrol plans this <u>also</u> means qualifying to receive a monthly retirement benefit." The application must be filed with the Public Employees Retirement Systems within 180 days of your date of hire.

All past retirement participation must be in Nebraska Governmental Plans. It is your responsibility to have the form properly completed and filed.

■ Print or type all the requested information

TOP SECTION:

- **School/Patrol Currently Employed By** is where you work now.
- **Date of Hire** is the date you commenced working in your new position. If you are with the State Patrol, this would be your date of graduation from camp. **Circle FT/PT** to indicate full or part time position.

MIDDLE SECTION:

- List your Nebraska Governmental Retirement Plan information and/or past participation with your current employer here.
- *Dates are the dates you were in the plan,* **not when you were employed**.

Sign the form and forward it to the Retirement Office immediately. Your Vesting Credit Application will be considered filed on time if mailed in an envelope properly addressed to the Nebraska Public Employees Retirement Systems, postage prepaid, and postmarked before midnight of the final filing date. If the final filing date for such application falls on a Saturday, Sunday, or legal holiday, the next secular or business day shall be the final filing date. If the application is not mailed, the date the application is received by NPERS shall be the date used to determine whether the application was timely filed.

NOTE: This is not a buy back. You will be notified by the Public Employees Retirement Board if you qualify for vesting credit. Vesting credit is not included in the calculation of your benefit.

If you need assistance, call the Retirement Office at **402-471-2053** (Lincoln) or Toll-Free at **1-800-245-5712**.

BAR CODE