***Please download this pdf to your desktop.**
Fill out the form, rename and save it.

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	
	Nebraska W-4N Form	All Employee Types	
	Direct Deposit Enrollment / Change Form	All Employee Types	
	403(b) Plan Notice	All Employee Types	
	MPS Board Policies & Rules Acknowledgement	All Employee Types	
	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:	Exception
	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 *Paraprofessionals may need a copy of their unofficial transcripts	Substitutes
	*Teaching Certificate / Nursing Certification	Certificated Staff	
	Social Security Number for Dependents/Beneficiaries	All Employee Types	Substitutes

BENEFIT ELIGIBILITY LIST 2021: HOURLY PROFESSIONAL TECHNICAL 10 MONTH FULL-TIME

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	$339.75	$113.25	$385.05	$67.95
EMPLOYEE + SPOUSE PPO HEALTH	$356.68	$594.47	$404.24	$546.92
EMPLOYEE + CHILDREN PPO HEALTH	$314.25	$523.75	$356.15	$481.85
EMPLOYEE + FAMILY PPO HEALTH	$478.91	$798.19	$542.77	$734.34
STANDARD HIGH DEDUCTIBLE PLAN OPTION #2	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$334.75	$37.19	$371.95	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$351.47	$429.58	$390.53	$390.53
EMPLOYEE + CHILDREN HDHP HEALTH	$309.41	$378.17	$343.79	$343.79
EMPLOYEE + FAMILY HDHP HEALTH	$471.69	$576.52	$524.11	$524.11
CHI NETWORK HIGH DEDUCTIBLE PLAN OPTION #3	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$293.92	$32.66	$326.58	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$307.66	$376.03	$341.84	$341.84
EMPLOYEE + CHILDREN HDHP HEALTH	$270.73	$330.90	$300.82	$300.82
EMPLOYEE + FAMILY HDHP HEALTH	$412.96	$504.73	$458.84	$458.84
NHN NETWORK HIGH DEDUCTIBLE PLAN OPTION #4	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$299.46	$33.27	$332.74	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$313.46	$383.12	$348.29	$348.29
EMPLOYEE + CHILDREN HDHP HEALTH	$275.85	$337.15	$306.50	$306.50
EMPLOYEE + FAMILY HDHP HEALTH	$420.77	$514.28	$467.53	$467.53

DENTAL INSURANCE*	District Pays 19 Pays Rate	Employee Pays 19 Pays Rate
SINGLE DENTAL	$18.32	$0.00
EMPLOYEE + SPOUSE DENTAL	$18.32	$22.11
EMPLOYEE + CHILDREN DENTAL	$18.32	$17.16
EMPLOYEE + FAMILY DENTAL	$18.32	$35.95

LIFE INSURANCE	District Pays 19 Pays Rate	Employee Pays 19 Pays Rate
$50,000 TERM LIFE	$2.05	$0.00
Supplemental Life per $50,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$6.32
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
Long Term Disability (required)	0.1600%	0.0000%
Nebraska Public Employees Retirement System (required) ****	9.8778%	9.7800%
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.
(2021 Limits = $2,750 per year for Section 125 Medical and $5,000 per year for Section 125 Child/Elder Care)
(2021 Limits for Health Savings Account = $2,500 per year for single or $5,000 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

BENEFIT ELIGIBILITY LIST 2021: HOURLY PROFESSIONAL TECHNICAL 10 MONTH PART-TIME

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	$169.88	$283.13	$192.53	$260.48
EMPLOYEE + SPOUSE PPO HEALTH	$356.68	$594.47	$404.24	$546.92
EMPLOYEE + CHILDREN PPO HEALTH	$314.25	$523.75	$356.15	$481.85
EMPLOYEE + FAMILY PPO HEALTH	$478.91	$798.19	$542.77	$734.34
STANDARD HIGH DEDUCTIBLE PLAN OPTION #2	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$167.38	$204.57	$185.97	$185.97
EMPLOYEE + SPOUSE HDHP HEALTH	$351.47	$429.58	$390.53	$390.53
EMPLOYEE + CHILDREN HDHP HEALTH	$309.41	$378.17	$343.79	$343.79
EMPLOYEE + FAMILY HDHP HEALTH	$471.69	$576.52	$524.11	$524.11
CHI NETWORK HIGH DEDUCTIBLE PLAN OPTION #3	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$146.96	$179.62	$163.29	$163.29
EMPLOYEE + SPOUSE HDHP HEALTH	$307.66	$376.03	$341.84	$341.84
EMPLOYEE + CHILDREN HDHP HEALTH	$270.73	$330.90	$300.82	$300.82
EMPLOYEE + FAMILY HDHP HEALTH	$412.96	$504.73	$458.84	$458.84
NHN NETWORK HIGH DEDUCTIBLE PLAN OPTION #4	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$149.73	$183.01	$166.37	$166.37
EMPLOYEE + SPOUSE HDHP HEALTH	$313.46	$383.12	$348.29	$348.29
EMPLOYEE + CHILDREN HDHP HEALTH	$275.85	$337.15	$306.50	$306.50
EMPLOYEE + FAMILY HDHP HEALTH	$420.77	$514.28	$467.53	$467.53

DENTAL INSURANCE*	District Pays 19 Pays Rate	Employee Pays 19 Pays Rate
SINGLE DENTAL	$9.16	$9.16
EMPLOYEE + SPOUSE DENTAL	$9.16	$31.26
EMPLOYEE + CHILDREN DENTAL	$9.16	$26.32
EMPLOYEE + FAMILY DENTAL	$9.16	$45.11

LIFE INSURANCE	District Pays 19 Pays Rate	Employee Pays 19 Pays Rate
$50,000 TERM LIFE	$2.05	$0.00
Supplemental Life per $50,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$6.32
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
Long Term Disability (required)	0.1600%	0.0000%
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.
(2021 Limits = $2,750 per year for Section 125 Medical and $5,000 per year for Section 125 Child/Elder Care)
(2021 Limits for Health Savings Account = $2,500 per year for single or $5,000 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

BENEFIT ELIGIBILITY LIST 2021: HOURLY PROFESSIONAL TECHNICAL 12 MONTH FULL-TIME

Premium Amounts Are Per Pay Check

HEALTH INSURANCE*	Bi-Weekly 24 Pays Non-Wellness Participant	Bi-Weekly 24 Pays Non-Wellness Participant	Bi-Weekly 24 Pays Wellness Participant	Bi-Weekly 24 Pays Wellness Participant
TRADITIONAL PREFERED PROVIDER OPTION #1	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE PPO HEALTH	$268.97	$89.66	$304.83	$53.79
EMPLOYEE + SPOUSE PPO HEALTH	$564.75	$188.25	$640.05	$112.95
EMPLOYEE + CHILDREN PPO HEALTH	$497.56	$165.85	$563.90	$99.51
EMPLOYEE + FAMILY PPO HEALTH	$758.28	$252.76	$859.39	$151.66
STANDARD HIGH DEDUCTIBLE PLAN OPTION #2	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$265.01	$29.45	$294.46	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$556.50	$61.83	$618.33	$0.00
EMPLOYEE + CHILDREN HDHP HEALTH	$489.90	$54.43	$544.33	$0.00
EMPLOYEE + FAMILY HDHP HEALTH	$746.85	$82.98	$829.83	$0.00
CHI NETWORK HIGH DEDUCTIBLE PLAN OPTION #3	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$232.69	$25.85	$258.54	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$487.13	$54.13	$541.25	$0.00
EMPLOYEE + CHILDREN HDHP HEALTH	$428.66	$47.63	$476.29	$0.00
EMPLOYEE + FAMILY HDHP HEALTH	$653.85	$72.65	$726.50	$0.00
NHN NETWORK HIGH DEDUCTIBLE PLAN OPTION #4	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$237.08	$26.34	$263.42	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$496.31	$55.15	$551.46	$0.00
EMPLOYEE + CHILDREN HDHP HEALTH	$436.76	$48.53	$485.29	$0.00
EMPLOYEE + FAMILY HDHP HEALTH	$666.23	$74.03	$740.25	$0.00

DENTAL INSURANCE*	District Pays Bi-Weekly 24 Pays	Employee Pays Bi-Weekly 24 Pays
SINGLE DENTAL	$14.50	$0.00
EMPLOYEE + SPOUSE DENTAL	$14.50	$17.50
EMPLOYEE + CHILDREN DENTAL	$14.50	$13.58
EMPLOYEE + FAMILY DENTAL	$14.50	$28.46

LIFE INSURANCE	District Pays Bi-Weekly 24 Pays	Employee Pays Bi-Weekly 24 Pays
$50,000 TERM LIFE	$1.63	$0.00
Supplemental Life per $50,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$5.00
Spouse Supplemental Life per $25,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$2.25
Dependent Child Life $10,000 Coverage	$0.00	$1.63

VISION INSURANCE	District Pays Bi-Weekly 24 Pays	Employee Pays Bi-Weekly 24 Pays
SINGLE VISION	$0.00	$3.28
EMPLOYEE + SPOUSE VISION	$0.00	$6.23
EMPLOYEE + CHILDREN VISION	$0.00	$6.56
EMPLOYEE + FAMILY VISION	$0.00	$9.64

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
Long Term Disability (required)	0.1600%	0.0000%
Nebraska Public Employees Retirement System (required) ****	9.8778%	9.7800%
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.
(2021 Limits = $2,750 per year for Section 125 Medical and $5,000 per year for Section 125 Child/Elder Care)
(2021 Limits for Health Savings Account = $2,500 per year for single or $5,000 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

BENEFIT ELIGIBILITY LIST 2021: HOURLY PROFESSIONAL TECHNICAL 12 MONTH PART-TIME

Premium Amounts Are Per Pay Check

HEALTH INSURANCE*	Bi-Weekly 24 Pays Non-Wellness Participant	Bi-Weekly 24 Pays Non-Wellness Participant	Bi-Weekly 24 Pays Wellness Participant	Bi-Weekly 24 Pays Wellness Participant
TRADITIONAL PREFERED PROVIDER OPTION #1	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE PPO HEALTH	$134.48	$224.14	$152.42	$206.21
EMPLOYEE + SPOUSE PPO HEALTH	$282.38	$470.63	$320.03	$432.98
EMPLOYEE + CHILDREN PPO HEALTH	$248.78	$414.64	$281.95	$381.46
EMPLOYEE + FAMILY PPO HEALTH	$379.14	$631.90	$429.69	$581.35
STANDARD HIGH DEDUCTIBLE PLAN OPTION #2	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$132.51	$161.95	$147.23	$147.23
EMPLOYEE + SPOUSE HDHP HEALTH	$278.25	$340.08	$309.17	$309.17
EMPLOYEE + CHILDREN HDHP HEALTH	$244.95	$299.38	$272.17	$272.17
EMPLOYEE + FAMILY HDHP HEALTH	$373.43	$456.41	$414.92	$414.92
CHI NETWORK HIGH DEDUCTIBLE PLAN OPTION #3	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$116.34	$142.20	$129.27	$129.27
EMPLOYEE + SPOUSE HDHP HEALTH	$243.56	$297.69	$270.63	$270.63
EMPLOYEE + CHILDREN HDHP HEALTH	$214.33	$261.96	$238.15	$238.15
EMPLOYEE + FAMILY HDHP HEALTH	$326.93	$399.58	$363.25	$363.25
NHN NETWORK HIGH DEDUCTIBLE PLAN OPTION #4	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$118.54	$144.88	$131.71	$131.71
EMPLOYEE + SPOUSE HDHP HEALTH	$248.16	$303.30	$275.73	$275.73
EMPLOYEE + CHILDREN HDHP HEALTH	$218.38	$266.91	$242.65	$242.65
EMPLOYEE + FAMILY HDHP HEALTH	$333.11	$407.14	$370.13	$370.13

DENTAL INSURANCE*	District Pays Bi-Weekly 24 Pays	Employee Pays Bi-Weekly 24 Pays
SINGLE DENTAL	$7.25	$7.25
EMPLOYEE + SPOUSE DENTAL	$7.25	$24.75
EMPLOYEE + CHILDREN DENTAL	$7.25	$20.83
EMPLOYEE + FAMILY DENTAL	$7.25	$35.71

LIFE INSURANCE	District Pays Bi-Weekly 24 Pays	Employee Pays Bi-Weekly 24 Pays
$50,000 TERM LIFE	$1.63	$0.00
Supplemental Life per $50,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$5.00
Spouse Supplemental Life per $25,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$2.25
Dependent Child Life $10,000 Coverage	$0.00	$1.63

VISION INSURANCE	District Pays Bi-Weekly 24 Pays	Employee Pays Bi-Weekly 24 Pays
SINGLE VISION	$0.00	$3.28
EMPLOYEE + SPOUSE VISION	$0.00	$6.23
EMPLOYEE + CHILDREN VISION	$0.00	$6.56
EMPLOYEE + FAMILY VISION	$0.00	$9.64

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
Long Term Disability (required)	0.1600%	0.0000%
Nebraska Public Employees Retirement System (required) ****	9.8778%	9.7800%
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.
(2021 Limits = $2,750 per year for Section 125 Medical and $5,000 per year for Section 125 Child/Elder Care)
(2021 Limits for Health Savings Account = $2,500 per year for single or $5,000 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

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BENEFIT ELIGIBILITY LIST 2021: SALARIED PROFESSIONAL TECHNICAL SALARIED FULL-TIME

Premium Amounts Are Per Pay Check

HEALTH INSURANCE*	Monthly Rate for Non-Wellness Participant	Monthly Rate for Non-Wellness Participant	Monthly Rate for Wellness Participant	Monthly Rate for Wellness Participant
TRADITIONAL PREFERED PROVIDER OPTION #1	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE PPO HEALTH	$537.94	$179.31	$609.66	$107.59
EMPLOYEE + SPOUSE PPO HEALTH	$1,129.50	$376.50	$1,280.10	$225.90
EMPLOYEE + CHILDREN PPO HEALTH	$995.13	$331.71	$1,127.81	$199.03
EMPLOYEE + FAMILY PPO HEALTH	$1,516.56	$505.52	$1,718.77	$303.31
STANDARD HIGH DEDUCTIBLE PLAN OPTION #2	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$530.03	$58.89	$588.92	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$1,113.00	$123.67	$1,236.67	$0.00
EMPLOYEE + CHILDREN HDHP HEALTH	$979.80	$108.87	$1,088.67	$0.00
EMPLOYEE + FAMILY HDHP HEALTH	$1,493.70	$165.97	$1,659.67	$0.00
CHI NETWORK HIGH DEDUCTIBLE PLAN OPTION #3	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$465.38	$51.71	$517.08	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$974.25	$108.25	$1,082.50	$0.00
EMPLOYEE + CHILDREN HDHP HEALTH	$857.33	$95.26	$952.58	$0.00
EMPLOYEE + FAMILY HDHP HEALTH	$1,307.70	$145.30	$1,453.00	$0.00
NHN NETWORK HIGH DEDUCTIBLE PLAN OPTION #4	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$474.15	$52.68	$526.83	$0.00
EMPLOYEE + SPOUSE HDHP HEALTH	$992.63	$110.29	$1,102.92	$0.00
EMPLOYEE + CHILDREN HDHP HEALTH	$873.53	$97.06	$970.58	$0.00
EMPLOYEE + FAMILY HDHP HEALTH	$1,332.45	$148.05	$1,480.50	$0.00

DENTAL INSURANCE*	District Pays Monthly Rate	Employee Pays Monthly Rate
SINGLE DENTAL	$29.00	$0.00
EMPLOYEE + SPOUSE DENTAL	$29.00	$35.00
EMPLOYEE + CHILDREN DENTAL	$29.00	$27.17
EMPLOYEE + FAMILY DENTAL	$29.00	$56.92

LIFE INSURANCE	District Pays Monthly Rate	Employee Pays Monthly Rate
$50,000 TERM LIFE	$3.25	$0.00
Supplemental Life per $50,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$10.00
Spouse Supplemental Life per $25,000 in coverage (any request for an increase requires Evidence of Insurability form)**	$0.00	$4.50
Dependent Child Life $10,000 Coverage	$0.00	$3.25

VISION INSURANCE	District Pays Monthly Rate	Employee Pays Monthly Rate
SINGLE VISION	$0.00	$6.55
EMPLOYEE + SPOUSE VISION	$0.00	$12.46
EMPLOYEE + CHILDREN VISION	$0.00	$13.12
EMPLOYEE + FAMILY VISION	$0.00	$19.28

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
Long Term Disability (required)	$0.00	0.1600%
Nebraska Public Employees Retirement System (required) ****	9.8778%	9.7800%
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.
(2021 Limits = $2,750 per year for Section 125 Medical and $5,000 per year for Section 125 Child/Elder Care)
(2021 Limits for Health Savings Account = $2,500 per year for single or $5,000 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

BENEFIT ELIGIBILITY LIST 2021: SALARIED PROFESSIONAL TECHNICAL PART-TIME

Premium Amounts Are Per Pay Check

HEALTH INSURANCE*	Monthly Rate for Non-Wellness Participant	Monthly Rate for Non-Wellness Participant	Monthly Rate for Wellness Participant	Monthly Rate for Wellness Participant
TRADITIONAL PREFERED PROVIDER OPTION #1	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE PPO HEALTH	$268.97	$448.28	$304.83	$412.42
EMPLOYEE + SPOUSE PPO HEALTH	$564.75	$941.25	$640.05	$865.95
EMPLOYEE + CHILDREN PPO HEALTH	$497.56	$829.27	$563.90	$762.93
EMPLOYEE + FAMILY PPO HEALTH	$758.28	$1,263.80	$859.39	$1,162.70
STANDARD HIGH DEDUCTIBLE PLAN OPTION #2	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$265.01	$323.90	$294.46	$294.46
EMPLOYEE + SPOUSE HDHP HEALTH	$556.50	$680.17	$618.33	$618.33
EMPLOYEE + CHILDREN HDHP HEALTH	$489.90	$598.77	$544.33	$544.33
EMPLOYEE + FAMILY HDHP HEALTH	$746.85	$912.82	$829.83	$829.83
CHI NETWORK HIGH DEDUCTIBLE PLAN OPTION #3	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$232.69	$284.40	$258.54	$258.54
EMPLOYEE + SPOUSE HDHP HEALTH	$487.13	$595.38	$541.25	$541.25
EMPLOYEE + CHILDREN HDHP HEALTH	$428.66	$523.92	$476.29	$476.29
EMPLOYEE + FAMILY HDHP HEALTH	$653.85	$799.15	$726.50	$726.50
NHN NETWORK HIGH DEDUCTIBLE PLAN OPTION #4	DISTRICT PAYS:	EMPLOYEE PAYS:	DISTRICT PAYS:	EMPLOYEE PAYS:
SINGLE HDHP HEALTH	$237.08	$289.76	$263.42	$263.42
EMPLOYEE + SPOUSE HDHP HEALTH	$496.31	$606.60	$551.46	$551.46
EMPLOYEE + CHILDREN HDHP HEALTH	$436.76	$533.82	$485.29	$485.29
EMPLOYEE + FAMILY HDHP HEALTH	$666.23	$814.28	$740.25	$740.25

DENTAL INSURANCE*	District Pays Monthly Rate	Employee Pays Monthly Rate
SINGLE DENTAL	$14.50	$14.50
EMPLOYEE + SPOUSE DENTAL	$14.50	$49.50
EMPLOYEE + CHILDREN DENTAL	$14.50	$41.67
EMPLOYEE + FAMILY DENTAL	$14.50	$71.42

LIFE INSURANCE	District Pays Monthly Rate	Employee Pays Monthly Rate
$50,000 TERM LIFE	$3.25	$0.00
Supplemental Life per $50,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$10.00
Spouse Supplemental Life per $25,000 in coverage (any request for an increase requires Evidence of Insurability form)*	$0.00	$4.50
Dependent Child Life $10,000 Coverage	$0.00	$3.25

VISION INSURANCE	District Pays Monthly Rate	Employee Pays Monthly Rate
SINGLE VISION	$0.00	$6.55
EMPLOYEE + SPOUSE VISION	$0.00	$12.46
EMPLOYEE + CHILDREN VISION	$0.00	$13.12
EMPLOYEE + FAMILY VISION	$0.00	$19.28

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
Long Term Disability (required)	$0.00	0.1600%
Nebraska Public Employees Retirement System (required) ****	9.8778%	9.7800%
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.
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(2021 Limits for Health Savings Account = $2,500 per year for single or $5,000 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

Millard PUBLIC SCHOOLS

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
https://www.mpsomaha.org/departments/human-resources/benefits - choose the wellness button
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 **Aetna Web Portal** **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. Log in to Aetna.com to complete your health assessment (health questionnaire). **Need assistance logging in? Call 1-800-225-3375.**

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 Benefits on the left. Choose the benefit button you are interested in.

- **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.
- **Best Care Employee Assistance Program:** 402-354-8000 or 800-666-8606. http://www.bestcareeap.org/

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 10/31/2022

►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 10/31/2022

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 147th 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
		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:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in 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**
(Rev. December 2020)
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

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

► _____ ► _____

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $25,100 if you're married filing jointly or qualifying widow(er)
- $18,800 if you're head of household
- $12,550 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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 with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$190	$850	$890	$1,020	$1,020	$1,020	$1,020	$1,020	$1,100	$1,870	$1,870
$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$440	$940	$1,020	$1,020	$1,410	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040	$2,040
$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$820	$930	$1,020	$1,020	$1,020	$1,420	$1,870	$1,870	$1,910	$2,040	$2,040
$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

NEBRASKA
Good Life. Great Service.
DEPARTMENT OF REVENUE

Employee's Nebraska Withholding Allowance Certificate

- **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the Nebraska Department of Revenue (DOR). Your employer may be required to send a copy of this form to DOR.**

FORM
W-4N

Your First Name and Initial	Last Name	Your Social Security Number

Current Mailing Address (Number and Street or PO Box)

City | State | Zip Code

☐ Single ☐ Married

Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. Individuals filing income tax returns with a "Head of Household" status check the "Single" box.

1 Total number of allowances you are claiming (from line 4g on the worksheet below)	**1**	
2 Additional amount, if any, you want withheld from each paycheck for Nebraska income tax withheld	**2**	
3 I claim exemption from withholding and I can provide satisfactory evidence to my employer that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of all Nebraska income tax withheld because I had no tax liability, and • This year I expect a refund of all Nebraska income tax withheld because I expect to have no tax liability. If you can provide evidence that you can meet both conditions, write "Exempt" here	**3**	

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

sign here ▶ Employee's Signature _____ Date _____

Employer's Name and Address (Employer: Complete employer information if sending to DOR)	Nebraska ID Number

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

Personal Allowances Worksheet

• Keep for your records.

Allowances approximate tax deductions that may reduce your tax liability. The number of allowances is determined by many factors including, but not limited to, filing status, how many jobs you have, tax credits, and how many children or dependents that you claim on your tax return.

Allowances claimed on the Form W-4N are used by your employer to determine the Nebraska state income tax withheld from your wages to meet your Nebraska state income tax obligation.

4 a Enter "1" for **yourself** if no one else can claim you as a dependent	**4a**	
b Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both for the year) are $1,500 or less	**4b**	
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)	**4c**	
d Enter number of Nebraska personal exemptions (other than your spouse or yourself) you will claim on your Nebraska tax return. This is the number of children and dependents you will list on your Nebraska return that qualify for either the child or dependent tax credit on the federal return	**4d**	
e Enter "1" if you will file as **head of household** on your tax return	**4e**	
f Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit	**4f**	
g Enter total of lines a through f here and on line 1 above. (Note: This may be different from the number of exemptions you claim on your Nebraska tax return)	**4g**	

Instructions

Purpose. The Nebraska Form W-4N was developed due to significant differences between the federal and Nebraska laws regarding standard deductions and because personal exemptions credits are allowed on the Nebraska return. Beginning January 1, 2020, the Nebraska Form W-4N will be used by your employer in conjunction with the Nebraska Circular EN to determine the correct Nebraska income tax withholding when the federal Form W-4 is completed on or after January 1, 2020. Employees who have completed the federal Form W-4 prior to January 1, 2020, are not required to submit a Nebraska Form W-4N and employers will continue to use the federal Form W-4 on file for Nebraska withholding purposes. For every federal Form W-4 employers receive, after January 1, 2020 a Nebraska W-4N must be completed. If you did not complete a federal Form W-4 prior to January 1, 2020 or beginning January 1, 2020 completed a federal Form W-4 but did not submit a Nebraska Form W-4N, your employer must withhold as if you were single and claimed no withholding allowances.

Withholding allowances directly affect how much money is withheld from your pay. The amount withheld is reduced for each allowance taken. Depending on your personal circumstances, you may not want to claim every allowance you are eligible to take. If you do not have enough state income tax withheld, an underpayment penalty may be charged.

Complete Form W-4N so your employer can withhold the correct Nebraska income tax from your pay. When your personal or financial situation changes, consider completing a new Form W-4N.

If you claim exemption from withholding, skip lines 1 and 2, write "exempt" on line 3, and sign the form to validate it. **An exemption is good for only 1 year**. You must give your employer a new Form W-4N by February 15 each year to continue your exemption. You cannot claim exemption from withholding if another person can claim you on their tax return; and your total income exceeds $1,100 and includes more than $350 of unearned income.

If your employer is subject to the special withholding procedures specified in the Nebraska Circular EN, you may be required to submit documentation to your employer to support your claim for exemption from withholding.

Employers

An employer may withhold an amount that is less than 1.5% of the employee's taxable wages if the employee provides sufficient documentation to verify that a lesser amount of income tax withholding is justified in the employee's particular circumstance. Documentation may include:

- Verification of number of children/dependents;
- Marital status; and/or
- The amount of itemized deductions.

Without documentation, the employee's income tax withholding must be set at 1.5% or at a higher level within the nonshaded area of the income tax withholding tables.

Penalties. The employer may be subject to a penalty of up to $1,000 for each employee under-withheld if the employee's low income tax withholding is not substantiated.

A taxpayer who intentionally claims an excessive number of exemptions is guilty of a Class II misdemeanor.

Any person who willfully attempts to evade the Nebraska income tax is guilty of a Class IV felony.

Any person who willfully fails to withhold, deduct, and truthfully account for and pay over any income tax withheld is guilty of a Class IV felony.

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://www.mpsomaha.org/board/policies

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
3911.1	Employee Indemnification/Hold Harmless
4001	Non-Discrimination and Harassment Policy
4001.1	Non-Discrimination and Harassment
4001.2	Non-Discrimination and Harassment Complaint Procedures
4001.3	Harassment Complaint Procedure
4140	Responsibilities and Duties
4140.1	Responsibilities and Duties – Certificated
4140.2	Responsibilities and Duties – Non- Certificated
4153	Professional Boundaries and Staff Relationships with Students
4153.1	Professional Boundaries and Staff Relationships with Students
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, marital status, disability, age, sex, sexual orientation, gender, gender identity, or on any other basis prohibited by federal, state, or local laws in admission to 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 and harassment policies: Associate Superintendent of Human Resources, 5606 S. 147th Street, Omaha, NE 68137 402-715-8200. The Associate Superintendent of Human Resources may delegate this responsibility as needed.
- Complaints by school personnel or job applicants regarding unlawful discrimination or unlawful harassment shall follow the procedures of District Rule 4001.2. School personnel or job applicant complaints regarding sexual harassment shall follow the procedures of District Rule 4001.3.

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, and job provides access to, electronically deliverable copies of the compliance notices, including but not limited to 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.

I consent to electronic delivery of compliance and other required notices.

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)
- Notice of Marketplace Coverage Options

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.

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

Signature: _____

Date _____

Millard PUBLIC SCHOOLS

Benefit Enrollment Form 2021

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.	Sex	Birthdate

Street Address	Apt. No.	City	State	ZIP	County

Home Phone	Work phone	Marital Status

Effective Date of Change in Benefits	Occupational / Job Title

☐ **Full-time** ☐ **12 Month** ☐ **Full-time** ☐ **10 Month**

☐ **Part-time** ☐ **12 Month (less than 1.0 FTE)** ☐ **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 OR choose a health plan and level below**

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

- ☐ List all family members to be covered. Write name as it should appear on I.D. card.
- ☐ Indicate dependent address (if different)
- ☐ 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 _____ To _____	Name of Policyholder	Policyholder's Birthdate	Family Members Covered

Policyholder's Employer: Name	Address	Phone Number

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

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.

HEALTH SAVINGS ACCOUNT ELIGIBILITY (REQUIRED)

☐ 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.*

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 eligible to be claimed as a dependent on another person's tax return.
- Not be enrolled in Medicare or Tricare
- Not be enrolled in Indian Health Services
- Have not received medical benefits from the VA for non-service connected to disabilities in the previous 3 months

Are you thinking of retiring within the next 6-12 months?

If you decide to delay participating in Medicare and later apply for Medicare outside your initial Medicare eligibility period, Medicare may be backdated six months. HSA contributions during the six-month retroactive period can result in tax penalties. You should speak with your tax advisor and Social Security specialist to understand your choices.

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

Total Annual Employee Deduction Amount $

Per Pay Check Deduction $

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

Total Annual Employer Contribution:

Single: $ _____

Family: $ _____

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. ***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: _____ DATE_____

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**.

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