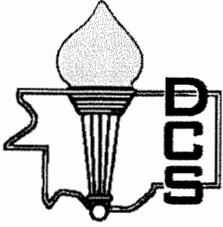


**NEW HIRE
PACKET**

**FULL-TIME
EMPLOYEES**

(Revised January 2020)



DESOTO COUNTY SCHOOLS

5 East South Street • Hernando, Mississippi 38632
662-429-5271 • fax 662-429-4198 • Website: www.desotocountyschools.org

"EXCELLENCE IS A COMMITMENT"

WELCOME TO DESOTO COUNTY SCHOOLS

Welcome to Desoto County Schools. It is a great honor to have you as part of our team.

Enclosed you will find forms that must be completed in order to process your employment. Please be advised that all forms need to be completed in **black/blue ink**. All forms will be returned to Human Resources during New Employee Orientation. All employees are required to provide their Social Security card and a valid form of photo identification (i.e. driver's license, passport, etc.)

The following employment forms are included within this packet:

- Employment Information Form
- Employment Eligibility Verification (I-9 Form)
- Federal Tax Withholding Allowance Certificate (W-4 Form)
- Mississippi Employee's Withholding Exemption Certificate
- Retirement Information Form
- PERS Membership Application (PERS Form 1)
- PERS Beneficiary Designation (PERS Form 1B)
- Direct Deposit Authorization Agreement (Mandatory)
- PowerSchool User and Responsibility Acknowledgement
- Employee Computer Network/Internet Acceptable Use Policy
- Confidentiality Statement
- Equal Employment Opportunity Form
- Insurance:
 - Health Insurance Enrollment Form
 - Life Insurance Enrollment Form
 - Vision/Dental Enrollment Form

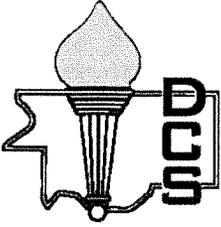
Insurance benefits participation is optional. However, each insurance form must be completed. If it is your decision not to participate in any insurance plans, please complete all forms accordingly to waive coverage.

Desoto County Schools also offers benefits through American Fidelity Assurance Company. These benefits include Cancer, Salary Protection (Disability), Accident, Long Term Care, GAP Insurance, as well as Life Insurance that may include your spouse and/or children. All of the above mentioned benefits are optional and the premiums are deducted through payroll. Representatives will offer these benefits to each full-time employee at each school or location.

If you are a **certified employee**, it is your responsibility to provide the following information before the payroll criteria deadline in order for pay to be set at the appropriate salary level:

- Copy of a valid Mississippi Educator's Licensure
- Verification of Years of Experience

All newly hired employees must attend New Employee Orientation before beginning employment. If you have any questions, please contact the Human Resources Department.



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"EXCELLENCE IS A COMMITMENT"

To: All Newly Hired DCS Employees

Re: Background Checks

- ✓ CIC (Criminal Investigation Check) fingerprint processing for State and Federal are performed for each newly hired employee prior to new hire orientation.
- ✓ The new employee may not report to work until the results of the background check have been received and approved by the Safety and Security Department.
- ✓ The current fee is \$32.00 and payment is due at the time of processing.
- ✓ Payment must be in the form of cash or check made payable to Desoto County Schools.
- ✓ Policies regarding the cost of background checks are subject to change at the discretion of the Desoto County School Board.



Instructions for Form I-9, Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047
Expires 08/31/2019

Anti-Discrimination Notice. It is illegal to discriminate against work-authorized individuals in hiring, firing, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) the employee may present to establish employment authorization and identity. The employer must allow the employee to choose the documents to be presented from the Lists of Acceptable Documents, found on the last page of Form I-9. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Immigrant and Employee Rights Section (IER) in the Department of Justice's Civil Rights Division at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TTY), or visit <https://www.justice.gov/crt/immigrant-and-employee-rights-section>.

What is the Purpose of This Form?

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

General Instructions

Both employers and employees are responsible for completing their respective sections of Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors, as defined in section 3 of the Migrant and Seasonal Agricultural Worker Protection Act, Public Law 97-470 (29 U.S.C. 1802). An "employee" is a person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term "Employee" does not include those who do not receive any form of remuneration (volunteers), independent contractors or those engaged in certain casual domestic employment. Form I-9 has three sections. Employees complete Section 1. Employers complete Section 2 and, when applicable, Section 3. Employers may be fined if the form is not properly completed. See 8 USC § 1324a and 8 CFR § 274a.10. Individuals may be prosecuted for knowingly and willfully entering false information on the form. Employers are responsible for retaining completed forms. **Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).**

These instructions will assist you in properly completing Form I-9. The employer must ensure that all pages of the instructions and Lists of Acceptable Documents are available, either in print or electronically, to all employees completing this form. When completing the form on a computer, the English version of the form includes specific instructions for each field and drop-down lists for universally used abbreviations and acceptable documents. To access these instructions, move the cursor over each field or click on the question mark symbol (?) within the field. Employers and employees can also access this full set of instructions at any time by clicking the Instructions button at the top of each page when completing the form on a computer that is connected to the Internet.

Employers and employees may choose to complete any or all sections of the form on paper or using a computer, or a combination of both. Forms I-9 obtained from the USCIS website are not considered electronic Forms I-9 under DHS regulations and, therefore, cannot be electronically signed. Therefore, regardless of the method you used to enter information into each field, you must print a hard copy of the form, then sign and date the hard copy by hand where required.

Employers can obtain a blank copy of Form I-9 from the USCIS website at <https://www.uscis.gov/sites/default/files/files/form/i-9.pdf>. This form is in portable document format (.pdf) that is fillable and savable. That means that you may download it, or simply print out a blank copy to enter information by hand. You may also request paper Forms I-9 from USCIS.

Certain features of Form I-9 that allow for data entry on personal computers may make the form appear to be more than two pages. When using a computer, Form I-9 has been designed to print as two pages. Using more than one preparer and/or translator will add an additional page to the form, regardless of your method of completion. You are not required to print, retain or store the page containing the Lists of Acceptable Documents.

The form will also populate certain fields with N/A when certain user choices ensure that particular fields will not be completed. The Print button located at the top of each page that will print any number of pages the user selects. Also, the Start Over button located at the top of each page will clear all the fields on the form.

The Spanish version of Form I-9 does not include the additional instructions and drop-down lists described above. Employers in Puerto Rico may use either the Spanish or English version of the form. Employers outside of Puerto Rico must retain the English version of the form for their records, but may use the Spanish form as a translation tool. Additional guidance to complete the form may be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) and on USCIS' Form I-9 website, [I-9 Central](#).

Completing Section I: Employee Information and Attestation

You, the employee, must complete each field in Section 1 as described below. Newly hired employees must complete and sign Section 1 no later than the first day of employment. Section 1 should never be completed before you have accepted a job offer.

Entering Your Employee Information

Last Name (Family Name): Enter your full legal last name. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the Last Name field. *Examples of correctly entered last names include De La Cruz, O'Neill, Garcia Lopez, Smith-Johnson, Nguyen.* If you only have one name, enter it in this field, then enter "Unknown" in the First Name field. You may not enter "Unknown" in both the Last Name field and the First Name field.

First Name (Given Name): Enter your full legal first name. Your first name is your given name. *Some examples of correctly entered first names include Jessica, John-Paul, Tae Young, D'Shaun, Mai.* If you only have one name, enter it in the Last Name field, then enter "Unknown" in this field. You may not enter "Unknown" in both the First Name field and the Last Name field.

Middle Initial: Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any. If you have more than one middle name, enter the first letter of your first middle name. If you do not have a middle name, enter N/A in this field.

Other Last Names Used: Provide all other last names used, if any (e.g., maiden name). Enter N/A if you have not used other last names. For example, if you legally changed your last name from Smith to Jones, you should enter the name Smith in this field.

Address (Street Name and Number): Enter the street name and number of the current address of your residence. If you are a border commuter from Canada or Mexico, you may enter your Canada or Mexico address in this field. If your residence does not have a physical address, enter a description of the location of your residence, such as "3 miles southwest of Anytown post office near water tower."

Apartment: Enter the number(s) or letter(s) that identify(ies) your apartment. If you do not live in an apartment, enter N/A.

City or Town: Enter your city, town or village in this field. If your residence is not located in a city, town or village, enter your county, township, reservation, etc., in this field. If you are a border commuter from Canada, enter your city and province in this field. If you are a border commuter from Mexico, enter your city and state in this field.

State: Enter the abbreviation of your state or territory in this field. If you are a border commuter from Canada or Mexico, enter your country abbreviation in this field.

ZIP Code: Enter your 5-digit ZIP code. If you are a border commuter from Canada or Mexico, enter your 5- or 6-digit postal code in this field.

Date of Birth: Enter your date of birth as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 1980 as 01/08/1980.

U.S. Social Security Number: Providing your 9-digit Social Security number is voluntary on Form I-9 unless your employer participates in E-Verify. If your employer participates in E-Verify and:

1. You have been issued a Social Security number, you must provide it in this field; or
2. You have applied for, but have not yet received a Social Security number, leave this field blank until you receive a Social Security number.

Employee's E-mail Address (Optional): Providing your e-mail address is optional on Form I-9, but the field cannot be left blank. To enter your e-mail address, use this format: name@site .domain. One reason Department of Homeland Security (DHS) may e-mail you is if your employer uses E-Verify and DHS learns of a potential mismatch between the information provided and the information in government records. This e-mail would contain information on how to begin to resolve the potential mismatch. You may use either your personal or work e-mail address in this field. Enter N/A if you do not enter your e-mail address.

Employee's Telephone Number (Optional): Providing your telephone number is optional on Form I-9, but the field cannot be left blank. If you enter your area code and telephone number, use this format: 000-000-0000. Enter N/A if you do not enter your telephone number.

Attesting to Your Citizenship or Immigration Status

You must select one box to attest to your citizenship or immigration status.

- 1. A citizen of the United States.**
- 2. A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
- 3. A lawful permanent resident:** An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. This term includes conditional residents. Asylees and refugees should not select this status, but should instead select "An Alien authorized to work" below.

If you select "lawful permanent resident," enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or USCIS Number in the space provided. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

- 4. An alien authorized to work:** An individual who is not a citizen or national of the United States, or a lawful permanent resident, but is authorized to work in the United States.

If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the document(s) evidencing your employment authorization. Refugees, asylees and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other aliens whose employment authorization does not have an expiration date should enter N/A in the Expiration Date field. In some cases, such as if you have Temporary Protected Status, your employment authorization may have been automatically extended; in these cases, you should enter the expiration date of the automatic extension in this space.

Aliens authorized to work must enter one of the following to complete Section 1:

1. Alien Registration Number (A-Number)/USCIS Number; or
2. Form I-94 Admission Number; or
3. Foreign Passport Number and the Country of Issuance

Your employer may not ask you to present the document from which you supplied this information.

Alien Registration Number/USCIS Number: Enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or your USCIS Number in this field. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. If you do not provide an A-Number or USCIS Number, enter N/A in this field then enter either a Form I-94 Admission Number, or a Foreign Passport and Country of Issuance in the fields provided.

Form I-94 Admission Number: Enter your 11-digit I-94 Admission Number in this field. If you do not provide an I-94 Admission Number, enter N/A in this field, then enter either an Alien Registration Number/USCIS Number or a Foreign Passport Number and Country of Issuance in the fields provided.

Foreign Passport Number: Enter your Foreign Passport Number in this field. If you do not provide a Foreign Passport Number, enter N/A in this field, then enter either an Alien Number/USCIS Number or a I-94 Admission Number in the fields provided.

Country of Issuance: If you entered your Foreign Passport Number, enter your Foreign Passport's Country of Issuance. If you did not enter your Foreign Passport Number, enter N/A.

Signature of Employee: After completing Section 1, sign your name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing this form, you attest under penalty of perjury (28 U.S.C. § 1746) that the information you provided, along with the citizenship or immigration status you selected, and all information and documentation you provide to your employer, is complete, true and correct, and you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties, removal proceedings and may adversely affect an employee's ability to seek future immigration benefits. If you cannot sign your name, you may place a mark in this field to indicate your signature. Employees who use a preparer or translator to help them complete the form must still sign or place a mark in the Signature of Employee field on the printed form.

If you used a preparer, translator, and other individual to assist you in completing Form I-9:

- Both you and your preparer(s) and/or translator(s) must complete the appropriate areas of Section 1, and then sign Section 1. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to sign these fields. You and your preparer(s) and/or translator(s) also should review the instructions for **Completing the Preparer and/or Translator Certification** below.
- If the employee is a minor (individual under 18) who cannot present an identity document, the employee's parent or legal guardian can complete Section 1 for the employee and enter "minor under age 18" in the signature field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The minor's parent or legal guardian should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) for more guidance on completion of Form I-9 for minors. If the minor's employer participates in E-Verify, the employee must present a list B identity document with a photograph to complete Form I-9.
- If the employee is a person with a disability (who is placed in employment by a nonprofit organization, association or as part of a rehabilitation program) who cannot present an identity document, the employee's parent, legal guardian or a representative of the nonprofit organization, association or rehabilitation program can complete Section 1 for the employee and enter "Special Placement" in this field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The parent, legal guardian or representative of the nonprofit organization, association or rehabilitation program completing Section 1 for the employee should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) for more guidance on completion of Form I-9 for certain employees with disabilities.

Today's Date: Enter the date you signed Section 1 in this field. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014. A preparer or translator who assists the employee in completing Section 1 may enter the date the employee signed or made a mark to sign Section 1 in this field. Parents or legal guardians assisting minors (individuals under age 18) and parents, legal guardians or representatives of a nonprofit organization, association or rehabilitation program assisting certain employees with disabilities must enter the date they completed Section 1 for the employee.

Completing the Preparer and/or Translator Certification

If you did not use a preparer or translator to assist you in completing Section 1, you, the employee, must check the box marked **I did not use a Preparer or Translator**. If you check this box, leave the rest of the fields in this area blank.

If one or more preparers and/or translators assist the employee in completing the form using a computer, the preparer and/or translator must check the box marked **"A preparer(s) and/or translator(s) assisted the employee in completing Section 1"**, then select the number of Certification areas needed from the dropdown provided. Any additional Certification areas generated will result in an additional page. [Form I-9 Supplement](#), Section 1 Preparer and/or Translator Certification can be separately downloaded from the USCIS Form I-9 webpage, which provides additional Certification areas for those completing Form I-9 using a computer who need more Certification areas than the 5 provided or those who are completing Form I-9 on paper. The first preparer and/or translator must complete all the fields in the Certification area on the same page the employee has signed. There is no limit to the number of preparers and/or translators an employee can use, but each additional preparer and/or translator must complete and sign a separate Certification area. Ensure the employee's last name, first name and middle initial are entered at the top of any additional pages. The employer must ensure that any additional pages are retained with the employee's completed Form I-9.

Signature of Preparer or Translator: Any person who helped to prepare or translate Section 1 of Form I-9 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. The Preparer and/or Translator Certification must also be completed if “Individual under Age 18” or “Special Placement” is entered in lieu of the employee’s signature in Section 1.

Today’s Date: The person who signs the Preparer and/or Translator Certification must enter the date he or she signs in this field on the printed form. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Last Name (Family Name): Enter the full legal last name of the person who helped the employee in preparing or translating Section 1 in this field. The last name is also the family name or surname. If the preparer or translator has two last names or a hyphenated last name, include both names in this field.

First Name (Given Name): Enter the full legal first name of the person who helped the employee in preparing or translating Section 1 in this field. The first name is also the given name.

Address (Street Name and Number): Enter the street name and number of the current address of the residence of the person who helped the employee in preparing or translating Section 1 in this field. Addresses for residences in Canada or Mexico may be entered in this field. If the residence does not have a physical address, enter a description of the location of the residence, such as “3 miles southwest of Anytown post office near water tower.” If the residence is an apartment, enter the apartment number in this field.

City or Town: Enter the city, town or village of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the residence is not located in a city, town or village, enter the name of the county, township, reservation, etc., in this field. If the residence is in Canada, enter the city and province in this field. If the residence is in Mexico, enter the city and state in this field.

State: Enter the abbreviation of the state, territory or country of the preparer or translator’s residence in this field.

ZIP Code: Enter the 5-digit ZIP code of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the preparer or translator's residence is in Canada or Mexico, enter the 5- or 6-digit postal code.

Presenting Form I-9 Documents

Within 3 business days of starting work for pay, you must present to your employer documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before Thursday of that week. However, if you were hired to work for less than 3 business days, you must present documentation no later than the first day of employment.

Choose which unexpired document(s) to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which document(s) you may present from the Lists of Acceptable Documents. You may present either one selection from List A or a combination of one selection from List B and one selection from List C. Some List A documents, which show both identity and employment authorization, are combination documents that must be presented together to be considered a List A document: for example, the foreign passport together with a Form I-94 containing an endorsement of the alien’s nonimmigrant status and employment authorization with a specific employer incident to such status. List B documents show identity only and List C documents show employment authorization only. If your employer participates in E-Verify and you present a List B document, the document must contain a photograph. If you present acceptable List A documentation, you should not be asked to present, nor should you provide, List B and List C documentation. If you present acceptable List B and List C documentation, you should not be asked to present, nor should you provide, List A documentation. If you are unable to present a document(s) from these lists, you may be able to present an acceptable receipt. Refer to the Receipts section below.

Your employer must review the document(s) you present to complete Form I-9. If your document(s) reasonably appears to be genuine and to relate to you, your employer must accept the documents. If your document(s) does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documents from the Lists of Acceptable Documents. Your employer may choose to make copies of your document(s), but must return the original(s) to you. Your employer must review your documents in your physical presence.

Your employer will complete the other parts of this form, as well as review your entries in Section 1. Your employer may ask you to correct any errors found. Your employer is responsible for ensuring all parts of Form I-9 are properly completed and is subject to penalties under federal law if the form is not completed correctly.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) for more guidance on minors and certain individuals with disabilities.

Receipts

If you do not have unexpired documentation from the Lists of Acceptable Documents, you may be able to present a receipt(s) in lieu of an acceptable document(s). New employees who choose to present a receipt(s) must do so within three business days of their first day of employment. If your employer is reverifying your employment authorization, and you choose to present a receipt for reverification, you must present the receipt by the date your employment authorization expires. Receipts are not acceptable if employment lasts fewer than three business days.

There are three types of acceptable receipts:

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

Receipts showing that you have applied for an initial grant of employment authorization, or for renewal of your expiring or expired employment authorization, are not acceptable.

Completing Section 2: Employer or Authorized Representative Review and Verification

You, the employer, must ensure that all parts of Form I-9 are properly completed and may be subject to penalties under federal law if the form is not completed correctly. Section 1 must be completed no later than the employee's first day of employment. You may not ask an individual to complete Section 1 before he or she has accepted a job offer. Before completing Section 2, you should review Section 1 to ensure the employee completed it properly. If you find any errors in Section 1, have the employee make corrections, as necessary and initial and date any corrections made.

You or your authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete Section 2 on or before Thursday of that week. However, if you hire an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment.

Entering Employee Information from Section 1

This area, titled, "Employee Info from Section 1" contains fields to enter the employee's last name, first name, middle initial exactly as he or she entered them in Section 1. This area also includes a Citizenship/Immigration Status field to enter the number of the citizenship or immigration status checkbox the employee selected in Section 1. These fields help to ensure that the two pages of an employee's Form I-9 remain together. When completing Section 2 using a computer, the number entered in the Citizenship/Immigration Status field provides drop-downs that directly relate to the employee's selected citizenship or immigration status.

Entering Documents the Employee Presents

You, the employer or authorized representative, must physically examine, in the employee's physical presence, the unexpired document(s) the employee presents from the Lists of Acceptable Documents to complete the Document fields in Section 2.

You cannot specify which document(s) an employee may present from these lists. If you discriminate in the Form I-9 process based on an individual's citizenship status, immigration status, or national origin, you may be in violation of the law and subject to sanctions such as civil penalties and be required to pay back pay to discrimination victims. A document is acceptable as long as it reasonably appears to be genuine and to relate to the person presenting it. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

List A documents show both identity and employment authorization. Some List A documents are combination documents that must be presented together to be considered a List A document, such as a foreign passport together with a Form I-94 containing an endorsement of the alien's nonimmigrant status.

List B documents show identity only, and List C documents show employment authorization only. If an employee presents a List A document, do not ask or require the employee to present List B and List C documents, and vice versa. If an employer participates in E-Verify and the employee presents a List B document, the List B document must include a photograph.

If an employee presents a receipt for the application to replace a lost, stolen or damaged document, the employee must present the replacement document to you within 90 days of the first day of work for pay, or in the case of reverification, within 90 days of the date the employee's employment authorization expired. Enter the word "Receipt" followed by the title of the receipt in Section 2 under the list that relates to the receipt.

When your employee presents the replacement document, draw a line through the receipt, then enter the information from the new document into Section 2. Other receipts may be valid for longer or shorter periods, such as the arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and a photograph of the individual, which is valid until the expiration date of the temporary I-551 stamp or, if there is no expiration date, valid for one year from the date of admission.

Ensure that each document is an unexpired, original (no photocopies, except for certified copies of birth certificates) document. Certain employees may present an expired employment authorization document, which may be considered unexpired, if the employee's employment authorization has been extended by regulation or a Federal Register Notice. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) or I-9 Central for more guidance on these special situations.

Refer to the M-274 for guidance on how to handle special situations, such as students (who may present additional documents not specified on the Lists) and H-1B and H-2A nonimmigrants changing employers.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the M-274 for more guidance on minors and certain persons with disabilities. If the minor's employer participates in E-Verify, the minor employee also must present a List B identity document with a photograph to complete Form I-9.

You must return original document(s) to the employee, but may make photocopies of the document(s) reviewed. Photocopying documents is voluntary unless you participate in E-Verify. E-Verify employers are only required to photocopy certain documents. If you are an E-Verify employer who chooses to photocopy documents other than those you are required to photocopy, you should apply this policy consistently with respect to Form I-9 completion for all employees. For more information on the types of documents that an employer must photocopy if the employer uses E-Verify, visit E-Verify's website at www.dhs.gov/e-verify. For non-E-Verify employers, if photocopies are made, they should be made consistently for ALL new hires and reverified employees.

Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or another federal government agency. You must always complete Section 2 by reviewing original documentation, even if you photocopy an employee's document(s) after reviewing the documentation. Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. You are still responsible for completing and retaining Form I-9.

List A - Identity and Employment Authorization: If the employee presented an acceptable document(s) from List A or an acceptable receipt for a List A document, enter the document(s) information in this column. If the employee presented a List A document that consists of a combination of documents, enter information from each document in that combination in a separate area under List A as described below. All documents must be unexpired. If you enter document information in the List A column, you should not enter document information in the List B or List C columns. If you complete Section 2 using a computer, a selection in List A will fill all the fields in the Lists B and C columns with N/A.

Document Title: If the employee presented a document from List A, enter the title of the List A document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviation to enter the document title or issuing authority. If the employee presented a combination of documents, use the second and third Document Title fields as necessary.

Full name of List A Document	Abbreviations
U.S. Passport	U.S. Passport
U.S. Passport Card	U.S. Passport Card
Permanent Resident Card (Form I-551)	Perm. Resident Card (Form I-551)
Alien Registration Receipt Card (Form I-551)	Alien Reg. Receipt Card (Form I-551)
Foreign passport containing a temporary I-551 stamp	1. Foreign Passport 2. Temporary I-551 Stamp
Foreign passport containing a temporary I-551 printed notation on a machine-readable immigrant visa (MRIV)	1. Foreign Passport 2. Machine-readable immigrant visa (MRIV)
Employment Authorization Document (Form I-766)	Employment Auth. Document (Form I-766)
For a nonimmigrant alien authorized to work for a specific employer because of his or her status, a foreign passport with Form I-94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Foreign Passport, work-authorized non-immigrant 2. Form I-94/I94A 3. "Form I-20" or "Form DS-2019" Note: In limited circumstances, certain J-1 students may be required to present a letter from their Responsible Officer in order to work. Enter the document title, issuing authority, document number and expiration date from this document in the Additional Information field.
Passport from the Federated States of Micronesia (FSM) with Form I-94/I-94A	1. FSM Passport with Form I-94 2. Form I-94/I94A
Passport from the Republic of the Marshall Islands (RMI) with Form I-94/I94A	1. RMI Passport with Form I-94 2. Form I-94/I94A
Receipt: The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and photograph	Receipt: Form I-94/I-94A w/I-551 stamp, photo
Receipt: The departure portion of Form I-94/I-94A with an unexpired refugee admission stamp	Receipt: Form I-94/I-94A w/refugee stamp
Receipt for an application to replace a lost, stolen or damaged Permanent Resident Card (Form I-551)	Receipt replacement Perm. Res. Card (Form I-551)
Receipt for an application to replace a lost, stolen or damaged Employment Authorization Document (Form I-766)	Receipt replacement EAD (Form I-766)
Receipt for an application to replace a lost, stolen or damaged foreign passport with Form I-94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Receipt: Replacement Foreign Passport, work-authorized nonimmigrant 2. Receipt: Replacement Form I-94/I-94A 3. Form I-20 or Form DS-2019 (if presented)
Receipt for an application to replace a lost, stolen or damaged passport from the Federated States of Micronesia with Form I-94/I-94A	1. Receipt: Replacement FSM Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A
Receipt for an application to replace a lost, stolen or damaged passport from the Republic of the Marshall Islands with Form I-94/I-94A	1. Receipt: Replacement RMI Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A

Issuing Authority: Enter the issuing authority of the List A document or receipt. The issuing authority is the specific entity that issued the document. If the employee presented a combination of documents, use the second and third Issuing Authority fields as necessary.

Document Number: Enter the document number, if any, of the List A document or receipt presented. If the document does not contain a number, enter N/A in this field. If the employee presented a combination of documents, use the second and third Document Number fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the Student and Exchange Visitor Information System (SEVIS) number in the third Document Number field exactly as it appears on the Form I-20 or the DS-2019.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List A document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. If the document uses text rather than a date to indicate when it expires, enter the text as shown on the document, such as “D/S”(which means, “duration of status”). For a receipt, enter the expiration date of the receipt validity period as described above. If the employee presented a combination of documents, use the second and third Expiration Date fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the program end date here.

List B - Identity: If the employee presented an acceptable document from List B or an acceptable receipt for the application to replace a lost, stolen, or destroyed List B document, enter the document information in this column. If a parent or legal guardian attested to the identity of an employee who is an individual under age 18 or certain employees with disabilities in Section 1, enter either "Individual under age 18" or "Special Placement" in this field. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on individuals under age 18 and certain person with disabilities.

If you enter document information in the List B column, you must also enter document information in the List C column. If an employee presents acceptable List B and List C documents, do not ask the employees to present a List A document. No entries should be made in the List A column. If you complete Section 2 using a computer, a selection in List B will fill all the fields in the List A column with N/A.

Document Title: If the employee presented a document from List B, enter the title of the List B document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority.

Full name of List B Document	Abbreviations
Driver's license issued by a State or outlying possession of the United States	Driver's license issued by state/territory
ID card issued by a State or outlying possession of the United States	ID card issued by state/territory
ID card issued by federal, state, or local government agencies or entities	Government ID
School ID card with photograph	School ID
Voter's registration card	Voter registration card
U.S. Military card	U.S. Military card
U.S. Military draft record	U.S. Military draft record
Military dependent's ID card	Military dependent's ID card
U.S. Coast Guard Merchant Mariner Card	USCG Merchant Mariner card
Native American tribal document	Native American tribal document
Driver's license issued by a Canadian government authority	Canadian driver's license
School record (for persons under age 18 who are unable to present a document listed above)	School record (under age 18)
Report card (for persons under age 18 who are unable to present a document listed above)	Report card (under age 18)
Clinic record (for persons under age 18 who are unable to present a document listed above)	Clinic record (under age 18)
Doctor record (for persons under age 18 who are unable to present a document listed above)	Doctor record (under age 18)
Hospital record (for persons under age 18 who are unable to present a document listed above)	Hospital record (under age 18)
Day-care record (for persons under age 18 who are unable to present a document listed above)	Day-care record (under age 18)
Nursery school record (for persons under age 18 who are unable to present a document listed above)	Nursery school record (under age 18)

Full name of List B Document	Abbreviations
Individual under age 18 endorsement by parent or guardian	Individual under Age 18
Special placement endorsement for persons with disabilities	Special Placement
Receipt for the application to replace a lost, stolen or damaged Driver's License issued by a State or outlying possession of the United States	Receipt: Replacement driver's license
Receipt for the application to replace a lost, stolen or damaged ID card issued by a State or outlying possession of the United States	Receipt: Replacement ID card
Receipt for the application to replace a lost, stolen or damaged ID card issued by federal, state, or local government agencies or entities	Receipt: Replacement Gov't ID
Receipt for the application to replace a lost, stolen or damaged School ID card with photograph	Receipt: Replacement School ID
Receipt for the application to replace a lost, stolen or damaged Voter's registration card	Receipt: Replacement Voter reg. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military card	Receipt: Replacement U.S. Military card
Receipt for the application to replace a lost, stolen or damaged Military dependent's ID card	Receipt: Replacement U.S. Military dep. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military draft record	Receipt: Replacement Military draft record
Receipt for the application to replace a lost, stolen or damaged U.S. Coast Guard Merchant Mariner Card	Receipt: Replacement Merchant Mariner card
Receipt for the application to replace a lost, stolen or damaged Driver's license issued by a Canadian government authority	Receipt: Replacement Canadian DL
Receipt for the application to replace a lost, stolen or damaged Native American tribal document	Receipt: Replacement Native American tribal doc
Receipt for the application to replace a lost, stolen or damaged School record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement School record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Report card (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Report card (under age 18)
Receipt for the application to replace a lost, stolen or damaged Clinic record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Clinic record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Doctor record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Doctor record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Hospital record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Hospital record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Day-care record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Day-care record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Nursery school record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Nursery school record (under age 18)

Issuing Authority: Enter the issuing authority of the List B document or receipt. The issuing authority is the entity that issued the document. If the employee presented a document that is issued by a state agency, include the state as part of the issuing authority.

Document Number: Enter the document number, if any, of the List B document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List B document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

List C - Employment Authorization: If the employee presented an acceptable document from List C, or an acceptable receipt for the application to replace a lost, stolen, or destroyed List C document, enter the document information in this column. If you enter document information in the List C column, you must also enter document information in the List B column. If an employee presents acceptable List B and List C documents, do not ask the employee to present a list A document. No entries should be made in the List A column.

Document Title: If the employee presented a document from List C, enter the title of the List C document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority. If you are completing the form on a computer, and you select an Employment authorization document issued by DHS, the field will populate with List C #7 and provide a space for you to enter a description of the documentation the employee presented. Refer to the M-274 for guidance on entering List C #7 documentation.

Full name of List C Document	Abbreviations
Social Security Account Number card without restrictions	(Unrestricted) Social Security Card
Certification of Birth Abroad (Form FS-545)	Form FS-545
Certification of Report of Birth (Form DS-1350)	Form DS-1350
Consular Report of Birth Abroad (Form FS-240)	Form FS-240
Original or certified copy of a U.S. birth certificate bearing an official seal	Birth Certificate
Native American tribal document	Native American tribal document
U.S. Citizen ID Card (Form I-197)	Form I-197
Identification Card for use of Resident Citizen in the United States (Form I-179)	Form I-179
Employment authorization document issued by DHS (List C #7)	Employment Auth. document (DHS) List C #7
Receipt for the application to replace a lost, stolen or damaged Social Security Account Number Card without restrictions	Receipt: Replacement Unrestricted SS Card
Receipt for the application to replace a lost, stolen or damaged Original or certified copy of a U.S. birth certificate bearing an official seal	Receipt: Replacement Birth Certificate
Receipt for the application to replace a lost, stolen or damaged Native American Tribal Document	Receipt: Replacement Native American Tribal Doc.
Receipt for the application to replace a lost, stolen or damaged Employment Authorization Document issued by DHS	Receipt: Replacement Employment Auth. Doc. (DHS)

Issuing Authority: Enter the issuing authority of the List C document or receipt. The issuing authority is the entity that issued the document.

Document Number: Enter the document number, if any, of the List C document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List C document. The document is not acceptable if it has already expired, unless USCIS has extended the expiration date on the document. For instance, if a conditional resident presents a Form I-797 extending his or her conditional resident status with the employee's expired Form I-551, enter the future expiration date as indicated on the Form I-797. If the document has no expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

Additional Information: Use this space to notate any additional information required for Form I-9 such as:

- Employment authorization extensions for Temporary Protected Status beneficiaries, F-1 OPT STEM students, CAP-GAP, H-1B and H-2A employees continuing employment with the same employer or changing employers, and other nonimmigrant categories that may receive extensions of stay
- Additional document(s) that certain nonimmigrant employees may present
- Discrepancies that E-Verify employers must notate when participating in the IMAGE program
- Employee termination dates and form retention dates
- E-Verify case number, which may also be entered in the margin or attached as a separate sheet per E-Verify requirements and your chosen business process.
- Any other comments or notations necessary for the employer's business process

You may leave this field blank if the employee's circumstances do not require additional notations.

Entering Information in the Employer Certification

Employee's First Day of Employment: Enter the employee's first day of employment as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy).

Signature of Employer or Authorized Representative: Review the form for accuracy and completeness. The person who physically examines the employee's original document(s) and completes Section 2 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing Section 2, you attest under penalty of perjury (28 U.S.C. § 1746) that you have physically examined the documents presented by the employee, the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 2 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who signs Section 2 must enter the date he or she signed Section 2 in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print the form to write the date in this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Title of Employer or Authorized Representative: Enter the title, position or role of the person who physically examines the employee's original document(s), completes and signs Section 2.

Last Name of the Employer or Authorized Representative: Enter the full legal last name of the person who physically examines the employee's original documents, completes and signs Section 2. Last name refers to family name or surname. If the person has two last names or a hyphenated last name, include both names in this field.

First Name of the Employer or Authorized Representative: Enter the full legal first name of the person who physically examines the employee's original documents, completes, and signs Section 2. First name refers to the given name.

Employer's Business or Organization Name: Enter the name of the employer's business or organization in this field.

Employer's Business or Organization Address (Street Name and Number): Enter an actual, physical address of the employer. If your company has multiple locations, use the most appropriate address that identifies the location of the employer. Do not provide a P.O. Box address.

City or Town: Enter the city or town for the employer's business or organization address. If the location is not a city or town, you may enter the name of the village, county, township, reservation, etc. that applies.

State: Enter the two-character abbreviation of the state for the employer's business or organization address.

ZIP Code: Enter the 5-digit ZIP code for the employer's business or organization address.

Completing Section 3: Reverification and Rehires

Section 3 applies to both reverification and rehires. When completing this section, you must also complete the Last Name, First Name and Middle Initial fields in the Employee Info from Section 1 area at the top of Section 2, leaving the Citizenship/Immigration Status field blank. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the new name in Block A.

Reverification

Reverification in Section 3 must be completed prior to the earlier of:

- The expiration date, if any, of the employment authorization stated in Section 1, or
- The expiration date, if any, of the List A or List C employment authorization document recorded in Section 2 (with some exceptions listed below).

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

You should not reverify U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551). Reverification does not apply to List B documents.

For reverification, an employee must present an unexpired document(s) (or a receipt) from either List A or List C showing he or she is still authorized to work. You CANNOT require the employee to present a particular document from List A or List C. The employee is also not required to show the same type of document that he or she presented previously. See specific instructions on how to complete Section 3 below.

Rehires

If you rehire an employee within three years from the date that the Form I-9 was previously executed, you may either rely on the employee's previously executed Form I-9 or complete a new Form I-9.

If you choose to rely on a previously completed Form I-9, follow these guidelines.

- If the employee remains employment authorized as indicated on the previously executed Form I-9, the employee does not need to provide any additional documentation. Provide in Section 3 the employee's rehire date, any name changes if applicable, and sign and date the form.
- If the previously executed Form I-9 indicates that the employee's employment authorization from Section 1 or employment authorization documentation from Section 2 that is subject to reverification has expired, then reverification of employment authorization is required in Section 3 in addition to providing the rehire date. If the previously executed Form I-9 is not the current version of the form, you must complete Section 3 on the current version of the form.
- If you already used Section 3 of the employee's previously executed Form I-9, but are rehiring the employee within three years of the original execution of Form I-9, you may complete Section 3 on a new Form I-9 and attach it to the previously executed form.

Employees rehired after three years of original execution of the Form I-9 must complete a new Form I-9.

Complete each block in Section 3 as follows:

Block A - New Name: If an employee who is being reverified or rehired has also changed his or her name since originally completing Section 1 of this form, complete this block with the employee's new name. Enter only the part of the name that has changed, for example: if the employee changed only his or her last name, enter the last name in the Last Name field in this Block, then enter N/A in the First Name and Middle Initial fields. If the employee has not changed his or her name, enter N/A in each field of Block A.

Block B - Date of Rehire: Complete this block if you are rehiring an employee within three years of the date Form I-9 was originally executed. Enter the date of rehire in this field. Enter N/A in this field if the employee is not being rehired.

Block C - Complete this block if you are reverifying expiring or expired employment authorization or employment authorization documentation of a current or rehired employee. Enter the information from the List A or List C document(s) (or receipt) that the employee presented to reverify his or her employment authorization. All documents must be unexpired.

Document Title: Enter the title of the List A or C document (or receipt) the employee has presented to show continuing employment authorization in this field.

Document Number: Enter the document number, if any, of the document you entered in the Document Title field exactly as it appears on the document. Enter N/A if the document does not have a number.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the document you entered in the Document Title field as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). If the document does not contain an expiration date, enter N/A in this field.

Signature of Employer or Authorized Representative: The person who completes Section 3 must sign in this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to sign your name in this field. By signing Section 3, you attest under penalty of perjury (28 U.S.C. §1746) that you have examined the documents presented by the employee, that the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 3 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who completes Section 3 must enter the date Section 3 was completed and signed in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to enter the date in this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Name of Employer or Authorized Representative: The person who completed, signed and dated Section 3 must enter his or her name in this field.

What is the Filing Fee?

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

USCIS Forms and Information

For additional guidance about Form I-9, employers and employees should refer to the *Handbook for Employers: Guidance for Completing Form I-9 (M-274)* or USCIS' Form I-9 website at <https://www.uscis.gov/i-9-central>.

You can also obtain information about Form I-9 by e-mailing USCIS at I-9Central@dhs.gov, or by calling 1-888-464-4218 or 1-877-875-6028 (TTY).

You may download and obtain the English and Spanish versions of Form I-9, the *Handbook for Employers*, or the instructions to Form I-9 from the USCIS website at <https://www.uscis.gov/i-9>. To complete Form I-9 on a computer, you will need the latest version of Adobe Reader, which can be downloaded for free at <http://get.adobe.com/reader/>. You may order USCIS forms by calling our toll-free number at 1-800-870-3676. You may also obtain forms and information by contacting the USCIS National Customer Service Center at 1-800-375-5283 or 1-800-767-1833 (TTY).

Information about E-Verify, a fast, free, internet-based system that allows businesses to determine the eligibility of their employees to work in the United States, can be obtained from the USCIS website at <http://www.uscis.gov/e-verify>, by e-mailing USCIS at E-Verify@dhs.gov or by calling 1-888-464-4218 or 1-877-875-6028 (TTY).

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling 1-888-897-7781 or 1-877-875-6028 (TTY).

Photocopying Blank and Completed Forms I-9 and Retaining Completed Forms I-9

Employers may photocopy or print blank Forms I-9 for future use. All pages of the instructions and Lists of Acceptable Documents must be available, either in print or electronically, to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer and for a specified period after employment has ended. Employers are required to retain the pages of the form on which the employee and employer entered data. If copies of documentation presented by the employee are made, those copies must also be retained. Once the individual's employment ends, the employer must retain this form and attachments for either 3 years after the date of hire (i.e., first day of work for pay) or 1 year after the date employment ended, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is 3 years after the date of hire (i.e., first day of work for pay).

Forms I-9 obtained from the USCIS website that are not printed and signed manually (by hand) are not considered complete. In the event of an inspection, retaining incomplete forms may make you subject to fines and penalties associated with incomplete forms.

Employers should ensure that information employees provide on Form I-9 is used only for Form I-9 purposes. Completed Forms I-9 and all accompanying documents should be stored in a safe, secure location.

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

USCIS Privacy Act Statement

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

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Providing the information collected by this form is voluntary. However an employer should not continue to employ an individual without a completed form. Failure of the employer to prepare and/or ensure proper completion of this form for each employee hired in the United States after November 6, 1986 or in the Commonwealth of the Mariana Islands after November 27, 2011, may subject the employer to civil and/or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer must retain this form for the required period and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor and the Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, when completing the form manually, and 26 minutes per response when using a computer to aid in completion of the form, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
<i>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.</i>	
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):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

STOP *Employer Completes Next Page* STOP



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div style="border: 1px solid black; padding: 5px;">Additional Information</div>		<div style="border: 1px solid black; padding: 5px; text-align: center;"> QR Code - Sections 2 & 3 Do Not Write in This Space </div>
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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

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

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative Human Resources Department	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name Desoto County Schools	
Employer's Business or Organization Address (Street Number and Name) 5 East South Street		City or Town Hernando	State MS	ZIP Code 38632

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
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
OR	AND	
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport, and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

Desoto County Schools

Employee Information Form

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ *City* _____ *State* _____ *ZIP Code*

Home Phone: () _____ Alternate Phone: () _____

E-mail Address: _____

Social Security Number : _____ - _____ - _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone: () _____

Job Information

Title: _____ Employee ID #: _____

Supervisor: _____ School Location: _____

Email Address: _____

Work Phone: () _____ Cell Phone: () _____

Start Date: _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ *City* _____ *State* _____ *ZIP Code*

Primary Phone: () _____ Alternate Phone: () _____

Relationship: _____

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.**

2020

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> 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 online estimator, 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 2020 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 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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 and you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

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 the 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. Step 3 of Form W-4 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 2020 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
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
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
c Add the amounts from lines 2a and 2b and enter the result on line 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.
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)

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



- 1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income
2 Enter: { \$24,800 if you're married filing jointly or qualifying widow(er); \$18,650 if you're head of household; \$12,400 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

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	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240



MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name _____ SSN _____

Employee's Residence Address _____
Number and Street City or Town State Zip Code

Mississippi Department of Revenue
 P. O. Box 960
 Jackson, MS 39205

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION

	Marital Status	Personal Exemption Allowed	Amount Claimed
EMPLOYEE: File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	1. Single	<input type="checkbox"/> Enter \$6,000 as exemption . . . ▶	\$
	2. Marital Status (Check One)	(a) <input type="checkbox"/> Spouse NOT employed: Enter \$12,000 ▶	\$
		(b) <input type="checkbox"/> Spouse IS employed: Enter that part of \$12,000 claimed by you in multiples of \$500. See instructions 2(b) below ▶	\$
3. Head of Family	<input type="checkbox"/> Enter \$9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d) below ▶		\$
EMPLOYER: Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	4. Dependents	You may claim \$1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim \$1,500 for each dependents excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by \$1,500. Enter amount claimed. . . ▶	\$
	5. Age and Blindness	♦ Age 65 or older <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Single ♦ Blind <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Single Multiply the number of blocks checked by \$1,500. Enter the amount claimed ▶ * Note: No exemption allowed for age or blindness for dependents.	\$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5 . . . ▶		\$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer ▶		\$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write "Exempt" on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim. . . ▶		_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ Date: _____

INSTRUCTIONS

- | | | | | | | | | | | | | | |
|--|------------------------|---------------------|----------------|---------|-----------------------------------|----------|---------------------|---------|--------------------|---------|---------------|---------|--|
| <p>1. The personal exemptions allowed:</p> <table border="0" style="width: 100%;"> <tr> <td>(a) Single Individuals</td> <td>\$6,000</td> <td>(d) Dependents</td> <td>\$1,500</td> </tr> <tr> <td>(b) Married Individuals (Jointly)</td> <td>\$12,000</td> <td>(e) Age 65 and Over</td> <td>\$1,500</td> </tr> <tr> <td>(c) Head of family</td> <td>\$9,500</td> <td>(f) Blindness</td> <td>\$1,500</td> </tr> </table> <p>2. Claiming personal exemptions:</p> <p>(a) Single Individuals enter \$6,000 on Line 1.</p> <p>(b) <u>Married individuals are allowed a joint exemption of \$12,000.</u>
 If the spouse is not employed, enter \$12,000 on Line 2(a). If the spouse is employed, the exemption of \$12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of \$500. For example, the taxpayer may claim \$6,500 and the spouse claims \$5,500; or the taxpayer may claim \$8,000 and the spouse claims \$4,000. The total claimed by the taxpayer and spouse may not exceed \$12,000. Enter amount claimed by you on Line 2(b).</p> <p>(c) <u>Head of Family</u>
 A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter \$9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).</p> <p>(d) <u>An additional exemption of \$1,500 may generally be claimed for each dependent of the taxpayer.</u> A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent <u>excluding</u> the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but</p> | (a) Single Individuals | \$6,000 | (d) Dependents | \$1,500 | (b) Married Individuals (Jointly) | \$12,000 | (e) Age 65 and Over | \$1,500 | (c) Head of family | \$9,500 | (f) Blindness | \$1,500 | <p>should not include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.</p> <p>(e) <u>An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the age of 65 before the close of the taxable year.</u> No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.</p> <p>(f) An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both are blind. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by \$1,500 and enter amount of exemption claimed.</p> <p>3. Total Exemption Claimed:
 Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.</p> <p>4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.</p> <p>5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION</p> <p>6. IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENEFIT OF EXEMPTION.</p> <p>7. To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.</p> |
| (a) Single Individuals | \$6,000 | (d) Dependents | \$1,500 | | | | | | | | | | |
| (b) Married Individuals (Jointly) | \$12,000 | (e) Age 65 and Over | \$1,500 | | | | | | | | | | |
| (c) Head of family | \$9,500 | (f) Blindness | \$1,500 | | | | | | | | | | |

DESOTO COUNTY SCHOOLS

RETIREMENT INFORMATION SHEET

Date: _____ Name: _____

Are you currently receiving compensation or benefits from the Retirement System of Mississippi (PERS)?

Please check one: _____ YES _____ NO

If YES, Complete PERS Form 4B (Re-Employment of Retiree)

Are you currently receiving compensation or benefits from another state's retirement system?

Please check one: _____ YES _____ NO

Signature: _____

PLEASE RETURN THIS FORM TO THE HUMAN RESOURCES DEPARTMENT OF
DESOTO COUNTY SCHOOLS

DeSoto County Schools EMPLOYEE DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Please Print:

Name: _____
Last Name: _____ First _____ M. _____

Employee ID Number: _____ School Name: _____
(Kronos # or the last 4 digits of your SSN.)

The State of Mississippi has mandated direct deposit for all schools districts effective July 01, 2012.

I hereby authorize DeSoto County Schools to initiate credit entries and if necessary, debit entries, adjustments for any credit entries to my checking account indicated below, and the depository institution named below to credit and/or debit the same to such account.

This authority is to remain in full force and effect until DeSoto County Schools has received written notification from me of it's termination in such time and manner as to afford DeSoto County Schools a reasonable opportunity to act on it.

I understand that a new authorization agreement must be completed if I change / close my account or change financial institutions. If any action taken by me results in non-acceptance of the direct deposit by my financial institution I understand DeSoto County Schools assumes no responsibility for processing supplemental payment until the funds are returned to DeSoto County Schools by my financial institution. I am allowed only one change per school year.

Signature: (Employee) _____ Date: _____

You may select only one type of direct deposit account. Checking: _____ Savings: _____

Checking: A VOIDED check, which bears the account name (your name), the institution (name of your bank), the bank routing number, and account number must be attached with the submission of this authorization agreement. If you do not wish to destroy a check, you may attach a clear photocopy of a check and void the copy. Make sure you do not write on the MICR numbers on the bottom of the check.

Attach Voided Check Here. Do Not Use a Deposit Slip!

Saving/Money Card: Requires you to have your bank complete & sign the information below. (Send to the Payroll Dept.)

Depository Name: _____ Branch: _____

City: _____ State: _____ Zip: _____ Phone: _____

Routing Number: _____ Account Number: _____

Signature: (Bank Official) _____ Date: _____

Cancel my current direct deposit: I understand direct deposit is mandatory with DeSoto County Schools and when I cancel my current direct deposit I must replace it with another active direct deposit of choice.

Please check here if you would like to stop your current direct deposit. _____

Signature: (Employee) _____ Date: _____

*If you are not a new employee: Please return this completed authorization to: Marsha Berryhill/ Payroll Manager
I encourage you to contact me directly at the central office with any questions or concerns you may have at 662-449-7107.



Membership Application

Form 1 – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Member Information – Attach a copy of the member's Social Security card.

First Name: _____ MI: _____ Last Name: _____ Gender: M F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date mm/dd/ccyy: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cellular Home Work Phone: _____ Cellular Home Work

Have you previously served on active duty in the U.S. Armed Forces? If yes, attach Form(s) DD214 Yes No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? Yes No

2 Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. Select applicable plan.

Public Employees' Retirement System of Mississippi (PERS) Mississippi Highway Safety Patrol Retirement System (MHSPRS)

Supplemental Legislative Retirement Plan (SLRP)

3 Family Information – Use additional Membership Applications if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B, Beneficiary Designation, to officially designate any and all beneficiaries.

Marital Status – Select one. Add date for last three. Single Married Divorced Widowed Effective Date mm/dd/ccyy: _____

Spouse's Full Name	Social Security No.	Birth Date mm/dd/ccyy	Wedding Date mm/dd/ccyy	Gender
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

Dependent Child's Full Name – Up to age 19, or 23 if unmarried and a full-time student	Social Security No.	Birth Date mm/dd/ccyy	Relationship	Gender
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

4 Member Certification – If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

Member's Signature: _____ Date mm/dd/ccyy: _____

5 Employer Certification – This section must be completed by an authorized employer representative, not the member.

Member's Position Held/Job Title: _____ Member's Hire Date mm/dd/ccyy: _____

Member's Status: Elected Official: Yes No Fee Paid Official: Yes No Public Safety Employee: Yes No

Employer Name: Desoto County Schools Employer No.: 0067 - _____

Employer Representative's Name: _____ Employer Representative's Title: Human Resources Department

Employer Representative's Phone: (662) 449-7100 Fax: (662) 449-7236 E-Mail: desotocountyschools.org

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, Eligibility of Part-time Employees for State Retirement Annuity Service Credit, and PERS Board of Trustees Regulation 36, Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS).

Employer Representative's Signature: _____ Date mm/dd/ccyy: _____



Beneficiary Designation

Form 1B – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ Member Retiree

Social Security No.: _____ Birth Date mm/dd/ccyy: _____ Gender: M F

2 Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. Select applicable plan.

Public Employees' Retirement System of Mississippi (PERS) Mississippi Highway Safety Patrol Retirement System (MHSPRS)

Supplemental Legislative Retirement Plan (SLRP)

3 Beneficiary Information – Use additional Form 1B, Beneficiary Designation, to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary and secondary beneficiary percentages must equal 100 percent.

Beneficiary Name	Social Security No.	Birth Date mm/dd/ccyy	Relationship	Beneficiary Percentage P=Primary, S=Secondary Use whole numbers	Gender
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F

4 Member/Retiree Certification – Check applicable acknowledgement then sign. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

Member – I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).

Retiree – I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date mm/dd/ccyy: _____

5 Employer Certification – This section must be completed by an authorized employer representative, not the member. Only complete for active members.

Employer Name: Desoto County Schools Employer No.: 0067

Employer Representative's Name: _____ Employer Representative's Title: Human Resources Dept.

Employer Representative's Phone: (662) 449-7100 Fax: (662) 449-7236 E-Mail: desotocountyschools.org

Employer Representative's Signature: _____ Date mm/dd/ccyy: _____

**DeSoto County Schools
PowerSchool
User and Responsibility Acknowledgement**

The DeSoto County School District POWERSCHOOL information is a vital but limited resource for our educational community. Therefore, DeSoto County School District has an obligation to protect that data and ensure that it is used properly. DeSoto County School District has a legal and other obligation to protect such information.

Because we cannot do this job alone, we depend on your cooperation. Responsible conduct on your part helps ensure that the information entailed in our POWERSCHOOL database is kept in utmost confidence.

Failure to use these resources properly may result in various penalties.

Your signature on this form implies that you have read and understand your responsibilities stated here. If you have any questions about this document, please contact DeSoto County School District Management Information Department. Otherwise, sign and return this form to enable/continue use of your account.

As a responsible employee of DeSoto County Schools, I acknowledge that I have requested and received authorization to use POWERSCHOOL. I understand that I share in the responsibility of keeping safe the data of DeSoto County School children.

My responsibilities include reporting any security concerns to the school district, guarding my password, changing my password on a regular basis, promptly logging off of my POWERSCHOOL session when finished or before leaving my computer and not disclosing any vital information concerning confidential data.

I understand that the school district may without prior notification disable my accounts as part of the overall security procedures.

Print Name Here

Sign Name Here

Date

E-mail address

Job Title

School

PowerSchool User and Responsibility Statement

(*PLEASE SIGN AND RETURN TO YOUR BUILDING PRINCIPAL/SUPERVISOR*)

DESOTO COUNTY SCHOOLS

Employee Computer Network/Internet Acceptable Use Policy

Dear DeSoto County Employee:

DeSoto County School System is pleased to offer employees access to computer usage to enhance academic development and skills in using media that are commonly found in all aspects of our daily lives. DeSoto County Schools is CIPA (Child Internet Protection Agency), FERPA (Family Educational Rights and Privacy Act) and COPPA (Children's On-line Privacy Protection Act) compliant.

The use of the Internet is a PRIVILEGE, and inappropriate use will result in a cancellation of those privileges. The user has rights (within the limits of these guidelines, responsibilities and prohibitions) to the instructional networked resources provided by the Desoto County Schools. The administrator of the school and/or the school technology committee will determine if an action is inappropriate use and their decision is final. This is a legal and binding document.

By signing this form I agree to the following terms:

1. I will not use the Internet provided at my school for illegal purposes of any kind.
2. I will not use the Internet provided at my school to transmit, receive, or view material that is pornographic in nature.
3. I will not use the Internet provided at my school to transmit, receive or view material that is threatening or harassing in nature.
4. I will not use the Internet provided at my school in an attempt to gain access or "hack" into computer systems that I have no permission to use.
5. I will not use the Internet and/or computers provided at my school to propagate computer viruses.
6. I will not use the Internet provided at my school for the purpose of lobbying or distributing of political information.
7. I will not use the Internet provided at my school for commercial ventures of purchasing, selling, taking orders or placing orders. DeSoto County Schools is not responsible for credit card fraud and theft incurred by using personal or commercial credit card numbers on the Internet access provided at my school.
8. I will not damage, abuse or misuse the equipment provided for my use at my school.
9. I will not make changes to the screen or appearance of the desktop on computers provided for my use.
10. I will not load games or other software brought from home or downloaded from the Internet onto the computers provided for my use.
11. I will not attempt to bypass school internet filters by way of internet proxy sites.
12. I will not use the Internet provided in the school district to access social networking websites, instant messaging systems, and chat rooms for personal use.
13. I will not use the Internet provided in the school district to engage in Cyberbullying of any type.
14. I will not use the Internet and/or computer to violate any state or federal law (ie. Copyright law).

County provided laptops: Laptops, even when taken home, are the property of DeSoto County Schools and are subject to the same guidelines and policies as computers located at school sites. Usage of these laptops should be limited to DeSoto County School Employees only.

Teacher Web Pages: DeSoto County Schools must have permission to use a child's picture and/or schoolwork, or an edited selection of schoolwork on the District Website, Teacher Website, printed publications or videos produced and broadcast. Each child will be given a permission form and this information will be tagged in PowerSchool.

The above terms take into consideration the necessity for Internet access for educational purposes as well as personal development. The primary purpose of the Internet access provided by DeSoto County Schools is for research and discovery or educational media and information.

I have read the above DeSoto County Schools Internet Terms and Conditions and the DeSoto County Schools Technology Procedures. I hereby agree to abide by those standards, restrictions and obligations. As an employee, I agree to instruct the students on acceptable use of Internet and proper etiquette. I agree to use reasonable care to supervise and protect students.

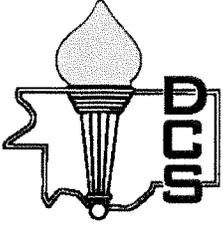
CONSEQUENCES:

Any user who knowingly and willingly violates this policy is subject to disciplinary action up to and including termination from employment.

Furthermore, in the event of an illegal activity, the user will also be reported to the appropriate law enforcement authority.

Employee Signature

Date



DESOTO COUNTY SCHOOLS

5 East South Street • Hernando, Mississippi 38632
662-429-5271 • fax 662-429-4198 • Website: www.desotocountyschools.org

"EXCELLENCE IS A COMMITMENT"

The DeSoto County School District strongly supports its policy of equal employment opportunity. Applicant flow data is kept to assist the District in regular evaluation of this policy and it asks your assistance by providing the few items of information requested below. THIS INFORMATION IS FOR STATISTICAL PURPOSES ONLY AND FEDERAL EEOC-5 REPORTING AND DOES NOT AFFECT YOUR JOB IN ANYWAY.

Name of Applicant: _____

Job Applied for: _____

1. Date of Application: _____

2. Birthdate: _____ / _____ / _____
Month Date Year

3. Sex (check): Male Female

4. Race/Ethnicity (check one)

_____ American Indian/Alaskan Native

_____ Asian/Pacific Islander

_____ Black (African American)

_____ White (Caucasian)

_____ Hispanic

_____ Other

5. Handicap. Check only if you have a physical or mental handicap and explain in the space provided. Yes _____

6. Give the city and state (and nation if not the U.S.A.) which is your current permanent address

7. How did you hear about the vacancy? (check one)

_____ Did not know there was a vacancy
but applied just in case

_____ From a friend who lives in the district

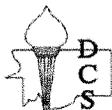
_____ From school district's advertisement
or vacancy notice

_____ From a placement bureau or agency
(Please give name below)

Other: (please specify): _____

An Equal Opportunity Employer: Equal Employment Opportunity Office (898)999-0101

DeSoto County Schools



Confidentiality Statement

All information (which includes salary, disciplinary, medical and financial information); in employee records, financial, and any other information of a private or sensitive nature are considered confidential. Confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements. Examples of inappropriate disclosures include:

- Employees discussing, revealing DCS records, or other confidential information to friends or family members.
- Employees discussing, revealing DCS records, or other confidential information to other employees without a legitimate need to know.

The unauthorized disclosure of DCS records or other confidential information by employees can subject each individual employee and the practice to civil and criminal liability. Disclosure of DCS records or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

Employee Confidentiality Agreement

I hereby acknowledge, by my signature below, that I understand that the all DCS employee information and other confidential records, and data to which I have knowledge and access in the course of my employment with DeSoto County Schools is to be kept confidential, and this confidentiality is a condition of my employment. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements. I understand that my duty to maintain confidentiality continues even after I am no longer employed.

I am familiar with the guidelines in place at DeSoto County Schools pertaining to the use and disclosure of employee information or other confidential information. Approval should first be obtained before any disclosure of employee records or other confidential information not addressed in the guidelines and policies and procedures of DeSoto County Schools. I also understand that the unauthorized disclosure of employee records and other confidential information of DeSoto County School is grounds for disciplinary action, up to and including immediate dismissal.

Date

Signature of Employee

Print Name

Human Resources Department

Date

Employee Benefits

*Full-Time Employee's Benefit
Forms*

IMPORTANT BENEFIT AND ENROLLMENT INFORMATION

BENEFITS DEPARTMENT:

Email: benefits@dcsms.org

Follow us on Twitter @dcsbenefits

Remind 101: To receive important benefit information via text message, text @a26gc4 to the number 81010

Employee Benefits Website: <http://www.desotocountyschools.org/?DivisionID=15690>

Phone: 662-449-7173 / 662-449-7112 / 662-449-7296

Fax: 662-429-4198

Contact the Benefits Department or access Employee Benefits Website for all necessary forms.

Note: Contact information below is provided to locate providers, benefit details, forms and individual plan documents. Employees must contact the Benefits Department to make ALL changes to insurance coverage.

HEALTH: State and School Employees' Health Insurance Plan (BCBS of MS)

Website: <https://knowyourbenefits.dfa.state.ms.us/>

Enrollment: New Employee Orientation or Open Enrollment (see Health Rates for premium information)

Customer Service: 1-800-709-7881

Pharmacy Help Desk: 1-855-457-0408

LIFE: State and School Employees' LIFE Insurance Plan (MINNESOTA LIFE)

Website: <https://myblue.bcbsms.com>

New Employee Orientation or Late Enrollee - See Employee Benefits Department

Customer Service: 1-877-348-9217

DENTAL AND VISION: Guardian Insurance (effective 1-1-2017)

Website: www.GuardianAnytime.com

Enrollment: New Employee Orientation or Open Enrollment (see application for premium information)

Customer Service: 1-888-600-1600

OTHER BENEFITS:

AMERICAN FIDELITY:

Website: <https://www.afadvantage.com/for-individuals/afes-landing-pages/desoto-county-schools-district.aspx>

Enrollment: New Employee Orientation or Open Enrollment (see American Fidelity Rep for premium information)

Customer Service: 1-800-654-8489

AFLAC:

Website: <http://www.aflac.com/>

Enrollment: Open Enrollment (see AFLAC Rep for premium information)

Customer Service: 1-870-394-4845

TELAMED:

Enrollment: New Employee Orientation or Open Enrollment (see application for fee information)

New Benefits Customer Service: 1-855-847-3627 or 662-349-2021

LEGALSHIELD AND IDSHIELD:

Enrollment: New Employee Orientation or Open Enrollment (see application for fee information)

Security Benefits Solutions Customer Service: 1-844-534-2515 - [1-844-LEGAL15]

OPEN ENROLLMENT DATES:

SEPTEMBER & OCTOBER: Add, change or terminate all benefits effective January 1st

ONLINE SELF-ENROLLMENT DATES: SEPTEMBER 1st - SEPTEMBER 23rd

Login: www.afenroll.com/enroll - PIN# - last 4 of SSN and last 2 of birth year

****Example: SSN: 123-45-6789 and birth year 1987 -- PIN# is 678987****

**STATE OF MISSISSIPPI
STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
APPLICATION FOR COVERAGE**

PLEASE PRINT		Employer Name			
Section A: Enrollee Information (all fields are required)					
Social Security Number	First Name	MI	Last Name		
Home Address		City	State	ZIP	
Primary Telephone Number	Secondary Telephone Number	Personal Email Address			
Marital Status Single Married	Gender Male Female	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement		
Were you ever a full-time employee of a covered entity under the Plan <u>prior to 1/1/2006</u> ? No (Horizon) Yes (Legacy)					
If <u>yes</u> , please list your most recent (pre-1/1/06) employer and dates of employment: _____					
If married, is your spouse a Plan participant? Yes No If yes, Spouse Name and SSN: _____					

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

I hereby apply to **ADD, CONTINUE AND/OR CHANGE COVERAGE** for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the *Plan Document*. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

I hereby **WAIVE COVERAGE** in the State and School Employees' Health Insurance Plan. I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. **If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.**

Enrollee Signature: _____ Date: _____

Section C: Coverage

Enrollee Type: Employee - Legacy Employee - Horizon Retiree COBRA Surviving Spouse	Coverage Type: Enrollee Only Enrollee + Spouse Enrollee + Child Enrollee + Children Enrollee + Spouse & Child(ren)	Coverage Option: (Choose Only One) Select Base (HIGH DEDUCTIBLE)	Do you have Medicare? Yes No Medicare Number: _____ "A" Effective Date: _____ "B" Effective Date: _____
			Reason for Entitlement: Age ESRD Disability
Are you a tobacco user? Yes No If yes, are you interested in participating in the Plan's free cessation program? Yes No			

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? Yes No If yes, please provide the following:							
Name of Individual Covered:	1. _____	2. _____	3. _____	4. _____			
Policyholder's Name:	_____	_____	_____	_____			
Policyholder's Date of Birth:	_____	_____	_____	_____			
Policyholder's Insurance Effective Date:	_____	_____	_____	_____			
Policy Number:	_____	_____	_____	_____			
Policyholder's Employment Status:	Active, Retiree or COBRA						
Insurance Company Name address & phone #:	_____	_____	_____	_____			
	_____	_____	_____	_____			
Coverage Type:	Group Non-Group	Group Non-Group	Group Non-Group	Group Non-Group	Group Non-Group		

Enrollee Last Name:	First Name:	Enrollee SSN:
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Section E: Dependents

Dependents to be Covered <small>(Last Name, First Name, MI)</small>	Relation to Enrollee	Social Security Number	Date of Birth <small>(mm/dd/yyyy)</small>	Address <small>(if different from Enrollee)</small>	Current Status
1.	Spouse Male Female				Employed? Yes No
2.	Son Daughter				Child under 26 Disabled
3.	Son Daughter				Child under 26 Disabled
4.	Son Daughter				Child under 26 Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? Yes No

If yes, please provide the following:

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Section F: Change Information

Add Enrollee:	Open Enrollment	Marriage	Birth	Adoption	Loss of Coverage due to Divorce
	Other: _____				Requested Effective Date: _____

Add Dependent(s):	Open Enrollment	Marriage	Birth	Adoption	Other: _____
	(List all dependents in Section E.)				Qualifying Event/ Effective Date: _____

Change Coverage:	Base Coverage	Select Coverage
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Drop Dependent(s):	Divorce	Deceased	Other: _____
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Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Changes (Explain):

FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER: _____

New Legacy Employee, Requested Effective Date: _____

New Horizon Employee, Requested Effective Date: _____

Retiree, Requested Effective Date: _____

COBRA, Requested Effective Date: _____

Surviving Spouse, Requested Effective Date: _____

Change(s), Requested Effective Date: _____

ENTERED BY: _____

DATE: _____

VERIFIED BY: _____

DATE: _____

HEALTH INSURANCE COVERAGE AND PREMIUM RATES - JANUARY 2020

BASE COVERAGE	In-Network	Out-of-Network
Calendar Year Deductible - Individual Coverage	\$1,800	
Calendar Year Deductible - Family Coverage	\$3,000	
Individual Coinsurance/Co-Pay Maximum	\$2,500	\$3,500
Family Coinsurance/Co-Pay Maximum	\$5,000	\$7,000
**Preventive Medications Deductible	\$75	
AMWELL - Online Primary Care Visit	\$10 co-pay; subject to deductible	
Out-of-Pocket Limit - Individual	\$6,500	
Out-of-Pocket Limit - Family Coverage	\$13,000	

SELECT COVERAGE	In-Network	Out-of-Network
Calendar Year Deductible - Individual Coverage	\$1,000	\$2,000
Calendar Year Deductible - Family Coverage	\$2,000	\$4,000
Individual Coinsurance/Co-Pay Maximum	\$2,500	\$3,500
Individual Prescription Drug Deductible	\$75	
AMWELL - Online Primary Care Visit	\$10 Co-Pay	
Out-of-Pocket Limit - Individual	\$6,500	
Out-of-Pocket Limit - Family Coverage	\$13,000	

HORIZON & LEGACY	BASE
EMPLOYEE	\$0
EMPLOYEE + SPOUSE	\$413
EMPLOYEE + SPOUSE + CHILDREN	\$629
EMPLOYEE + CHILD	\$107
EMPLOYEE + CHILDREN	\$274

HORIZON	SELECT
EMPLOYEE	\$40
EMPLOYEE + SPOUSE	\$510
EMPLOYEE + SPOUSE + CHILDREN	\$726
EMPLOYEE + CHILD	\$205
EMPLOYEE + CHILDREN	\$371

***Legacy:** An active employee initially hired prior to January 1, 2006. This includes new hires employed full-time by a MS state agency before January 1, 2006.

***Horizon:** An active employee initially hired on or after January 1, 2006. This employee has never worked full-time for a MS state agency.

LEGACY	SELECT
EMPLOYEE	\$20
EMPLOYEE + SPOUSE	\$490
EMPLOYEE + SPOUSE + CHILDREN	\$706
EMPLOYEE + CHILD	\$185
EMPLOYEE + CHILDREN	\$351

****Preventive** Medications: 2019 Plan Document pgs. 5 and 6

Base Coverage meets the federal government's criteria of a qualifying high deductible health plan under Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 in regard to establishing a Health Savings Account.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <http://KnowYourBenefits.dfa.ms.gov> or call 1-800-709-7881. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined terms](#) see the [Glossary](#). You can also view the Glossary at www.ccio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network and Out-of-network : \$1,800/individual; \$3,000/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care network is covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Preventive prescription drugs : \$75/individual . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	Network providers : \$6,500/individual; \$13,000/family. Out-of-network providers : no out-of-pocket limit .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. Go here for a list of network providers or call 1-800-294-6307.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness Specialist visit	20% coinsurance	40% coinsurance	Online provider visit: \$10 (Subject to deductible)
	Preventive care/screening/immunization	No charge. Deductible does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work). Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
	Generic drugs Preferred brand drugs Non-preferred brand drugs	Retail: \$12 copay Mail order: \$24 copay Retail: \$45 copay Mail order: \$90 copay Retail: \$100 copay Mail order: \$200 copay	You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay .	\$75 individual preventive prescription drug deductible (for certain preventive medications) if the Base Coverage deductible has not been met. Mail Order quantity 60-90 day supply. No charge for FDA-approved generic contraceptives or brand name contraceptives if a generic is medically inappropriate or unavailable. If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the generic copayment . Certain prescriptions require prior approval.
If you have outpatient surgery	Specialty drugs	Retail: \$100 copay	Not covered.	
	Facility fee (e.g., ambulatory surgery center) Provider/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	\$50 copay /1 st visit; \$200 copay /each additional visit plus 20% coinsurance .	\$50 copay /1 st visit; \$200 copay /each additional visit plus 20% coinsurance .	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room) Provider/surgeon fees	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services . Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Certification required.
	Habilitation services	20% coinsurance	40% coinsurance	Maintenance or exercise therapy is excluded.
	Skilled nursing care	20% coinsurance	40% coinsurance	Certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	Hospice services	20% coinsurance	40% coinsurance	Certification Required. Benefits available for up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in network .
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in network .
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in network .

[Excluded Services & Other Covered Services:](#)

Services Your Plan Generally Does NOT Cover (Check your policy or [plan document](#) for more information and a list of any other [excluded services](#).)

- Acupuncture
- Dental care (Children)
- Routine eye care (Children)
- Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)
- Hearing aids
- Routine foot care
- Dental care (Adult)
- Infertility treatment
- Routine eye care (Adult)
- Weight loss programs (except as required by ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan document](#).)

- Bariatric surgery (prior approval required)
- Chiropractic services (limited to 30 visits/individual/year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (prior approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccoio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit <https://www.healthcare.gov/> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your [appeal](#). Contact [Health Help Mississippi](#) at 1-877-314-3843 or healthhelpms@mhap.org.

Does this [plan](#) provide [Minimum Essential Coverage](#)? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this [plan](#) meet the [Minimum Value Standards](#)? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

_____To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

- The [plan's overall deductible](#) \$1,800
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This **EXAMPLE** event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost \$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$60
Coinsurance	\$2,132
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,992

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$1,800
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This **EXAMPLE** event includes services like:

[Primary care provider](#) office visits (*including disease education*)
[Diagnostic test](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,250
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,050

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

- The [plan's overall deductible](#) \$1,800
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This **EXAMPLE** event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*X-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost \$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$50
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,880

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <http://KnowYourBenefits.dfa.ms.gov> or call 1-800-709-7881. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined terms](#) see the [Glossary](#). You can also view the Glossary at www.ccio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network : \$1,000/individual; \$2,000/family. Out-of-network : \$2,000/individual; \$4,000/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care network provider office visits are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Prescription drugs : \$75/individual. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	Network providers : \$6,500/individual; \$13,000/family. Out-of-network providers : no out-of-pocket limit .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. Go here for a list of network providers or call 1-800-294-6307.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay /visit. Deductible does not apply.	40% coinsurance	Online provider visit: \$10 copayment
	Specialist visit	20% coinsurance	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
	Preventive care/screening/immunization	No charge. Deductible does not apply.	Not covered.	
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	40% coinsurance	
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition, or information about prescription drug coverage . Additional information is available at www.MyPrime.com	Generic drugs	Retail: \$12 copay Mail order: \$24 copay	You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay .	\$75 individual prescription drug deductible Mail Order Quantity: 60-90-day supply. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate or unavailable). If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the generic copayment . Certain prescriptions require prior approval
	Preferred brand drugs	Retail: \$45 copay Mail order: \$90 copay		
	Non-preferred brand drugs	Retail: \$100 copay Mail order: \$200 copay	Not covered.	
	Specialty drugs	Retail: \$100 copay		
	Facility fee (e.g., ambulatory surgery center) Provider/surgeon fees	20% coinsurance	40% coinsurance	
If you have outpatient surgery	Emergency room care	\$50 copay /1 st visit; \$200 copay /each additional visit plus 20% coinsurance	\$50 copay /1 st visit; \$200 copay /each additional visit plus 20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
	Provider/surgeon fees			
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services . Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children. Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services			
	Home health care	20% coinsurance	40% coinsurance	
	Rehabilitation services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Habituation services	20% coinsurance	40% coinsurance	Certification required. Certification required. Maintenance or exercise therapy is excluded. Certification required. Coverage is limited to allowable charge for basic equipment. Prior approval recommended. Certification Required. Benefits available for up to six months.
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	
	Hospice services	20% coinsurance	40% coinsurance	
	Children's eye exam	Not covered.	Not covered.	
If your child needs dental or eye care	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in-network . You must pay 100% of this service, even in-network . You must pay 100% of this service, even in-network .
	Children's dental checkup	Not covered.	Not covered.	

Excluded Services and Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)• Dental care (Adult) | <ul style="list-style-type: none">• Dental care (Children)• Hearing aids• Infertility treatment• Routine eye care (Adult) | <ul style="list-style-type: none">• Routine eye care (Children)• Routine foot care• Weight loss programs (except as required by ACA) |
|--|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (prior approval required)
- Chiropractic services (limited to 30 visits/individual/year)
 - Non-emergency care when traveling outside the U.S.
 - Private-duty nursing (prior approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccoio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit <https://www.healthcare.gov/> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a [claim](#). This complaint is called a [grievance](#) or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your [appeal](#). Contact [Health Help Mississippi](#) at 1-877-314-3843 or healthhelpms@mhnp.org.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

_____To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

- **The plan's overall deductible** \$1,000
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost \$12,800

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles (Medical and Rx)	\$1,075
Copayments	\$0
Coinsurance	\$2,282
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,357

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$1,000
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

[Primary care provider](#) office visits (*including disease education*)
[Diagnostic test](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost \$7,400

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,075
Copayments	\$810
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,885

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

- **The plan's overall deductible** \$1,000
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*X-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost \$1,900

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$50
Coinsurance	\$180
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,230



MISSISSIPPI STATE AND
SCHOOL EMPLOYEES'
HEALTH INSURANCE PLAN

See a doctor now with
Amwell



ONLINE DOCTOR VISITS are now available for participants of the State and School Employees' Health Insurance Plan.

See and speak with U.S. board-certified doctors, right away. Easy to use. No hassle. 24/7/365. \$10* copay.

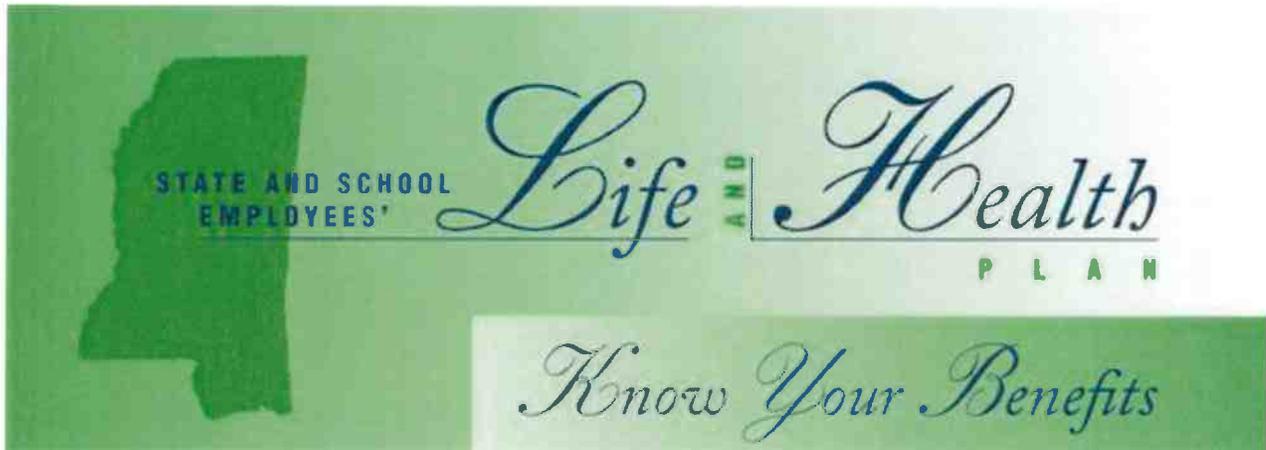
Doctors can diagnose and prescribe medication (if appropriate) for:

- Cold/flu
- Allergies
- Pink eye
- Sore throat
- Rashes
- and more!

* For participants with Base coverage, the \$10 copay applies once the deductible has been met. Until then, the visit is only \$49.



To see a doctor online, go to mssehip.amwell.com or download the Amwell app on your cell phone or other mobile device. Create a username and password, and enter Service Key **MSSEHIP** for the new benefit. Participants will need their BCBSMS ID number to complete enrollment.



The *State and School Employees' Life and Health Insurance Plan Document* contains the benefits and eligibility guidelines of the State and School Employees' Life and Health Insurance Plan. You can find the latest Plan Document on our website, KnowYourBenefits.dfa.ms.gov under "Publications." Also on the site are links to find a participating provider, information on covered wellness and preventive services, and the latest premium rates.

You may request a paper copy of the Plan Document by calling the Office of Insurance toll free at (866) 586-2781 or (601) 359-3411, or send an email to KnowYourBenefits@dfa.ms.gov.

- The Office of Insurance provides day-to-day management of the Plan for the State and School Employees Health Insurance Management Board.
- Blue Cross & Blue Shield of Mississippi is the Plan's medical claims administrator, and processes health claims and maintains eligibility information.
- ActiveHealth is the Plan's medical management administrator, and provides medical management and precertification services.
- Prime Therapeutics is the Plan's pharmacy benefit manager and is responsible for processing prescription drug claims and managing the Plan's prescription drug mail order program.
- The AHS State Network is a system of physicians, hospitals and other health care providers who have agreed to accept the allowable charges set by the Network and file claims for medical services provided to Plan participants. Participant will receive the maximum benefit by using a "participating" network provider.

For questions about medical claims, call Blue Cross & Blue Shield of Mississippi (800) 709-7881	To certify a hospital admission or other service, call ActiveHealth (866) 939-4721	For questions about prescription drug claims, call Prime Therapeutics (855) 457-0408	To find a participating provider, call AHS State Network (800) 294-6307	For general questions about the Plan, call the Office of Insurance (866) 586-2781
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Mississippi State and School Employees' Health Insurance Plan Wellness/Preventive Coverage

1. Eleven visits within the first 23 months of life; two visits per year ages 2-3; one visit per year ages 4 through 17; two visits per year ages 18 and over.

2. Hemoglobin, hematocrit, CBC, only once between 6-24 months. Females, only performed if pregnant, once per pregnancy.

3. Lipid screenings begin at age 20.

4. Pap smears are recommended only for women age 21 to 65 once every 3 years, or for women ages 30-65 who wish to lengthen the screening interval, screening with a combination of cytology and HPV testing every 5 years.

5. Pelvic and breast exams are available for females beginning at age 12 if medically appropriate.

6. HIV screenings are for adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.

7. Hepatitis C screening is a one-time screening for adults born between 1945 and 1965.

8. The USPSTF recommends biennial screening (once every 2 years) for women aged 50 to 74 years.

9. Bone density studies are covered for women once every 2 years beginning at age 60.

10. Flexible sigmoidoscopy and colonoscopy screenings begin at age 50. Additional screenings for individuals considered to be at high-risk for colorectal cancer may be covered under the medical portion of the Plan. High-risk individuals are defined as a:

- Strong family history of colorectal cancer or polyps (in first-degree relative younger than 60 or two first-degree relatives of any age). A first-degree relative is defined as a parent, sibling or child.
- Known family history of colorectal cancer syndrome
- Personal history of colorectal cancer polyps.

A gastroenterology consult prior to a colonoscopy is not covered under a wellness visit.

Wellness/Preventive Services and Screenings Covered at 100%	Birth to 2 years	Ages 3-11 years	Ages 12-17	Female 18-34	Male 18-39	Female 35-39	Male 40-49	Female 40-49	Male 50+	Female 50+
Wellness visits, preventive medicine evaluations or re-evaluations including blood pressure, dental caries screening, vision and hearing screening for ages 3-5, and counseling as appropriate for risk factors, age or stage of development.	1	1	1	1	1	1	1	1	1	1
Hemoglobin, hematocrit or CBC	2	2	2	2		2	2	2	2	2
TB skin testing as needed										
Diabetes screening (A1c) once per calendar year										
Glucose once per calendar year (only for high-risk individuals) beginning at age 3				3	4	4	4	4	4	4
Lipid profile once per calendar year				4	5	5	5	5	5	5
Pap smear once every three or five years				5	6	6	6	6	6	6
Pelvic and breast exam once per calendar year, included in wellness visit				6	6	6	6	6	6	6
Sexually transmitted disease screenings (chlamydia infection [age 18-24], syphilis, gonorrhea)										
HIV screening										
Hepatitis B screening, for non-pregnant adolescents and adults at high-risk for infection										
Hepatitis C (HCV) screening										
Mammogram once per calendar year						8	8	8	8	8
Osteoporosis in post-menopausal women screening										
Breast and ovarian cancer susceptibility, genetic risk assessment and BRCA mutation testing, once per lifetime										
Flexible sigmoidoscopy once every five years or colonoscopy once every ten years									10	10
Stool for occult blood once per calendar year										
Lung cancer screening, once per year for smokers with a history of at least 30-pack years and who have quit within the previous 15 years, ages 55-80										
Abdominal aortic aneurysms screening men ages 65-75, once per lifetime										

Beginning at age 20, the following biometrics are required to be collected for a compliant wellness visit: height, weight, blood pressure, A1c, total cholesterol (HDL, LDL), triglycerides and tobacco usage.

Preventive Wellness Guidelines are based on recommendations from the following:

- U.S. Preventive Services Task Force (USPSTF)
- Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP)
- U.S. Health Resources & Services Administration (HRSA), Preventive Care and Screenings of Infants, Children and Women
- National Medical Societies



Call your primary care network provider to schedule your wellness visit. To locate a network provider, call 800-294-6307 or go to the "Provider Search" tab at <http://KnowYourBenefits.dfa.ms.gov/provider-search/>.

Life INSURANCE



Designate your beneficiary today!

We strongly encourage you to designate as soon as possible, even if you believe the selected individual may receive the benefit by default. Designating a beneficiary speeds payment and ensures proceeds from your policy would be distributed according to your wishes.

To Designate Your Beneficiary Online:

1. Log into the myBlue site:
<https://www.bcbsms.com>
2. Click on the “My Benefits” tab
3. Click on the “Life Benefits” section
4. Click on the link “Click here to update your beneficiary information”
5. Click “Name a new beneficiary”
6. Enter the name(s), address and the respective benefit percentages for each beneficiary
7. Securian will mail you a confirmation letter after you complete your designation

Basic coverage



Basic Term Life and
Accidental Death &
Dismemberment (AD&D)

2x base annual pay

Maximum coverage: **\$100,000**

Includes matching AD&D benefit

Need assistance?

Instructions and/or forms for designating a beneficiary may be found on Securian’s website: lifebenefits.com/plandesign/mississippi.
Or call (877) 627-6337.

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life Insurance Company to Mississippi State and School Employees’ Life Insurance Plan. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage. All elections or increases are subject to the actively at work requirement of the policy.

Insurance products are underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. Products offered under policy form series MHC-96-13180.

Underwritten by Minnesota Life Insurance Company

STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN ENROLLMENT/CHANGE REQUEST FORM

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.
Policy 33683-G

SECTION A: Employee/Employer Information

Employee/Retiree Last Name:	First Name:	MI:	Social Security Number:	Birthdate: (MM/DD/YYYY):
Employee/Retiree Home Address:			Email Address:	Home Phone:
				Alternate Phone:
Employer Name: DeSoto County Schools				Employer Phone: (662) 429-5271
Employer Address: 5 East South Street, Hernando, MS 38632				

SECTION B: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)

ACTIVE FULL-TIME EMPLOYEE: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of \$30,000 and a maximum of \$100,000. The employee and employer each pay 50 percent of the monthly premium.

New Employee – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.

Late Enrollee Applicant – Applications made after initial 31 days of employment will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life. **(Employee must also complete the Minnesota Life GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form.)**

Date of Employment: _____

RETIRED EMPLOYEE: Life benefit amounts are limited to \$5,000, \$10,000 or \$20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

Date of Retirement: _____ COVERAGE AMOUNT REQUESTED: \$5,000 \$10,000 \$20,000

DISABLED EMPLOYEE: Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months.
(Employee must also complete the Minnesota Life NOTICE OF DISABILITY and ATTENDING PHYSICIAN'S STATEMENT forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

NOTE: You cannot designate your life insurance beneficiary on this form. To designate your life insurance beneficiary, please follow the instructions below:

1. Log in to your *myBlue* site, <https://myblue.bcbsms.com>, and click on the My Benefits tab.
2. Scroll down to the Life Benefits section below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on the site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through the *myBlue* portal.

If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the policy.

If you do not have Internet access, contact Minnesota Life toll free at **877-348-9217** to request a paper beneficiary designation form.

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone
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SECTION D: Authorization and Certification

I am applying for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Insurance Company, Group Policy #33683-G, and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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/Retiree Signature (Required) _____
Date

SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)

Waiver of Coverage – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

Cancellation of Coverage – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.

Employee/Retiree Signature _____
Date

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT <http://KnowYourBenefits.dfa.ms.gov/> OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	GROUP NUMBER:	INFORMATION VERIFIED: (INITIAL AND DATE)



Mississippi State & School Employees' Life Insurance Plan

Group term life and accidental death & dismemberment (AD&D) benefit

Active full-time employees

Insurance products issued by:
Minnesota Life Insurance Company

Designate your beneficiary today!



We strongly encourage you to designate your beneficiary as soon as possible, even if you believe the selected individual may receive the benefit by default. Designating a beneficiary speeds payment and ensures the proceeds from your policy will be distributed according to your wishes.

To designate your beneficiary online:

1. Log into Blue Cross & Blue Shield of Mississippi: bcbsms.com
2. Click on the "My Benefits" tab
3. Click on the "Life Benefits" section
4. Click on the link "Click here to update your beneficiary information"
5. Click "I agree" to go to Securian Financial's LifeBenefits to add, view or update your beneficiary
6. Click "View details or make changes"
7. Enter the name(s), address and the respective benefit percentages for each beneficiary
8. Securian will mail you a confirmation letter after you complete your designation

Need assistance?

Instructions and/or forms for designating a beneficiary may be found on Securian Financial's website: lifebenefits.com/plandesign/mississippi or call 877-348-9217.

Your basic coverage

Basic coverage (automatically enrolled)

Basic term life and AD&D 2x base annual pay

- Maximum coverage: \$100,000
- Includes matching AD&D benefit

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life Insurance Company to Mississippi State and School Employees' Life Insurance Plan. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage. All elections or increases are subject to the "actively at work" requirement of the policy.

Insurance products are underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. Products offered under policy form series MHC-96-15180.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its affiliates.

Securian Financial Group, Inc.
securian.com

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EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%
					Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%
					Total = 100%

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	03-03-1980	123 4th Street, Anywhere, MN 12345, 651-665-3456	XXX-XX-XXXX	Daughter	40%
Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%
					Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Jones	06-06-1980	3 Main Street, Anywhere, MN 45685, 651-665-6789	XXX-XX-XXXX	Sister	50%
Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 58978, 651-665-7890	XXX-XX-XXXX	Brother	50%
					Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Doe - Trustee, his successors or successor in trust under the John Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008.			N/A	Trust	100%
					Total = 100%

Beneficiary Designation

Securian Financial Group, Inc.
 Minnesota Life Insurance Company
 Securian Life Insurance Company, a New York authorized insurer
 400 Robert Street North • St. Paul, Minnesota 55101-2098

Group Customer Service
 Fax (651) 665-4827



Visit www.lifebenefits.com/plandesign/mississippi to designate your beneficiary.

EMPLOYER NAME: Mississippi State & School Emp

POLICY NUMBER: 33683

Insured's name (last, first, middle initial)	ID
--	----

Address (street, city, state, zip)

Insured's date of birth	Policyowner (if different than the insured)	Policyowner's phone number	Email address
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This beneficiary designation applies to all eligible coverages.

INSTRUCTIONS:

1. Clearly print or type the information below.
2. Sign and date the completed form,
3. Return to Securian at address above.

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children", without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit.

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

SIGNATURE REQUIRED

Policyowner's signature X	Date
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Dental Benefit Summary

Group Number: 00530560

About Your Benefits:

Taking care of your teeth can be expensive. That's why the right dental insurance is so important — it not only pays for preventive care that can keep you and your family healthy, but it also helps pay for more extensive, costly and often unexpected expenses — such as fillings, crowns and root canals. Plus, you save money and have the assurance that you are getting the right care when you use one of our contracted dentists. Guardian has been providing outstanding dental plans to millions of Americans for more than 50 years. When you enroll with Guardian, you have access to one of the nation's largest dental networks offering significant discounts so you know there's always high-quality, affordable dental care close by. From preventive checkups and cleanings, to comprehensive oral care treatments, we have you covered.

Option 1 or 2: With your **Low Plan or High Plan** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: Low Plan		Option 2: High Plan	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Your Monthly premium	\$17.14		\$30.31	
You and spouse	\$34.25		\$60.61	
You and child(ren)	\$37.68		\$66.68	
You, spouse and child(ren)	\$55.68		\$96.85	
Lifetime deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$100	\$100	\$100	\$100
Family limit	3 per family		3 per family	
Waived for	None	None	None	None
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	90%	100%	90%
Basic Care	80%	80%	100%	80%
Major Care	0%	0%	60%	50%
Orthodontia	Not Covered (applies to all levels)		50%	50%
Annual Maximum Benefit	\$750	\$750	\$2000	\$2000
Maximum Rollover	Yes		Yes	
Rollover Threshold	\$300		\$800	
Rollover Amount	\$150		\$400	
Rollover In-network Amount	\$200		\$600	
Rollover Account Limit	\$500		\$1500	
Lifetime Orthodontia Maximum	Not Applicable		\$1000	
Dependent Age Limits	26		26	

A Sample of Services Covered by Your Plan:

		Option 1: Low Plan Plan pays (on average)		Option 2: High Plan Plan pays (on average)	
		In-network	Out-of-network	In-network	Out-of-network
Preventive Care	Cleaning (prophylaxis)	100%	90%	100%	90%
	Frequency:	2 in 12 Months		2 in 12 Months	
	Fluoride Treatments	100%	90%	100%	90%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	90%	100%	90%
	Sealants (per tooth)	100%	90%	100%	90%
	X-rays	100%	90%	100%	90%
		X-rays other than bitewings in Basic 80%		X-rays other than bitewings in Basic 100%	
Basic Care	Anesthesia*	80%	80%	100%	80%
	Fillings‡	80%	80%	100%	80%
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%	100%	80%
	Simple Extractions	80%	80%	100%	80%
	Surgical Extractions	80%	80%	100%	80%
Major Care	Bridges and Dentures	0%	0%	60%	50%
	Dental Implants	Not Covered	Not Covered	60%	50%
	Inlays, Onlays, Veneers**	0%	0%	60%	50%
	Perio Surgery	0%	0%	60%	50%
	Periodontal Maintenance	0%	0%	100%	80%
	Frequency:	Not Covered		2 in 12 months	
	Root Canal	0%	0%	60%	50%
	Scaling & Root Planing (per quadrant)	0%	0%	60%	50%
Orthodontia	Single Crowns	0%	0%	60%	50%
	Orthodontia	Not Covered		50%	50%
	Limits:			Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-I-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

Dental Maximum Rollover[®]

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
\$750	\$300	\$150	\$200	\$500
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed \$1,250 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, (\$1500 PPO/\$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

Here's how the benefits work:

YEAR ONE: Jane starts with a \$750 Plan Annual Maximum. She submits \$150 in dental claims. Since she did not reach the \$300 Threshold, she receives a \$150 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of \$900. This year, she submits \$50 in claims and receives an additional \$150 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of \$1,050. This year, she submits \$950 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is \$850 (\$750 Plan Annual Maximum + \$100 remaining in her Maximum Rollover Account)



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.

Dental Maximum Rollover[®]

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
\$2000	\$800	\$400	\$600	\$1500
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed \$3,500 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, (\$1500 PPO/\$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

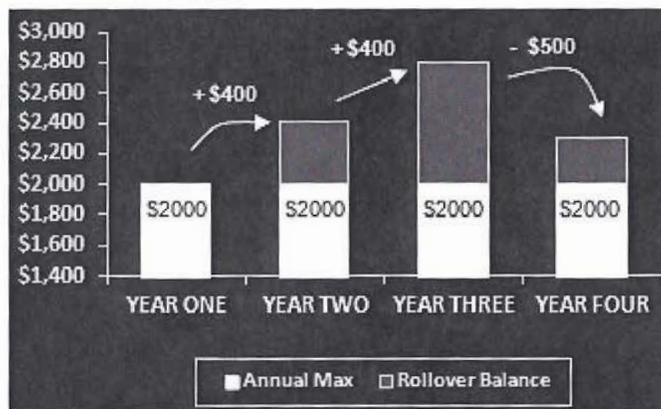
Here's how the benefits work:

YEAR ONE: Jane starts with a \$2000 Plan Annual Maximum. She submits \$150 in dental claims. Since she did not reach the \$800 Threshold, she receives a \$400 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of \$2,400. This year, she submits \$50 in claims and receives an additional \$400 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of \$2,800. This year, she submits \$2,500 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is \$2,300 (\$2,000 Plan Annual Maximum + \$300 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.

Vision Benefit Summary

Group Number: 00530560

About Your Benefits:

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides rich, flexible plans that allow you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you.

Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of Davis Vision's network locations including retail centers such as Wal-Mart®, JCPenney®, Sears®, Target®, Sam's Club®, Pearle®, and Visionworks®.

Your Vision Plan	Full Feature - Designer	
Your Network is	Davis Vision	
Your Monthly premium	\$ 8.48	
You and spouse	\$ 17.28	
You and child(ren)	\$ 15.24	
You, spouse and child(ren)	\$ 23.73	
Copay		
Exams Copay	\$ 10	
Materials Copay (waived for non-formulary elective contact lenses)	\$ 25	
Sample of Covered Services	<i>You pay (after copay if applicable):</i>	
	<i>In-network</i>	<i>Out-of-network</i>
Eye Exams	\$0	Amount over \$50
Single Vision Lenses	\$0	Amount over \$48
Lined Bifocal Lenses	\$0	Amount over \$67
Lined Trifocal Lenses	\$0	Amount over \$86
Lenticular Lenses	\$0	Amount over \$126
Frames	80% of amount over \$150*2	Amount over \$48
Contact Lenses (Elective and conventional)	85% of amount over \$150*	Amount over \$105
Contact Lenses (Planned replacement and disposable)	85% of amount over \$150*	Amount over \$105
Contact Lenses (Medically Necessary)	\$0	Amount over \$210
Cosmetic Extras	Avg. 40-60% off retail price	No discounts
Glasses (Additional pair of frames and lenses)	Courtesy discount from most providers	No discounts
Laser Correction Surgery Discount	Up to 25% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses (for glasses or contact lenses)‡‡	Every calendar year	
Frames	Every calendar year	
Network discounts (glasses and contact lens professional service)	Applies to first purchase & courtesy discount from most providers on subsequent purchases.	
Dependent Age Limits	26	

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

Davis

- ‡Benefit includes coverage for glasses or contact lenses, not both.
- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- *Due to lower prices available at Wal-mart and Sam's Club locations, discounts do not apply. Members will pay 100% of the amount over their allowance.
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.
- ²Extra \$50 at Visionworks stores

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-DAVIS-05-VIS et al.

Laser Correction Surgery:

Up to 25% off for vision laser surgery.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 05/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at www.guardianlife.com/privacy-policy.

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures.

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI may require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Accounting of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

Your Right to Amend Your PHI If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention: Guardian Corporate Privacy Officer
National Operations

Address: The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

WorkLifeMatters

Your Confidential Employee Assistance Program – Helping find balance between work and home life.

WorkLifeMatters provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- **Unlimited free telephonic consultation with an EAP counselor available 24/7 at 800-386-7055**
- **Referrals to local counselors — up to three sessions free of charge**
- **State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center**

WorkLifeMatters can offer help with:		
Education <ul style="list-style-type: none">▪ Admissions testing & procedures▪ Adult re-entry programs▪ College Planning▪ Financial aid resources▪ Finding a pre-school	Dependent Care & Care Giving <ul style="list-style-type: none">▪ Adoption Assistance▪ Before/after school programs▪ Day Care/Elder Care▪ Elder care▪ In-home services	Legal and financial <ul style="list-style-type: none">▪ Basic tax planning▪ Credit & collections▪ Debt Counseling▪ Home buying▪ Immigration
Lifestyle & Fitness Management <ul style="list-style-type: none">▪ Anxiety & depression▪ Divorce & separation▪ Drugs & alcohol	Working Smarter <ul style="list-style-type: none">▪ Career development▪ Effective managing▪ Relocation	

For more information about WorkLifeMatters, go to www.ibhworklife.com; User Name: Matters; Password: wlm70101

WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters Program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters Program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.



Guardian Life, P.O. Box 981585,
El Paso, TX 79998-1585

Please print clearly and mark carefully.

Employer Name: DESOTO COUNTY SCHOOL DISTRICT	Group Plan Number: 00530560	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change		

Class: _____ Division: _____ Subtotal Code: _____ (Please obtain this from your Employer)

About You: First, MI, Last Name:		Social Security Number ____ - ____ - ____	
Address	City	State	Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): ____ - ____ - ____	Phone: () - ____ - ____	
Email Address:	Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: ____ - ____ - ____	
	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: ____ - ____ - ____	

About Your Job:	Hours worked per week: _____	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation	Date of full time hire: ____ - ____ - ____	

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	
Address/City/State/Zip:		Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () - ____ - ____			
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____
Address/City/State/Zip:		Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Phone: () - ____ - ____			
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____
Address/City/State/Zip:		Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Phone: () - ____ - ____			

Child/Dependent 3: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

<p>Drop Coverage:</p> <input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: ____ - ____ - ____ <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____	<p>Coverage Being Dropped:</p> <input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
<p>Loss Of Other Coverage:</p> I and/or my dependents were previously covered under <u>another insurance plan</u> . Loss of coverage was due to: <input type="checkbox"/> Termination of Employment: ____ - ____ - ____ <input type="checkbox"/> Divorce ____ - ____ - ____ <input type="checkbox"/> Death of Spouse ____ - ____ - ____ <input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____ Coverage Lost <input type="checkbox"/> Dental <input type="checkbox"/> Vision	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)

Dental Coverage: You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: Low Plan	<input type="checkbox"/> \$17.14	<input type="checkbox"/> \$34.25	<input type="checkbox"/> \$37.68	<input type="checkbox"/> \$55.68
Option 2: High Plan	<input type="checkbox"/> \$30.31	<input type="checkbox"/> \$60.61	<input type="checkbox"/> \$66.68	<input type="checkbox"/> \$96.85

I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

- I am covered under another Dental plan
- My spouse is covered under another Dental plan
- My dependents are covered under another Dental plan

Vision Coverage: You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature - Designer	<input type="checkbox"/> \$8.48	<input type="checkbox"/> \$17.28	<input type="checkbox"/> \$15.24	<input type="checkbox"/> \$23.73

I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

- I am covered under another Vision plan
- My spouse is covered under another Vision plan
- My dependents are covered under another Vision plan

Signature

- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____

DATE _____

Enrollment Kit 00530560, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.



HAVE YOU EVER?

- | | |
|---|--|
| <input type="checkbox"/> Needed your Will prepared or updated | <input type="checkbox"/> Worried about being a victim of Identity theft |
| <input type="checkbox"/> Been overcharged for a repair or paid an unfair bill | <input type="checkbox"/> Been concerned about your child's identity |
| <input type="checkbox"/> Had trouble with a warranty or defective product | <input type="checkbox"/> Lost your wallet |
| <input type="checkbox"/> Signed a contract | <input type="checkbox"/> Worried about entering personal information on-line |
| <input type="checkbox"/> Received a moving traffic violation | <input type="checkbox"/> Feared the security of your medical information |
| <input type="checkbox"/> Had concerns regarding child support | <input type="checkbox"/> Been pursued by a collection agency |

WHAT IS LEGALSHIELD?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1 million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

THE LEGALSHIELD® MEMBERSHIP INCLUDES:

-  ✓ Personal Legal advice on unlimited issues
-  ✓ Letters/ calls made on your behalf
-  ✓ Contracts & documents reviewed (up to 15 pages)
-  ✓ Residential Loan Document Assistance
-  ✓ Lawyers prepare your Will, your Living Will and your Health Care Power of Attorney
-  ✓ Moving Traffic Violations (available 15 days after enrollment)
-  ✓ IRS Audit Assistance
-  ✓ Trial Defense (if named defendant/ **respondent** in a covered civil action suit)
-  ✓ Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
-  ✓ 25% Preferred Member Discount (Bankruptcy, Criminal Charges, DUI, Other Matters, etc.)
-  ✓ 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member, member's spouse, never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children. An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

THE IDSHIELD™ MEMBERSHIP INCLUDES:

-  **Privacy Monitoring**
Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, and medical ID numbers (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.
-  **Security Monitoring**
SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle. With the family plan, Minor Identity Protection is included and provides monitoring for up to 8 children under the age of 18.
-  **Consultation**
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited **counseling**, identity alerts, data breach notifications and lost wallet protection.
-  **Full Service Restoration**
Complete identity recovery services by Kroll Licensed Private Investigators and our \$5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.

IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents up to the age of 18.

Payroll Deduction Monthly	Individual	Family
LegalShield	\$14.95	\$15.95
IDShield	\$8.45	\$15.95
Combined	\$23.40	\$28.90

For more information, please call your independent associate

Security Benefits Solutions
877-5-LEGAL (877-574-4353)

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.



Benefit Application

CWA	
FOB	
MODE	
PLAN	
FRAN	
GR#	

Please print.

Member Information

Today's Date / /

Month Day Year

Time of Day _____ A.M. (Circle One)
P.M.

SSN # - -

For internal use only by LegalShield. Our privacy policy is available upon request.

Name Last _____

First _____ MI _____

Mailing Address Apt. / Ste.# _____

Street Address _____

City _____

State _____ ZIP + 4 _____

Primary Member's Date of Birth / /

Month Day Year

Co-Applicant Last _____

First _____ MI _____

Work Phone - - Ext.

Home Phone - -

Cell Phone - -

Spouse Email Address _____

I do not wish to receive email updates from LegalShield about my membership. (Your privacy is a priority with us! LegalShield will not sell your email address or personal information of any kind to third party vendors.)

Applicant: I understand that the written contract sets forth the terms of my membership, including any exclusions or limitations, and agree to be bound by the same. I further understand that the company will mail the written contract to me at the address noted herein within the next fourteen days. If I have not received my contract within that time frame, I understand that it is my responsibility to call the LegalShield Home Office at 1-800-654-7757 to obtain a copy. The written contract, together with this application, constitutes the entire agreement between the company and the member with respect to the membership, and there are no agreements, understandings, warranties or representations other than as set forth herein and in the membership contract.

Applicant Email Address _____

Dependents Last / First / MI _____ Date of Birth ____/____/____

Last / First / MI _____ Date of Birth ____/____/____

Last / First / MI _____ Date of Birth ____/____/____

Spouse Date of Birth ____ / ____ / ____

Applicant Signature X _____

Coverage Options:

Option 1: IDShield

- Privacy Monitoring
- Security Monitoring
- Consultation
- Full Service Restoration
- Purchase for whole family or individual

Option 2: LegalShield

- Legal Advice on Unlimited Issues
- Letters/Calls on Your Behalf
- Preparation of Will/Living Will
- Review of Contracts/Documents
- Purchase for whole family or individual

Option 3: Combination

- Most Comprehensive
- Best Value
- Includes both Option 1 & Option 2
- Purchase for whole family or individual

Selected Coverage Option (please check one)

Individual IDShield - \$8.45/mo Individual LegalShield - \$14.95/mo Combination Indiv \$23.40/mo

Family IDShield - \$15.95/mo Family LegalShield - \$15.95/mo Combination Family \$28.90/mo

Decline coverage



Discount Medical Plan Application Summary

Plan: Preferred Plus - \$12.00

Benefits: Teladoc (no consult), Dental, Vision, Pharmacy, Diabetic Supplies, Durable Medical Equipment, Hearing Aids, MRI & CT Scans, Lab Testing and Vitamin Discounts

Disclosures:

This plan is NOT insurance.

This discount card program contains a 30 day cancellation period.

LA, MS, ND, OK, RI, SC, SD and TX residents: Member shall receive a full refund of membership fees, excluding registration fee, if membership is cancelled within the first 30 days after the effective date. AR and TN residents: A refund of all fees will be issued if membership is cancelled within the first 30 days. MD Residents: The membership fee and one-time registration fee (minus \$5.00) will be refunded if cancelled within the first 30 days and upon return of the discount card.

MA Residents: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00.

Discount Medical Plan Organization: New Benefits, Ltd., Attn: Compliance Department, PO Box 671309 Dallas, TX 75367-1309.

Pharmacy discounts are Not Insurance, and are Not Intended as a Substitute for Insurance

The discount is only available at participating pharmacies.

The program administrator may obtain fees from pharmacies based on your prescription drug purchases. These fees may be retained by the program administrator or shared with you and/or your pharmacy.

Not available to residents of KS, UT, VT, WA and AR



**Payroll Deduction Authorization
Discount Medical Plan Application**

Agent: South Group Insurance	TM+ ID: LBC059	Date:
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Internal Use Only

Company Name: Desoto County Schools		Social Security Number:	
First Name:		MI:	Last Name:
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth:	
Address 1:		Address 2:	
City:		State:	Zip Code:
Home Phone:		Mobile Phone:	
Plan: Preferred Plus Benefits: Teladoc (no consult), Dental, Vision, Pharmacy, Diabetic Supplies, Durable Medical Equipment, Hearing Aids, MRI & CT Scans, Lab Testing and Vitamin Discounts			
Card Program Cost (per month): \$12.00		Membership Effective Date:	

Employee has the right to discontinue any above program at any time with thirty (30) days advance notice. The undersigned Employee agrees to the conditions printed above and assumes no liability other than as specified.

I hereby authorize my employer to deduct from my earnings such amounts as may now or hereafter be payable by me under the discount plan purchased through Tela Med Plus, Inc. I also acknowledge all rates are deducted from my paycheck post-tax. By signing below I confirm receipt of plan disclosures at the time of application.

Employee Signature

Date

Printed Name



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address	

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

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

All employees. Eligible employees are:

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

We do not offer coverage.

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

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

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

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

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

Yes (Continue)

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

No (STOP and return this form to employee)

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

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

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

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

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

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

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

Employer won't offer health coverage

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

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

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

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