

# Mississippi New Hire Reporting Form



Mail completed form to: Mississippi State Directory of New Hires  
P.O. Box 312  
Holbrook, MA 02343

Or fax completed form to: 1-800-937-8668

Effective October 1, 1997, all Mississippi employers (or independent contractors) are required to report certain information about personnel who have been newly hired, rehired, or have returned to work. **Reports must be made within 15 calendar days from date of hire.** Employers must either (1) complete this form, or (2) submit a copy of the worker's IRS W-4 form with the "other information section" completed on this form, or (3) submit the information by magnetic tape or floppy diskette. *To submit new hire reports electronically, call 1-800-241-1330 to obtain information.*

*Below, please complete all employer information*

## EMPLOYER INFORMATION

\*Federal Employer Identification Number (FEIN):   -         
(Please the same FEIN for which listed employee(s) quarterly wages will be reported under)

State Employer Identification Number (SEIN):   -

\*Employer Name: \_\_\_\_\_ DBA: \_\_\_\_\_

\*Address: \_\_\_\_\_  
\_\_\_\_\_

(Please indicate the address where the Income Withholding Order will be sent)

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip Code: \_\_\_\_\_ +4: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

*Below, please complete one entry for each new employee*

## EMPLOYEE INFORMATION

\*Social Security Number:    -   -       Gender (circle one): Male Female

\*First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

\*Last Name: \_\_\_\_\_

\*Employee Address: \_\_\_\_\_  
\_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip Code: \_\_\_\_\_ +4: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_ State of Hire \_\_\_\_\_

Employee Salary: \_\_\_\_\_ Payment Frequency (circle one): Weekly Bi-weekly Monthly Annually

Is this employee eligible for medical insurance (circle one)? Yes No

For information please visit our website at [www.ms-newhire.com](http://www.ms-newhire.com) or call us toll-free at 1-800-241-1330

# Form W-4 (2017)

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

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

The exceptions don't apply to supplemental wages greater than \$1,000,000.

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

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

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

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

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

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

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b>	Enter "1" if: { • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } . . . . .	<b>B</b> _____
<b>C</b>	Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b> _____
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____
<b>F</b>	Enter "1" if you have at least \$2,000 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . . ( <b>Note:</b> Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	<b>F</b> _____
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then <b>less "1"</b> if you have two to four eligible children or <b>less "2"</b> if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.	<b>G</b> _____
<b>H</b>	Add lines A through G and enter total here. ( <b>Note:</b> This may be different from the number of exemptions you claim on your tax return.) ►	<b>H</b> _____
	For accuracy, complete all worksheets that apply. { • If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2. • If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld. • If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.	

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

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b> ► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		OMB No. 1545-0074 <b>2017</b>
1 Your first name and middle initial		Last name		2 Your social security number
Home address (number and street or rural route)			3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code			4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5 _____
6 Additional amount, if any, you want withheld from each paycheck				6 \$ _____
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had <b>no tax liability, and</b> • This year I expect a refund of all federal income tax withheld because I expect to have <b>no tax liability.</b> If you meet both conditions, write "Exempt" here . . . . . ► 7 _____				
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (This form is not valid unless you sign it.) ►				Date ►
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)			9 Office code (optional)	10 Employer identification number (EIN)

**Deductions and Adjustments Worksheet**

**Note:** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over \$313,800 and you're married filing jointly or you're a qualifying widow(er); \$287,650 if you're head of household; \$261,500 if you're single, not head of household and not a qualifying widow(er); or \$156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 \$ \_\_\_\_\_

2 Enter: { \$12,700 if married filing jointly or qualifying widow(er)  
\$9,350 if head of household  
\$6,350 if single or married filing separately } . . . . . 2 \$ \_\_\_\_\_

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

4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) . . . . . 4 \$ \_\_\_\_\_

5 Add lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 \$ \_\_\_\_\_

6 Enter an estimate of your 2017 nonwage income (such as dividends or interest) . . . . . 6 \$ \_\_\_\_\_

7 Subtract line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 \$ \_\_\_\_\_

8 Divide the amount on line 7 by \$4,050 and enter the result here. Drop any fraction . . . . . 8 \_\_\_\_\_

9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 . . . . . 9 \_\_\_\_\_

10 Add lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . . . . . 10 \_\_\_\_\_

**Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)**

**Note:** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) . . . . . 1 \_\_\_\_\_

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3" . . . . . 2 \_\_\_\_\_

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 \_\_\_\_\_

**Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 \_\_\_\_\_

5 Enter the number from line 1 of this worksheet . . . . . 5 \_\_\_\_\_

6 Subtract line 5 from line 4 . . . . . 6 \_\_\_\_\_

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 \$ \_\_\_\_\_

8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . 8 \$ \_\_\_\_\_

9 Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 \$ \_\_\_\_\_

**Table 1**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$7,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
7,001 - 14,000	1	8,001 - 16,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 22,000	2	16,001 - 26,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
22,001 - 27,000	3	26,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 70,000	5	405,001 and over	1,600		
44,001 - 55,000	6	70,001 - 85,000	6				
55,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 95,000	10	140,001 and over	10				
95,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

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

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

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

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



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

# MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name \_\_\_\_\_ SSN \_\_\_\_\_

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

## CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION

	Marital Status	Personal Exemption Allowed	Amount Claimed
<b>EMPLOYEE:</b>	1. Single	<input type="checkbox"/> Enter \$6,000 as exemption . . . . ▶	\$
<b>File this form with your employer.</b> Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	2. Marital Status <small>(Check One)</small>	(a) <input type="checkbox"/> Spouse <b>NOT</b> employed: Enter \$12,000 ▶	\$
		(b) <input type="checkbox"/> Spouse <b>IS</b> 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 . . . . . ▶	\$
<b>EMPLOYER:</b> 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 . . . . . ▶		\$
<b>Military Spouses Residency Relief Act Exemption from Mississippi Withholding</b>	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><b>1. The personal exemptions allowed:</b></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><b>2. Claiming personal exemptions:</b></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><br/>                     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><br/>                     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 <u>blind</u>. 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><b>3. Total Exemption Claimed:</b><br/>                     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><b>4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.</b></p> <p><b>5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION</b></p> <p><b>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.</b></p> <p><b>7. To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.</b></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        |         |                                   |          |                     |         |                    |         |               |         |   |

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

<b>PLEASE PRINT</b>		Employer Name	
<b>Section A: Enrollee Information (all fields are required)</b>			
Social Security Number	First Name	MI	Last Name
Home Address		City	State ZIP
Primary Telephone Number	Secondary Telephone Number	Personal Email Address	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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 prior to 1/1/2006? <input type="checkbox"/> No (Horizon) <input type="checkbox"/> Yes (Legacy)			
If yes, please list your most recent (pre-1/1/06) employer and dates of employment: _____			
If married, is your spouse a Plan participant? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

<b>Enrollee Type:</b> <input type="checkbox"/> Employee - Legacy <input type="checkbox"/> Employee - Horizon <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse	<b>Coverage Type:</b> <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee + Spouse <input type="checkbox"/> Enrollee + Child <input type="checkbox"/> Enrollee + Children <input type="checkbox"/> Enrollee + Spouse & Child(ren)	<b>Coverage Option:</b> (Choose Only One) <input type="radio"/> Select <input type="radio"/> Base (HIGH DEDUCTIBLE)	<b>Do you have Medicare?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Medicare Number:</b> _____ <input type="checkbox"/> "A" Effective Date: _____ <input type="checkbox"/> "B" Effective Date: _____ <b>Reason for Entitlement:</b> <input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability
Are you a tobacco user? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you interested in participating in the Plan's free cessation program? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	_____	_____	_____
Insurance Company Name address & phone #: _____	_____	_____	_____
Coverage Type: <input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled
3.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled
4.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> 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

**Drop Dependent(s):**  Divorce  Deceased  Other: \_\_\_\_\_

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: \_\_\_\_\_

**Print**

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

**Underwritten by Minnesota Life Insurance Company**

**PLEASE PRINT LEGIBLY**

**MINNESOTA LIFE POLICY # 33683-G**

**SECTION A: Employee/Employer Information**

New Enrollment     Change

Employee Last Name:	Employee First Name:	MI:	Social Security No.:	Birthdate (MMDDYYYY):	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Employee Home Address:				Employee Home Telephone No.:	
Employer Name:				Date of Employment:	
Employer Address:				Employer Telephone No.:	

**SECTION B: 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 HERE ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE**

\_\_\_\_\_

**Employee Signature**

\_\_\_\_\_

**Date**

**SECTION C: Type of Coverage (Check One)**

**ACTIVE EMPLOYEE:** Life benefit amounts equal twice the amount of the employee's annual wage rounded to the next higher one thousand dollars. Minimum \$30,000; Maximum \$100,000. Employee and employer each pay 50% of the monthly premium.

- New Employee** – applying within 31 days of employment; coverage will become effective on the first day of employment.
- Late Enrollee Applicant** – applying 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 Insurance Company.

(Employee Must Also Complete the Minnesota Life **GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form.**)

Date of Employment: \_\_\_\_\_

**RETIRED EMPLOYEE:** Life benefit amounts limited to \$5,000, \$10,000, or \$20,000. Retired Employees are not eligible for AD&D coverage. A Retired Employee should apply prior to, but no later than 31 days after, the date Active Employee coverage terminates. Retiree pays 100% of the monthly premium.

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

**DISABLED EMPLOYEE:** Life benefit amount is equal to employee's current benefit level at the time coverage ceases as an Active Employee. Disabled Employee must apply no later than 31 days from the date Active Employee coverage terminates. Minnesota Life Insurance Company is solely responsible for evaluating applications for coverage continuation. Premium is waived after 1<sup>st</sup> 9 months of premium are paid by the disabled employee.

(Employee Must Also Complete the Minnesota Life **NOTICE OF DISABILITY.**)

Date of Disability: \_\_\_\_\_

Employee Last Name	Employee First Name	MI	Social Security Number	Daytime Telephone # ( )
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**SECTION D: Beneficiary Information**

If more than one **Primary Beneficiary** is named, the Primary Beneficiaries shall share equally unless otherwise indicated below. Likewise, if more than one **Contingent Beneficiary** is named, the Contingent Beneficiaries shall share equally unless otherwise indicated below. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1<sup>st</sup> contingent, 2<sup>nd</sup> contingent, 3<sup>rd</sup> contingent, etc., in the **Percentage of Benefit** block, and list each in the order of precedence. **If beneficiary shares are not equal, please ensure the percentage of benefits = 100%, USING WHOLE NUMBERS ONLY (ex: 33% + 33% + 34% = 100%).**

<b>1. Beneficiary Name, Address, and Telephone #:</b>			<input checked="" type="checkbox"/> <b>Primary Beneficiary</b>
Relationship to Insured:	Social Security Number:	Date of Birth:	Percentage of Benefit:
<b>2. Beneficiary Name, Address, and Telephone #:</b>			<input type="checkbox"/> <b>Primary Beneficiary</b> <i>or</i> <input type="checkbox"/> <b>Contingent Beneficiary*</b> <b><u>PLEASE CHECK DESIRED BENEFICIARY TYPE</u></b>
Relationship to Insured:	Social Security Number:	Date of Birth:	Percentage of Benefit:
<b>3. Beneficiary Name, Address, and Telephone #:</b>			<input type="checkbox"/> <b>Primary Beneficiary</b> <i>or</i> <input type="checkbox"/> <b>Contingent Beneficiary*</b> <b><u>PLEASE CHECK DESIRED BENEFICIARY TYPE</u></b>
Relationship to Insured:	Social Security Number:	Date of Birth:	Percentage of Benefit:
<b>4. Beneficiary Name, Address, and Telephone #:</b>			<input type="checkbox"/> <b>Primary Beneficiary</b> <i>or</i> <input type="checkbox"/> <b>Contingent Beneficiary*</b> <b><u>PLEASE CHECK DESIRED BENEFICIARY TYPE</u></b>
Relationship to Insured:	Social Security Number:	Date of Birth:	Percentage of Benefit:

\*NOTE: Contingent Beneficiaries will only receive proceeds if all Primary Beneficiaries have predeceased the Insured.

**SECTION E: Authorization and Certification**

I apply 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 Insurance Company. 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 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 that 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 Insurance Company as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan. Subject to the terms of Minnesota Life Group Policy #33683-G, I request that any sum becoming payable by reason of my death be payable to the beneficiary(ies) listed above. It is my understanding that this designation shall operate so as to revoke all designations of beneficiary previously made by me under this Policy.

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.

<b>Employee Signature</b> (Required)	<b>Date</b>
--------------------------------------	-------------

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





# 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: \_\_\_\_\_ Employer No.: \_\_\_\_\_

Employer Representative's Name: \_\_\_\_\_ Employer Representative's Title: \_\_\_\_\_

Employer Representative's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

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: \_\_\_\_\_ Employer No.: \_\_\_\_\_ - \_\_\_\_\_  
Employer Representative's Name: \_\_\_\_\_ Employer Representative's Title: \_\_\_\_\_  
Employer Representative's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer Representative's Signature: \_\_\_\_\_ Date mm/dd/ccyy: \_\_\_\_\_



# Change of Information

Form 1C – Revised 8/23/2016

Please print or type in black ink. Active members (currently contributing to PERS) should submit completed form to employer (see Section 6 for details). Inactive members and benefit recipients should submit completed form to PERS. See bottom of form for contact information.

**1 Member/Benefit Recipient Information** – Fill in your name as currently filed with PERS and use sections 2, 3, and 4 to submit new information.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  Member  Benefit Recipient  
Social Security No.: \_\_\_\_\_ Birth Date mm/dd/ccyy: \_\_\_\_\_ Gender:  M  F

**2 Changes to Member/Benefit Recipient Name and Address** – If necessary, check items to be updated then fill in only applicable information.

To Change                      New Information                      Effective Date mm/dd/ccyy: \_\_\_\_\_  
\_\_\_\_ Name                      First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
\_\_\_\_ Address                      Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**3 Changes to Member/Benefit Recipient E-Mail and Phone** – If necessary, check items to be updated then fill in only applicable information.

To Change                      New Information                      Effective Date mm/dd/ccyy: \_\_\_\_\_  
\_\_\_\_ E-Mail                      \_\_\_\_\_  
\_\_\_\_ Phone                      \_\_\_\_\_  Cellular  Home  Work  
\_\_\_\_ Phone                      \_\_\_\_\_  Cellular  Home  Work

**4 Changes to Family Information** – If necessary, list applicable changes below. Use additional Form 1C, Change of Information, if listing more than three dependent children. Information is for determining statutory benefits only. Use Form 1B, Beneficiary Designation, or Form 16, Advanced Application, as applicable, to designate any and all beneficiaries. If changes to marital status are marked, attach a copy of the marriage, divorce, or death certificate.

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

**5 Member/Benefit Recipient Certification** – Active members (those currently contributing to PERS) should sign and submit form to employer for completion of Section 6. Employers will be responsible for submitting completed form to PERS, if necessary. Inactive members and benefit recipients should sign and submit form directly to PERS, as Section 6 is not applicable to these individuals. 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/Benefit Recipient's Signature: \_\_\_\_\_ Date mm/dd/ccyy: \_\_\_\_\_

**6 Employer Certification** – Completion of Section 6 and submission of this form to PERS by the employer is only necessary when changes are being made to sections 3 and 4 (e-mail, phone numbers, marital status, or family information). Changes to Section 2 (name or address) will be submitted to PERS by the employer via monthly wage and contribution reports not via this form. This process helps ensure consistency in the name used for reporting PERS, Social Security, and W-2 wage information by the employer. If completion of Section 6 is necessary, an authorized employer representative, must sign.

Employer Name: \_\_\_\_\_ Employer No.: \_\_\_\_\_  
Employer Representative's Name: \_\_\_\_\_ Employer Representative's Title: \_\_\_\_\_  
Employer Representative's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

As employer representative, I am submitting this form to PERS because changes are being made to Section 3 (e-mail and phone) and/or Section 4 (family information). I hereby certify that any name and address change information provided above is consistent with the active member's name used on the employer's records for reporting PERS, Social Security, and W-2 wage information.

Employer Representative's Signature: \_\_\_\_\_ Date mm/dd/ccyy: \_\_\_\_\_



# Non-Covered Employment Acknowledgment

Form 4A – Revised 12/1/2013

Complete only if employee is not receiving PERS service retirement benefits and is not contributing to PERS through another employer. Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

## 1 Employee Information

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender:  M  F

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

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_  Cellular  Home  Work Phone: \_\_\_\_\_  Cellular  Home  Work

## 2 Employee Acknowledgment

I hereby acknowledge that I am not receiving service retirement benefits from PERS and that my employment does not meet 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), and that I, therefore, am not eligible for coverage for this employment under the provisions of PERS.  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.

Employee's Signature: \_\_\_\_\_ Date mm/dd/ccyy: \_\_\_\_\_

## 3 Employer Certification – This section must be completed by an authorized employer representative, not the employee.

Employee's Position Held/Job Title: \_\_\_\_\_

Employee's Hire Date mm/dd/ccyy: \_\_\_\_\_ Employee's Termination Date mm/dd/ccyy: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer No.: \_\_\_\_\_ - \_\_\_\_\_

Employer Representative's Name: \_\_\_\_\_ Employer Representative's Title: \_\_\_\_\_

Employer Representative's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

As employer representative, I understand that wages earned and paid to the above named individual during this period of employment will not be subject to withholding for state retirement. I further understand that any person who makes a false statement or shall falsify or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution. With that understanding, I certify that the above information is true and correct and that employment in this position does not meet 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: \_\_\_\_\_



# SUNFLOWER COUNTY CONSOLIDATED SCHOOL DISTRICT AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)

I authorize the Sunflower County Consolidated School District to initiate entries to the account indicated below as follows:

1. They may initiate CREDIT entries, which moves money into my account according to the schedule and other conditions to which the Sunflower County Consolidated School District and I have agreed.
2. They may initiate DEBIT entries to reverse any transactions they have originated to my account in error.

Name: \_\_\_\_\_  
(please print)

Account Number: \_\_\_\_\_

Name of Depository Financial Institution: \_\_\_\_\_

Location of Depository Financial Institution: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please enter your bank's routing and transit number here and staple a VOIDED CHECK below.\*

--	--	--	--	--	--	--	--	--

(nine digits)

This authority is to remain in effect until the Sunflower County Consolidated School District has **received written notification** of its termination and has had a reasonable opportunity to act upon it.

Also, by signing this document, I agree to provide written instructions regarding any changes to my information as soon as possible. I further understand that if I fail to provide updated information, that future payments may require an additional amount of time before being credited to my account.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**\*DO NOT USE A DEPOSIT SLIP.** Many banks print internal transaction codes instead of their routing and transit numbers on their deposit slips. Using an invalid routing and transit number will prevent your transaction from being directed to the correct bank, resulting in delays in the posting of your payment.

## MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN Tobacco Use Attestation Form

All sections of the form below must be completed in order for the form to be processed. Please print in blue or black ink.

LAST NAME:	FIRST NAME:	MI:	LAST FOUR OF SSN:	
HOME ADDRESS:	CITY:	STATE:	ZIP:	
PERSONAL TELEPHONE NUMBER:	PERSONAL EMAIL ADDRESS:			

- Please initial the appropriate box below to indicate whether or not you use tobacco on a regular basis.
- If you are a regular user of tobacco, please indicate whether or not you are interested in receiving information about the Mississippi State and School Employees' Health Insurance Plan's (Plan) free tobacco cessation programs.

NON-TOBACCO USER	
<input type="checkbox"/>	I attest that I do not regularly use a tobacco product in any form (cigarettes, cigars, pipe, oral tobacco products, etc.).  I certify that all information provided by me on this form is complete and accurate.  <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; border-top: 1px solid black; padding-top: 2px;">Signature</div> <div style="width: 45%; border-top: 1px solid black; padding-top: 2px;">Date</div> </div>
TOBACCO USER	
<input type="checkbox"/>	I acknowledge that I regularly use a tobacco product in some form (cigarettes, cigars, pipe, oral tobacco products, etc.).  <input type="checkbox"/> I am interested in receiving information about tobacco cessation programs offered by the Plan.  I certify that all information provided by me on this form is complete and accurate.  <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; border-top: 1px solid black; padding-top: 2px;">Signature</div> <div style="width: 45%; border-top: 1px solid black; padding-top: 2px;">Date</div> </div>

**Form Submission:**

- If you are an **active employee**, please return your form to your employer's Human Resources Department.
- If you are a **non-Medicare retiree or COBRA participant**, please mail or fax your form to:
 

Blue Cross & Blue Shield of Mississippi  
 P.O. Box 23734  
 Jackson, MS 39225-3734  
 Fax: (601) 664-5342

For more information visit [KnowYourBenefits.dfa.ms.gov](http://KnowYourBenefits.dfa.ms.gov)

# Sunflower County Consolidated School District

"United For Excellence"



## VERIFICATION OF TEACHING EXPERIENCE

**WILL BE PAID AT 0 YEAR EXPERIENCE, IF NOT RETURNED WITHIN FIVE DAYS**

To be completed by applicant:

Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
*Last First Middle/Maiden*

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**The information below is to be completed by School District Administrator or Human Resources office and returned to the applicant for inclusion in the application packet:**

This is to certify that educator \_\_\_\_\_  
Social Security # \_\_\_\_\_ has successfully completed years of experience as a classroom teacher in our district:

Name of School	Start/Ending Date Mo/Dav/Year	TOTAL YEARS	POSITION Or GRADE*	School State Accredited? (Yes or No)

*Signature of Human Resources or Personnel Director*

*Position*

\_\_\_\_\_  
*Name of School District*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*State*

\_\_\_\_\_  
*Phone*



**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>	
<p><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></p> <p>1. Alien Registration Number/USCIS Number: _____  <b>OR</b>          2. Form I-94 Admission Number: _____  <b>OR</b>          3. Foreign Passport Number: _____          Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">           QR Code - Section 1            Do Not Write In This Space         </div>	

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



*Employer Completes Next Page*







**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.")*

<b>Employee Info from Section 1</b>	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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
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	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name		
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

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

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
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)
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**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative	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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport, and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security</li> </ol>

**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.**



# SUNFLOWER COUNTY CONSOLIDATED SCHOOL DISTRICT

## CONSENT AND INFORMATION RELEASE FORM

- I understand that a condition of employment/volunteer work with the Sunflower County Consolidated School District is a criminal background investigation
- I authorize the Sunflower County Consolidated School District to conduct a criminal background investigation and understand that the results will be part of my personnel/volunteer file.

---

Signature

Date

## BACKGROUND CHECK INFORMATION FORM

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Name:

---

Address:

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SSN:

Date of Birth:

**Gender:**

- Female
- Male

**Race:**

- Black
- White
- Hispanic
- Other



# SUNFLOWER COUNTY CONSOLIDATED SCHOOL DISTRICT CRIMINAL BACKGROUND QUESTIONNAIRE FORM

With respect to the City/Community in which you have resided for the past ten years, state the following below:

The name of the City/Community and the period of time you resided in each.

<u>City/Community</u>	<u>Date</u>
1. _____	From _____ To _____
2. _____	From _____ To _____
3. _____	From _____ To _____

Have you ever been convicted of the following crimes: (a) Felony Possession or Sale of Drugs; (b) Murder; (c) Manslaughter; (d) Armed Robbery; (e) Rape; (f) Sex Battery; (g) Sex Offenses; (h) Child Abuses; (i) Arson; (j) Grand Larceny (k) Burglary (l) Gratification of Lust; (m) Aggravated Assault.

Yes \_\_\_\_ No \_\_\_\_

If your answer is yes, provide information with regard to each charge or conviction.

<u>The Crime (Identify)</u>	<u>Date Charged</u>	<u>Disposition</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Are you presently on probation or on parole from a criminal conviction? Yes \_\_\_\_ No \_\_\_\_

Do you presently have any criminal charge pending against you at this time? Yes \_\_\_\_ No \_\_\_\_

I understand that the information requested above will be used for purposes of evaluating my suitability for employment by the Sunflower County Consolidated School District only and will not be disclosed to any third party or agency. Further, I hereby certify under penalty or perjury that my answers to the forgoing questions are true and complete.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date