Calhoun County School District
119 West Main Street
Pittsboro, MS 38951
Phone 662-412-3152

New Employee Packet Coversheet

Name: **Date Sent:**

Position: **Date Returned:**

Where to submit completed packet: Call District Payroll Clerk Annette Clanton at 662-412-3152 to schedule time to bring completed packet for review of all documents

Complete the following forms and return for review:

- Employment Eligibility Verification (Form I-9)
- Federal Withholding Form (Form W-4)
- Mississippi Employee's Withholding Exemption Certificate
- PERS Form I – Retirement Enrollment
- PERS Form IB - Beneficiary Nomination
- State and School Employees' Health Insurance Plan Application for Coverage
- Unum Provident Mississippi Schools Active Employee & Dependents Enrollment Form for Basic Life Insurance and Supplemental Life Insurance
- Direct Deposit Authorization Form
- Fingerprinting Certification and Scheduling Form
- Copy of Drivers License
- Copy of Social Security Card
- Notice of Payroll Deduction Services for Voluntary Insurance
- New Health Insurance Marketplace Coverage Options and Your Health Coverage

Bring the following documents for copying (or bring copies):

- Valid Mississippi Teacher's License (if applicable to the position)
- Previous Employer's written verification of prior work experience (or other experience applicable to position pay).
- Copy of College Transcript
- Driver's License (must include picture identification)
- Social Security Card

STATE HEALTH INSURANCE IS PAID BY THE STATE FOR ALL FULL-TIME EMPLOYEES. DEPENDENT COVERAGE IS PAID BY THE EMPLOYEE.

LIFE INSURANCE IS OFFERED BY THE STATE FOR ALL FULL-TIME EMPLOYEES. COVERAGE IS BASED ON AN AMOUNT EQUAL TO TWICE YOUR ANNUAL SALARY ROUNDED UP TO THE NEXT 1000. THE MINIMUM COVERAGE IS 30,000 AND THE MAXIMUM COVERAGE IS 100,000. THE COST IS $.18 PER THOUSAND. THE STATE PAYS HALF. YOUR COST IS $.09 PER 1000. ADDITIONAL OPTIONS FOR SUPPLEMENTAL AND DEPENDENT COVERAGE LIFE INSURANCE ARE AVAILABLE AND ARE PAID BY THE EMPLOYEE.

Employee Benefits Summary

Social Security and Medicare:
The District pays the rate set by Congress for social security and Medicare benefits. Currently the rate is 7.65% of social security taxable wages. Some exemptions apply.

Retirement:
Participation in the Mississippi Public Employees' Retirement System is mandatory for full-time employees. The District pays the rate set by the State of Mississippi Public Employees Retirement System for deposit into the employee's retirement account at PERS. Currently the rate is 15.75%.

Health Insurance:
The District offers qualifying employees the opportunity to enroll in group health insurance. Enrollment is optional. Dependent coverage is also optional and if desired is paid by the employee through payroll deduction.

Life Insurance:
The District offers qualifying employees the opportunity to enroll in group life insurance. Enrollment is optional. Allowable coverage is based on an amount equal to twice the annual salary rounded up to the next thousand. Minimum coverage, though, is $30,000 and maximum coverage is $100,000. Cost is $.18 per month per $1,000 of coverage. The School District pays half and the employee pays half through payroll deduction. Supplemental and dependent coverage is available at the employees expense and if desired will be paid by payroll deduction.

Section 125 Cafeteria Plan:
The District provides employees the option of enrolling in the Cafeteria Plan administered by American Fidelity for the purpose of tax sheltering certain eligible expenses. Certain payroll deducted insurance premiums may be tax sheltered. In addition the employee may choose to participate in flexible spending plans or dependent child care reimbursement programs. Enrollment is optional. Specific IRS and Cafeteria Plan rules apply.

Payroll Deduction Services for Voluntary Employee-paid Insurance:
The District provides payroll deduction service for some voluntary insurance premiums. The insurance vendors allowed in the District are at the District's discretion.

The payroll deduction service is provided to give employees the benefit of lower premiums and an opportunity to tax shelters some premiums. If authorized in writing by the employee, the District's payroll office will send the payroll deducted premium to the insurance company on behalf of the employee.

The District does not endorse any policy, does not try to sell any policy, does not assume responsibility for interpreting any policy, is not responsible for notifying employees of policy changes, does not file claims or assist employees with claims filing, does not serve as a claims mediator, does not determine coverage eligibility, and does not pay any portion of the voluntary insurance premiums. Employees are to deal directly with their insurance representative regarding coverage and claims issues.

The District reserves the right to terminate payroll deduction services or terminate voluntary insurance coverage options. To the extent possible employees will be notified in advance of any District plans to terminate a voluntary insurance so the employee can make arrangements with the insurance representative for payment of premiums through bank draft, etc. in order for there to be no lapse in coverage.

Listed below are authorized insurance vendors. Please contact the vendor if you are interested in the product they are selling.

Mississippi Deferred Compensation – contact Willie Berry, Retirement Plan Counselor
Email: willie.berry@empower-retirement.com
111 E. Capitol Street
Suite 260
Jackson, MS 39201
Cell: 601-506-9745
Fax 1-601-355-0089
Toll Free 1-800-846-4551
Website Address: www.mdcplan.com

Unum Life Insurance - alternate state life insurance (supplemental and dependent life)
Milette Administrators
Phone for Terry Crane, Representative - 1-800-456-8647, extension 103
Phone for Roy Crane, Representative – 1-800-456-8647, extension 104

American Fidelity-David Jenkins, Representative
Cell – 662-401-4653

Guardian– Phillip Kennedy, Representative
Cell 1-662-489-9611

State of Mississippi Health Insurance – for additional or dependent coverage contact the District's payroll clerk at 662-412-3152 for assistance

I certify by signing below that I have received the new employee packet that includes the New Health Insurance Marketplace Coverage Options and Your Health Coverage

_____ Signature _____ Date

CALHOUN COUNTY SCHOOL DISTRICT

NOTICE OF PAYROLL DEDUCTION SERVICES

Calhoun County School District provides a payroll deduction service to employees for some voluntary insurance premiums.

Listed below are insurance companies whose premiums are currently processed through payroll deduction.

- GUARDIAN DENTAL AND VISION INSURANCE
- STATE OF MISS. HEALTH INSURANCE PLAN
- ALTERNATE STATE LIFE INSURANCE WITH UNUM INSURANCE CO.
- AFLAC ACCIDENT, DISABILITY AND CANCER INSURANCE

Employees may place eligible premiums under the Cafeteria Plan for tax purposes. Employees may enroll in Medical Reimbursement, Dependent Childcare Reimbursement, and Individual Insurance Premium Reimbursement programs through the Section 125 Cafeteria Plan.

Calhoun County School District does not:

- Endorse any policy
- Assume responsibility for interpreting policy
- Notify employees of policy changes
- File claims
- Serve as a claims mediator
- Determine coverage eligibility
- Pay premiums (other than employee coverage for State Health & Life insurance)
- Initiate or terminate payroll deductions without signed authorization

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THE AVAILABILITY OF PAYROLL DEDUCTION SERVICES.

_____ _____

SIGNATURE DATE

Calhoun County School District

Employee Information Form

Personal Information

Full Name: _____ _____
Last First M.I.

Address: _____
Street Address

_____
City State ZipCode

Home Phone: _____ Alternate Phone: _____ _____ _____

Email Address: _____

Social Security Number: _____

Birth Date: _____ Martial Status: _____ _____

Spouse's Name: _____

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

Job Information

Title: _____ Supervisor: _____ _____

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one)

☐ 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

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

Additional Information

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

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

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

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

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.)*

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2018)

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

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

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2018

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

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here	7	

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

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

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

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

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

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

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

Two-Earners/Multiple Jobs Worksheet

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

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

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

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

Instructions for Employer

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A
B	Enter "1" if you will file as married filing jointly	B
C	Enter "1" if you will file as head of household	C
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E
F	**Credit for other dependents.** • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-"	F
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here	G
H	Add lines A through G and enter the total here ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details	1 $
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	2 $
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3 $
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4 $
5	**Add** lines 3 and 4 and enter the total	5 $
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	6 $
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7 $
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8
9	Enter the number from the **Personal Allowances Worksheet,** line H above	9
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10

Two-Earners/Multiple Jobs Worksheet

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

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

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

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

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

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

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

9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

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

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

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

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

Form 89-350-12-8-1-000 (Rev. 11/12)

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

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

Employee's Name _____ SSN _____

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

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION

EMPLOYEE: File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.

EMPLOYER: Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.

Marital Status	Personal Exemption Allowed	Amount Claimed
1. Single	☐ Enter $6,000 as exemption . . . . ▶	$
2. Marital Status (Check One)	(a) ☐ Spouse NOT employed: Enter $12,000 ▶	$
	(b) ☐ 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	☐ 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 . . . . . ▶	$
4. Dependents — Number Claimed	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 ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ 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 . . . . . ▶		$
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..▶		_____

Military Spouses Residency Relief Act exemption from Mississippi withholding

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

Allowable personal exemptions allowed:

Single Individuals	$6,000	(d) Dependents	$1,500
Married Individuals (Jointly)	$12,000	(e) Age 65 and Over	$1,500
Head of family	$9,500	(f) Blindness	$1,500

Claiming personal exemptions:

Single Individuals enter $6,000 on Line 1.

Married individuals are allowed a joint exemption of $12,000.

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).

Head of Family

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).

An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. 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 excluding 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 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.

(e) 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. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(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.

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.

4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION

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..

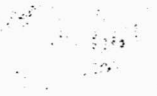
7. To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.

PERS RETIREE

YES

OR

NO



PERS of MISSISSIPPI

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.

❶ 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

❷ 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)

❸ 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**
				☐ M ☐ 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**
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

❹ 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*: _____

❺ 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: CALHOUN COUNTY SCHOOL DISTRICT Employer No.: 0091 - 001

Employer Representative's Name: ANNETTE CLANTON Employer Representative's Title: PAYROLL

Employer Representative's Phone: (662) 412-3152 Fax: (662) 412-3157 E-Mail: ACLANTON@CALHOUNK12.COM

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*: _____

PERS of MISSISSIPPI

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.

❶ Member/Retiree Information

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

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

❷ 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)

❸ 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
				☐P ☐S _____%	☐M ☐F
				☐P ☐S _____%	☐M ☐F
				☐P ☐S _____%	☐M ☐F
				☐P ☐S _____%	☐M ☐F
				☐P ☐S _____%	☐M ☐F

❹ 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*: _____

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

Employer Name: CALHOUN COUNTY SCHOOL DISTRICT Employer No.: 0091 - 001

Employer Representative's Name: ANNETTE CLANTON Employer Representative's Title: PAYROLL

Employer Representative's Phone: (662) 412-3152 Fax: (662) 412-3157 E-Mail: ACLANTON@CALHOUNK12.COM

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

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
Effective January 1, 2017

Legacy - Initially hired before 1/1/2006
Horizon - Initially hired on or after 1/1/2006

ACTIVE EMPLOYEE	LEGACY EMPLOYEES				HORIZON EMPLOYEES			
	BASE		SELECT		BASE		SELECT	
	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee	$356	$0	$376	$20	$356	$0	$394	$38
Employee + Spouse	$745	$389	$819	$463	$745	$389	$837	$481
Employee + Spouse & Child(ren)	$949	$593	$1,023	$667	$949	$593	$1,041	$685
Employee + Child	$457	$101	$531	$175	$457	$101	$549	$193
Employee + Children	$614	$258	$688	$332	$614	$258	$706	$350

RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	LEGACY RETIREES		HORIZON RETIREES	
	BASE	SELECT	BASE	SELECT
Retiree	$409	$432	$653	$676
Retiree + Spouse (Non-Medicare)	$856	$941	$1,309	$1,394
Retiree + Spouse & Child(ren) (Non-Medicare)	$1,091	$1,176	$1,464	$1,549
Retiree + Child	$525	$587	$746	$831
Retiree + Children	$706	$744	$903	$988
Retiree + Spouse (Medicare)	N/A	$616	N/A	$860
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$771	N/A	$1,015

RETIRED EMPLOYEE - MEDICARE ELIGIBLE	BASE	SELECT	BASE	SELECT
Retiree	N/A	$184	N/A	$184
Retiree + Spouse (Non-Medicare)	N/A	$693	N/A	$902
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	$928	N/A	$1,057
Retiree + Child	N/A	$339	N/A	$339
Retiree + Children	N/A	$496	N/A	$496
Retiree + Spouse (Medicare)	N/A	$368	N/A	$368
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$523	N/A	$523

COBRA	BASE	SELECT	BASE	SELECT
Participant	$363	$383	$363	$401
Participant + Spouse	$759	$835	$759	$853
Participant + Spouse & Child(ren)	$967	$1,043	$967	$1,061
Participant + Child	$466	$541	$466	$559
Participant + Children	$626	$701	$626	$720

COBRA DISABILITY EXTENSION	BASE	SELECT	BASE	SELECT
Participant	$534	$564	$534	$591
Participant + Spouse	$1,117	$1,228	$1,117	$1,255
Participant + Spouse & Child(ren)	$1,423	$1,534	$1,423	$1,561
Participant + Child	$685	$796	$685	$823
Participant + Children	$921	$1,032	$921	$1,059

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

PLEASE PRINT **Section A: Enrollee Information (all fields are required)**		**Employer Name**		
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 prior to 1/1/2006? ☐ No (Horizon) ☐ 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? ☐ 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:	**Coverage Type:**	**Coverage Option:** (Choose Only One)	**Do you have Medicare?** ☐ Yes ☐ No
☐ Employee - Legacy ☐ Employee - Horizon ☐ Retiree ☐ COBRA ☐ Surviving Spouse	☐ Enrollee Only ☐ Enrollee + Spouse ☐ Enrollee + Child ☐ Enrollee + Children ☐ Enrollee + Spouse & Child(ren)	◯ Select ◯ Base (HIGH DEDUCTIBLE)	**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:

	1.	2.	3.	4.
Name of Individual Covered:				
Policyholder's Name:				
Policyholder's Date of Birth:				
Policyholder's Insurance Effective Date:				
Policy Number:				
Policyholder's Employment Status:	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐
Insurance Company Name address & phone #:				
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:

Section E: Dependents

Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security Number	Date of Birth (mm/dd/yyyy)	Address (if different from Enrollee)	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

☐ **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

Alternate State Life Insurance Plan

Underwritten by *UNUM LIFE INSURANCE COMPANY OF AMERICA*
Administered by Millette Administrators, Inc., Moss Point, MS
Phone 1-800-456-8647 or 1-228-475-8687 Ext. 0

07/01/14

Basic State Public Employees Plan

- All employees must participate unless they sign a wavier in the Superintendent's Office.
- Your benefit is 2x your annual salary rounded to the next highest $1,000 with a minimum of $30,000 and a maximum of $100,000.
- Accidental Death & Dismemberment (AD&D) benefits included for Active Employee.
- Includes Wavier of Premium to age 65.
- The State pays for half the benefit.
- Active employee cost is $ 0.09 per $1,000/month. The State cost is $0.09 per $1,000/month for actives.
- Retirees pay 100% of their premium. The State does not contribute for retirees.

Supplemental Life Insurance To State Life Plan

- Supplemental Life is offered in addition to the Basic Life and is optional. Paid for 100% by the employee.
- Accidental Death & Dismemberment (AD&D) benefits included for employee only.
- Includes Wavier of Premium to age 65.
- Employee must be actively at work to enroll for supplemental coverage
- New employees may enroll within first 30 days of employment without evidence of insurability. Evidence of insurability is required after 30 days of employment.

Active Employees	
$10,000 for	$ 4.00 / month
$25,000 for	$10.00 / month
$50,000 for	$20.00 / month

Dependent Coverage	$ 5.00/month
Spouse	$10,000*
Children over 6 months	$ 5,000**
Life birth to 6 months	$ 100

* **Dependent spouse monthly premium will increase at the spouse's age 70 from $5.00 to $23.50**

** Unmarried dependent children to age 19 or 25 if enrolled as full-time student in an accredited school. Employee must notify Unum Life Insurance Company of a change in dependent status effecting coverage

Retiree Life Benefit and Premiums

- At retirement, employee can continue life insurance as provided for in the policy.
- You are ***not*** eligible to elect retiree life insurance if you did not have the life insurance as an active employee
- **Maximum** benefit of $50,000 (this can be a combination of basic & supplemental life) **Minimum** benefit of $ 5,000
- **Premiums may be deducted from monthly PERS retirement benefit or, paid annually by direct pay.**
- Retiree Dependent spouse (if available) will increase from $5.00 to $23.50 at the spouse's age 70
- A retiree may not increase the amount of coverage he/she had at the time of retirement.
- Retirees do not have the extra benefit of AD&D. There is no reduction of benefit at any age level. Benefit is group term life and does not build cash value. Benefit chosen remains same as long as premiums are paid.

Benefit Amount	Current Premium	Benefit Amount	Current Premium
$ 5,000	$ 9.80 / month	$30,000	$ 54.50 / month
$10,000	$13.60 / month	$40,000	$ 81.80 / month
$20,000	$27.20 / month	$50,000	$109.10 / month

Unum

Mississippi Schools
Active Employee & Dependents Enrollment Form for Basic Life Insurance and Supplemental Life Insurance
Policy #537377-015

Employee Name (Last name, first, middle initial)		Social Security Number
Employee Address (street, city, state, zip code)		Date of Birth
Gender ☐ Male ☐ Female	Date of Employment	Annual Earnings
Employer *Calhoun County School District*		Occupation

Employee Life Insurance Amount: $_____ Eligible Active Employees receive coverage of two times annual salary rounded to next highest $1,000, subject to a minimum of $30,000 and a maximum of $100,000.

Note: All employees are automatically covered for Basic Life and AD&D unless a waiver is signed. (waiver on back of this form)

I am: ☐ New Enrollee ☐ Late Enrollee (Evidence of Insurability is required) ☐ Changing Beneficiary

☐ Changing Name (previous name _____) ☐ Adding Dependent(s)

Beneficiary Information

Designate your beneficiary(ies) for your Basic and Supplemental Life coverage below:

Name	Relationship to You		Benefit %
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	

If no primary beneficiary(ies) survive you, the proceeds will be paid to the surviving contingent beneficiary(ies).

SUPPLEMENTAL LIFE AND DEPENDENT LIFE INSURANCE:

Choose from the following for electing Supplemental Life Insurance: List spouse & dependents to be covered:

Employee must notify Unum Life Insurance Company of any change in dependent status effecting coverage

Employee Life and AD&D	DEPENDENT/FAMILY COVERAGE
☐ $10,000	Spouse.....$10,000
☐ $25,000	Per Child.....$ 5,000
☐ $50,000	To 6 Months per Child....$ 100
☐ None	☐ I elect dependent coverage.
	☐ I decline dependent coverage.
	Spouse cost increases at age 70

Dependent Name	Relationship	Date of Birth

Certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I hereby authorize my employer to deduct monthly, the appropriate life insurance premium and also I further authorize my employer to forward payment of such premium amount to UNUM or its authorized agent/representative on the first working day of each month to cover the cost of my life insurance. I understand that UNUM and/or its authorized agent/representative is responsible for billing my employer monthly for the appropriate premium amount. I further understand that I am responsible for notifying UNUM and/or its authorized agent/representative concerning cancellation, premium changes, policy questions, and/or general information. Employee and Dependents must be actively at work and not disabled for coverage to be effective.

Employee Signature	Date	Work Phone	Home Phone

STATE OF MISSISSIPPI WAIVER OF BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMEMT PLAN 537377

If you do not want to elect Life coverage at this time, please mark the box below, and complete the form at the bottom. Be sure to sign and date the form.

☐ I do not wish to enroll in the State Life Insurance Plan. I realize that if I choose to enroll at a later date, my application will be subject to Medical Evidence of Insurability.

Employee Name _____ Social Security #_____

School District or Community College_____

Signature_____ Date _____

Calhoun County School District

DIRECT DEPOSIT AUTHORIZATION FORM

(For Direct Deposit of Payroll Check)

I hereby authorize Calhoun County School District to initiate a direct deposit of my payroll check to my checking/savings account(s) at the Financial Institution indicated below and initiate adjustments (if necessary) for any transactions credited/debited in error.

This authority will remain in effect until the Calhoun County School District is notified by me in writing to cancel it in such time as to afford the school district and bank a reasonable opportunity to act on it.

Please complete this form and verify accuracy of all information by comparing it to the voided check you will attach at the bottom.

Employee Name: _____

Employee Social Security Number: _____

Account 1:

Type of account: (circle one) ***Checking*** ***Savings***

Bank Name _____

Bank Routing Transit Number _____

(This number will appear on your check between symbols – "/: /:") May be the first set of #'s at the bottom of your check.

Your Bank Account Number _____

Distribution type: (Select only one distribution type per account)

1. Percentage of my check to this account _____(must complete Account 2 for balance of check)
2. Fixed dollar amount to this account _____(must complete Account 2 for balance of check)
3. Residual (balance of check to this account) _____(must complete Account 2 for balance of check)
4. All to this account. _____(must complete Account 2 for balance of check)

Account 2:

Type of account: (circle one) ***Checking*** ***Savings***

Bank Name _____

Bank Routing Transit Number _____

(This number will appear on your check between symbols – "/: /:") May be the first set of #'s at the bottom of your check.)

Your Bank Account Number _____

Distribution type: (Select only one distribution type per account)

5. Percentage of my check to this account _____(must complete Account 2 for balance of check)
6. Fixed dollar amount to this account _____(must complete Account 2 for balance of check)

Employee Signature:_____ Date:_____

Voided check(s) for each checking account & deposit receipts for savings accounts must be attached.

STAPLE VOIDED CHECK(S) HERE.

DIRECT DEPOSIT QUESTIONS

1. Can I have some of my check direct deposited to savings and some to checking?

   Yes. Complete Account 1 section for one account. Complete Account 2 section for other account. The maximum number of accounts is two.

2. When will my check actually get in my bank account?

   Your check will be posted to your account around 1:00 a.m. on the morning checks are sent to the schools. This is normally on the last working day of the month. (See school calendar for specific payroll dates.)

3. Is everyone required to use direct deposit?

   Yes

4. What happens if my check is wrong thus making direct deposit wrong?

   Corrections will be made on the next month's payroll.

5. How will I know if my check is really in my account?

   You may call your bank, check on-line, or call a service like Money Link. The school district does not have access to your account information, so this will be your responsibility. You must log onto activeresources.calhoun.k12.ms.us and set up an account to view or print direct deposit statements.

6. Can I have part of my check sent by direct deposit and get a real payroll check from the school district for the rest?

   No.

7. Will I get something from the district office that would have the same information as was on my check stub?

   No. You must log onto activeresources.calhoun.k12.ms.us and set up an account to view or print direct deposit statements.