



SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO

300 East Broad Street, Suite 100, Columbus, Ohio 43215-3746
614-222-5853 • Toll-Free 1-800-878-5853 • www.ohsers.org

MEMBERSHIP RECORD

PART A - TO BE COMPLETED BY MEMBER

Social Security Number input boxes

SOCIAL SECURITY NUMBER

LAST NAME FIRST MIDDLE MAIDEN

PERMANENT MAILING ADDRESS: STREET

MALE FEMALE checkboxes

CITY STATE ZIP

DATE OF BIRTH: MONTH DAY YEAR E-MAIL ADDRESS:

PHONE NUMBER: SINGLE MARRIED DIVORCED WIDOWED checkboxes

FAMILY DATA

LAST NAME FIRST MIDDLE OR MAIDEN DATE OF BIRTH MONTH/DAY/YEAR

SPOUSE:

CHILDREN:

FATHER:

MOTHER:

JOB CLASSIFICATION Mark one box only:

- Administrative Educational Aide Supplemental (Coach, Advisor, Etc.)
Clerical/Secretarial Food Service School Board Member
Custodial/Maintenance Transportation Other

If an employee of the schools through an outside contract company:
Name of contract company:

MEMBERSHIP IN OTHER OHIO SYSTEM

For all of the following, check "yes" or "no" if you ever were a member of or received benefits from:

Table with columns for MEMBER (Yes/No) and BENEFIT (None/Service/Disability/Survivor) for various Ohio retirement systems.

MEMBER CERTIFICATION

I hereby certify the information given here to be true to the best of my knowledge.

SIGNATURE: DO NOT PRINT DATE:

PART B - TO BE COMPLETED BY EMPLOYER

Shawnee Local Schools Allen COUNTY 02 DISTRICT NO. 010

SCHOOL DISTRICT COUNTY COUNTY DISTRICT NO.

MEMBER'S FIRST DATE OF SERVICE THIS SCHOOL YEAR (July 1 - June 30):

I hereby certify that I have verified the employee's Social Security number, the job title, and the first date of service for the current employment.

AUTHORIZED OFFICER'S SIGNATURE: 25.52 Rev. 11/09

Employee's Withholding Certificate

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

2022

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

Step 2:
Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____ Multiply the number of other dependents by \$500 ▶ \$ _____ Add the amounts above and enter the total here		
		3	\$
Step 4 (optional): Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. Other This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	▶ _____ ▶ Employee's signature (This form is not valid unless you sign it.)		▶ _____ ▶ Date

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
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Ohio Employee's Withholding Exemption Certificate

Submit form IT 4 to your employer on or before the start date of employment so your employer will withhold and remit Ohio income tax from your compensation. If applicable, your employer will also withhold school district income tax. You must file an updated IT 4 when any of the information listed below changes (including your marital status or number of dependents). You should contact your employer for instructions on how to complete an updated IT 4. **Your employer may require you to complete this form electronically.**

Section I: Personal Information

Employee Name:	Employee SSN:
Address, city, state, ZIP code:	
School district of residence (See <i>The Finder</i> at tax.ohio.gov):	School district number (####):

Section II: Claiming Withholding Exemptions

1. Enter "0" if you are a dependent on another individual's Ohio return; otherwise enter "1"
2. Enter "0" if single or if your spouse files a separate Ohio return; otherwise enter "1"
3. Number of dependents
4. Total withholding exemptions (sum of line 1, 2, and 3)
5. Additional Ohio income tax withholding per pay period (optional)\$

Section III: Withholding Waiver

I am **not** subject to Ohio or school district income tax withholding because (check all that apply): I am a full-year

- resident of Indiana, Kentucky, Michigan, Pennsylvania, or West Virginia.
- I am a resident military servicemember who is stationed outside Ohio on active duty military orders. I am a
- nonresident military servicemember who is stationed in Ohio due to military orders.
- I am a nonresident civilian spouse of a military servicemember and I am present in Ohio solely due to my spouse's military orders.
- I am exempt from Ohio withholding under R.C. 5747.06(A)(1) through (6).

Section IV: Signature (required)

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

Signature _____ Date _____



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

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

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

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

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

Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State
Date of Birth <i>(mm/dd/yyyy)</i>		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: _____</p> <p align="center">OR</p> <p>2. Form I-94 Admission Number: _____</p> <p align="center">OR</p> <p>3. Foreign Passport Number: _____</p> <p>Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

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

STOP Employer Completes Next Page **STOP**

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	OR	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	AND	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
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		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 the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



Ohio Department of Public Safety

DIVISION OF HOMELAND SECURITY

http://www.homelandsecurity.ohio.gov

PUBLIC EMPLOYMENT

In accordance with section 2909.34 of the Ohio Revised Code

DECLARATION REGARDING MATERIAL ASSISTANCE/NO ASSISTANCE TO A TERRORIST ORGANIZATION

This form serves as a declaration of the provision of material assistance to a terrorist organization or organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List (see the Ohio Homeland Security Division Web site for the Terrorist Exclusion List).

Any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided. Failure to disclose the provision of material assistance to such an organization or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree.

For the purposes of this declaration, "material support or resources" means currency, payment instruments, other financial securities, funds, transfer of funds, and financial services that are in excess of one hundred dollars, as well as communications, lodging, training, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials.

Form with fields: LAST NAME, FIRST NAME, MIDDLE INITIAL, HOME ADDRESS, CITY, STATE, ZIP, COUNTY, HOME PHONE, WORK PHONE

DECLARATION

In accordance with section 2909.32 (A)(2)(b) of the Ohio Revised Code

For each question, indicate either "yes," or "no" in the space provided. Responses must be truthful to the best of your knowledge.

- 1. Are you a member of an organization on the U.S. Department of State Terrorist Exclusion List?
2. Have you used any position of prominence you have with any country to persuade others to support an organization on the U.S. Department of State Terrorist Exclusion List?
3. Have you knowingly solicited funds or other things of value for an organization on the U.S. Department of State Terrorist Exclusion List?
4. Have you solicited any individual for membership in an organization on the U.S. Department of State Terrorist Exclusion List?
5. Have you committed an act that you know, or reasonably should have known, affords "material support or resources" to an organization on the U.S. Department of State Terrorist Exclusion List?
6. Have you hired or compensated a person you knew to be a member of an organization on the U.S. Department of State Terrorist Exclusion List, or a person you knew to be engaged in planning, assisting, or carrying out an act of terrorism?

In the event of a denial of licensure due to a positive indication that material assistance has been provided to a terrorist organization, or an organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List, a review of the denial may be requested. The request must be sent to the Ohio Department of Public Safety's Division of Homeland Security. The request forms and instructions for filing can be found on the Ohio Homeland Security Division Web site.

CERTIFICATION

I hereby certify that the answers I have made to all of the questions on this declaration are true to the best of my knowledge. I understand that if this declaration is not completed in its entirety, it will not be processed and I will be automatically disqualified. I understand that I am responsible for the correctness of this declaration. I understand that failure to disclose the provision of material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List, or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree. I understand that any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided by myself or my organization. If I am signing this on behalf of a company, business or organization, I hereby acknowledge that I have the authority to make this certification on behalf of the company, business or organization referenced above.

X _____
APPLICANT SIGNATURE

DATE



Dave Yost
Ohio Auditor of State

Bulletin 2012-003

Auditor of State Bulletin

Date Re-Issued: **April 4, 2012**

TO: **All Public Offices Community
 Schools**

FROM: **Dave Yost, Ohio Auditor of State**

SUBJECT: **House Bill 66 – Fraud Hotline**

In 2003, then Auditor of State Betty Montgomery created the Auditor of State’s fraud hotline. The hotline was established as a way for all Ohioans to report potential fraud throughout government. Since its inception, not a week passes without the Auditor of State’s office receiving tips or complaints.

Recently passed legislation House Bill 66 (HB 66) makes several changes to the Auditor of State’s fraud hotline. The bill requires the Auditor of State to maintain a system for the reporting of fraud, including misuse of public money by any public official or office. The system allows all Ohio citizens the opportunity to make anonymous complaints through a toll-free telephone number, the Auditor of State’s website, or through the United States’ mail.

The Auditor of State is required to keep a log of all complaints filed. The log is a public record under Section 149.43 of the Revised Code and must contain the following: the date the complaint was received, a general description of the nature of the complaint, the name of the public office or agency with regard to which the complaint is directed, and a general description of the status of the review by the Auditor’s office. Information in the log may be redacted if Section 149.43 of the Revised Code or another statute provides an applicable exemption. During the course of Auditor of State investigations, information will be redacted pursuant to Section 149.43(A)(2) in order to conduct thorough investigations.

The new legislation also has a direct impact on all public employers. On the bill’s effective date, May 4, 2012, public offices, including community schools, must make their employees aware of the fraud-reporting system. Public offices also must provide information about the fraud reporting system to all new hires. All new employees must confirm that they received this information within thirty days after beginning employment. Section 117.103 requires the Auditor of State to confirm that public offices have so notified new employees. The statute provides two ways to verify compliance. First, public offices may require new employees to sign forms acknowledging the employees were notified of the fraud-reporting system. The Auditor of State has created a model form, which is appended to this Bulletin and may be found on the Auditor of State website. Alternatively, public offices may consider providing the fraud reporting system information in the employee manual for the public office. The employee should sign and verify the employee’s receipt of such a manual. This option satisfies the bill’s requirements on public employers.

Finally, the legislation also extends the current whistle-blower protections contained in Section 124.341 of the Revised Code to employees who file a complaint with the new fraud-reporting system. If a classified or unclassified employee becomes aware of a situation and reports it to the Auditor of State’s fraud-reporting system, the employee is protected against certain retaliatory or disciplinary actions. If retaliatory or disciplinary action is taken against the employee, the employee has the right to appeal with the State Personnel Board of Review.

Example language regarding the Auditor of State's fraud reporting-system

The Ohio Auditor of State's office maintains a system for the reporting of fraud, including misuse of public money by any official or office. The system allows all Ohio citizens, including public employees, the opportunity to make anonymous complaints through a toll free number, the Auditor of State's website, or through the United States mail.

Auditor of State's fraud contact information:

Telephone: 1-866-FRAUD OH (1-866-372-8364)

US Mail: Ohio Auditor of State's office
Special Investigations Unit 88 East
Broad Street
P.O. Box 1140 Columbus, OH
43215

Web: www.ohioauditor.gov

Acknowledgement of receipt of Auditor of State fraud reporting-system information

Pursuant to Ohio Revised Code 117.103(B)(1), a public office shall provide information about the Ohio fraud-reporting system and the means of reporting fraud to each new employee upon employment with the public office.

Each new employee has thirty days after beginning employment to confirm receipt of this information.

By signing below you are acknowledging (insert public employer) provided you information about the fraud-reporting system as described by Section 117.103(A) of the Revised Code, and that you read and understand the information provided. You are also acknowledging you have received and read the information regarding Section 124.341 of the Revised Code and the protections you are provided as a classified or unclassified employee if you use the before-mentioned fraud reporting system.

I _____, have read the information provided by my employer regarding the fraud-reporting system operated by the Ohio Auditor of State's office. I further state that the undersigned signature acknowledges receipt of this information.

PRINT NAME, TITLE, AND DEPARTMENT

PLEASE SIGN NAME

DATE



Health Insurance Marketplace Coverage

Options and Your Health Coverage

Form Approved

OMB No. 1210-0149

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

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

All employees. Eligible employees are:

Some employees. Eligible employees are:

•With respect to dependents:

We do offer coverage. Eligible dependents are:

-the subscriber's legal spouse; the subscriber's or the subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children; also children determined to be covered by a QMCSO; also children for whom the subscriber or subscriber's spouse is a legal guardian.

We do not offer coverage.

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

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

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

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

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

Yes (Continue)

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

No (STOP and return this form to employee)

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

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

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

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

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

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

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

Employer won't offer health coverage

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

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

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

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

Consent for Electronic Disclosures
(Employees)

I authorize you to send, and I consent to receiving the following documents by electronic means:

- Plan Descriptions
- Summaries of Material Modification
- Summaries of Benefits and Coverage (SBC)
- Annual Notices
- 1095-C Form

I understand that if my mailing address or e-mail address changes, I must notify Chris Cross, Treasurer in writing at Shawnee Local School District, 3255 Zurmehly Road, Lima, OH 45806 or via e-mail at chris@limashawnee.com.

I affirm that I have the ability to access information in Microsoft Word for Windows 97 or higher and/or Adobe Acrobat Reader. I understand that I will receive the documents listed above only in electronic form unless I request a paper copy of such documents by notifying Chris Cross, Treasurer in writing at Shawnee Local School District, 3255 Zurmehly Road, Lima, OH 45806 or via e-mail at chris@limashawnee.com with "Request for Paper Copy" in the subject line.

I understand that this consent may be withdrawn at any time by notifying Chris Cross, Treasurer in writing at Shawnee Local School District, 3255 Zurmehly Road, Lima, OH 45806 or via e-mail at chris@limashawnee.com with "Consent Withdrawn for Electronic Disclosure" in the subject matter. Include your full name, address and phone number in the body of the e-mail.

Print Name

Signature

Date

**SHAWNEE LOCAL SCHOOL DISTRICT
PAYROLL DIRECT DEPOSIT – AUTHORIZATION AGREEMENT**

I hereby authorize Shawnee Local School District to initiate electronic entries to my checking and/or savings account(s) at the following financial institution(s):

ACCOUNT #1: (Please circle one - Checking or Savings Account)

FINANCIAL INSTITUTION NAME: _____

ROUTING/TRANSIT NUMBER: _____

ACCOUNT NUMBER: _____

AMOUNT: \$ _____ OR _____ %

ACCOUNT #2: (Please circle one - Checking or Savings Account)

FINANCIAL INSTITUTION NAME: _____

ROUTING/TRANSIT NUMBER: _____

ACCOUNT NUMBER: _____

AMOUNT: \$ _____ OR _____ %

ACCOUNT #3: (Please circle one - Checking or Savings Account)

FINANCIAL INSTITUTION NAME: _____

ROUTING/TRANSIT NUMBER: _____

ACCOUNT NUMBER: _____

AMOUNT: \$ _____ OR _____ %

If only percentages are used, total must equal 100%. If dollar amounts are used, one account must be marked as “remaining” amount.

The Routing/Transit Number is a nine-digit number, generally located in the bottom left-hand corner of bank checks or deposit slips.

This authorization is to remain in full force and effect until the Shawnee Local School Treasurer receives written notification from me of its termination in such time and in such manner as to afford the Shawnee Local School District and the Financial Institution reasonable time to act upon it.

EMPLOYEE NAME: _____ S.S. #: _____

SIGNATURE: _____ DATE: _____

You may have your direct deposit notification for each payroll sent to you in an email instead of receiving a paper copy. If you wish to do so, please provide your email address below. You may have it sent to more than one email address.

E-Mail Address: _____

E-Mail Address: _____

PLEASE ATTACH A COPY OF YOUR **DRIVERS LICENSE** AND **SOCIAL SECURITY CARD**.

ALL EMPLOYEES ARE REQUIRED TO HAVE THEIR FUNDS DIRECT DEPOSITED.

ADDITIONAL INFORMATION REGARDING FORM I-9 OR ANY OTHER PAYROLL DOCUMENTS, PLEASE CONTACT THE TREASURER'S OFFICE.

ALL INFORMATION IS DUE NO LATER THAN 10:00 AM ON FRIDAY PRIOR TO THE NEXT PAYDAY.