Bloomington Independent School District

2022-2023 Substitute Packet

For Office Use Only.
☐ DL ☐ SSC

Bloomington ISD

167 N. Williams St.
Placedo, TX 77977

(361) 333-8016
(361) 333-8026 fax

All Prospective Substitutes:

All requested documents must be turned in to me at the Administration Office before you will be placed on the Substitute List.

Requested Documents:

- **Substitute Application**
- **Substitute Packet Completed**
- **A copy of your diploma or equivalent (College transcripts will be fine also.)**
- **A copy of your driver's license**
- **A copy of your social security card**
- **Per state law, now all substitutes must be fingerprinted before they will be able to work for any school district in the state.**
    - **Please contact me for details on how to get this completed.**

We are extremely excited that you have decided to join us and look forward to meeting you!

Thank you for taking interest in our school district.

Kellye Chavana
Superintendent Secretary
Kellye.chavana@bisd-tx.org

Bloomington ISD
An Equal Opportunity Employer*

Date of application _____

Personal Data

Name _____
Last *First* *Middle initial*

Mailing address _____
Street/Box *City* *State* *ZIP Code*

E-mail address _____

Home phone _____ Cell phone _____ Other phone _____

Other name that may appear on records _____

(Used for certification, reference, and criminal history record checks)

Position Data

List the position(s) for which you are applying _____

Type of employment: ☐ Full-time ☐ Part-time ☐ Summer only

Date you can begin work _____

Have you been employed by Bloomington ISD in the past? ☐ Yes ☐ No

If you answered yes, provide dates of employment _____

Special Skills

List specific skills, software proficiency, and any machines or equipment you can operate. Include number of years of experience.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Work Experience

Please provide a complete list of all positions you have held in the past 10 years. List the most recent first. Attach additional sheets if necessary (bus driver applicants, see addendum). Attach résumé if available.

Employer name and location		Employer name and location	
Position/title held		Position/title held	
Dates employed		Dates employed	
Supervisor's name and phone		Supervisor's name and phone	
Reason for leaving		Reason for leaving	

Work Experience

Employer name and location		Employer name and location	
Position/title held		Position/title held	
Dates employed		Dates employed	
Supervisor's name and phone		Supervisor's name and phone	
Reason for leaving		Reason for leaving	

References

Please list references the district can contact regarding your work history.

Full name of reference	School district/ firm name	Mailing address	Position/title	Area code/ phone number

Education/Training

List the highest level of education attained: _____

Licenses and certificates granted _____

_____

Name and location of schools attended	Course of study and major/minor	Diploma, degree, certificate, or license granted	Year graduated *(College only)*

General Information

Do you have a relative who serves on the Board of Education or is an employee of _____ ISD?

❑ Yes ❑ No If yes, please provide the relative's name and relationship: _____

_____

Have you ever been convicted of, pled guilty or no contest (nolo contendre) to, or received probation, suspension, or deferred adjudication for a felony or any offense involving moral turpitude (including, but not limited to, theft, rape, murder, swindling, and indecency with a minor)? ❑ Yes ❑ No

If yes, please state where, when, and the nature of the offense _____

_____

_____

_____

_____

_____

(A felony conviction is not an automatic bar to employment. The district will consider the nature, date, and relationship between the offense and the position for which you are applying.)

Verification

I hereby affirm that all information provided in this application is true and accurate to the best of my knowledge and understand that any deliberate falsifications, misrepresentations, or omissions of fact may be grounds for rejection of my application or dismissal from subsequent employment.

I authorize the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all such parties from liability for any damage that may result from furnishing the same to you.

I understand that the district is required by Texas Education Code to review criminal history of applicants.

_____ _____

Signature Date

This application becomes the property of the district. The district reserves the right to accept or reject it. This application shall be considered active for _____ months. If you have not received a response during this time period, you may reapply or reactivate your application.

**Applicants for all positions are considered without regard to race, color, sex (including pregnancy), national origin, religion, age, disability, genetic information, veteran or military status, or any other legally protected status. Additionally, the district does not discriminate against an applicant who acts to oppose such discrimination or participates in the investigation of a complaint related to a discriminating employment practice.*

The district Title IX Coordinator is ***Mark Anglin, Superintendent, P.O. Box 158 Bloomington, TX 77951***

SUB LETTER OF REASONABLE ASSURANCE

Dear Substitutes:

This letter provides notice of reasonable assurance of continued employment with the district when each school term resumes after a scheduled school break. By virtue of this notice, please understand that you may not be eligible for unemployment insurance benefits drawn on school district wages during any scheduled school breaks including, but not limited to, the summer, winter, and spring breaks. This assurance is contingent upon continued school operations and will not apply in the event of any disruption that is beyond the control of the district (e.g., lack of school funding, natural disasters, court orders, public insurrections, war, etc.).

This is not an employment contract. Your continued employment is on an at-will basis. Employers may terminate at-will employees at any time for any reason or for no reason, except for legally impermissible reasons. At-will employees are free to resign at any time for any reason or for no reason.

Your services on behalf of the children of the district are appreciated, and we hope that you will be able to continue your association with the district.

Sincerely,

Kellye Chavana

.....

Return to:

Kellye Chavana BISD Central Office P.O. Box 158 Bloomington, TX 77951

Please check who you would be willing to sub for:

❑ Teacher ❑ Paraprofessional ❑ Nurse (must be qualified)
❑ Custodian ❑ Cafeteria ❑ Maintenance

Please check all campuses that you would like to sub at:
Teacher and Paraprofessional subs only.

❑ Placedo Elementary School (PK-1st Grade)
❑ Bloomington Elementary School (2nd-5th Grade)
❑ Bloomington Middle School (6th-8th Grade)
❑ Bloomington High School (9th-12th Grade)

Name (Print)	Date
Signature	Employee number
Address	Telephone
City	State ZIP Code

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

▶ 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*.

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 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): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ 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 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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

Additional Information

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

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

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

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

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 report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

Bloomington ISD

Pre-Employment Affidavit for Applicant Offered Employment
For purposes of this affidavit:

***Adjudication** and **conviction** refer to a conviction, plea of guilty or no contest (nolo contendre), probation, suspension, or deferred adjudication.*
***Charge** refers to a formal criminal charge as documented by a primary charging instrument (a complaint, information, or indictment) under the Texas Code of Criminal Procedure.*
***Inappropriate relationship** refers to the crime of improper relationship between educator and student in Texas Penal Code section 21.12, and any other inappropriate relationship as determined by the State Board for Educator Certification.*

I declare the following:

o I have never been charged with, adjudicated for, or convicted of having an inappropriate relationship with a minor.

o I have been charged with, adjudicated for, or convicted of having an inappropriate relationship with a minor. The charge, adjudication, or conviction was determined to be **false**. The following are all of the relevant facts pertaining to the charge, adjudication, or conviction:_ .

o I have been charged with, adjudicated for, or convicted of having an inappropriate relationship with a minor. The charge, adjudication, or conviction was determined to be **true**. The following are all of the relevant facts pertaining to the charge, adjudication, or conviction:_ .

Bloomington ISD

Affidavit of Applicant Offered Employment

The following affidavit is offered to satisfy the requirement of Texas Education Code section 21.009 for a pre-employment affidavit.

I declare under penalty of perjury that the foregoing is true and correct.

_____ _____

Name (*First, Middle, Last*) **Date of Birth**

_____ _____

Address (*Street, City, State, Zip Code*) **County**

Executed in _____ ___County, State of Texas, on the _____ day of _____, _____.

_____

(*Signature of Declarant*)

State of Texas
County of _____

Before me, _____(insert the name of the notary), on this day personally appeared _____ (insert the name of the applicant), known to me through _____ (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument] and acknowledged to me that he executed the same for the purposes and consideration therein expressed. Given under my hand and seal of office this _____ day of _____, _____.

Month Yr

(Personalized Seal)

_____

Notary Public's Signature

I understand that the date of birth I am providing will not be used to determine eligibility for employment but will be used solely for the purpose of this pre-employment affidavit. This form will be processed separately and not shared with the hiring manager. Approved by the Texas Commissioner of Education, October 2017.

Bloomington Independent School District

P.O. Box 158 Bloomington, TX 77951
Phone (361) 333-8016 Fax (361) 333-8026

DESIGNATION OF BENEFICIARY

(Wages or Salary)

In the event that Bloomington Independent School District (the "District") owes me any wages or salary at the time of my death, I hereby designate the following person as the beneficiary to whom any such wages or salary shall be paid by the "District" after my death, in accordance with Section 450 of the Texas Probate Code.

Beneficiary's Name_____

Beneficiary's Address_____

Beneficiary's Relation to me_____

If the beneficiary designated above is my current spouse; if I am divorced from such spouse at the time of my death, and if I have not changed by then the name of my beneficiary on the District's records, the District shall have the option of paying the above-described monies either to the beneficiary designated above or to my estate. This instrument applies to wages or salary only, and does not affect any other payments which may owe for example: insurance proceeds, death benefits, deferred compensation, retirement benefits or any other.

Dated and Effective the _____ **day of** _____, _____.

Signature _____

_____
Printed Name & Social Security Number

STATE OF TEXAS
COUNTY OF VICTORIA

This instrument was subscribed, sworn to, and acknowledged before me, the undersigned authority by _____, on the _____ day of _____, _____.

_____
Notary Public, State of Texas

_____
Notary's Printed Name

ACCEPTABLE USE POLICY

The Rules

BLOOMINGTON ISD ACCEPTABLE USE POLICY (AUP) for the Internet

Internet access is now available to students and teachers at Bloomington ISD. Our goal in providing this service to teachers and students is to promote educational excellence in schools by facilitating resource sharing, innovation, and communication. We (Bloomington ISD) firmly believe that the valuable information and interaction available on this worldwide network far outweighs the possibility that users may procure material that is not consistent with the educational goals of the District. The smooth operation of the network relies upon the proper conduct of the end users who must adhere to strict guidelines. These guidelines are provided here so that you are aware of your responsibilities. As a user you are required to make efficient, ethical and legal utilization of the network resources. If a Bloomington user violates any of these provisions, his or her account will be terminated and future access could possibly be denied. The signature(s) at the end of this document is (are) legally binding and indicates the party (parties) who signed has (have) read the terms and conditions carefully and understand(s) their significance. Internet – Terms and Conditions

1) Acceptable Use- The purpose of the Internet is to support research and education in and among academic institutions in the U.S. by providing access to unique resources and the opportunity for collaborative work. The use of your account must be in support of education and research and consistent with the educational objectives of the Bloomington Independent School District. Transmission of any material in violation of any US or state regulation is prohibited. This includes, but is not limited to: copyrighted material, threatening or obscene material, or material protected by trade secret. Use for commercial activities, use for product advertisement, or political lobbying is also prohibited.
2) Privileges- The use of Internet is a privilege, not a right, and inappropriate use will result in a cancellation of those privileges. Network administrators will deem what is inappropriate use. Also, network administrators may close an account at any time as required. The administration, faculty, and staff of Bloomington Independent School District may request the network administrator to deny, revoke, or suspend specific user accounts.
3) Network Etiquette- You are expected to abide by the generally accepted rules of network etiquette. These include (but are not limited to) the following: a) Be polite. Do not get abusive in your messages to others. b) Use appropriate language. Do not swear, use vulgarities or any other inappropriate language. Illegal activities are strictly forbidden. c) Do not reveal your personal address or phone numbers of students or colleagues. d) Note that electronic mail (e-mail) is not guaranteed to be private. People who operate the system do have access to all mail. Messages relating to or in support of illegal activities may be reported to the authorities. e) Do not use the network in such a way that you would disrupt the use of the network by other users. f) All communications and information accessible via the network should be assumed to be private property.

4) Email- an integral part of the Internet, is a privilege that is offered to the employees. They must use it properly. Email is not to be used during class time unless it is a part of educational activities. Attachments, chain letters, jokes, pictures and sending to large groups of people are easy prey for viruses and are not allowed if they are not part of an educational lesson.
5) Security- Security on any computer system is a high priority, especially when the network involves many users. If you feel you identify a security problem on the Internet, you must notify an administrator or email mark.anglin@bisd-tx.org. Do not demonstrate the problem to other users. Do not use another individual's account or allow anyone to use yours. Attempts to login to the Internet as a network administrator will result in cancellation of user privileges. Any user identified as a security risk or having a history of problems with other computer systems may be denied access to the Internet.
6) Vandalism- Vandalism will result in cancellation of privileges. Vandalism is defined as any malicious attempt to harm, destroy, or disable any part of a computer or data, Internet, or any of the above listed agencies or other networks that are connected to the Internet backbone. This includes, but not limited to, the uploading or creation of computer viruses.
7) Updating User Information- Each student will complete an AUP form, which includes a request for an account. The Bloomington Computer Technologist, after receiving the AUP form, will give each student a user name and password. At the Elementary schools, each classroom will have one student account to be used by all students in that class.
8) Exception of Terms and Condition- All terms and conditions as stated in this document are applicable to the Bloomington Independent School District. These terms and conditions reflect the entire agreement of the parties and supersede all prior oral or written agreements and understandings of the parties. These terms and conditions shall be governed and interpreted in accordance with the laws of the State of Texas, and the United States of America. Bloomington Independent School District makes no warranties of any kind, whether expressed or implied, for the service it is providing. Bloomington Independent School will not be responsible for any damages you suffer. This includes loss of data resulting from delays, non-deliveries, miss-deliveries, or service interruptions caused by its own negligence or your errors or omissions. Use of any information obtained via Bloomington Independent School District is at your own risk. Bloomington Independent School District denies any responsibility for the accuracy or quality of information obtained through its services.

This document is for your use. Please sign and return the AUP Summary form following.

Thank you.

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

BLOOMINGTON INDEPENDENT SCHOOL DISTRICT

Emergency Contact Form

EMPLOYEE'S NAME: _____

CAMPUS: _____

HOME PHONE # _____

CELL PHONE # _____

PERSONAL E-MAIL ADDRESS _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____

HOME PHONE # _____

CELL PHONE # _____

WORK PHONE # _____

DIRECT DEPOSIT AUTHORIZATION
(ACH CREDITS) & CANCELLATIONS

Company Name: BLOOMINGTON INDEPENDENT SCHOOL DISTRICT

I (we) hereby authorize Bloomington ISD, hereinafter called company, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) account indicated below and the depository named below, hereinafter called the Depository, to credit and/or debit the same to such account.

Depository Name: _____ Branch: _____

City: _____ State: _____ Zip: _____

Transit Number: _____ Account Number: _____

☐ Checking Account ☐ Savings Account

EXAMPLE OF A CHECK

Jane Doe 1106
PO Box 158
Bloomington, Texas 77951 Date_____

Pay to the order of _____ $_____

_____Dollars

Prosperity Bank
1205 N. Navarro PLEASE ATTACH VOIDED CHECK HERE

For_____ _____

113122655 2684978 1106

Transit # Account #

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of it's termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

☐ Please cancel my Direct Deposit.

Name: _____ Social Security #: _____

Signature: _____ Date: _____

FICA ALTERNATIVE

DEFERRED COMPENSATION PLAN PARTICIPATION AGREEMENT

☐ PST

☐ NEW ENROLLMENT ☐ ADDRESS CHANGE ☐ BENEFICIARY CHANGE ☐ NAME CHANGE

PARTICIPANT INFORMATION

NAME _____
(Last) (First) (Middle)

ADDRESS _____
(Street / P. O. Box) (Apt. #) (City) (State) (Zip)

SOCIAL SECURITY NUMBER _____ BIRTH DATE _____

HOME PHONE ( ) _____ WORK PHONE ( ) _____ FEMALE_____ MALE_____

Beginning (Hire Date) _____, I will participate in the (Employer)_____ Deferred Compensation Plan, I.R.C. Section 457, and hereby forego my rights to receive compensation to the _____% of my eligible gross annual compensation in return for the benefits provided thereunder. I wish this contribution to be invested in an annuity contract with ING Reliastar. I understand that my total amount of deferred compensation shall not exceed the lesser of the Section 457 dollar limit or 100% of the Participant's includable compensation or such other sum as is permissible pursuant to the provisions of Section 457 of the Code in any calendar year. I understand that my participation in this Plan is a condition of employment required by I. R. C. Section 3121 (b) (7) OBRA 1990. I further understand that payment(s) will be based on the value of the individual account (s). I acknowledge that a copy of the Deferred Compensation Plan Document is available to me for my review and understanding. The terms, conditions, and provisions of the Plan Document are hereby incorporated into this agreement.

*** NEW EMPLOYEES MUST COMPLETE THE FOLLOWING BENEFICIARY DESIGNATIONS.**

PRIMARY: NAME_____ DATE OF BIRTH _____

RELATIONSHIP_____ SOCIAL SECURITY # _____

ADDRESS_____
(STREET / P.O. BOX) (APT. #) (CITY) (STATE) (ZIP)

CONTINGENT: NAME_____ DATE OF BIRTH _____

RELATIONSHIP_____ SOCIAL SECURITY # _____

ADDRESS_____

NAME CHANGE

FROM : _____ TO : _____

REASON FOR CHANGE : ☐MARRIAGE ☐DIVORCE ☐OTHER _____

****

Statement Concerning Your Employment in a Job Not Covered by Social Security

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to the Social Security Publication, "Windfall Elimination Provision".

Government Pension Offset Provision

Under the Government Pension Offset Provision, and Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security, ($500 - $400 = $100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to the Social Security publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or, for the deaf or hard of hearing, call the TTY number 1-800-325-0778, or contact your local Social Security office. I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.

Form SSA-1945 (12-2004)

_____ _____ _____ _____

SIGNATURE OF EMPLOYEE DATE EMPLOYER PAYROLL SIGNATURE DATE

FORM MUST BE SIGNED, DATED AND APPROVED BY THE EMPLOYER (PLAN SPONSOR)

white - FFCC yellow - Payroll/HR pink - Employee

TRS ActiveCare

Enrollment, Change and Declination Form

WellSystems

ELIGIBILTY:	Are you an active employee and making monthly contributions to TRS? ☐ Yes ☐ No If no, are you regularly scheduled to work 10 or more hours per week? ☐ Yes ☐ No	(If no to both, you are not eligible for TRS ActiveCare coverage)

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

☐ Annual Enrollment ☐ New Employee ☐ Add Dependent ☐ Special Enrollment

☐ **For New Employee** (check one): ☐Effective on Actively at Work ☐Effective 1st day of month following

Special Enrollment Event Date: __/__/____ ☐Marriage ☐Court Order ☐Birth/Adoption ☐Loss of Coverage ☐Other:

Change Only:
☐ Name
☐Address
☐Plan/Coverage

Decline Coverage:
☐Yes (Complete Section 6)
☐N/A

Effective Date of Change/Cancel
____/____/_____

Cancel Employee
☐Death
☐Loss of Eligibility
☐Retirement/Terminated
☐Non-Payment
☐Other: _____

Cancel Dependent
☐Divorce
☐Death
☐Loss of Eligibility
☐Dropped Coverage
☐Other: _____

For District Use Only
TRS District #
Actively at Work Date:
Effective/Change Date:
Employer Approval: _____
Were you covered by another district? ☐ Yes ☐ No
If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security #:
Mailing Address:	City:	State:	Zip:
Residence Address:	City:	State:	Zip:
Home Phone Number:	Cell Phone Number:	Email:	
Date of Birth:	Sex: ☐M ☐F	Language: ☐ English ☐Spanish	Ethnicity:

Do you have a disability affecting your ability to communicate or read? ☐Yes (Please complete Section 8) ☐ No

Is the Employee Covered By Other Insurance? ☐Yes Carrier/Plan: ☐No

Is the Employee Covered by Medicare? ☐Yes ☐Part A ☐Part B ☐Part C ☐Part D Effective: ☐No

Reason for Medicare Coverage: ☐ Entitlement Age ☐ Disability ☐End Stage Renal Disease (ESRD)

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage – Plan or HMO - and Coverage Type)

Plan Selection: ☐ActiveCare 1-HD ☐ActiveCare Select ☐ActiveCare 2

HMO Selection: ☐FirstCare Health Plans ☐Scott & White Health Plan ☐Allegian Health Plans (formerly Valley Baptist Health Plans)

Coverage Type Selected: ☐Employee Only ☐Employee + Spouse ☐Employee + Child(ren) ☐Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name:	First Name:		MI:
Street Address:			☐Same as Employee
City:	State:	Zip:	Phone Number:
Sex: ☐M ☐F	Date of Birth:	Social Security #:	

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

CHILD Last Name:	First Name:		MI:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other

Street Address:			☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: ☐M ☐F

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

CHILD Last Name:	First Name:		MI:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other

Street Address:			☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: ☐M ☐F

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:	First Name:	MI:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other

Street Address:			☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: ☐M ☐F

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

CHILD Last Name:	First Name:	MI:

☐Natural/Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Legal Guardian ☐Disabled ☐ Other

Street Address:			☐Same as Employee
City:	State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: ☐M ☐F:

Other Insurance: ☐Yes. Carrier/Plan ☐No ☐Medicare: ☐Part A ☐Part B ☐Part C ☐Part D

SECTION 5: DISABLED DEPENDENTS OVER AGE 26

☐Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement

Please note that a Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement are required for coverage of a disabled child over age 26. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF COVERAGE

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name:	SSN:	☐Employee	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Spouse	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee
Name:	SSN:	☐Child	Reason:	☐Other Coverage	☐Other:
Gender: ☐F ☐M	Date of Birth:	Address:			☐same as employee

SECTION 7: COVERAGE CONDITIONS

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare Health Plan, Scott and White Health Plan, and Allegian Insurance Company dba Allegian Health Plans. On behalf of myself and any dependents listed on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
  - o If I am enrolling a grandchild in Section 4, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
  - o If I am enrolling a child as an "other Child" in Section 4, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on the Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature: ______________________________ Date: ______________

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)