Substitute Employee Paperwork

Return completed to
Business Office
on or before

_____

2019 - 2020
TRS ActiveCare Rates
for Substitutes

	ActiveCare 1-HD	ActiveCare Select
EMPLOYEE ONLY		
Monthly Total Cost	$ 378.00	$ 556.00
EMPLOYEE/SPOUSE		
Monthly Total Cost	$ 1,066.00	$1,367.00
EMPLOYEE/CHILD(REN)		
Monthly Total Cost	$ 722.00	$ 902.00
EMPLOYEE/FAMILY		
Monthly Total Cost	$ 1,415.00	$ 1,718.00

2019–20 TRS-ActiveCare Plan Highlights

Effective Sept. 1, 2019 through Aug. 31, 2020 | In-Network Level of Benefits[1]

TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

Medical Coverage	TRS-ActiveCare 1-HD	TRS-ActiveCare Select/ TRS-ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	TRS-ActiveCare 2 NOTE: If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan. However, as of Sept. 1, 2018, TRS-ActiveCare 2 is closed to new enrollees.
Deductible (per plan year)			
In-Network	$2,750 employee only/$5,500 family	$1,200 individual/$3,600 family	$1,000 individual/$3,000 family
Out-of-Network	$5,500 employee only/$11,000 family	Not applicable. This plan does not cover out-of-network services except for emergencies.	$2,000 individual/$6,000 family
Out-of-Pocket Maximum (per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum)	The individual out-of-pocket maximum only includes covered expenses incurred by that individual.		
In-Network	$6,750 individual/$13,500 family	$7,900 individual/$15,800 family	$7,900 individual/$15,800 family
Out-of-Network	$20,250 individual/$40,500 family	Not applicable. This plan does not cover out-of-network services except for emergencies.	$23,700 individual/$47,400 family
Coinsurance			
In-Network Participant pays (after deductible)	20%	20%	20%
Out-of-Network Participant pays (after deductible)	40% of allowed amount unless otherwise noted	Not applicable. This plan does not cover out-of-network services except for emergencies.	40% of allowed amount unless otherwise noted
Office Visit Copay Participant pays	20% after deductible	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist
Diagnostic Lab Participant pays	20% after deductible	20% after deductible (Kelsey Select-plan pays 100%)	20% after deductible
Preventive Care See below for examples	Plan pays 100%	Plan pays 100%	Plan pays 100%
Teladoc® Physician Services	$40 consultation fee (counts toward deductible and out-of-pocket maximum)	Plan pays 100%	Plan pays 100%
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	20% after deductible	$100 copay plus 20% after deductible	$100 copay plus 20% after deductible
Inpatient Hospital Facility Charges Only (preauthorization required)			
In-Network	20% after deductible	$150 copay per day plus 20% after deductible ($750 maximum copay per admission)	$150 copay per day plus 20% after deductible ($750 maximum copay per admission; $2,250 maximum copay per plan year)
Out-of-Network	Plan pays up to $500 per day cap of covered charges after deductible; you pay the excess over the $500 per day cap	Not applicable. This plan does not cover out-of-network services except for emergencies.	Plan pays up to $500 per day cap of covered charges after deductible; you pay the excess of over the $500 per day cap
Urgent Care	20% after deductible	$50 copay per visit	$50 copay per visit
Freestanding Emergency Room Participant pays	$500 copay per visit plus 20% after deductible	$500 copay per visit plus 20% after deductible	$500 copay per visit plus 20% after deductible
Emergency Room (true emergency use) Participant pays	20% after deductible	$250 copay plus 20% after deductible (copay waived if admitted)	$250 copay plus 20% after deductible (copay waived if admitted)
Outpatient Surgery Participant pays	20% after deductible	$150 copay per visit plus 20% after deductible	$150 copay per visit plus 20% after deductible
Bariatric Surgery (only covered if performed at an IOQ facility) Physician charges; Participant pays	$5,000 copay (does apply to out-of-pocket maximum) plus 20% after deductible	Not covered	$5,000 copay (does not apply to out-of-pocket maximum) plus 20% after deductible
Annual Vision Examination (one per plan year; performed by an ophthalmologist or optometrist) Participant pays	20% after deductible	$70 copay for specialist	$70 copay for specialist
Annual Hearing Examination Participant pays	20% after deductible	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist

Preventive Care

Some examples of preventive care frequency and services:

- **Routine physicals** – annually age 12 and over
- **Mammograms** – one every year age 35 and over
- **Smoking cessation counseling** – eight visits per 12 months
- **Well-child care** – unlimited up to age 12
- **Colonoscopy** – one every 10 years age 45 and over
- **Healthy diet/obesity counseling** – unlimited to age 22; age 22 and over – 26 visits per 12 months
- **Well woman exam & pap smear** – annually age 18 and over
- **Prostate cancer screening** – one per year age 50 and over
- **Breastfeeding support** – six lactation counseling visits per 12 months

Note: Covered services under this benefit must be billed by the provider as "preventive care." Non-network preventive care is not paid at 100%. If you receive preventive services from a non-network provider, you will be responsible for any applicable deductible and coinsurance under the TRS-ActiveCare 1-HD and TRS-ActiveCare 2. There is no coverage for non-network services under the TRS-ActiveCare Select plan or TRS-ActiveCare Select Whole Health. For more information, please view the Benefits Booklet at www.trsactivecareaetna.com.

TRS-ActiveCare is administered by Aetna Life Insurance Company. Aetna provides claims payment services only and does not assume any financial risk or obligation with respect to claims. Prescription drug benefits are administered by Caremark.

2019–20 TRS-ActiveCare Plan Highlights

Prescription Coverage	TRS-ActiveCare 1-HD	TRS-ActiveCare Select/ ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	TRS-ActiveCare 2 NOTE: If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan. However, as of Sept. 1, 2018, TRS-ActiveCare 2 is closed to new enrollees.
Drug Deductible (per person, per plan year)	Must meet plan-year deductible before plan pays.[2]	$0 generic; $200 brand	$0 generic; $200 brand
Short-Term Supply at a Retail Location (up to a 31-day supply)			
Tier 1 – Generic	20% coinsurance after deductible, except for certain generic preventive drugs that are covered at 100%.[2]	$15 copay	$20 copay
Tier 2 – Preferred Brand	25% coinsurance after deductible[3]	25% coinsurance (min. $40[4]; max. $80)[3]	25% coinsurance (min. $40[4]; max. $80)[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible[3]	50% coinsurance[3]	50% coinsurance (min. $100[4]; max. $200)[3]
Extended-Day Supply at Mail Order or Retail-Plus Pharmacy Location (60- to 90-day supply)[5]			
Tier 1 – Generic	20% coinsurance after deductible	$45 copay	$45 copay
Tier 2 – Preferred Brand	25% coinsurance after deductible[3]	25% coinsurance (min. $105[4]; max. $210)[3]	25% coinsurance (min. $105[4]; max. $210)[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible[3]	50% coinsurance[3]	50% coinsurance (min. $215[4]; max. $430)[3]
Specialty Medications (up to a 31-day supply)			
Specialty Medications	20% coinsurance after deductible	20% coinsurance	20% coinsurance (min. $200[4]; max. $900)
Short-Term Supply of a Maintenance Medication at Retail Location (up to a 31-day supply) The second time a participant fills a short-term supply of a maintenance medication at a retail pharmacy, they will be charged the coinsurance and copays in the rows below. Participants can save more over the plan year by filling a larger day supply of a maintenance medication through mail order or at a Retail-Plus location.			
Tier 1 – Generic	20% coinsurance after deductible	$30 copay	$35 copay
Tier 2 – Preferred Brand	25% coinsurance after deductible[3]	25% coinsurance (min. $60[4]; max. $120)[3]	25% coinsurance (min. $60[4]; max. $120)[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible[3]	50% coinsurance[3]	50% coinsurance (min. $105[4]; max. $210)[3]

What is a maintenance medication?

Maintenance medications are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

When does the convenience fee apply?

For example, if you are covered under TRS-ActiveCare Select, the first time you fill a 31-day supply of a generic maintenance drug at a retail pharmacy you will pay $15, then you will pay $30 each month that you fill a 31-day supply of that generic maintenance drug at a retail pharmacy. A 90-day supply of that same generic maintenance medication would cost $45, and you would save $180 over the year by filling a 90-day supply.

A specialist is any physician other than family practitioner, internist, OB/GYN or pediatrician.

[1] Illustrates benefits when in-network providers are used. For some plans non-network benefits are also available; there is no coverage for non-network benefits under the TRS-ActiveCare Select or TRS-ActiveCare Select Whole Health Plan; see Enrollment Guide for more information. Non-contracting providers may bill for amounts exceeding the allowable amount for covered services. Participants will be responsible for this balance bill amount, which maybe considerable.

[2] For TRS-ActiveCare 1-HD, certain generic preventive drugs are covered at 100%. Participants do not have to meet the deductible ($2,750 – individual, $5,500 – family) and they pay nothing out of pocket for these drugs. Find the list of drugs at info.caremark.com/trsactivecare.

[3] If a participant obtains a brand-name drug when a generic equivalent is available, they are responsible for the generic copay plus the cost difference between the brand-name drug and the generic drug.

[4] If the cost of the drug is less than the minimum, you will pay the cost of the drug.

[5] Participants can fill 32-day to 90-day supply through mail order.

Monthly Premiums

TRS-ActiveCare Monthly Premium	TRS-ActiveCare 1-HD			TRS-ActiveCare Select/ ActiveCare Select Whole Health			TRS-ActiveCare 2		
	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***	Full monthly premium*	Premium with min. state/district contribution**	Your monthly premium***
Individual	$378	$153		$556	$331		$852	$627	
+Spouse	$1,066	$841		$1,367	$1,142		$2,020	$1,795	
+Children	$722	$497		$902	$677		$1,267	$1,042	
+Family	$1,415	$1,190		$1,718	$1,493		$2,389	$2,164	

*If you are not eligible for the state/district subsidy, you will pay the full monthly premium. Please contact your Benefits Administrator for your monthly premium.

**The premium after state, $75 and district, $150 contribution is the maximum you may pay per month. Ask your Benefits Administrator for your monthly cost. (This is the amount you will owe each month after all available subsidies are applied to your premium.)

***Completed by your benefits administrator. The state/district contribution may be greater than $225.

Enrollment, Change and Declination Form

Eligibility:

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

**Carefully review Options 1-3 before making any selections.

Option 1: Enrollments

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

*Choose effective date if selecting **New Employee**:
☐ Effective on actively at work
☐ Effective 1st day of the following month

For District Use Only
TRS District #:
Actively at Work Date: / /
Effective/Change Date: / /
Employer Approval:

Choose a Life Event type if selecting **Special Enrollment:
☐ Marriage
☐ Birth/Adoption
☐ Loss of Coverage***
☐ Court Order
☐ Other: _____

***If you selected **Loss of Coverage** please specify:

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

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

Date of Life Event: ___/___/___

Were you previously covered by a different district? ☐ Yes ☐ No

If yes, District Name: _____

Option 2: Changes

☐ Name
☐ Address
☐ Plan/Coverage

Effective Date of Change: ___/___/___

Option 3: Decline Coverage

☐ Yes
☐ N/A

*If selecting yes, must complete Section 6

Section 2: Employee Information

Last Name: _____ First Name: _____ MI: ____ SSN: ___-___-___

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

Alternate Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ___/___/___ Work Phone: ___-___-___ Work Email: _____

Sex: ☐ M ☐ F Language: ☐ English ☐ Spanish Tobacco User: ☐ Yes ☐ No Race/Ethnicity: _____

Are you covered by other insurance? ☐ Yes ☐ No

Are you covered by Medicare? ☐ Yes ☐ No

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

Medicare Coverage Type:
☐ Medicare A and D Primary
☐ Medicare A, B, and D Primary
☐ Medicare B and D Primary
☐ Medicare D Primary
☐ Medicare A Primary
☐ Medicare A and B Primary
☐ Medicare B Primary
☐ Medicare Unknown
☐ Other Coverage

Section 3: Coverage Selection

Plan Selection:
☐ ActiveCare 1-HD
☐ ActiveCare Select
☐ ActiveCare 2
☐ ActiveCare Baptist Select*
☐ ActiveCare Baylor Select*
☐ ActiveCare Kelsey Select*
☐ ActiveCare Memorial Hermann Select*
☐ ActiveCare Seton Select*

OR

HMO Selection:
☐ First Care Health Plans
☐ Scott & White Plan
☐ Blue Essential Access Plan

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

*plan eligibility is determined by home address zip code

Section 4: Primary Care Provider (PCP)

To elect coverage in the ActiveCare 1-HD if you or your dependents live in Harris, Fort Bend, Brazoria, Galveston, or Montgomery counties you must choose a Primary Care Provider (PCP) for yourself and your dependents. If you already have a PCP, you can enter the information in the box below. You can find your PCP number by contacting your provider or by going to www.TRSActiveCareAetna.com and clicking on *Find a Doctor or Facility*. If you do not have a PCP you can look up a provider in your area at the website address above. You must list a PCP for all dependents listed below.

If you enroll in ActiveCare 1-HD and do not choose a PCP one will be chosen for you and the provider number will be on your new ID cards for you and all dependents listed below. If you have questions, please call the TRS-ActiveCare Service Center at (833) 682-8972.

Primary Physician name:

Provider ID #:

Section 5: Dependent Information (Use additional form for more dependents)

SPOUSE Last Name: _____ First Name: _____ MI: _____

Address: _____ ☐ Same as Employee

City: _____ State: _____ Zip: _____

Phone Number: ___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth: ___/___/___ SSN: ___ - ___ - ____

Primary Physician Name: _____

Provider ID #: _____

Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan: _____

Tobacco User: ☐ Yes ☐ No

If Medicare, select a coverage type:

☐ Medicare A and D Primary ☐ Medicare D Primary ☐ Medicare B Primary
☐ Medicare A, B, and D Primary ☐ Medicare A Primary ☐ Medicare Unknown
☐ Medicare B and D Primary ☐ Medicare A and B Primary ☐ Other Coverage

CHILD Last Name: _____ First Name: _____ MI: _____

☐ Child ☐ Grandchild ☐ Disabled ☐ Other ☐ Tobacco user (*required for children 18 and older)

Address: _____ ☐ Same as Employee

City: _____ State: _____ Zip: _____

Phone Number: ___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth: ___/___/___ SSN: ___ - ___ - ____

Primary Physician Name: _____

Provider ID #: _____

Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan: _____

If Medicare, select a coverage type:

☐ Medicare A and D Primary ☐ Medicare D Primary ☐ Medicare B Primary
☐ Medicare A, B, and D Primary ☐ Medicare A Primary ☐ Medicare Unknown
☐ Medicare B and D Primary ☐ Medicare A and B Primary ☐ Other Coverage

CHILD Last Name: _____ First Name: _____ MI: _____

☐ Child ☐ Grandchild ☐ Disabled ☐ Other ☐ Tobacco user (*required for children 18 and older)

Address: _____ ☐ Same as Employee

City: _____ State: _____ Zip: _____

Phone Number: ___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth: ___/___/___ SSN: ___ - ___ - ____

Primary Physician Name: _____

Provider ID #: _____

Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan: _____

If Medicare, select a coverage type:

☐ Medicare A and D Primary ☐ Medicare D Primary ☐ Medicare B Primary
☐ Medicare A, B, and D Primary ☐ Medicare A Primary ☐ Medicare Unknown
☐ Medicare B and D Primary ☐ Medicare A and B Primary ☐ Other Coverage

CHILD Last Name: _____ First Name: _____ MI: ____

☐ Child ☐ Grandchild ☐ Disabled ☐ Other ☐ Tobacco user (*required for children 18 and older)

Address: _____ ☐ Same as Employee

City: _____ State: _____ Zip: _____

Phone Number: ___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth: ___/___/___ SSN: ___ - ___ - ____

Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan: _____

If Medicare, select a coverage type:

☐ Medicare A and D Primary	☐ Medicare D Primary	☐ Medicare B Primary
☐ Medicare A, B, and D Primary	☐ Medicare A Primary	☐ Medicare Unknown
☐ Medicare B and D Primary	☐ Medicare A and B Primary	☐ Other Coverage

CHILD Last Name: _____ First Name: _____ MI: ____

☐ Child ☐ Grandchild ☐ Disabled ☐ Other ☐ Tobacco user (*required for children 18 and older)

Address: _____ ☐ Same as Employee

City: _____ State: _____ Zip: _____

Phone Number: ___ - ___ - ____ Sex: ☐ M ☐ F Date of Birth: ___/___/___ SSN: ___ - ___ - ____

Are you covered by other insurance? ☐ Yes ☐ No If yes, Carrier/Plan: _____

If Medicare, select a coverage type:

☐ Medicare A and D Primary	☐ Medicare D Primary	☐ Medicare B Primary
☐ Medicare A, B, and D Primary	☐ Medicare A Primary	☐ Medicare Unknown
☐ Medicare B and D Primary	☐ Medicare A and B Primary	☐ Other Coverage

Section 6: 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 and must be **submitted within 31 days** of the child's 26th birthday. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

Section 7: 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

Gender: ☐ M ☐ F Date of Birth: ___/___/___ ☐ Other Coverage: _____

Address: _____

Name: _____ SSN: ___ - ___ - ____ ☐ Spouse

Gender: ☐ M ☐ F Date of Birth: ___/___/___ ☐ Other Coverage: _____

Address: _____ ☐ Same as Employee

Name: _____ SSN: ___ - ___ - ____ ☐ Child

Gender: ☐ M ☐ F Date of Birth: ___/___/___ ☐ Other Coverage: _____

Address: _____ ☐ Same as Employee

Name: _____ SSN: ___ - ___ - ____ ☐ Child

Gender: ☐ M ☐ F Date of Birth: ___/___/___ ☐ Other Coverage: _____

Address: _____ ☐ Same as Employee

Name: _____ SSN: ___ - ___ - ____ ☐ Child

Gender: ☐ M ☐ F Date of Birth: ___/___/___ ☐ Other Coverage: _____

Address: _____ ☐ Same as Employee

Name: _____ SSN: ___ - ___ - ____ ☐ Child

Gender: ☐ M ☐ F Date of Birth: ___/___/___ ☐ Other Coverage: _____

Address: _____ ☐ Same as Employee

Section 8: Coverage Conditions

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 Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation Health Plans. On behalf of myself and any dependents listed, I apply for those coverage(s) for which I am eligible.

- If I am enrolling a grandchild, 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.
- 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 resides 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 my coverage requests are accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.

I understand that by enrolling for coverage 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 provided in this enrollment 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: ____/____/____

Form W-4 (2019)

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 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 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 2019 expires February 17, 2020. 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 2019 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 not subject to withholding 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 2019. 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 filing jointly 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 not subject to withholding, 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 Additional 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 may 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 may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. 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 if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. 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

---------- **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

2019

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 2019, 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)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). 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. Enter "-0-" on lines E and F if you use Worksheet 1-6.

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 not subject to withholding, 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/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 $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $179,051 to $200,000 ($345,851 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.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 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 $179,050 ($345,850 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. If you use Worksheet 1-6, enter "-0-" on lines E and F	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 not subject to withholding 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 $53,000 ($24,450 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 not subject to withholding.

1	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	1	$
2	Enter: $24,400 if you're married filing jointly or qualifying widow(er); $18,350 if you're head of household; $12,200 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 2019 adjustments to income, qualified business income deduction, 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 2019 nonwage income not subject to withholding (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 $4,200 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 of that worksheet on 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 2019. 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 2019. 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 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 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 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 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.

PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

Complete and return to the payroll department. Forms received prior to the 5th of the month will be activated for the current month.

I authorize Van Vleck Independent School District and the financial institution(s) named below to automatically deposit my net pay as indicated below (this includes my authorization to you to reverse any entries made in error). This authority will remain in effect until I give written notice to my payroll department.

Account type:

☐ Checking Account No: _____ ☐ Savings Account No: _____

_____ _____ _____

Financial Institution Amount *Routing number

Account type:

☐ Checking Account No: _____ ☐ Savings Account No: _____

_____ _____ _____

Financial Institution Amount *Routing number

*Make sure you have the correct routing number because the routing number on the check and the deposit slip are not always the same. Check with your financial institution for the correct number.

_____ _____

Printed Name Signature

_____ _____

Date Payroll Effective Date

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

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.

TCG ADMINISTRATORS

900 S Capital of Texas Hwy, Suite 350
Austin, TX 78746
Phone: 512.795.8999 Fax: 512.795.0414
Toll Free: 800.943.9179 Fax: 888.989.9247
Email: 457@tcgservices.com

457(B) FICA ALTERNATIVE PLAN AND TRUST

WHAT IS A 457(b) FICA ALTERNATIVE?

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) mandates that employees of public agencies, including school districts who are not members of the employer's existing retirement system as of January 1, 1992, be covered under Social Security or a qualifying alternate plan. The ESC Region 10 457(b) FICA Alternative Plan satisfies federal requirements and provides substantial cost savings compared to Social Security.

BENEFITS OF CONTRIBUTING TO A 457(b) FICA ALTERNATIVE PLAN

- Bridge your retirement income gap
- Lower your taxes
- Automatic saving; Payroll deducted

IMPORTANT POINTS ABOUT YOUR 457(b) FICA ALTERNATIVE

Eligibility: An employee is required to participate in the FICA Alternative Plan if they meet one of the eligibility requirements listed below.

- Part-time (20 hours or less per week)
- Seasonal (five months or less per year)
- Temporary (contract of two years or less in duration)
- Not covered by TRS in a position otherwise covered by TRS

Contributions: Social Security requires that the equivalent of 12.4% of an employee's salary be contributed each month (6.2% employee, 6.2% employer). However, the FICA Alternative Plan requires only a 7.5% contribution to a retirement account. The deferrals are made on a "pretax" basis, unlike Social Security, which are made on an "after-tax" basis.

Investments: The portfolio selection is designated by the employer. The options are as follows:

- *FICA Diversified Portfolio*–The Diversified Portfolio is directly overseen by the Region 10 RAMS Investment Advisory Committee. The portfolio is comprised of a broad range of equity and bond mutual funds, as well as individual bonds typically held to maturity, and is periodically changed to adapt to changing market conditions.

- *FICA Government Income Portfolio*–All investment instruments issued by and/or backed by the U.S. Government.

Distributions: The employee or their beneficiary will receive the FICA Alternative Plan account balance when an employee becomes eligible for a distribution for any of the following reasons:

- Termination of Employment
- Death
- Age 70 1/2
- Permanent and Total Disability
- Retirement
- Changed employment status to a position covered by another retirement system (e.g., TRS)

  If there have been no contributions to the account for two (2) years and the account balance is less than $5,000, the employee may be able to request a distribution.

Taxation: When the employee begins to receive benefits, the funds received become taxable income. If the taxable portion of the account balance exceeds $200, the employee can avoid immediate taxation by directing the account balance to:

- A traditional IRA
- An eligible employer plan that accepts the rollover (i.e., TRS, 403(b), 457, etc.)

(cont. on back)

TCG
ADMINISTRATORS

457(B) FICA ALTERNATIVE PLAN AND TRUST

MORE IMPORTANT POINTS ABOUT YOUR 457(b) FICA ALTERNATIVE

Designating a Beneficiary: If the employee dies while a participant in the Plan, the account balance will be distributed to the employee's beneficiary. If the employee is married at the time of death, the spouse is automatically the beneficiary. If the employee wishes to designate someone other than the spouse as beneficiary, the employee must do so in writing and the spouse must sign a spousal consent form. If the employee is unmarried at the time of death, the account balance will be paid to the employee's estate unless another beneficiary has been designated. To designate a beneficiary, please login to your account at www.region10rams.org using the instructions under "Account Access" below.

Company Offering Services: The Company chosen to provide the 457(b) FICA Alternative Plan is TCG Administrators, a company with many years of proven expertise in administering retirement plans to public sector employees.

Protection from Liability: The District as a 457(b) plan sponsor is responsible for the types of investments offered to participants. Most 457(b) plans do not protect the District from fiduciary liability. The ESC Region 10 457(b) FICA Alternative Retirement Plan offers fiduciary protection for the District through an Investment Advisory Agreement with TCG Investment Advisory Services, LP.

Fees: TCG Administrators receives 1.15% of the plan assets and $.50 per participant per month paid by the participant, TCG Advisors receives .35% of assets as the investment advisory fee, Region 10 receives $.10 per participant per month (normally deducted from participant accounts) as its fee for running the RAMS program and the individual investments have fees that vary by type of investment. The investment fees are shown on the Region 10 RAMS website at www.region10rams.org.

Account Access: To review your account balance or request a distribution, you can access your account on the Region 10 RAMS website at www.region10rams.org. Please follow the steps below to access your account online.

1. Click the green Login box in the upper right-hand corner
2. Click the yellow Retirement Login box
3. User Name will be your Social Security Number (no spaces or dashes): #########
4. Password will be your date of birth (MMDDYYYY): #########

900 S Capital of Texas Hwy, Suite 350
Austin, TX 78746
Phone: 512.795.8999 Fax: 512.795.0414
Toll Free: 800.943.9179 Fax: 888.989.9247
Email: 457@tcgservices.com