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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

AR4EC

STATE OF ARKANSAS
Employee's Withholding Exemption Certificate

Print Full Name _____ Social Security Number _____

Print Home Address _____ City _____ State _____ Zip _____

Employee: File this form with your employer. Otherwise, your employer must withhold state income tax from your wages without exemptions or dependents.

Employer: Keep this certificate with your records.

How to Claim Your Withholding
See instructions below

	Number of Exemptions Claimed
1. CHECK ONE OF THE FOLLOWING FOR EXEMPTIONS CLAIMED	
a. ☐ You claim yourself. *(Enter one exemption)* 1a	
b. ☐ You claim yourself and your spouse. *(Enter two exemptions)* 1b	
c. ☐ Head of Household, and you claim yourself. *(Enter two exemptions)* 1c	
2. NUMBER OF CHILDREN or DEPENDENTS. *(Enter one exemption per dependent)* 2	
3. TOTAL EXEMPTIONS. *(Add Lines 1a, b, c, and 2)* If no exemptions or dependents are claimed, enter zero 3	
4. Additional amount, if any, you want deducted from each paycheck. *(Enter dollar amount)* 4	
5. I qualify for the low income tax rates. *(See below for details)* ..... 5 Please check filing status: ☐ Single ☐ Married Filing Jointly ☐ Head of Household	☐ Yes ☐ No

I certify that the number of exemptions and dependents claimed on this certificate does not exceed the number to which I am entitled.

Signature: _____ Date: _____

Instructions

TYPES OF INCOME - This form can be used for withholding on all types of income, including pensions and annuities.

NUMBER OF EXEMPTIONS – *(Husband and/or Wife)* Do not claim more than the correct number of exemptions. However, if you expect to owe more income tax for the year, you may increase your withholding by claiming a smaller number of exemptions and/or dependents, or you may enter into an agreement with your employer to have additional amounts withheld. This is especially important if you have more than one employer, or if both husband and wife are employed.

DEPENDENTS – To qualify as your dependent *(line 2 of form)*, a person must *(a)* receive more than 1/2 of their support from you for the year, *(b)* not be claimed as a dependent by such person's spouse, *(c)* be a citizen or resident of the United States, and *(d)* have your home as their principal residence and be a member of your household for the entire year or be related to you as follows: son, daughter, grandchild, stepson, stepdaughter, son-in-law or daughter-in-law; your father, mother, grandparent, stepfather, stepmother, father-in-law or mother-in-law; your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law or sister-in-law; your uncle, aunt, nephew or niece *(but only if related by blood)*.

CHANGES IN EXEMPTIONS OR DEPENDENTS – You may file a new certificate at any time if the number of exemptions or dependents INCREASES. You must file a new certificate within 10 days if the number of exemptions or dependents previously claimed by you DECREASES for any of the following reasons:

(a) Your spouse for whom you have been claiming an exemption is divorced or legally separated from you, or claims his or her own exemption on a separate certificate, **or**

(b) The support you provide to a dependent for whom you claimed an exemption is expected to be less than half of the total support for the year.

OTHER DECREASES in exemptions or dependents, such as the death of a spouse or a dependent, does not affect your withholding until next year, but requires the filing of a new certificate by December 1 of the year in which they occur.

You may claim additional amounts of withholding tax if desired. This will apply most often when you have income other than wages.

You qualify for the low income tax rates if your **total** income from all sources is:

(a) Single	$12,260	to	$15,900
(b) Married Filing Jointly (1 or less dependents)	$20,675	to	$25,500
(c) Married Filing Jointly (2 or more dependents)	$24,883	to	$31,800
(d) Head of Household/Qualifying Widow(er) (1 or less dependents)	$17,431	to	$22,500
(e) Head of Household/Qualifying Widow(er) (2 or more dependents)	$20,778	to	$25,400

For additional information consult your employer or write to:

Arkansas Withholding Tax Section
P. O. Box 8055
Little Rock, Arkansas 72203-8055

ARBenefits

Return this form to EBD:

Employee Benefits Division
P.O. Box 15610
Little Rock, AR 72231

Fax
501-683-0983

Online
https://my.arbenefits.org

Affidavit of Spousal Health Care Coverage

This Affidavit must be completed for consideration to cover a spouse.

Employee Name:		**Employee SSN:**	
Spouse Name:		**Spouse SSN:**	

To be completed by employee electing to enroll a spouse in coverage.

Pursuant to Arkansas Code §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the Plan.

1. Is your spouse currently employed?

   ☐ **Yes** (If yes, please proceed to question #2)

   ☐ **No** (If no, sign and return this form along with your election form and a copy of your Marriage License.)

2. Is your spouse currently employed by an Arkansas state agency or public school district?

   ☐ **Yes** (If yes, sign and return this form along with your election form and a copy of your Marriage License.)

   ☐ **No** (If no, proceed to question #3)

3. Does your spouse's employer offer health insurance coverage?

   ☐ **Yes** ☐ **No**

4. Is your spouse covered by his/her employer sponsored health plan?
   ** If No, please submit information from your spouse's employer as to why your spouse is not covered.*

   ☐ **Yes** ☐ **No**

5. Does your spouse's employer sponsored coverage meet the Affordable Care Act (ACA) minimum guidelines?
   ** If No, please provide information from your spouse's employer stating that coverage does not meet ACA guidelines.*

   ☐ **Yes** ☐ **No**

For any questions or concerns, contact EBD Member Services at 1-877-815-1017x1

By signing this affidavit, I certify that the information provided above is accurate. I understand that any misrepresentation in the information I provided above will permit the Plan to terminate my coverage. If applicable, I authorize the release of the information noted above, and agree to its use in the application process for ARBenefits plan coverage.

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

ARBenefits

ACTIVE STATE & PUBLIC SCHOOL CHANGE FORM

Part 1: Employee Information

First Name	MI	Last Name	Date of Birth	Gender ☐M ☐F	Social Security Number

Agency/School District Name (Required):	Group#	Home/Cell Phone Number	Work Phone Number

Home Address	City	State	Zip Code

Part 2: Action Requested

Type of Action

- ☐ Cancel Coverage
- ☐ Add/Drop Dependent

Reason for this Action (You must check one of the following)

- ☐ Legal Guardianship
- ☐ Newborn/Adoption
- ☐ Marriage
- ☐ Divorce
- ☐ Death
- ☐ Gain/Loss of Employment
- ☐ Medicare/Medicaid/Tricare
- ☐ Other:

Select a Coverage Level

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family

Part 3: Add/Drop Dependents

Check the appropriate column to ADD eligible dependents not currently covered and/or DROP ineligible dependents. Proof of a dependent's eligibility must be submitted with this application for all dependents.

To complete the RELATIONSHIP column, use the number that describes your dependent(s).
Spouse - 1, Child - 2, Permanent Legal Guardianship - 3

Add	Drop	Name (First, MI, Last)	Date of Birth	Social Security Number	Male	Female	Relationship
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Part 4: Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying status change event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 60 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

Employee Signature	Date	Email Address:

SUBMISSION TO EBD IS FINAL

ARBenefits • Department of Transformation and Shared Services • Employee Benefits Division
Post Office Box 15610 • Little Rock, AR 72231-5610 • Fax: 501.683.0983

ONLY FOR ARKANSAS DEPARTMENT OF EDUCATION USE

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

By the Arkansas Child Maltreatment Central Registry

Applicant Instructions: Complete this form, have it notarized, and submit a preprinted check or a U.S. money order for $10.00 made payable to the Arkansas Department of Human Services. DO NOT SEND CASH OR A TEMPORARY CHECK-YOUR REQUEST WILL NOT BE PROCESSED. Make and keep a copy of this form for your records.

INCOMPLETE OR UNNOTARIZED FORMS WILL NOT BE PROCESSED BY THE CENTRAL REGISTRY OR THE ADE!

Mail this form to and the fee payment to: Arkansas Child Maltreatment Central Registry
P.O. Box 1437, Slot S 566
Little Rock, Arkansas 72203

Applicant- Check Only One:
☐ Licensed Teacher
☐ Non-licensed/Classified

Applicant's full name (print or type): _____
First Middle Last

List ALL other names used: _____

Applicant's Social Security Number: _____-_____-_____

Applicant's Birth Date (Month/Day/Year): _____ Age: _____ Race/ethnicity: _____ Gender: ____

Applicant's mailing address: _____ Physical Address: _____
Street or P.O. Box Street

_____ _____
City State Zip Code City State Zip Code

Applicant's phone number: _____ (home) _____(cell)_____(other)

List the full name and date of birth (Month/Day/Year) for all of the applicant's children, attach additional paper if necessary:

1. Child's Full Name: Child's Date of Birth:
2. Child's Full Name: Child's Date of Birth:
3. Child's Full Name: Child's Date of Birth:

I hereby request that the Arkansas Child Maltreatment Central Registry release any information their files may contain indicating the undersigned applicant as an offender of a true report of child maltreatment to the **ARKANSAS DEPARTMENT OF EDUCATION.** **By signing below, I swear or affirm that the foregoing statements are true to the best of my knowledge and belief under penalty of perjury.**

Applicant's Signature: _____ Date _____

State of Arkansas County of _____

On this the _____ day of _____, 20___, before me, _____(name of notary), the undersigned notary, personally appeared _____(**applicant's name**) known to me (or satisfactorily proven) to be the person whose name(s) is/are subscribed to the within instrument and acknowledged that he/she/they executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Notary Public:_____ My Commission Expires: _____

(APPLICANTS DO NOT WRITE BELOW THIS LINE)

School/District Contact Person | District Phone Number | District Fax

School Mailing Address | School District | LEA Number

ADE Form Effective Date (01/15/13)

ARTRS
Arkansas Teacher Retirement System

Form # 9
Effective 7/1/2007
1400 West Third, Little Rock, AR 72201
Phone (501) 682-1517 or (800) 666-2877
Fax (501) 682-2359
Website - http://www.artrs.gov

LUMP SUM DEATH BENEFIT - BENEFICIARY DESIGNATION FORM

Arkansas Code Annotated § 24-7-720 provides that upon the death of an active or retired member of the Arkansas Teacher Retirement System (ATRS), with 10 or more years of actual service, a Lump Sum Death Benefit payment in an amount set by the Board of Trustees shall be paid to such person(s) as the member has designated in writing and filed with ATRS. Effective for a member dying after June 30, 2006, if there is no designated person surviving, the lump sum shall be paid to the member's estate.

Member's Name _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

PART 1 - Designation of Primary Beneficiary(ies)

I hereby designate the following as the primary beneficiary(ies) of the Lump Sum Death Benefit due from ATRS. In the event of my death, I authorize ATRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death. I understand that equal shares will be distributed among multiple surviving primary beneficiaries. At least one primary beneficiary must be listed.

Name of Primary Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the member. I hereby designate the following as contingent beneficiary(ies) of the Lump Sum Death Benefit. I understand that equal shares will be distributed among multiple surviving contingent beneficiaries.

Name of Contingent Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Lump Sum Death Beneficiary Designations filed previously with ATRS.

Member Signature _____ Date _____

To Be Completed By Notary Public

(Notary Seal)

State of _____)
County of _____)

Subscribed and Sworn before me on this _____ day of _____, 20 ___.

Notary Signature _____ My commission expires: _____

ARTRS
Arkansas Teacher Retirement System

Form # 4
1400 West Third
Little Rock, AR 72201
Phone (501) 682-1517
Fax (501) 682-2359
www.artrs.gov

Disposition of Residue – Beneficiary Designation Form

Member Information

Member's Name _____ SSN _____

Mailing Address _____

City _____ State _____ Zip _____

Mobile Phone (____) _____ Email Address _____

If a member of the Arkansas Teacher Retirement System (ATRS) dies with residual account balance(s) standing to the member's credit at their death, the residual balance(s) will be paid to such person(s) as the member has designated in writing and filed with ATRS. The residual and T-DROP balances are only paid to beneficiaries if a survivor or retirement option annuity does not become payable at the member's death.

I hereby acknowledge that should I choose someone other than my spouse as one of my primary beneficiaries, I am electing to waive any right my spouse may have to a survivor benefit based on my service in the Arkansas Teacher Retirement System.

Part 1- Designation of Primary Beneficiary(ies) (At least one primary beneficiary must be listed)

I hereby designate the following as the primary beneficiary(ies) of any residual balance due from ATRS. In the event of my death, I authorize ATRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death.

Name of Primary Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

Part 2 – Designation of Contingent Beneficiary(ies) - Optional

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the member. I hereby designate the following as contingent beneficiary(ies) of any residual balance.

Name of Contingent Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Residue Designations filed previously with ATRS.

Member's Signature _____ **Date** _____

To Be Completed By Notary Public

State of _____)

(Notary Seal)

County of _____)

Subscribed and Sworn before me on this _____ day of _____, 20____.

Notary Signature _____ My commission expires: _____.

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

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

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

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

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

ARTRS
Arkansas Teacher Retirement System

Form # 1
Revised 10/2017
1400 West Third, Little Rock, AR 72201
Phone (501) 682-1517 or (800) 666-2877
Fax (501) 682-2359
Website - www.artrs.gov

Membership Data Form – School Districts

To be Completed by Member

Member's Social Security Number _____ - _____ - _____

Name (Last, First, Middle) _____

Maiden Name (If applicable) _____

Address _____

☐ Male ☐ Female Date of Birth _____ County of Residence _____

City _____ State _____ Zip _____

Telephone Number (_____) _____ Email _____

Member's Signature _____ Date _____

Member History

Previous Service:

Arkansas Public Schools	☐ Yes	☐ No	Dates _____
Arkansas State Agency	☐ Yes	☐ No	Dates _____
Arkansas Highway Dept.	☐ Yes	☐ No	Dates _____
Arkansas State Police	☐ Yes	☐ No	Dates _____
Private Schools	☐ Yes	☐ No	Dates _____
Out-of-State Service	☐ Yes	☐ No	Dates _____
Active Military Service	☐ Yes	☐ No	Dates _____

Have you ever participated in an Alternate Retirement Plan? (i.e. TIAA-Cref, Valic) ☐ Yes ☐ No
Have you ever been a member of ATRS? ☐ Yes ☐ No
Have you ever received an ATRS refund? ☐ Yes ☐ No

To be Completed by Employer

Employer _____ Employer Code _____

Employee's Primary Position _____

Is Employee on contract? ☐ Yes ☐ No If yes, number of days on contract? _____

Employee Enrolled as ☐ Contributory ☐ Noncontributory Verified by ATRS _____

Employee's first day of work (Month/Day/Year) _____

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)

Hermitage School District

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **Hermitage School District** to initiate automatic deposits to my account at the financial institution named below. I also authorize Hermitage School District to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Hermitage School District** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Hermitage School District** receives a written notice of cancellation from my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____ ☐ Checking | ☐ Savings

Account Number: _____

Signature: _____

Authorized Signature (Primary): _____ Date: _____

Authorized Email Address for DD Vouchers: _____

Instruction Page

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

Review your current benefits, the available plans and options. Then select the benefit options most suited to your personal needs.

Social Security Numbers are required for enrollment. If you do not provide a Social Security Number for yourself or your dependents, health insurance coverage cannot be provided. Exception: A newborn's Social Security number will be accepted after enrollment, but must be sent in once it is received.

You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received while your dependent was incorrectly listed as eligible.

Members may make changes to their plan if they experience a qualifying status change, but they may not elect a different plan.

If you experience a qualifying event that allows you to cancel your health insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event. Qualifying status change events include those listed on this form, and may require that you provide proof that you have gained or lost group health care coverage.

You should receive plan information and ID cards in a timely manner from ARBenefits. If you do not, call ARBenefits at 1-877-815-1017 (When you hear the recording, Just Press One).

Your elections will remain in effect for the remainder of the calendar year unless you experience a qualifying status change event, as defined by the ARBenefits Summary Plan Description.

Your effective date of coverage will be the first of the month following date of application and following your qualifying event. Note: The qualifying event date is not the date of eligiblity.

Members who turn age 65 or become eligible for Medicare must send in a copy of their Medicare card to ARBenefits.

Proof of dependent eligibility is required. Examples of required documentation are: birth certificates, marriage licenses, spousal affidavit, court documents and a Certificate of Credible Coverage for loss of coverage.

Please mail or fax your completed and signed Health Insurance Election Form to:

ARBenefits
P.O. Box 15610
Little Rock, AR
72231-5610
Fax: 501-683-0983

For assistance, contact ARBenefits at 1-877-815-1017 Monday through Friday, from 8:00 a.m. to 4:30 p.m. CST.
Learn more about plans, costs and providers at www.arbenefits.org.