New Employee Packet

Index

INSTRUCTIONS FOR TAX PACKET
NEW EMPLOYEES

FORM W-4
COMPLETE: 1, 2, 3, 5 SIGN AND DATE

STATE TAX
COMPLETE: NAME, SS #, ADDRESS, CLAIM WITHHOLDING EXEMPTION, SIGN AND DATE

EMPLOYMENT ELIGIBILITY VERIFICATION FORM
COMPLETE: SECTION 1, SIGN AND DATE
NEED COPY OF SOCIAL SECURITY CARD AND DRIVERS LICENSE (REQUIRED TO RECEIVE A PAY CHECK)

RETIREMENT FORMS: 2 FORMS/ENROLLMENT (FORM 1) AND BENEFICIARY (FORM 1B)
COMPLETE: (FORM 1) MEMBER INFORMATION, FAMILY INFORMATION, SIGN AND DATE UNDER MEMBER CERTIFICATION -- **COPY OF SS CARD REQUIRED**
COMPLETE: (FORM 1B) MEMBER INFORMATION, BENEFICIARY INFORMATION, SIGN AND DATE UNDER MEMBER/RETIREE AUTHORIZATION. **YOU MUST INCULDE YOUR BENEFICIARIES SOCILA SECURITY NUMBERS.**

STATE HEALTH INSURANCE FORM: SECTION A, SECTION B (APPLY OR WAIVE) **SIGN AND DATE.**
YOU MUST COMPLETE SECTION C AND CHOOSE A COVERAGE OPTION. IF YOU HAVE WORKED FOR A SCHOOL SYSTEM OR FOR THE STATE OF MS. AT ANY TIME BEFORE 2006, YOU ARE CONSIDERED A **LEGACY EMPLOYEE**. THE COST OF YOUR HEALTH INSURANCE IS $20.00 PER MONTH FOR SELECT COVERAGE. IF YOU HAVE **NEVER** WORKED FOR A SCHOOL SYSTEM/STATE OF MS. YOU ARE A **HORIZON EMPLOYEE** THE COST IS $38.00 PER MONTH FOR SELECT COVERAGE. SELECT COVERAGE HAS A DEDUCTABLE OF $1000.00 (SINGLE) AND $2000.00 (FAMILY), WITH A PHARMACY CARD. THE BASE PLAN IS NO COST TO THE EMPLOYEE WITH A DEDUCTABLE $1,800.00 (SINGLE) AND $3000.00 (FAMILY), WITH NO PHARMACY CARD. **YOU MUST ANSWER THE QUESTIONS ON SECTION A.**

STATE LIFE INSURANCE FORM: IF YOU WANT THE LIFE INSURANCE, COMPLETE THE FRONT OF THE FORM. IF YOU DO NOT WANT THE LIFE, COMPLETE THE NAME/ADDRESS/SS ON THE FRONT AND SIGN ON THE BACK (DO NOT LIST BENEFICIARIES IF YOU DON'T WANT THE INSURANCE).

ANY QUESTIONS PLEASE CONTACT THE FOLLOWING:

LIZ LEWIS/PAYROLL 601-879-3024
ROXIE WILLIAMS/STATE HEALTH/LIFE INSURANCE/PAYROLL 601-879-3029
CAROLYN VARNER/OTHER INSURANCE 601-879-3061.

WE REQUIRE A BACKGROUND CHECK ON ALL EMPLOYEES. YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.

IF YOU ARE COMING FROM ANOTHER MISSISSIPPI SCHOOL SYSTEM/STATE AGENCY, YOU WILL BE CONSIDERED A TRANSFER AS FAR AS THE HEALTH INSURANCE IS CONCERNED. PLEASE MARK TRANSFER ON THE ENROLLMENT FORM FOR THE HEALTH INSURANCE AND LIST THE SCHOOL/AGENCY YOU ARE COMING FROM.

YOU WILL NEED TO COMPLETE BOTH FORMS REGARDLESS OF YOUR STATUS.

STATE HEALTH and STATE LIFE INSURANCE INFORMATION

To assist in filling out applications please read the following information!

HEALTH:

LEGACY EMPLOYEE: This means you *have worked* for a State (Mississippi) agency/school district *prior* to January 1, 2006 (01/01/06).

The cost for premiums:

Employee:	$ 20.00	*** This is not included in the dependent coverage.*
Emp. + Spouse	$ 443.00	Select coverage: $1,000 per person/$2,000 per family
Emp.+ Sp + Children	$ 647.00	deductable. Drug Card to help with prescriptions.
Emp. + 1 child	$ 155.00	Base Coverage: no cost to employee - $1800 per person/
Emp. + Children	$ 312.00	$3000 per family deductable. NO drug card.

HORIZON EMPLOYEE: This means you *have not* worked for a State (Mississippi) agency/school district OR you did but was not hired until *after* January 1, 2006 (01/01/06).

The cost for premiums:

Employee:	$ 38.00	*** This is not included in the dependent coverage.*
Emp. + Spouse	$ 443.00	Select coverage: $1,000 per person/$2,000 per family
Emp.+ Sp + Children	$ 647.00	deductable. Drug Card to help with prescriptions.
Emp. + 1 child	$ 155.00	Base Coverage: no cost to employee - $1800 per person/
Emp. + Children	$ 312.00	$3000 per family deductable. NO drug card.

The application must be completed within 31 days of your hire date. BUT please keep in mind that premiums are paid a month in advance. (Aug. check pays Sept Premiums.) If the application is not received in MCSD Payroll Dept. in time to take out premiums on the right schedule, the amount you signed up for will be taken out multiple times to cover past months.

LIFE

This application is simple to fill out due to only the top portion has to be completed.
If you *DO* want the Life Coverage, sign the front bottom provided area.
If you *DO NOT* want the Life Coverage, sign the back in the provided area to Waive coverage.
Please do not sign in both areas.

Life Coverage is based on your annual salary. Take your salary and times it by 2. This is the amount of coverage you can receive. (ex: Annual pay $10,000 x2= $20,000 coverage).
Dependent coverage is also offered for spouse and children. See application for details.

Premium cost for Life insurance coverage is based upon your annual salary/coverage.

The minimum coverage premium cost:	$3.60	a month
The maximum coverage premium cost:	$12.00	a month
Dependent coverage premiums cost:	$5.00	a month

Please note that if you do not participate in the Life Insurance upon hire, you can still get it at a later date but will have to go through underwriting for approval.

~ BOTH APPLICATIONS MUST BE FILLED OUT, SIGNED AND MARKED "WAIVED" IF YOU ARE NOT WANTING TO TAKE OUT HEALTH OR LIFE INSURANCE. ~

All Health Insurance Participants:

As of January 1, 2012 you **are not** required to complete a Health Risk Assessment in order to receive the $1,000 wellness benefit. The State Health Insurance Plan would like for you to participate for survey purposes.

If you or a dependent age 18 or older and would like to participate, you will have separate user ID's and password. The member ID will be your ID number located on the front of your health insurance card.

In order to complete the Health Risk Assessment:

1. You can go online to http://knowyourbenefits.dfa.state.ms.us
2. Go to Click here to take Health Quotient
3. If you have never logged in before – You will need to create an ID and Password. Please remember this information as you will have to do the survey every calendar year to receive the wellness benefit.
4. Any questions or want to request a paper survey, call Web MD at 1-866-789-4594.

This information is being provided as a courtesy reminder. Please contact Web MD for more information.

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

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

Social Security Number	First Name	MI	Last Name

Home Address	City	State	ZIP

Primary Telephone Number	Secondary Telephone Number	Email Address

Marital Status	Sex	Date of Birth (MMDDYYYY)	Date of Employment/Retirement
❑ Single ❑ Married	❑ Male ❑ Female		

Were you ever a full-time employee of a covered entity under the State and School Employees' Health Insurance Plan (PLAN) prior to 1/1/2006? ❑ No (Horizon) ❑ Yes (Legacy) If Yes, please list your most recent (pre-1/1/06) employer and dates of employment: _____

_____

If married, is your spouse a participant in the PLAN? ❑ Yes ❑ No

If Yes, please provide your spouse's name and Social Security Number:_____

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

❑ **I hereby apply to ADD, CONTINUE AND/OR CHANGE COVERAGE** for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the *Plan Document*. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

❑ **I hereby WAIVE COVERAGE in the State and School Employees' Health Insurance Plan.** I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. **If you are waiving coverage because you are currently covered under another health insurance plan, please complete Section D.**

Enrollee Signature _____ Date _____

Section C: Coverage

Enrollee Type:	Coverage Type:	Coverage Option (Choose Only One)	Do you have Medicare? ❑ Yes ❑ No
❑ Employee - Legacy	❑ Enrollee Only	❑ Select	Medicare Number _____
❑ Employee - Horizon	❑ Enrollee + Spouse	OR	❑ "A" Effective Date _____
❑ Retiree	❑ Enrollee + Child	❑ Base (HIGH DEDUCTIBLE)	❑ "B" Effective Date _____
❑ COBRA	❑ Enrollee + Children		Reason for Entitlement:
❑ Surviving Spouse	❑ Enrollee + Spouse & Child(ren)		❑ Age ❑ ESRD ❑ Disability

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? ❑ No ❑ Yes If Yes, please provide the following information:

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

Enrollee Last Name:	First Name:	Enrollee SSN:

Section E: Dependents

Dependents to be Covered (Last Name, First Name, MI)	**Relation to Enrollee**	**Social Security Number**	**Date of Birth**	**Address** (if different from Enrollee)	**Current Status**
1.	❑ Husband ❑ Wife				Employed? ❑ Yes ❑ No
2.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
3.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
4.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
5.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? ❑ No ❑ Yes If Yes, please provide the following information:

NAME	**Medicare Number**	**Part A Effective Date**	**Part B Effective Date**	**Medicare Reason**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Section F: Change Information

❑ **Add Enrollee**: ❑ Open Enrollment ❑ Marriage ❑ Loss of Coverage due to Divorce ❑ Birth ❑ Adoption

❑ Other _____ **Requested Effective Add Date** _____

❑ **Add Dependent(s)**: ❑ Open Enrollment ❑ Marriage ❑ Birth ❑ Adoption ❑ Other _____

Requested Effective Add Date_____ **IMPORTANT: List all dependents to be covered in Section E.**

❑ **Change Coverage Option to:** ❑ **Base Coverage (HIGH DEDUCTIBLE)** ❑ **Select Coverage**

❑ **Drop Dependent(s)**: ❑ Divorce ❑ Deceased ❑ Other_____

List all dependents to be dropped and provide the requested information in the spaces below:

NAME	**SOCIAL SECURITY NUMBER**	**REQUESTED TERMINATION DATE**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

❑ **Other Changes** (Explain):

FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER:_____

❑ New Legacy Employee, Requested Effective Date _____ ENTERED BY: _____

❑ New Horizon Employee, Requested Effective Date _____ DATE: _____

❑ Retiree, Requested Effective Date _____

❑ COBRA, Requested Effective Date _____ VERIFIED BY: _____

❑ Surviving Spouse, Requested Effective Date _____ DATE: _____

❑ Change(s), Requested Effective Date _____

State Of Mississippi

Alternate State Life Insurance Plan

Underwritten by *UnumProvident Insurance Company of America*
Administered by Millette Administrators, Inc., Moss Point, MS
Phone 1-800-456-8647 or 1-228-475-8687 Ext. 0 **01/01/2014**

Basic State Public Employees Plan

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

Supplemental Life Insurance To State Life Plan

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

Active Employees

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

Dependent Coverage $5.00/month Until Spouse's Age 70. At Spouse's Age 70, Premium Increases to $23.50/month	
Spouse	$10,000
Each Child over 6 months	$ 5,000**
Each Child live birth to 6 months	$ 100

** Unmarried dependent children to age 19 or 25 if enrolled as full-time student in an accredited school.

Retiree Life Benefits and Premiums

a At retirement, employee can continue life insurance as provided for in the policy.
b You are ***not*** eligible to elect retiree life insurance if you did not have the life insurance as an active employee.
c Maximum benefit of $50,000 Minimum benefit of $ 5,000
d **Premiums may be deducted from monthly PERS retirement benefit or, paid annually by direct pay.**
e Premiums per $1,000 are the same for all retirees regardless of age.
f A retiree may not increase the amount of coverage he/she had at the time of retirement.
g Retirees do not have the extra benefit of AD&D. There is no reduction of benefit at any age level.

Benefit Amount	Premium	STATE>69	Benefit Amount	Premium
$ 5,000	$ 3.75/month	$15.00/month	$30,000	$30.00/month
$10,000	$ 7.50/month	$30.00/month	$40,000	$45.00/month
$20,000	$15.00/month	$60.00/month	$50,000	$60.00/month

DEPENDENT AND SUPPLEMENTAL FAQ

Does it cost $5 per dependent?

No it does not, your one $5 for dependent coverage covers all of your dependents even if they aren't listed on your enrollment form as long as they qualify as dependents when you enroll or you acquire them.

Does the Supplemental and Dependent coverage include Accidental Death & Dismemberment (AD&D), also known as "Double Indemnity"?

The Supplemental coverage does include AD&D but the Dependent coverage does not.

How much coverage can I keep on me when I retire?

You can't keep more coverage than you have when you are an Active employee, that includes if you have $30,000 as an Active and get $25,000 Supplemental coverage you can then keep $50,000 when you retire because you had $55,000 coverage when you were Active.

Can I keep dependent coverage when I retire?

Yes you can keep dependent coverage when you retire on your spouse and any children that qualify for the same $5/month premium until your spouse reaches their Age 70. At your spouse's Age 70, the premium for your spouse's coverage increases from $5/month to $23.50/ month for the rest of your spouse's life. FYI, if you could buy this same coverage from the State (you can't), it would cost $30/ month and $66.20/month through PERS with Monumental Life.

What is the maximum age for a dependent child?

The cut off age is 19 or 25 if they are in an accredited school.

If my spouse and I both work for Madison County Schools, can both of us buy Dependent Life?

No. Either of you may buy it as you choose, but not both of you because you both work for the same employer. If your spouse works for another employer that has this coverage, then both of you may buy it. FYI, statistically, women outlive men by 3 years.

Are these rates guaranteed for life?

No. They are not guaranteed for life. But this is a very stable group. We have had these same rates since 1999 (13 years) and do NOT anticipate an increase.

Can I add either Dependent or Supplemental this coverage at any time?

If you have ANY dependents now, this is the only guaranteed issue "open enrollment" opportunity you will have. You may be able to add this coverage later at any time IF you and your dependents can pass Evidence of Insurability (medical questions).

You may also add this coverage without any medical questions asked when you add your first dependent, either a child or a spouse if you do so within 30 days of acquiring that first dependent (childbirth or date of marriage).

This is your only guaranteed issue "open enrollment" opportunity you can add the Supplemental Life on yourself. You may be able to add this coverage later at any time IF you can pass Evidence of Insurability (medical questions).

UNUM

Mississippi Schools
Active Employee & Dependents Enrollment Form for Supplemental & Dependent Life Insurance
537377-114

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

I am covered under the Basic State Life Insurance Plan. ☐ **Yes** ☐ **No**

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

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

Beneficiary Information

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

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

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

SUPPLEMENTAL LIFE AND DEPENDENT LIFE INSURANCE:

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

Employee Life and AD&D	**DEPENDENT/FAMILY COVERAGE**	**Dependent Name**	**Relationship**	**Date of Birth**
☐ **$10,000**	Spouse.....$10,000			
☐ **$25,000**	Per Child.....$ 5,000			
☐ **$50,000**	To 6 Months per Child....$ 100			
☐ **None**	☐ **I elect dependent coverage.**			
	☐ **I decline dependent coverage.**			
	Spouse premium increases age 70			

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

Employee Signature	Date	Work Phone	Home Phone

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

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

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

Employee Name _____ Social Security #_____

School District or Community College MADISON COUNTY SCHOOL DISTRICT

Signature_____ Date _____

Membership Application

Form 1 – Revised 8/1/2012

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member Information – *Attach a copy of the member's Social Security card.*

First Name: _____ MI: _____ Last Name: _____ Gender: ☐ M ☐ F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ E-Mail: _____

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

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

Have you previously served on active duty in the U.S. Armed Forces? *If yes, attach Form(s) DD214* ..... ☐ Yes ☐ No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? ..... ☐ Yes ☐ No

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Family Information – *Use additional* Membership Applications *if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B,* Beneficiary Designation, *to officially designate any and all beneficiaries.*

Marital Status – *Select one. Add date for last three.* ☐ Single ☐ Married ☐ Divorced ☐ Widowed Effective Date *mm/dd/ccyy:* _____

Spouse's Full Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Wedding Date** *mm/dd/ccyy*	**Gender**
				☐ M ☐ F

Dependent Child's Full Name – *Up to age 19, or 23 if unmarried and a full-time student*	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Gender**
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

❹ Member Certification – *If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

Member's Signature: _____ Date *mm/dd/ccyy*: _____

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

Member's Position Held/Job Title: _____ **Member's Hire Date** *mm/dd/ccyy:* _____

Member's Status: Elected Official: ☐ Yes ☐ No Fee Paid Official: ☐ Yes ☐ No Public Safety Employee: ☐ Yes ☐ No

Employer Name: Madison County School District Employer No.: 0387 - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: (601) 879-3000 Fax: (601) 879-3037 E-Mail: _____

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, *Eligibility of Part-time Employees for State Retirement Annuity Service Credit*, and PERS Board of Trustees Regulation 36, *Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS)*.

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

Beneficiary Designation

Form 1B – Revised 6/7/2013

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member/Retiree Information

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

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

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Beneficiary Information – *Use additional Form 1B,* Beneficiary Designation, *to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary and secondary beneficiary percentages must equal 100 percent.*

Beneficiary Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Beneficiary Percentage** *P=Primary, S=Secondary Use whole numbers*	**Gender**
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F

❹ Member/Retiree Certification – *Check applicable acknowledgement then sign. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

☐ **Member** – I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).

☐ **Retiree –** I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date *mm/dd/ccyy*: _____

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

Employer Name: Madison County School District Employer No.: 0387 - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: (601) 879-3000 Fax: (601) 879-3037 E-Mail: _____

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

Form W-4 (2014)

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. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity iincome, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . .	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 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 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

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

Employee's Withholding Allowance Certificate

► **Whether you are 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

2014

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, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	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 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6** $	
7	I claim exemption from withholding for 2014, 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 lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 if 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 2014 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2014 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,950 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not 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 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. 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 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

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 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

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

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

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

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

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

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

Employee's Name _____ **SSN** _____

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

	CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION		
	Marital Status	**Personal Exemption Allowed**	**Amount Claimed**
EMPLOYEE:	**1. Single**	☐ Enter $6,000 as exemption . . . . ▶	$
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	**2. Marital Status** (Check One)	(a) ☐ Spouse **NOT** employed: Enter $12,000 ▶	$
		(b) ☐ Spouse **IS** employed: Enter that part of $12,000 claimed by you in multiples of $500. See instructions 2(b) below . ▶	$
	3. Head of Family	☐ Enter $9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d)below . . . . . ▶	$
EMPLOYER: **Keep this certificate with your records.** If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	**4. Dependents** Number Claimed	You may claim $1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim $1,500 for each dependents excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by $1,500. Enter amount claimed. . . ▶	$
	5. Age and Blindness	• Age 65 or older ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ Single Multiply the number of blocks checked by $1,500. Enter the amount claimed . . . . . ▶ *** Note:** No exemption allowed for age or blindness for dependents.	$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5...▶		$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer . . . . . ▶		$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write "**Exempt**" on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▶		_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ **Date:** _____

INSTRUCTIONS

1. The personal exemptions allowed:

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

2. Claiming personal exemptions:

(a) Single Individuals enter $6,000 on Line 1.

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

If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of $500. For example, the taxpayer may claim $6,500 and the spouse claims $5,500; or the taxpayer may claim $8,000 and the spouse claims $4,000. The total claimed by the taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter $9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. Total Exemption Claimed:
Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

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

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION

6. IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENEFIT OF EXEMPTION..

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

Instructions for Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit **www.justice.gov/crt/about/osc**.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**
2. **A noncitizen national of the United States:** Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.
4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:

   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CBP).

   (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

   (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on **www.uscis.gov/I-9Central** before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include **(1)** the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and **(2)** the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at **www.uscis.gov/I-9Central** for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.
3. Complete Block C if:
   a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
   b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

   To complete Block C:
   a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
   b. Record the document title, document number, and expiration date (if any).
4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

   For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the **"USCIS Privacy Act Statement"** below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)*.

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at **I-9Central@dhs.gov**, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at **E-Verify@dhs.gov** or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028.**

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Form I-9 may be signed and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

USCIS Privacy Act Statement

AUTHORITIES: The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a).

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer will keep this form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:			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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		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)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print 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)
		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		
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				

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

MADISON COUNTY SCHOOL DISTRICT
DIRECT DEPOSIT AUTHORIZATION/CANCELLATION FORM

I hereby authorize Madison County School District (MCSD) to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my accounts indicated below and the depository institution named below to credit and/or debit the same to such account. I understand that in the event my bank is not able to deposit my paycheck into my account due to any action I take; that I am responsible for any resulting bank fees incurred, and that MCSD cannot issue the payroll funds to me until the funds are returned to MCSD by my bank.

ACCOUNT #1 □ Checking □ Savings **ACTION:** □ New □ Change □ Cancel

DEPOSITORY (BANK) NAME: _____

ADDRESS: _____

ROUTING/ABA NO: _____ACCOUNT NO: _____

□ NET PAY (OR REMAINDER OF NET PAY IF AUTHORIZING MORE THAN ONE ACCOUNT)

ACCOUNT #2 □ Checking □ Savings **ACTION:** □ New □ Change □ Cancel

DEPOSITORY (BANK) NAME: _____

ADDRESS: _____

ROUTING/ABA NO: _____ACCOUNT NO: _____

□ AMOUNT_____

ACCOUNT #3 □ Checking □ Savings **ACTION:** □ New □ Change □ Cancel

DEPOSITORY (BANK) NAME: _____

ADDRESS: _____

ROUTING/ABA NO: _____ACCOUNT NO: _____

□ AMOUNT_____

This authority is to remain in full force and effect until Madison County School District has received an updated Direct Deposit Authorization form from me of its termination in such time and in such manner as to afford Madison County School District and the Depository (Bank) indicated above a reasonable opportunity to act on it.

- **MUST ATTACH VOIDED CHECK OR SAVINGS ACCOUNT CARD**

EMPLOYEE NAME: _____SOC. SEC. #_____
(Please Print)

DATE: _____SIGNATURE:_____

Delta Dental PPO℠ – Easy, Friendly, Accessible

We'll do **whatever it takes and then some.**

Greatest potential savings when you visit a Delta Dental PPO dentist

OUT-OF-POCKET COSTS

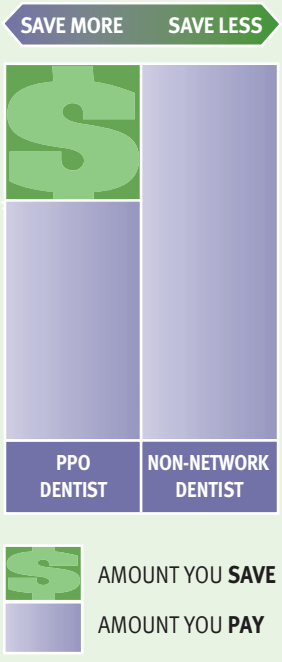


Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to one of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Many dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at deltadentalins.com to search our dentist directory by location or specialty.
- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

** In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.*

DELTA DENTAL®

WE KEEP YOU SMILING®

Plan Benefit Highlights for: Madison County School District

Group No: **Effective Date:** 6/1/2014

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26		
Deductibles*	$100 per person per Lifetime		
Deductibles waived for D & P?	Yes		
Maximums*	High Plan - $1,500 per person each plan year Low Plan - $1,000 per person each plan year		
D & P counts toward maximum?	No		
Waiting Period(s) The waiting periods are calculated from each individual enrollee's effective date in a dental program as reported by the employer.	Basic Benefits 0 Months	Major Benefits 12 Months	Orthodontics 12 Months

Rates Effective 6/1/2014-05/31/2016	**High Plan**	**Low Plan**
	EE Only $33.89	**EE Only $19.37**
	EE & Spouse $68.46	**EE & Spouse $38.73**
	EE & Child(ren) $75.33	**EE & Child(ren) $42.59**
	EE + Family $109.42	**EE + Family $62.93**

Benefits and Covered Services*	**Delta Dental PPO dentists†**	**Non-DeltaDental dentists†**	**Delta Dental PPO dentists†**	**Non-DeltaDental dentists†**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays, sealants	100 %	100 %	100 %	100 %
Basic Services Fillings, simple tooth extractions	80 %	80 %	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %	80 %	80 %
Endodontics (root canals) Covered Under Major Services	50 %	50 %	0 %	0 %
Periodontics (gum treatment) Covered Under Major Services	50 %	50 %	0 %	0 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures	50 %	50 %	0 %	0 %
Implants	50 %	50 %	0 %	0 %
Orthodontic Benefits Dependent children to age 19	50 %	50 %	0 %	0 %
Orthodontic Maximums Lifetime	$1,000	$1,000	N/A	N/A

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Enrollees moving from the Low plan to the High plan must satisfy the 12 months waiting period for Major and Orthodontia services.

† Fees are based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 80th percentile for non-Delta Dental dentists.

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Customer Service
800-521-2651

Claims Address
P.O. Box 1809
Alpharetta, GA 30023-1809

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_HILO_DDIC (Rev. 2 5/11)

Delta Dental Enrollment Form
Madison County School District
Group # MS 15843

Effective Date: _____

Sub Location: _____

Pay Location _____

Please complete the following information.

Social Security #	Last Name	First Name	MI	Date of Birth / /
Home Address		Home Phone # ( )		Sex M F
City	State / Zip Code	Business Phone # ( )		

List all Eligible Dependents that are to be covered.

	First	Mi	Last	Sex	Date of Birth
Spouse:				M F	/ /
Child:				M F	/ /
Child:				M F	/ /
Child:				M F	/ /
Child:				M F	/ /

Please Check Your Choice

		12-Month EE Deduction Amt
HIGH PLAN		
6/1/14-5/31/16	☐ Employee Only	$33.89
	☐ Employee + Spouse	$68.46
	☐ EE + Child(ren)	$75.33
	☐ Employee + Family	$109.42
LOW PLAN		
6/1/14-5/31/16	☐ Employee Only	$19.37
	☐ Employee + Spouse	$38.73
	☐ EE + Child(ren)	$42.59
	☐ Employee + Family	$62.93

Status Change Information

Is this a qualifying - ¡Please list qualifying event _____.
Add the dependent(s) listed above - Effective date _____/_____/_____
Delete the dependent(s) listed above - Effective date _____/_____/_____
Terminate employee coverage Effective date _____/_____/_____
Name Change (From) _____ (To) _____
COBRA- Effective date _____/_____/_____
Transfer from sub. Loc # _____ to sub. Loc # _____ Effective date _____/_____/_____

I wish to enroll in the plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X _____ Date:

AlwaysCare

Madison County School District

Renewal: 6/01/2014—6/01/2016

Elite Education Vision Plan

Visit www.AlwaysCareBenefits.com
Provider Search • View Benefits • View Claims • Print ID Cards • Add/Term Employees • View Billing & Payment History • Access Forms & Documents
Order Contact Lenses Online • Vision Health Center

Available exclusively through:

GG&A Glynn Griffing & Associates

Glynn Griffing
Brent Walker
Debbie Whittington
(601) 982-0331

PLAN DESCRIPTION: Full service plan with generous in-network allowances for frames and contact lenses. Low in-network co-pays.

SELECTION OF PROVIDERS: Members may access our national network of participating vision provider locations, or choose an out-of-network provider. Options include independent optometrists and ophthalmologists, plus regional and national retail chains (i.e., Wal-Mart, Sam's Club, Pearle Vision, Target, Sears, JCPenney, Costco* and Visionworks). Members may choose different providers for vision exam and materials purchases. Visit www.AlwaysVision.com or call 888-729-5433 for a list of participating providers. Most participating providers (excluding Costco, Wal-Mart and Sam's Club) offer discounts on items purchased after the insurance benefit has been used and on non-covered items.

	Elite Plan	Out-of-Network Allowances
Exam (1 per 12 months)	$10 co-pay	Up to $35
Materials	$10 co-pay	See below
Standard Plastic Lenses: (1 per 12 months)		
Single Vision	Covered by co-pay	Up to $25
Bifocal	Covered by co-pay	Up to $40
Trifocal	Covered by co-pay	Up to $50
Lenticular	$80 allowance	Up to $50
Progressive	$70 allowance	Up to $40
Lens Options:		
Standard Scratch Resistant Coating	Covered in full	N/A
Polycarbonate Lenses for children to age 19 only	Covered at Wal-Mart & Sam's Club only	N/A
Frames: (1 per 24 months) Members choose from any frame at provider locations	$120 retail allowance. ($94 retail frame at Costco*, Wal-Mart, & Sam's Club)	Up to $50 retail
Contact Lenses: (1 per 12 months) In lieu of eyeglass lenses & frames (Includes, fit, follow-up and materials)		
Elective	Up to $130 retail	Up to $100
Medically Necessary	Up to $210 retail	Up to $210

Rate Guarantee: 12 months from the renewal/effective date of coverage.
*Special payment and reimbursement terms apply for materials purchased at Costco.

Monthly Rates:	
Employee Only	$8.14
Employee & Spouse	$16.62
Employee & Child(ren)	$14.66
Employee & Family	$22.80

Final rates subject to home office underwriting verification of participation and other factors. This is only an outline. This outline provides a very brief description of some of the important features of the vision policy. This is not the policy, and only the actual policy provisions prevail. The Elite Education rates above become effective for existing groups beginning with 09/01/11 renewal dates and new groups beginning with a 06/01/11 effective date. Rates are guaranteed 12 months from the renewal effective date. Members must enroll for a minimum of 12 months.

Underwritten by: Starmount Life Insurance Company | **Administered by**: AlwaysCare Benefits, Inc. (part of the Starmount Life Insurance family)
The Starmount Building, 8485 Goodwood Blvd., Baton Rouge, LA 70806 Phone: 1-888-729-5433, Ext. 2013

Other AlwaysVision℠ Specifications

Dependent Children: Dependent age guidelines vary by state. Please refer to your policy certificate or contact customer service at 888-729-5433, Ext. 2013.

Services Not Listed: If you expect to require a vision service not included on this brochure, it may still be covered. Please contact customer service at 1-888-729-5433, Ext. 2013 to confirm your exact benefits.

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Medical or surgical treatment of eye disease or injury is not provided under this plan. Coverage may not exceed the lesser of actual cost of covered services and materials or the limits of the policy.

Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the Plan Design; however, these materials and any items not covered below may be purchased at Preferred Pricing from a Participating Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage is in force.

This plan will not cover:

- Orthoptics or vision training and any supplemental testing; Plano (non- prescription) lenses; or two pair of eyeglasses in lieu of bifocals or trifocals;
- Medical or surgical treatment of the eyes;
- An eye exam or corrective eye wear required by an employer as a condition of employment;
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related;
- Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses (subject to allowance);
- Sub-normal vision aids;
- Services rendered or materials purchased outside the U.S. or Canada, unless: the insured resides in the U.S. or Canada, and the charges are incurred while on a business or pleasure trip;
- Charges in excess of Usual and Customary for services and materials;
- Experimental or non-conventional treatments or devices;
- Safety eyewear;
- Spectacle lens styles, materials, treatments or "add-ons" not shown in the Schedule of Benefits.

Laser Vision Correction Network
Membership provides access to preferred pricing. Transactions are handled directly between Members and Providers. Refractive surgery is an elective procedure and may involve potential risks to patients. **This is not an insured benefit.** AlwaysCare Benefits, Inc. cannot and does not guarantee the outcome of any refractive surgical procedure or a total elimination of the need for glasses or contacts. Providers may not be available in all metropolitan areas. Visit www.AlwaysCareBenefits.com for a list of participating laser vision correction providers.

AlwaysHearing℠ Savings Plan

- **Available at no cost to all AlwaysCare Members**
- **Material discounts of between 30%-60% on all major name brand hearing instruments and accessories**
- **Battery program discounts up to 40% off retail pricing**

To access call 1-888-729-5433, Ext. 2013

Underwritten by: Starmount Life Insurance Company
Administered by: AlwaysCare Benefits, Inc.
(a Starmount Life Insurance company), The Starmount Building,8485 Goodwood Boulevard
Baton Rouge, LA 70806; PH: 1-888-729-5433, ext 2013.
Policy Forms: Vision – VI-2002 and VI-2007

Administered by:

AlwaysCare

Enrollment Form for Group Insurance

Underwritten by: Starmount Life Insurance Company
Administered by: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
P.O. Box 98100 Baton Rouge, LA 70898-9100, (225) 926-2888 or (888) 729-5433

1. MEMBER INFORMATION ☐A: Add (enroll) ☐T: Terminate ☐C: Change (change of name or coverage)

Group/Policyholder Name	Group Number	Location	Effective Date
Madison County School District	**MCSD502**		

Gender	Last Name (Member or subscriber)	First Name	M.I.	Date of Birth	Social Security Number
☐ M ☐ F					

Home Street Address	City/State/Zip	Home Phone	Work Phone	Cell Phone
			Email:	

Please include me in future communications regarding product offerings. ☐ Yes ☐ No
You may opt out at any time by contacting Customer Service.

COMPLETED BY EMPLOYER

Date of Hire	☐ Full time ☐ Part time If part time: Hrs worked per week: ________	Occupation	Class

Salary $: ______________ ☐ Yearly ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly ☐ hourly

2. FAMILY INFORMATION (Only those eligible may be enrolled. Use additional paper if needed) (Relationship – If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.)

	Gender	Relationship	Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)	
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Husband ☐ Wife	(Spouse)				
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐Son ☐ Stepson ☐Daughter ☐Stepdaughter ☐Other____________	(Dependent)				Handicapped? ☐ Yes ☐ No
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐Son ☐ Stepson ☐Daughter ☐Stepdaughter ☐Other____________	(Dependent)				Handicapped? ☐ Yes ☐ No
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐Son ☐ Stepson ☐Daughter ☐Stepdaughter ☐Other____________	(Dependent)				Handicapped? ☐ Yes ☐ No

3. BENEFIT ELECTIONS (Employer determines benefits available for election): Monthly rates valid 6/1/2014 – 6/1/2016

Vision	Member Only	Member & Spouse	Member & Child(ren)	Member & Family	Waive	Mode Premium
	☐ $8.14	☐ $16.62	☐ $14.66	☐ $22.80	☐	$

STATEMENTS AND AGREEMENTS:

- My dependents are not eligible for coverages I don't have. If I refuse dental or vision coverage, I and/or my dependents may enroll later but this will affect the level of benefits. If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health. If I refuse coverage, I cannot enroll after retirement. If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution: (1) I authorize my employer to deduct from my pay; and (2) I understand that no insurance is in force until the first premium is paid.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage.
- I agree Starmount Life Insurance Company (the Company) is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- I authorize the Company to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date of signature. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Company for claims administration and determining eligibility for life and disability insurance. Information will not be used for any purpose prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection

of social security numbers from myself and/or my dependents will be used by the Company only as allowed by law.

- NOTE for Dental: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under Coverage A in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date.
- NOTE for Vision: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. These limited coverages also apply to the Late Entrant's or Re-enrollee's Dependents, if enrolled.

AUTHORIZATION AND AGREEMENT: I hereby declare that all the statements made in this application are, to the best of my knowledge and belief, true and complete, and that they are the basis on which insurance requested by me may be issued. I understand that coverage will not become effective until the Company grants its underwriting approval if required. I understand that there is no coverage for a Pre-existing Condition except as described in the Certificate of Insurance.

I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, pharmacy benefit manager or other medically related facility, insurance company or its reinsurer, MIB, Inc., formerly known as Medical Information Bureau, or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, or that of any member of my family whose name appears in the application to which this is attached, to give the Company and its affiliates or authorized representative any such information. I authorize Starmount Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB. This information will be used to determine eligibility for insurance. I understand that I may revoke this authorization at any time by sending a written revocation to the Company at the address above. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right the Company has to contest an insurance policy / certificate, or to contest a claim under an insurance policy / certificate. I understand that if I revoke this authorization, the Company may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement. I understand that once this information is received by the authorized person/organization, then this information may be subject to re-disclosure, and may no longer be protected by federal privacy laws. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 12 months from the date signed. I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation. I also certify that the producer and I, if applicable, also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Notice of Disclosure of Information.

In the past 12 months, have you had continuous group coverage providing like or similar benefits (for yourself and/or your dependents) with a prior carrier?
☐ Yes ☐ No

If yes, please provide: Policyholder _____ and Insurance Company _____

Important! If declining any coverage for yourself or any dependent, give reason. Covered under: ☐ Spouse's group coverage
☐ Individual insurance ☐ other coverage offered by my employer ☐ other_____

I declare that the information I have completed on this enrollment form is complete and true. I have read and understand the statements and understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the Company.

Your Signature: x_____ Date signed _____

Spouse's Signature: x_____ Date signed _____

A copy of this form will be as valid as the original. After this form is completed and signed, make one copy for the Policyholder and a copy of page one only for the Member.

Notice of Disclosure of Information

Information regarding your insurability will be treated as confidential. Starmount Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Starmount Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumer about MIB may be obtained on its Website at www.mib.com.

Preferred Vision Plan
Madison County School District
Plan Features

- **No Deductible**
- **No Waiting Period**
- **A Vision Examination Annually**
- **Contact Lenses, Once Per Year**
- **Your Choice of Eye Care Providers**
- **One Set of Frames each 24 months**
- **One Pair of Standard Lenses or**
  - **Laser Vision Correction discount through Laser Vision Network of America (LVNA)**

Schedule of Benefits

(Out-of-Network – Reimbursement up to the following amounts once in a 12 month period – frames once in a 24 month period)

Annual Vision Examination	**$ 40.00**
Single Vision Lenses	**$ 40.00**
Bifocal	**$ 60.00**
Trifocal	**$ 80.00**
Frames	**$ 50.00**
Elective Contacts	**$105.00**
Necessary Contacts	**$210.00**

"In-Network" Benefits **

- **A comprehensive vision examination annually with only a $15.00 co-payment.**
- The $25.00 materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
- If prescribed, one pair of stardard single vision or standard multi-focal (lined bifocal/trifocal) lenses is covered in full.
- Members receive a $130 retail frame allowance toward the purchase of their frame.
- **In lieu of lenses and a frame, you may select from Spectera Vision's** selection of covered-in-full elective contact lenses. The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after $25.00 copay). If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider.
- For all other elective contact lenses chosen outside of Spectera Vision's covered-in-full selection. A $105.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply).

Monthly Group Rates

Employee	**$9.40**
Employee & One	**$14.95**
Employee & Family	**$22.50**

A Product of:

MorganWhiteGroup
P.O. Box 14067
Jackson, Ms 39236

** **In- Network Provider Access**

Call Spectera Vision at 1-800-839-3242
Or go online at www.mySpectera.com

Agent: Tom Tharp

SEE OTHER SIDE OF THIS OF THIS PAGE FOR IMPORTANT INFORMATION ABOUT THE USE OF YOUR VISION INSURANCE

"Spectera Vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06 and associated COC form number VCOC.INT.06.TX."

"VISION CARE BENEFITS"

IMPORTANT INFORMATION

(ABOUT THE USE OF YOUR VISION INSURANCE)

WHO WILL PROVIDE MY VISION BENEFITS?

Spectera Vision - Customer Service may be reached at 800-638-3120

- For Benefit Information
- For Claim Information

HOW SOON CAN I USE MY BENEFITS?

Out-of-Network: On the first day your plan is effective.

In-Network: Allow 2-3 weeks for your information to be entered in the system.

HOW DO I LOCATE AN IN-NETWORK PROVIDER?

Simply Call:

Provider location service at **800-839-3242**

OR Use Spectera Vision's web site **www.mySpectera.com**

HOW DO I LOCATE A LASER VISION CORRECTION PROVIDER?

Call: 877-287-4448

Website: specteralasik.com

IN-NETWORK BENEFITS

EXAMINATION:

A comprehensive vision examination by a participating optometrist or ophthalmologist every 12 months based on last date of service with only a $15.00 co-pay.

MATERIALS:

The $25.00 materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.

LENSES:

If prescribed, a pair of single vision or standard lined multi-focal lenses are available every 12 months based on last date of service.

CONTACT LENSES:

In lieu of spectacle lenses and a frame, you may select contact lenses every 12 months based on last date of service. Spectera Vision covers a wide variety of contact lenses, including disposable, when obtained from a participating provider. If you elect contact lenses outside of Spectera Vision's covered selection, you will receive an allowance of $105.00 toward the retail cost of the lenses and any dispensing and fitting fees and the co-pay is waived.

LASER VISION CORRECTION:

Save 15% off standard prices or 5% off promotional prices

FRAMES:

Your choice from a wide selection of fashionable frames will be covered-in-full every 24 months based on last date of service. Members receive a $130 retail frame allowance towards their purchase of frames.

PATIENT OPTIONS:

Should you select items not covered by the program, such as: progressive lenses, tints, coatings, etc., there will be an additional charge. These charges, however, are below usual retail costs.

OUT-OF-NETWORK BENEFITS:

Spectera Vision will accept receipts, and reimburse you once (up to the amounts shown on the other side of this flyer), when you use an "out-of-network" provider. Receipts must be submitted within 12 months of the date of service. While you can file for reimbursement anytime after you receive your exam and eyewear, in order to maximize your "out-of-network" benefits, itemized receipts should be collected (i.e. several purchases of contact lenses) **until they total (at least)** the maximum reimbursement amounts shown on the other side of this sheet. Be sure to include with the receipts the participant's member ID number and patient's date of birth.

MAIL TO: Spectera Vision Claims Department
PO Box 30978
Salt Lake City, UT 84130

When scheduling your appointment, be sure to say that you are covered under the MorganWhiteGroup/Spectera Vision Plan so that the provider can confirm your eligibility and benefits prior to the appointment.

Group Vision Benefits – See Other Side Of This Page

MWG VISION ENROLLMENT FORM

Vision Application

- ☐ New Application
- ☐ Change Card
- ☐ Decline Coverage

- ☐ Member
- ☐ Member & One
- ☐ Member & Family

Payment Mode

- ☐ Group Billing

Home Office Use

Effective Date

Plan

Rate Code

Rate

Group Code

Last Name | First Name | MI

Home Address | City, State, Zip

Home Phone | Employer/Group | Employer Phone

Employee SSN | Employee DOB | Marital Status | Employee Sex

Dependent(s) Name	DOB	Relationship	Sex	Student (Y/N)

" I understand and agree that the insurance shall not take effect unless the application has been accepted and approved by the Company and until the Effective Date of the Certificate." California law prohibits an HIV test from being required or used by health insurance companies as a condition.

Signature of Member | Date

Agent complete & sign

Rev. 070209

Employee Only	$9.40
Employee & One	$14.95
Employee & Family	$22.50

Go to **www.madison-schools.com** website/on left hand side there is "Quick Links" - click on Active Resources. Then follow the instructions below.

Active Resources

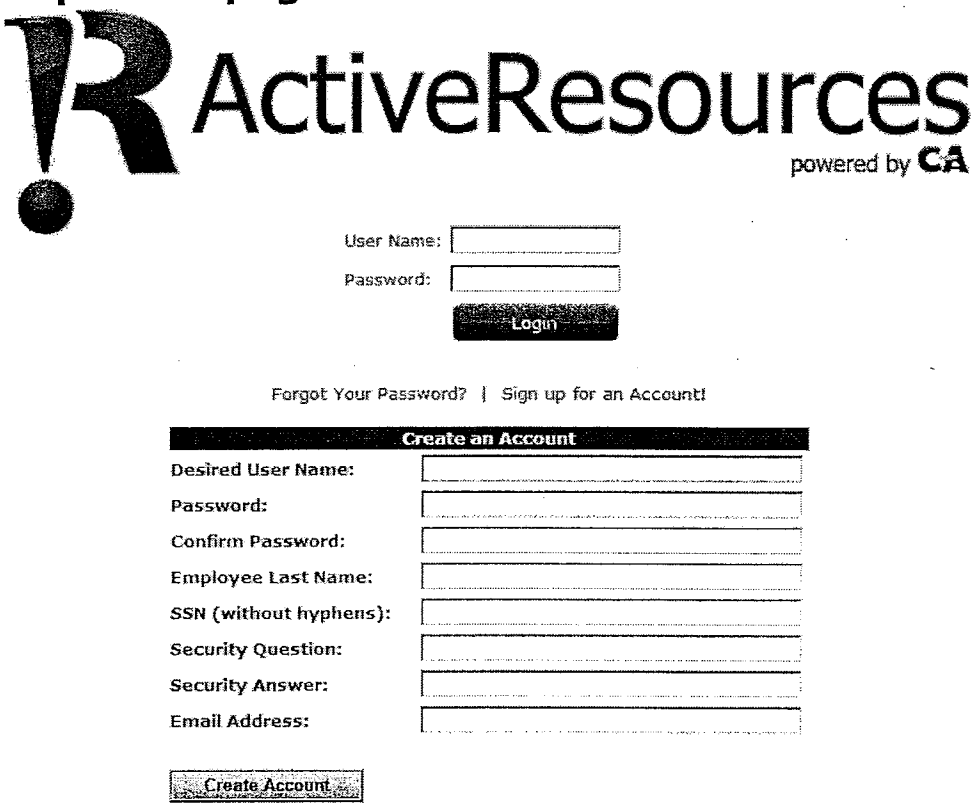
Create an Employee Account

All district employees will need to create an account on your initial visit to the Active Resources site.

To do this you will need to click on the **Sign up for an Account** option.

Clicking this option will expand the page where you will create an account.

Expanded page



All fields must be completed in order for an account to be created.

Desired User Name: This can be anything that you want to use. It may be all alpha characters or an alphanumeric combination and there is no set length required.

Password: The password that you create must follow guidelines that are setup in Marathon. Parameters are the password length and whether or not non-alphabetic characters are required. You will receive notification if your password does not meet these criteria and you will be given an opportunity to try again.

Confirm Password: You will need to confirm your password by entering it again.

Employee Last Name: The last name entered **must** match your last name as it exists in your Marathon Payroll Employee folder.

SSN: The social security number entered **must** match your social security number maintained in your Marathon Payroll Employee folder. The employee's last name **and** social security number establishes the link between Active Resources and Marathon.

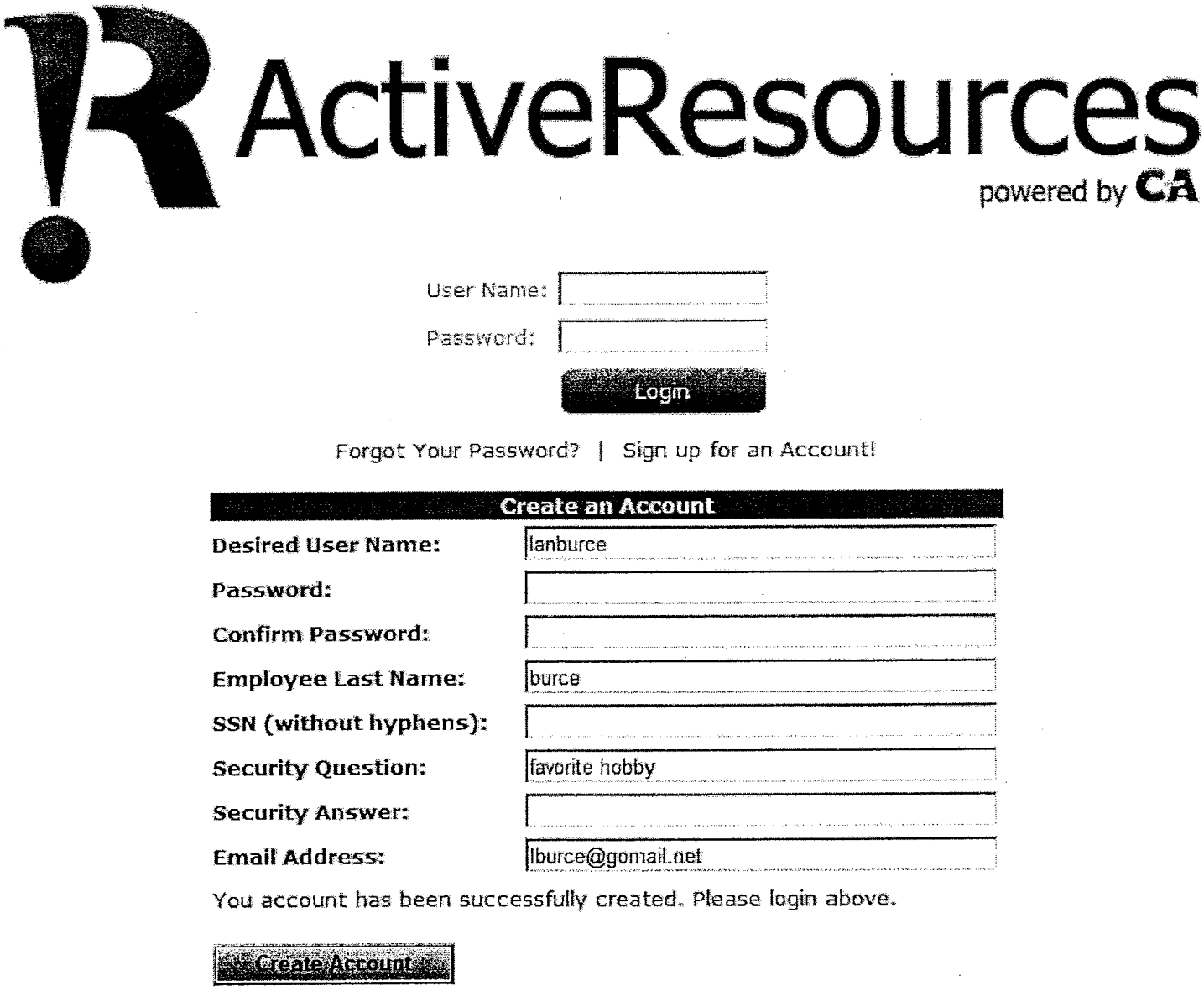
Security Question: This should be something that is meaningful to you.

Security Answer: This is the answer to your security question.

Email Address: This should be the email address that you want any correspondence from Active Resources to be sent to.

Once all of the information has been entered click on the **Create Account** button.

Shown below is an example of an account **after** clicking the Create Account button.



Because the password, social security number and security answer are encrypted they are removed from the page.

You will receive a visual confirmation that the account was created. You may now log in to Active Resources by entering your user name and password and clicking on the **Login** button.

Shown below is an example of an account **before** clicking the Create Account button.

The password, social security number and security answer are encrypted.

Madison County Schools

Product	Company	Contact	
Accidental	* AFLAC	Emily Ingram	601-853-0664
Annuities	Miss. Deferred Compensation	www.mdcplan.com Great-West Financial	1-800-846-4551
	Valic	Matthew Newman	601-850-4908
	Equi-Vest	Cliff Shirley	601-898-1919
	Primerica	Horace Adair	601-898-8378
	Horace Mann		1-800-999-1030
Cancer	* USAble Life	Wes Dozier	615-791-0404 ext 120
	*Humana/Glynn Griffing & Associates	Brent Walker	601-982-0331
Credit Union	Statewide Federal Credit Union	Bruce Ulrich	601-420-5535
Dental	*Glynn Griffing & Associates Delta Dental	Brent Walker Mary Ray	601-982-0331 1-800-521-2651
Health (State of MS)	* Blue Cross and Blue Shield	Central Office - Roxie	601-879-3029
Pre-Paid Legal & Identity Protection	Legal Shield	Teresa Burgess	601-954-1288
Life	Millette	Central Office - Roxie	601-879-3029
Disability/Salary Protection	USAble Life	Wes Dozier	615-791-0404 ext 120
Dread Diseases	* USAble Life	Wes Dozier	615-791-0404 ext 120
Vision - Always Care/Starmount	*Glynn Griffing & Associates	Brent Walker	601-982-0331
Vision - Spectera	* Morgan White	Tom Tharp	601-956-2028
Cafeteria Plan: Flexible Spending Accounts Unreimbursed Medical Plan Dependent Day Care Plan	* Southern Administrators		601-856-9933

* Denotes eligible to be pretaxed under the Section 125 Cafeteria Plan

MCSD offers the insurances listed through payroll deduction. If you are interested in purchasing any of these insurances, you must do it within 31 days of your hire date by contacting the agent listed above.