McCormick School District
NEW HIRE ENROLLMENT CHECKLIST
(Enrollment Documents should be placed in the following order)

Required Documentation	**Date Submitted to Payroll**
1) 1-9 Employment Eligibility	☐ _____
2) W-4 Tax Withholding Statement	☐ _____
3) Copy of Social Security Card & Picture ID	☐ _____
4) Direct Deposit Authorization	☐ _____
5) Employee Emergency Information Sheet	☐ _____

Insurance Enrollment Documentation (Must Receive within 31 Days of Hire)	
6) Notice or Election (New)	☐ _____
7) O.I.S. Transfer N.O.E. (Transfers)	☐ _____
8) SLTD Enrollment	☐ _____
9) Long Term Care Enrollment	☐ _____
10) Personal Health Statement	☐ _____
11) Letter of Credible Coverage	☐ _____
12) Other: _____	☐ _____

Retirement Documentation	
13) Retirement Plan Disclosure Form	☐ _____
14) Retirement Plan Enrollment Form	☐ _____
15) Retirement Plan Beneficiary Form	☐ _____
16) Notification of Employed Retiree	☐ _____
17) Beneficiary/Trustee Designation & Certification	☐ _____
18) ORP Vendor Application (w/in15 days of hire)	☐ _____
19) Non-election Form (Retirees Only)	☐ _____

Other Required Documentation:	
20) Universal Change of Address Form	☐ _____
21) Sick Leave Transfer Verification	☐ _____
22) MoneyPlus Refusal to Participate	☐ _____
23) MoneyPlus Spending Account Enrollment	☐ _____
24) Other. _____	☐ _____
25) Other _____	☐ _____

EMPLOYEE: _____ **(Please Print)**
Social Security No: _____ **Date of Birth:** _____
Mailing Address: _____
_____
Home Phone: (____) _____ **Email:** _____
Date of Hire: _____ **Position:** _____ **Location:** _____
I am: ☐ 1st year teacher ☐ Transfer from _____ **☐ Retiree/TERI**

AUTHORIZATION AGREEMENT
FOR ELECTRONIC DEPOSITS
McCormick County School District

☐ ADD NEW ACCT
☐ CHANGE ACCT
☐ CHANGE AMOUNT
☐ CANCEL
☐ TERMINATION

EMPLOYEE NAME _____
Last First Middle

SOCIAL SECURITY NUMBER: _____

I hereby authorize the McCormick County School District, hereinafter referred to as the District, to initiate credit entries to my checking and/or saving account(s) as identified below and to the Financial Institution named below, hereinafter referred to as the Depository, to credit the same to my account. In the event of overpayment to my account, I authorize the District to make an adjusting debit entry to my account up to the amount of the overpayment.

ACCOUNTS: If more than one account, specify amount to be credited to each account; one account may specify "remaining balance". If more than three (3) accounts, attach another sheet.

MUST ATTACH VOIDED CHECK TO THIS FORM FOR PROCESSING.

First Account: ☐ Checking Account ☐ Savings Account

FINANCIAL INSTITUTION: _____
CITY AND STATE: _____
Bank ABA Number: _____ Account Number: _____

AMOUNT OF DEPOSIT: $ _____ OR ☐ **REMAINING BALANCE**

Second Account: ☐ Checking Account ☐ Savings Account

FINANCIAL INSTITUTION: _____
CITY AND STATE: _____
Bank ABA Number: _____ Account Number: _____

AMOUNT OF DEPOSIT: $ ____ OR ☐ **REMAINING BALANCE**

Third Account: ☐ Checking Account ☐ Savings Account

FINANCIAL INSTITUTION: _____
CITY AND STATE: _____
Bank ABA Number: _____ Account Number: _____

AMOUNT OF DEPOSIT: $ ____ OR ☐ **REMAINING BALANCE**

This authority is to remain in full force and effect until the District has received written notification from me to terminate said authority. Such written notification must be received in such time and manner as to afford the District reasonable opportunity to act upon it.

Signed: _____ Dated: _____

Address: _____

_____

Form W-4 (2017)

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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total income exceeds $1,050 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 don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't 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 income, 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 2017. 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're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**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 $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 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

2017

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 2017, 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)

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		
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		9. Driver's license issued by a Canadian government authority		8. Employment authorization document issued by the Department of Homeland Security
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

You must also complete a Tobacco Certification form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTIVE EMPLOYEE NOTICE OF ELECTION (NOE)
SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
INSURANCE BENEFITS

A
See Instructions - If Completing By Hand Use Black Ink

ACTION

Select One:	Type of Change	BA Use Only	MoneyPlus Pretax Premiums
☐ New Hire ☐ Transfer ☐ Change	☐ Enrollment Other *(specify)* _____ Date of Change Event: _____	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)* Group ID #: _____ Group Name: _____	☐ Refuse ☐ Yes

Eligible due to the Affordable Care Act: ☐ Full-time nonpermanent ☐ Variable-Hour

ENROLLEE INFO

1. Soc. Sec. # (SSN) BIN #	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth MM/DD/YYYY
_____ _____					

7. Sex	8. Marital Status	9. Home Phone #	10. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated	( )	( )	

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code	18. Annual Salary	19. Date of Hire MM/DD/YYYY

MEDICARE

20. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

Name	Medicare #	Eligible Due To	Effective Date Part A MM/DD/YYYY	Effective Date Part B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

COVERAGE

21. HEALTH PLAN *(Refuse or select one plan and one level of coverage)*

PLAN ☐ Refuse ☐ TRICARE Supplement ☐ Standard ☐ Savings
Basic Life and Basic Long Term Disability included automatically with Standard and Savings plans

COVERAGE LEVEL ☐ Employee ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Family

22. STATE DENTAL PLAN *(Select One)*
☐ Refuse ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

23. DENTAL PLUS *(Select One)*
☐ Refuse ☐ Yes

24. DEPENDENT LIFE - Child(ren) *(Select One)*
☐ Refuse ☐ $15,000

25. DEPENDENT LIFE - Spouse *(Select One)*
☐ Refuse ☐ Coverage Level $_____
(Must be in increments of $10,000)

26. OPTIONAL LIFE *(Select One)*
☐ Refuse ☐ Coverage Level $_____
(Must be in increments of $10,000)

27. SUPPLEMENTAL LTD *(Select One)*
☐ Refuse
☐ Plan One - *90-day benefit waiting period*
☐ Plan Two - *180-day benefit waiting period*

28. VISION CARE *(Select One)*
☐ Refuse ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

BENEFICIARIES

In blocks 29 and 30, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.

29. Basic Life/Optional Life *(Select one or both)*	SSN#	Last Name	First Name	Relationship	Date of Birth MM/DD/YYYY	Primary or Contingent?
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent

If beneficiary is an estate or trust, complete the following:
Estate/Trust_____ Address_____ If Trust, Date Signed_____

DEPENDENTS

30. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For a child age 19-24 to be eligible for Dependent Life-Child coverage, your child must be eligible according to the requirements on the reverse of this NOE.

Add (A) or Delete (D)	Dependent SSN#	Last Name	First Name	Sex M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Special Status
	Spouse						Does PEBA Insurance Benefits already cover your spouse? ☐ Yes ☐ No
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated

CERTIFICATION & AUTHORIZATION

31. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I certify that any child enrolled in Dependent Life/Child insurance is eligible according to the requirements on the reverse of this NOE. I also understand that proof of eligibility (at the time of enrollment and at the time of the claim) will be required before any Dependent Life/Child insurance claim is paid. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period. Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. I further acknowledge that the eligibility status of any covered individual is subject to audit at any time.

AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Employee Signature _____ Date _____

32. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, this form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Phone _____ Date _____

south carolina peba
state health plan | retirement systems

Serving those who serve South Carolina

Certification regarding tobacco use

Check the appropriate box, sign and return to S.C. PEBA, 202 Arbor Lake Drive, Columbia, SC 29223.

Subscriber name:_____ Subscriber BIN/SSN: _____

Non-tobacco user premium

- ❑ I certify that I am eligible for the Non-Tobacco-User Premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:
  - I certify that all persons covered on my health insurance coverage through PEBA (including myself and any dependents) are not currently using, and have not used, any tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last six months.
  - I certify that if this information changes at any time in the future, while I have health insurance coverage through PEBA, I will notify PEBA of such change within 30 days through completion and resubmission of this form.
  - I certify that this information is true and correct to the best of my knowledge.
  - I understand that if it is determined that I (or any of my covered dependents) have used tobacco products within the last six months or if I (or any of my covered dependents) start using tobacco products subsequent to the date of this certification without notifying PEBA, I will be subject to penalties including, but not limited to, payment of premium difference since last certification plus a 10 percent penalty and elimination of tobacco user's out-of-pocket maximum for current year and subsequent year.
  - I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid.
- ❑ I certify that I am eligible for the Non-Tobacco-User Premium by checking this box and returning this form to PEBA Insurance Benefits. By checking this box, I certify truth and understanding of the following:
  - I certify that all covered individuals who use tobacco have completed the Quit for Life® smoking cessation program.
  - I certify that this information is true and correct to the best of my knowledge.
  - I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid.

Tobacco user premium

- ❑ I acknowledge that I will pay the Tobacco-User Premium by checking this box. I declare that one or more persons covered on my health insurance coverage through PEBA uses tobacco products in some form or that I choose not to disclose my status as it relates to tobacco use. I understand that by not making an election I am choosing to pay the Tobacco-User Premium. Please do not send me this certification again unless upon request.

Subscriber signature: _____ Date: _____

Benefits administrator signature:_____ Date: _____

The language used in this document does not create an employment contract between the employee and the agency. This document does not create any contractual rights or entitlements. The agency reserves the right to revise the content of this document in whole or in part. No promises or assurances, whether written or oral, which are contrary to or inconsistent with the terms of this paragraph create any contact of employment.

D H E C

PROMOTE PROTECT PROSPER

School Employee/Individual Certificate Of Evaluation For Tuberculosis

Name: Last _____ First _____ M.I. _____ Residence Address _____ City _____ County _____

Public or private school, kindergarten, nursery or day care center of current employment or other employer or individual _____ Date employed _____

TEST RESULTS

TUBERCULIN SKIN TEST _____ Date Given

5 TU PPD **MANTOUX METHOD**

_____ mm _____ Date Interpreted

CHEST X-RAY

Date

Interpretation

REMARKS

DISPOSITION

_____ No tuberculosis infection per 5 TU PPD [1]

_____ Tuberculosis infection, no evidence of disease

_____ Preventive treatment started _____ and completed _____ [1]

_____ Preventive treatment started _____ but not completed [2]

_____ Preventive treatment not prescribed/refused [2]

_____ History of tuberculosis disease Treatment started _____ and completed _____

_____ Current tuberculosis disease

_____ Non-contagious as of _____ and medically cleared to start/resume school/other employment on _____

[1] No further routine screening required. [2] Remains at lifelong risk of developing tuberculosis.

CERTIFICATION

_____ This is to certify that I have examined the school employee named herein for tuberculosis and report my findings as indicated above pursuant t the Code of Laws of South Carolina, 1976, as amended April 24, 1979.

_____ This is to certify that I have examined the individual named herein for tuberculosis and report my findings as indicated above.

_____

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.