Mississippi Valley State University

Human Resources New Hire Orientation

2015-2016

Mississippi Valley State University™

To complete the employment application process with Mississippi Valley State University, you will need to complete and submit an on-line application.

Access website, https://client.verifiedcredentials.com/mvsu to complete the employment application.

Before accessing the website, you will need to have the following information available:

1) A list of all previous residential addresses for the past 7 years
2) Employment information for the past 7 years
   (a) Company name(s), locations (city, state), dates of employment, job title, and contact numbers if available.
3) Academic information (highest degree only)
   (a) Name of school, Awarded degree, Date of graduation, location (city and state) and dates attended

Please be advised: It is critical that you provide accurate and complete information. Failure to comply may jeopardize your employment opportunity. If you do not have this information, please do not move forward past this point.

It is crucial that you provide accurate and complete information. **Once you have completed the application, you will NOT have the opportunity to adjust the date that you have provided.** Please collect all information before initiating the online application. The system is designed to time out after 30 minutes. If this occurs, you will be required to submit a new online application.

You will see symbols –" " – throughout the process. Hover over these symbols with your cursor for additional information/details.

If you have questions about the online application, please contact Verified Credentials Client Services department at 1-800-938-6090 or email clientservices@verifiedcredentials.com .

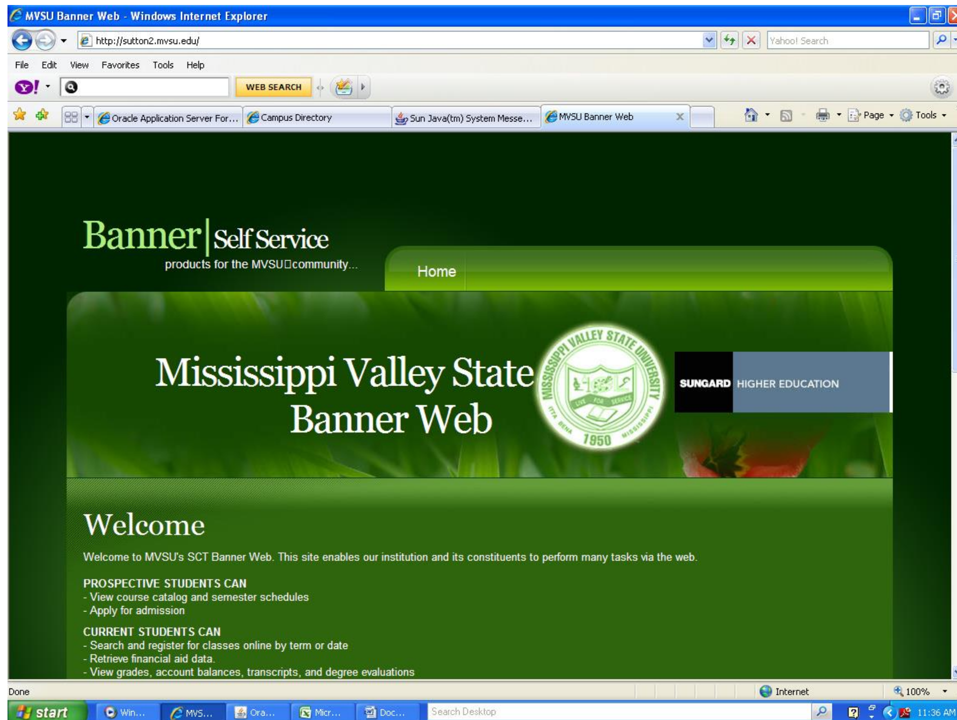
OFFICE OF HUMAN RESOURCES

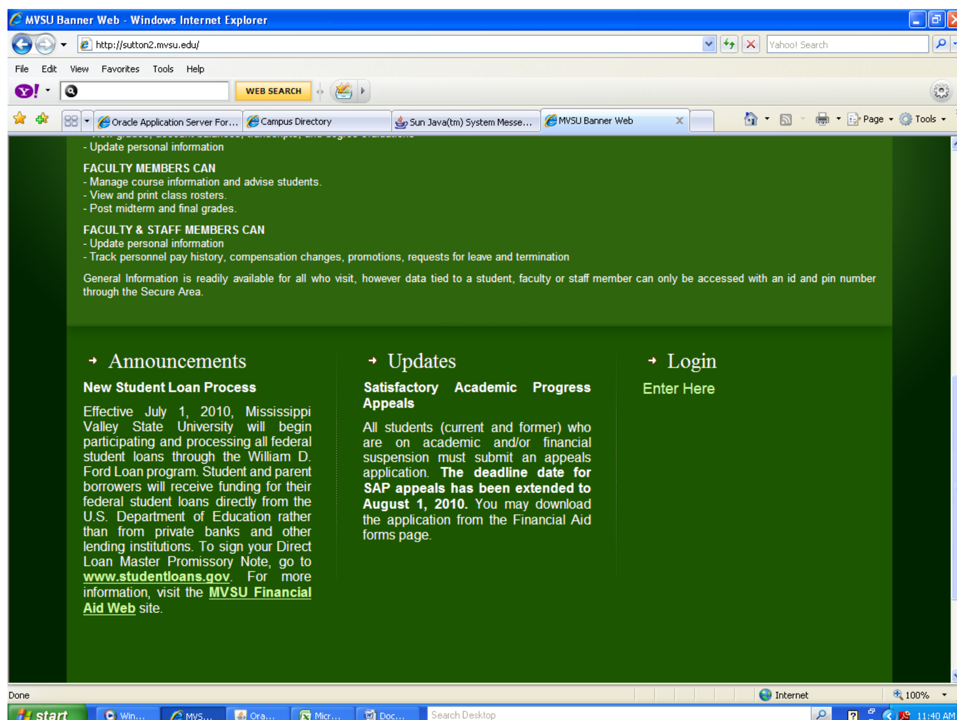
14000 HWY 82 W
BOX 7260
ITTA BENA, MS 38941-1400
(662) 254-3531
FAX (662) 254-3784
www.mvsu.edu

INSTRUCTIONS FOR ACCESSING THE CAMPUS DIRECTORY

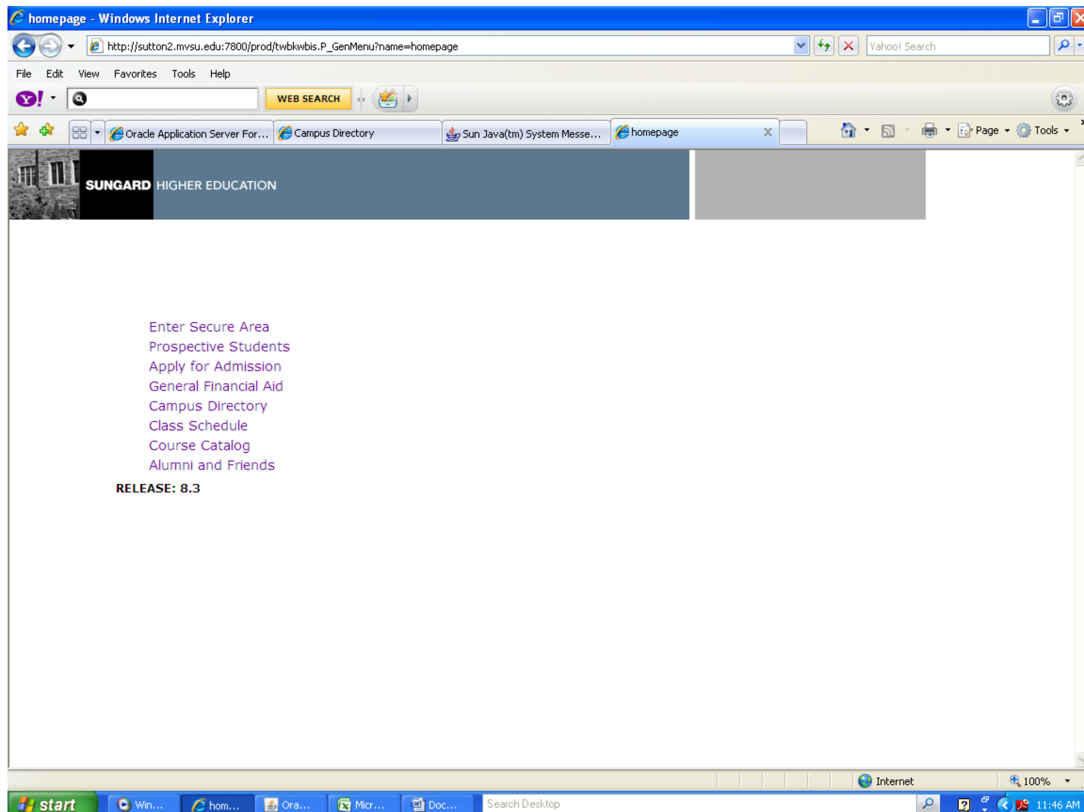
Step 1: Log on to http://sutton2.mvsu.edu

Step 2: Click on the “Enter Here” link



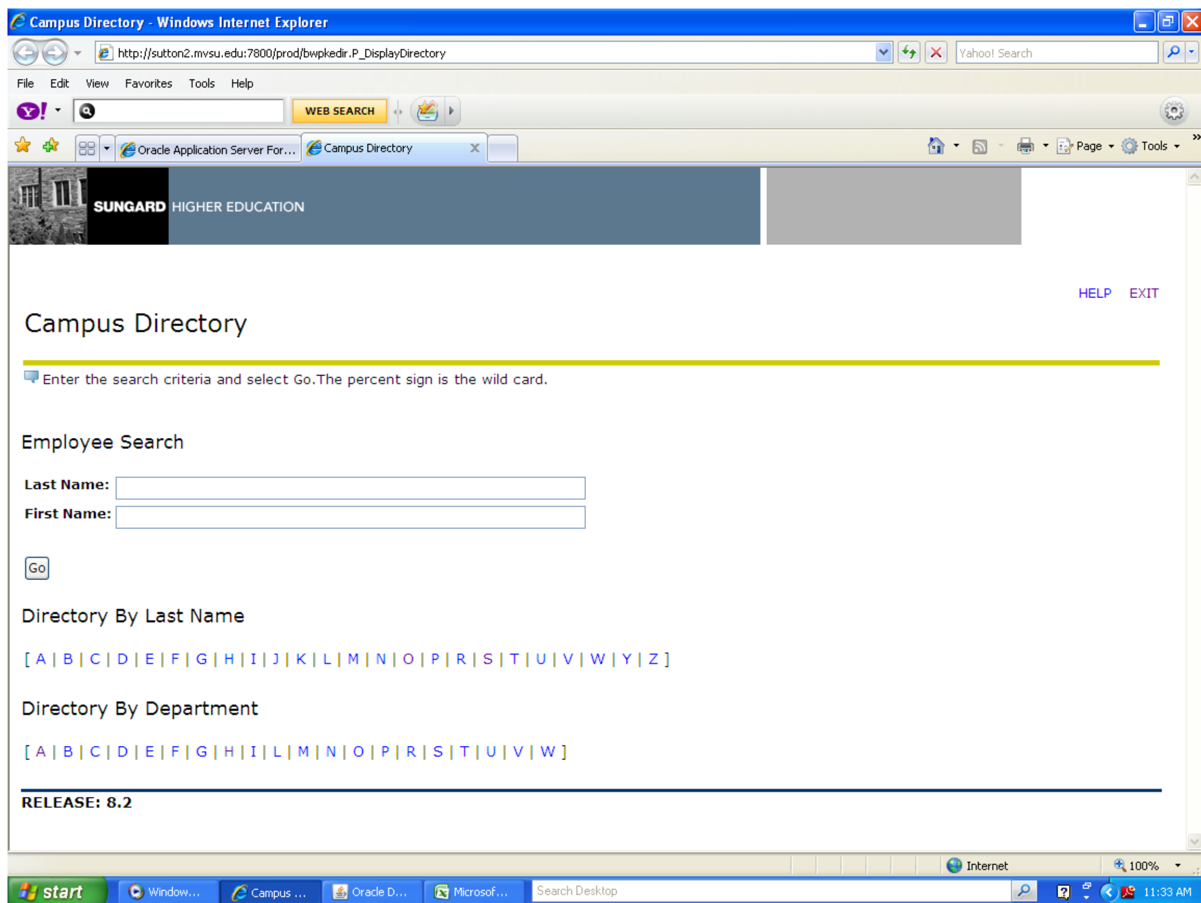


Step 3: Select "Campus Directory" from the menu



Step 4: Initiate an employee search by either typing the employee's last and/or first name, or by selecting the corresponding alphabet for "last name" or department.

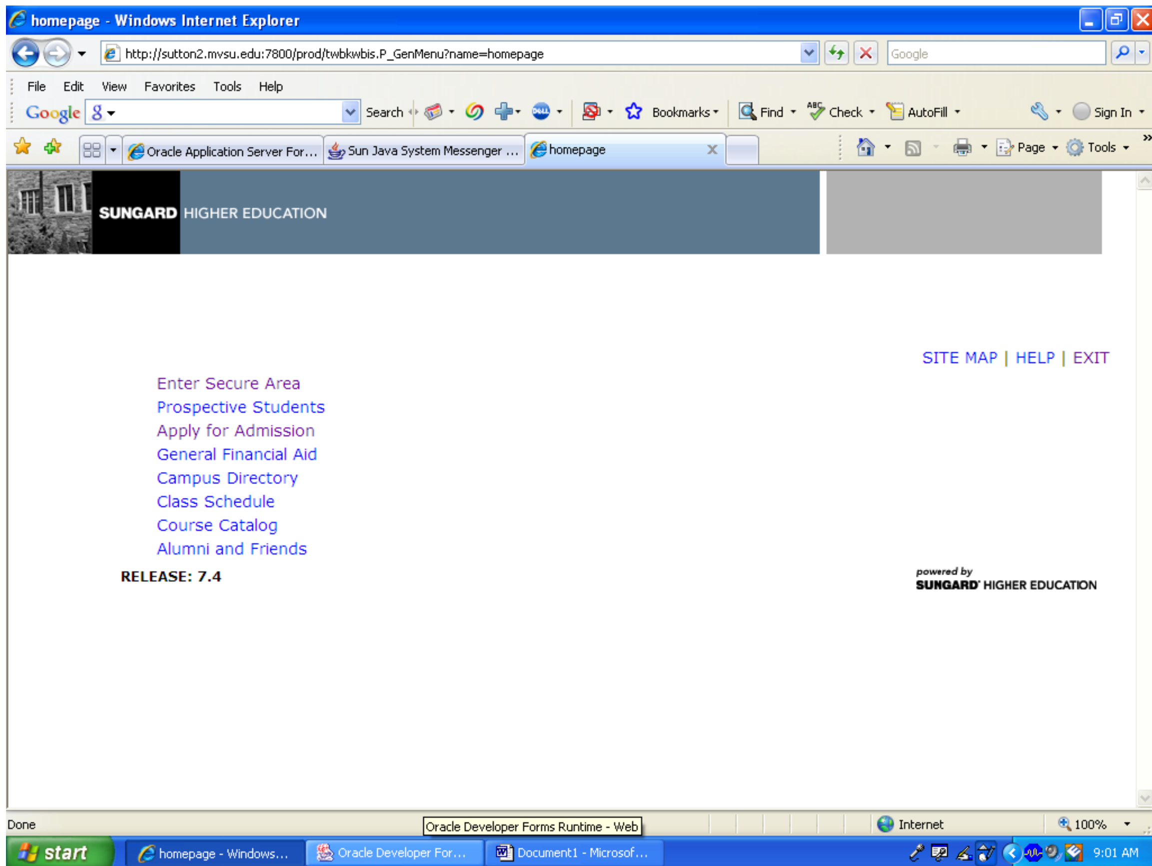
Step 5: Click the "Go" button



Instructions for Viewing Pay Stubs Online

Step 1: Go to www.sutton2.mvsu.edu and click on the "Payroll Information" link under the Faculty/Staff tab.

Step 2: Select "Enter Secure Area"



Step 3: Enter your personal security question and answer.

Verify Login - Windows Internet Explorer

http://sutton2.mvsu.edu:7800/prod/twbkwbis.P_ValLogin

SUNGARD HIGHER EDUCATION

Search Go

SITE MAP HELP EXIT

Login Verification Security Question and Answer

If you ever forget your PIN, you can reset it yourself, without calling for assistance.

Enter your personal Security Question, along with the Answer. This will enable you to reset your PIN and gain access to your information. To help you to remember your answer, keep it short, limit spaces, and do not use special characters. Your answer is limited to 30 characters.

Enter Question:

Answer:

Submit

RELEASE: 7.4

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Once you have completed all parts of the initial setup, please proceed to Step 4.

Step 4: Enter your user id #:
Enter your pin #:

Please contact Tamara Verdell in Human Resources at ext 3531 if you have not been assigned a user id and pin #.

User Login - Windows Internet Explorer

http://sutton2.mvsu.edu:7800/prod/twbkwbis.P_WWWLogin

File Edit View Favorites Tools Help

SUNGARD HIGHER EDUCATION

Search Go

SITE MAP HELP EXIT

User Login

Please enter your user Identification Number (ID) and your Personal Identification Number (PIN). When finished, click Login.

When you are finished, please Exit and close your browser to protect your privacy.

User ID:

PIN:

Login Forgot PIN?

RELEASE: 7.4

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Step 5: Select "Employee"

Main Menu - Windows Internet Explorer

http://sutton2.mvsu.edu:7800/prod/twbkwbis.P_GenMenu?name=bmenu.P_MainMnu&msg=WELCOME+<b>Welcome,+Tam

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Personal Information | Employee | Finance

Search [Go] SITE MAP HELP EXIT

Welcome, Tamara L. Verdell, to the MVSU Information System! Last web access on Feb 16, 2009 at 08:55 am

Employee
Time sheets, time off, benefits, leave or job data, paystubs, W2 and T4 forms,W4 data.

View or update your address(es), phone number(s), e-mail address(es), emergency contact information, & marital status; View name change & social security number change information; Change your PIN; Customize your directory profile .

Finance
Query, Update or View Budgets

Return to Homepage

RELEASE: 7.3

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Step 6: Select "Pay Information"

Employee Main Menu - Windows Internet Explorer

http://sutton2.mvsu.edu:7800/prod/twbkwbis.P_GenMenu?name=pmenu.P_MainMnu

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Personal Information | Employee | Finance

Search [Go]

RETURN TO MENU SITE MAP HELP EXIT

Time Sheet
Request Time Off
Benefits and Deductions
Update or view your retirement plans, Health insurance information, Flex spending accounts, miscellaneous deductions; Change your beneficiary information; Access open enrollment.
Pay Information
View your Direct Deposit breakdown; View your Earnings and Deductions History; View your Pay Stubs.
Tax Forms
Change W-4 information; View your W-2 Form or T4 Form.
Current and Past Jobs
Time Off Current Balances and History

RELEASE: 7.3.3

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Step 7: Select "Pay Stub"

SCT WWW Information System - Windows Internet Explorer

http://sutton2.mvsu.edu:7800/prod/twbkwbis.P_GenMenu?name=pmenu.P_PayMenu

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Personal Information | Employee | Finance

Search [Go]

RETURN TO MENU SITE MAP HELP EXIT

Direct Deposit Breakdown
Earnings History
Pay Stub
Deductions History

RELEASE: 7.3.3

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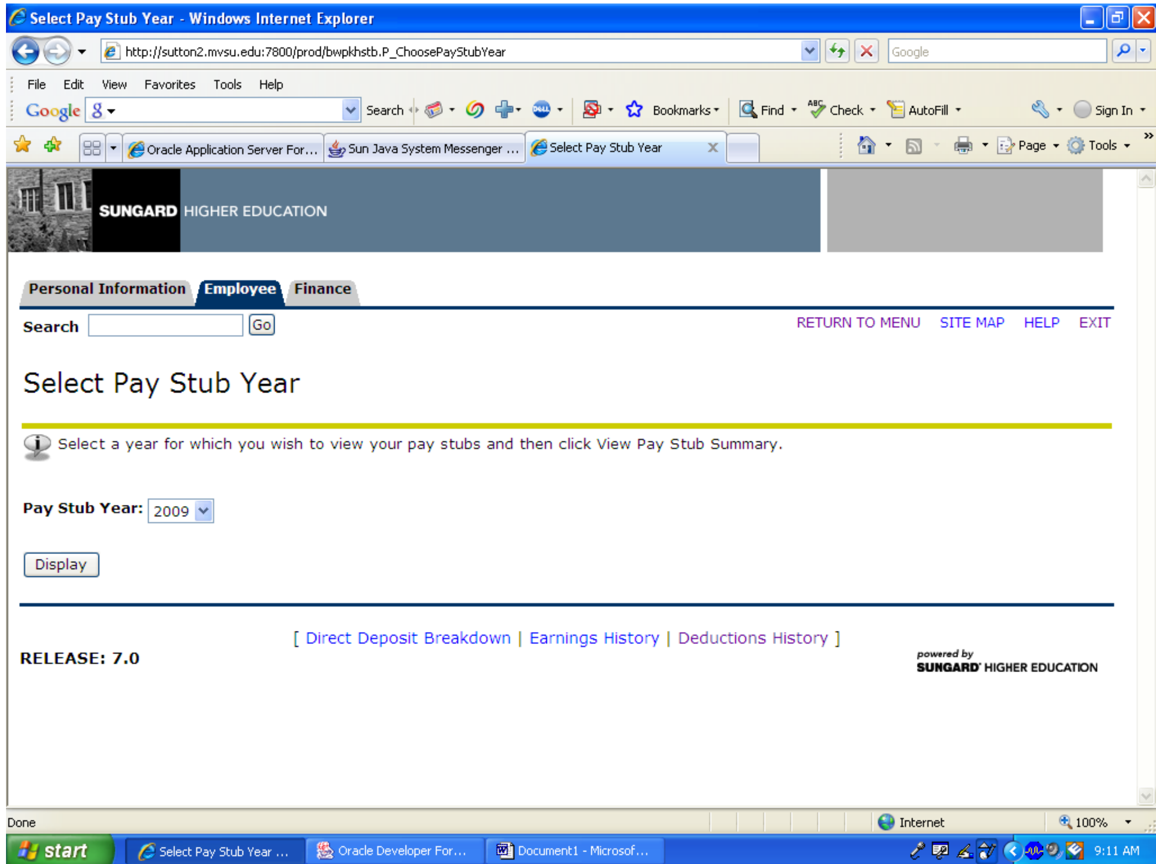
Step 8: Select the desired pay stub year and click "Display"

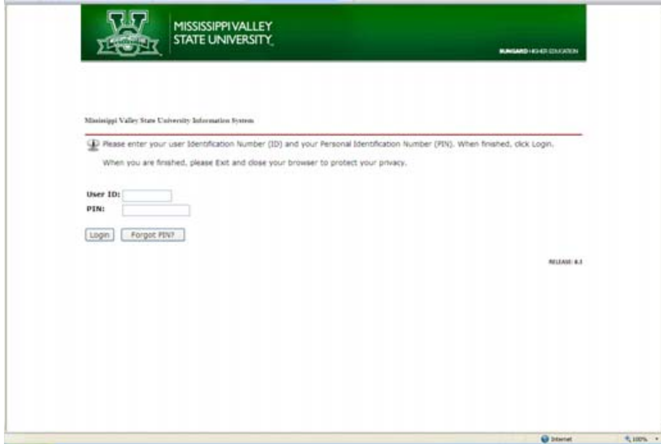


Step 9: Select the pay stub date of your choice from the 'View Pay Stub Summary" page to view your paystub.

UPDATE YOUR DIRECTORY ADDRESS
USING BANNER SELF-SERVE

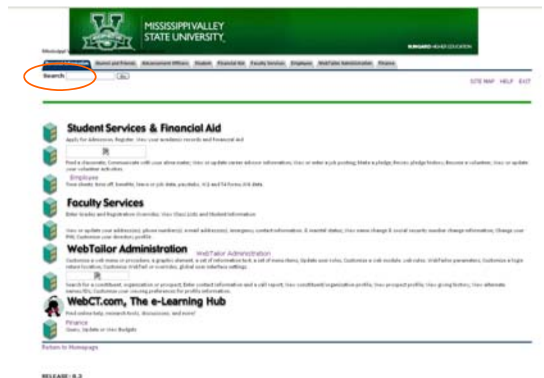
LOGIN **to Banner Self-Service**

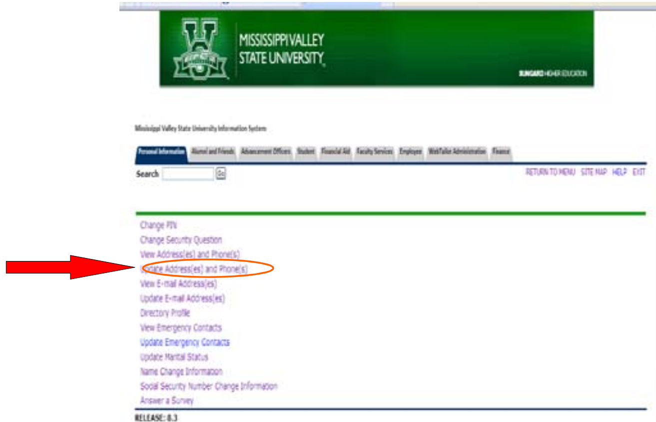
1. Navigate your web browser to http://sutton2.mvsu.edu
2. Click Enter here
3. **Login using your University ID number and Pin**



ADD Office Address Field

1. Click the **PERSONAL INFORMATION** tab
2. Click **UPDATE ADDRESS(ES) AND PHONE(S)** link





3. Choose **OFFICE / DEPARTMENT** in the Type of Address to Insert: Drop down box at the bottom of the page

UPDATE Office Address

You are here: Update Address(es) and Phone(s) - Update/Insert Page

Fill in the following fields

Field	Data
Valid From This Date:	Today's Date
Address Line 1: Address Line 2: Address Line 3: Address Line 4:	Full name of Building Suite #, Office # (Department's Box Number) 14000 HWY 82 W # 0000
If no Suite	
Address Line 1: Address Line 2: Address Line 3: Address Line 4:	Full name of Building Office # (Department's Box Number) 14000 HWY 82 W # 0000
If no actual Office #	
Address Line 1: Address Line 2: Address Line 3: Address Line 4:	Full name of Building (Department's Box Number) 14000 HWY 82 W # 0000
City:	Itta Bena
State or Province:	MS
ZIP or Postal Code:	38941
Primary Phone Number For This Address:	
ADD the following phone types **Office** **xxxFax**	 Your direct line. The phone number at your desk The main office's fax number.

Example 1 Suite & Office

Example 2 No Suite

Example 3 Building Only

SUBMIT Click Submit

UPDATE Email Address

1. Click the **PERSONAL INFORMATION** tab
2. Click **UPDATE E-MAIL ADDRESS(ES)**
3. *Note: We are using Work Email 1 in the directory, therefore,*
4. If Work Email 1 is listed,
   a. EDIT Work Email1
      (1) Click the email address
      (2) Make the necessary changes.
      (3) **Click Submit**

   Note: Please use your campus email address in this field.
5. If Work Email 1 is **NOT** listed
   b. ADD Work Email1
      (1) Choose Work Email 1 form drop down list
      (2) Insert the necessary changes.
      (3) Click Submit

To include other email addresses choose the email type from the list and insert the information.

DISPLAY Directory Profile

To display the new or edited address information on your Directory Profile,

1. Click the PERSONAL INFORMATION tab

2. Click DIRECTORY PROFILE link

3. Click the YES CHECK BOX in the DISPLAY IN DIRECTORY column for the Office address,
Office phone number,
Office Fax number and Email address(es) you would like to appear on your profile.

Click Submit Changes

VIEW **Directory Listing**

1. **Click Exit**
2. **Click Return to Banner Self-Service Homepage**
3. **Click Campus Directory**
4. **Search for your name.**

Mississippi Valley State University

Human Resources New Hire Benefits

2015-2016

White – Human Resources
Yellow- Employee
Pink – Payroll

Fiscal Year ________
Prorated: Yes ___ No ___
Bi-weekly: Yes ___ No ___

Mississippi Valley State University
BENEFIT DEDUCTION FORM

NAME: ______________________ Employee Number: ____________ Department: ____________________

Date: ______/________/________ Hire Date: ____________ 12 Mo. ____ 10 Mo. ____ 9 Mo. ____

The deductions listed below will start and/or be cancelled from my payroll check as indicated by the check mark. I understand that a new form must be completed for any changes made.

GROUP INSURANCES	Start Deduction (Date)	Amount to be Deducted	Amount to be Cancelled	Date Processed In Banner	CAFÉ. Plan
Health Insurance - Blue Cross Blue Shield of MS ___Legacy ___Horizon ___Select Coverage ___Base Coverage					
Life - Minnesota Life Insurance LFE-LIF-I5O					
Dental Insurance - Delta Dental Inc. or Brokers National					
Vision Insurance - EyeMed Vision Care					
Supplemental Insurances					
American Fidelity					
Accident "AFA" pretax					
Cancer "AFP" pretax					
Disability "AF" post tax					
Flex Spending ___Dependent Care "FSD" ___Healthcare "FSH"					
GAP "AFG" pretax					
Life "AFL" post tax					
AFLAC					
Accident					
Cancer					
Hospital					
Life					
Cigna Life Insurance					
Tax Sheltered Annuities (TSAs)					
American Express "AET"					
American Fidelity "AFT"					
Equitable Life "ELT"					
ING "INT"					
TIAA CREF "TCT"					
VALIC "VAT"					
Mississippi Deferred Compensation "DCT"					
Other					

Employee Signature ______________ Date ________ Human Resources ______________ Date ________

I hereby apply for the options listed above. I authorize MVSU to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until January 1 of each year, unless I experience a Life Status Change as defined in the Cafeteria Plan document (i.e. marriage, divorce, birth, etc.). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with the current plan provisions and tax laws.

Summary of Benefits

Mississippi Valley State University is proud to provide eligible employees a comprehensive benefit package which includes the following:

- **PAID HOLIDAYS** (Provided by Mississippi Valley State University)

Dr. Martin Luther King's Birthday
Good Friday
Memorial Day
Independence Day
Labor Day
Thanksgiving Day and Friday after Thanksgiving
Christmas Break (the length of Christmas break varies from year to year as determined by the President)
New Years Day

- **PERSONAL LEAVE**

Continuous Service	Accrual Rate (Monthly)	Accrual Rate (Annually)
1 month to 36 months (3 years)	12 hours per month	18 days per year
37 to 96 months (8 years)	14 hours per month	21 days per year
97 to 180 months (15 years)	16 hours per month	24 days per year
Over 15 years	18 hours per month	27 days per year

- **MAJOR MEDICAL LEAVE**

Continuous Service	Accrual Rate (Monthly)	Accrual Rate (Annually)	9-month Employees Accrual Rate
1 month to 36 months (3 years)	8 hours per month	12 days per year	13.33 hours per month
37 to 96 months (8 years)	7 hours per month	10.5 days per year	14.20 hours per month
97 to 180 months (15 years)	6 hours per month	9 days per year	15.40 hours per month
Over 15 years	5 hours per month	7.5 days per year	16 hours per month

Note: Personal and Major medical leave balances carry over from year to year. Major medical leave may be used for illness or injury of an employee or member of the employee's immediate family, only after the employee has used (1) day of accrued personal or compensatory leave for each absence due to illness, or leave without pay if the employee has no accrued personal or compensatory leave. Major medical leave may be used, without prior use of personal leave, to cover regularly scheduled visits to a doctor's office or a hospital for the continuing treatment of a chronic disease, as certified in advance by a physician.

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
Effective January 1, 2016

Legacy - Initially hired before 1/1/2006
Horizon - Initially hired on or after 1/1/2006

	LEGACY EMPLOYEES				HORIZON EMPLOYEES			
	BASE		SELECT		BASE		SELECT	
ACTIVE EMPLOYEE	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	$356	$0	$376	$20	$356	$0	$394	$38
Employee + Spouse	$745	$389	$819	$463	$745	$389	$837	$481
Employee + Spouse & Child(ren)	$949	$593	$1,023	$667	$949	$593	$1,041	$685
Employee + Child	$457	$101	$531	$175	$457	$101	$549	$193
Employee + Children	$612	$258	$688	$332	$614	$258	$706	$350

***The State pays 100% of the employee's premium for Base Coverage. Active employees enrolling in Select Coverage must pay a portion of the employee premium.**

	LEGACY RETIREES		HORIZON RETIREES	
RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	BASE	SELECT	BASE	SELECT
Retiree	$409	$432	$597	$620
Retiree + Spouse (Non-Medicare)	$856	$941	$1,232	$1,317
Retiree + Spouse & Child(ren) (Non-Medicare)	$1,091	$1,176	$1,387	$1,472
Retiree + Child	$525	$587	$690	$775
Retiree + Children	$706	$744	$847	$932
Retiree + Spouse (Medicare)	N/A	$612	N/A	$800
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$767	N/A	$955
RETIRED EMPLOYEE - MEDICARE ELIGIBLE	BASE	SELECT	BASE	SELECT
Retiree	N/A	$180	N/A	$180
Retiree + Spouse (Non-Medicare)	N/A	$689	N/A	$877
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	$924	N/A	$1,032
Retiree + Child	N/A	$335	N/A	$335
Retiree + Children	N/A	$492	N/A	$492
Retiree + Spouse (Medicare)	N/A	$360	N/A	$360
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$515	N/A	$515
RETIRED NON-MEDICARE MARRIED TO ACTIVE	BASE	SELECT	BASE	SELECT
Retiree	$409	$432	$409	$432
Retiree + Child	$510	$587	$510	$587
Retiree + Children	$667	$744	$667	$744

	LEGACY		HORIZON	
COBRA	BASE	SELECT	BASE	SELECT
Participant	$363	$383	$363	$401
Participant + Spouse	$759	$835	$759	$853
Participant + Spouse & Child(ren)	$967	$1,043	$967	$1,061
Participant + Child	$466	$541	$466	$559
Participant + Children	$626	$701	$626	$720
COBRA DISABILITY EXTENSION	BASE	SELECT	BASE	SELECT
Participant	$534	$564	$534	$591
Participant + Spouse	$1,117	$1,228	$1,117	$1,255
Participant + Spouse & Child(ren)	$1,423	$1,534	$1,423	$1,561
Participant + Child	$685	$796	$685	$823
Participant + Children	$921	$1,032	$921	$1,059

- **BEREAVEMENT**

An employee may use up to three (3) days of earned major medical leave for each occurrence of death in the immediate family requiring an employee's absence from work. No qualifying time or use of personal leave is required prior to use of major medical leave for this purpose. Immediate family for the purpose of this policy includes; spouse, parent, step-parent, sibling, child, step-child, grandchild, grandparent, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law. MVSU requires documentation such as an obituary or newspaper death notice, to validate this type of major medical leave.

- **HEALTH INSURANCE**

State and Public School's Health Insurance Plan

BlueCross BlueShield of Mississippi

The state and public school's health insurance plan is provided through Blue Cross Blue Shield of Mississippi. The Plan provides two types of coverage from which active employees, COBRA participants, non-Medicare eligible retirees, and non-Medicare eligible surviving spouses can choose: Base Coverage and Select Coverage. Each coverage option will provide the same health coverage, but have some differences. To list some of the differences include: monthly premiums, calendar year deductibles, maximum out-of-pocket expenses, and pharmacy deductibles. Additional details concerning the health insurance plan can be found in Plan Document located on the State Health & Life Plans website @ http://knowyourbenefits.dfa.state.ms.us.

The University pays the entire premium for Legacy/Horizon employees' coverage when enrolled in "Base coverage." All employees enrolled in Select Coverage pay a portion of their active employee premium.

- Horizon Employees pay $38 per month for employee only coverage.
- Legacy Employees pay $20 per month for employee only coverage.

If any participant elect to have dependent coverage, he/she is totally responsible for payment of premiums. **See rates listed below**.

- **Legacy Employees** refers to all current employees hired prior to January 1, 2006 or newly hired after January 1, 2006 who have been employed full-time by any State or Mississippi agency covered by the Plan (for example: public library, public school district, community/junior colleges, or other State agency or university).
- **Horizon Employees** refers to any employees initially hired at any State agency on or after January 1, 2006
- **Coverage Effective Date** is effective the first date of employment if coverage is elected within the first 31 days of hire. Anyone who fails to elect coverage within specified time frame will have to apply during the next Open Enrollment period. See Plan Document for any exceptions to this rule for allowing special enrollment period.

Motivating Mississippi - Keys to Living Healthy
Motivating Mississippi is the Plan's wellness and health promotion program. Through this program, participants can volunteer to complete a HealthQuotientSM (HQ) health risk assessment and receive a personalized wellness plan, access to lifestyle management programs, and access to personal wellness coaches. These services are provided at no additional charge to the participant. All adult participants age 18 and older are eligible for wellness benefits. These services are not subject to the calendar year deductible. The HQ can be found at www.webmdhealth.com/mississippi or may be accessed through a link on the Plan's website at http://knowyourbenefits.dfa.state.ms.us.

Prescription Drug Program
The plan includes a co-payment program for prescription drugs. An enrollee must elect health insurance coverage in order to participate in the prescription drug program. Refer to the Plan Document for information on Base and Select Coverage deductibles, Co-payments, Mail Order Service, Generic Drugs, Preferred Brand Drugs, etc. located in the Plan Document at http://knowyourbenefits.dfa.state.ms.us.

To be covered under the Plan, prescription drugs must be prescribed by a physician, dispensed by a licensed pharmacist, and found to be medically necessary for the treatment of the participant's illness or injury. Participants may purchase medically necessary prescription drugs at participating retail pharmacies, through the Catalyst Rx mail order service, or through the dedicated specialty pharmacy program. Coverage for prescription drugs purchased at a retail pharmacy or through the mail order service is limited to a 90-day supply. Coverage for prescription drugs purchased through the specialty pharmacy program is limited to a 30-day supply. When a prescription drug is purchased at a participating retail pharmacy, the participant is only required to pay the appropriate co-payment amount (after the applicable deductible is met) or the cost of the drug, whichever is less. There is no claim form to file. When a prescription drug is purchased at a non-participating pharmacy, the participant must file a claim with Catalyst Rx. Payment of the claim will be made based upon the Plan's allowable charge. The participant is responsible for any amount in excess of the allowable charge, plus the applicable deductible and/or co-payment.

- **LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (ADD) INSURANCE**

  Effective January 1, 2009, Minnesota Life Insurance Company is the carrier for the State and School Employees' Life Insurance Plan. MVSU offers life and ADD insurance at 2 times the employees' annual salary from a minimum of $30,000.00 to a maximum of $100,000.00. The cost of the premium is shared equally (50/50) between MVSU and the employee.

Your Plan at a Glance (Active Employees)

Coverage type	Coverage	Additional Information
Employee Group Term Life	200% of your basic annual earnings rounded to the next higher $1,000	• Minimum coverage is $30,000 • Maximum coverage is $100,000 • Evidence of insurability is required if the coverage is elected outside of initial eligibility • Coverage increases due to changes in annual earnings are guaranteed to the plan maximum
Accidental Death & Dismemberment (AD&D)	200% of your basic annual earnings rounded to the next higher $1,000	• AD&D coverage terminates at retirement • For more information about the schedule of benefits, please review the Your Group Plan booklet

Service Retirees

Coverage type	Coverage options	Additional Information
Retiree Group Term Life	Retired prior to July 1, 1999 • $2,000, $4,000 or $10,000 Retired on or after July 1, 1999 • $5,000, $10,000 or $20,000	

- **DENTAL INSURANCE AND VISION INSURANCE**

Optional dental insurance and vision insurance plans, with the premium paid by the employee, are available for those who desire the coverage. Employees who elect the coverage may pay the full premium by payroll deduction, and may insure a spouse and dependent children from birth to 26 years of age, if a full time student.

Delta Dental Incorporated
www.deltadentalins.com

This dental insurance program allows employees the freedom to visit any licensed dentist of choice; however, there are advantages to visiting a Delta Dental PPO network dentist instead of an out-of-network dentist. The plan includes employee only and dependent coverage. Two options are available to employees with this dental plan: low option and high option. Both options offer similar benefits for diagnostic/preventive, basic and major services. Assigned co-insurance, annual limits, and monthly premiums will vary depending on the option elected. The employee is responsible for 100% of the premium for coverage in this plan.

High Plan Option

Employee Only	$22.85
Employee + One Dependent	$44.50
Employee + 2 or more Dependents	$65.56

Low Plan Option

Employee Only	$14.41
Employee + One Dependent	$28.06
Employee + 2 or more Dependents	$41.31

Vision Insurance –EyeMed Vision Care
www.eyemedvisioncare.com

EyeMed Vision Care's Network consists of private practicing optometrist, ophthalmologist, opticians, and optical retailers such as LensCrafters, Pearle Vision, Sears Optical, Target Optical and JC Penny Optical. The plan coverage includes expenses related to eye exams, lens with frames (including single, bifocals or trifocal) and contact lenses at pre-determined rates. The plan includes employee only and dependent coverage. The employee is responsible for 100% of the premium.

Premiums

Subscriber amount .... $ 6.70
Subscriber and Family $17.08

- **RETIREMENT PLAN**

Public Employees Retirement System of Mississippi (PERS) is the retirement plan offered by Mississippi Valley State University. PERS is a governmental defined benefit plan qualified under Section 401(a) of the Internal Revenue Code. A defined benefit plan determines a member's retirement benefit using a formula based on the member's average compensation, years of creditable service, and the benefit payment option selected at retirement. As a participant, employees contribute 9.00% of gross income (income before taxes are deducted) and MVSU contributes 12.93% of the employees' gross income into the retirement plan. Effective July 1, 2013, employer contribution will increase from 14.26% to 15.75%: Employee contributions are not taxable for income tax purposes until they are either withdrawn as a refund or monthly benefits. There is a penalty for early withdrawal from the retirement plan. However, employees are not fully vested at 100% until after four or eight years of continuous service depending on hired date. Vesting means the extent to which an employee and your beneficiaries are entitled to contributions in their retirement plan. In addition, PERS offer disability and survivor protection. The retirement plan is available online: www.pers.state.ms.us

Membership: Mandatory

- To become a member, one must be employed as a regular employee whose employment is anticipated to exceed **four and one-half** consecutive months.
- Perform services and receive compensation for **20 hours or more per week or 80 hours per month,** or in the case of contract school personnel, one must perform services and receive compensation for **half-time or more for the academic year.**

Eligibility: Ways to Retire

- Age 60 (as long as vested)
  - Hired on or before June 30, 2007 requires 4 year vesting period
  - Hired July 1, 2007 or later requires 8 year vesting period

- Appropriate years of service, regardless of age
  - Hired June 30, 2011 or earlier requires 25 years of service
  - Hired July 1, 2011 or later requires 30 years of service

- If one become disabled before age 60 and must be vested
- Or from the first day of a work-related disability

Options on leaving University: There are no provisions for loans, partial refunds, or hardship withdrawals from membership contributions.

- **Refund of Contribution is permitted upon termination; however, one will receive only your contributions and interest less 20% to be withheld for federal taxes from the taxable portion and 10% early withdrawal before age of 55. Refund will be issued but no later than 90 calendar days from date of termination.**
- **Rollover (One can move money directly to another qualified retirement account)**
- **Leave Contributions with PERS (One can retain their rights to a lifetime retirement benefit when one meets eligibility requirements and retain rights to survivor benefits, if eligible). If one goes to work for another state agency-funds must be left in PERS until retirement.**

- **OPTIONAL RETIREMENT PLAN**

Prior to July 1, 1990, all eligible employees of the Institutions of Higher Learning were covered under PERS; however, in the 1990 Legislative session, the Institutions of Higher Learning (IHL) were instrumental in getting House Bill 1070 passed which made an optional retirement plan available to the IHL teaching and administrative faculty. The Optional Retirement Plan (ORP) is a governmental defined contribution plan qualified under Section 401(a) of the Internal Revenue Code. This alternative plan is structured so as to be portable and transferable as teaching and administrative staff move from one state to another.

In order to participate in the Optional Retirement Plan, an employee must first be eligible to participate in PERS. Therefore, the individual must first be in a covered position. If initially employed in a qualifying position after July 1, 1990, an eligible employee has the option to elect to participate in the Optional Retirement Plan. This option is only available during the first 30 days of employment. If no election is made during that period of time, the employee automatically becomes a member of PERS. The decision is then irrevocable. Information on the three ORP retirement plans is included in the new employee orientation packet. It is also available in the Human Resource department. **Remember that you must act within 30 days of employment. If you take no action, you will automatically become a member of PERS.**

If one choose to enroll in the Optional Retirement Plan, your member account will consist of your contributions of 9.00% and employer contributions of 15.75% (13.1175% to individuals fund and 2.6325% goes to PERS to fund the unfunded accrued liability and is never a benefit to the employee. Your account will be 100% vested on day one. http://www.orp.state.ms.us/

Eligibility: Teaching Faculty, Administrative Faculty, Coaches, Librarians with Academic Rank, Administrative Directors of Recognized departments, Research Scientist, and Post Doctoral Fellows

Investment Vehicles

ING Website
ING Performance High Service Model
ING Performance Low Service Model
ING Investment Management & Expense Information

TIAA-CREF Website
TIAA-CREF Performance
TIAA-CREF Investment Management and Expense Information

VALIC Website

VALIC Performance
VALIC Investment Management and Expense Information

STATE DEFERRED COMPENSATION PROGRAM

http://www.pers.state.ms.us/

The Mississippi Deferred Compensation Plan & Trust (MDCPT), offered through the Mississippi Public Employees' Retirement System (PERS), is a supplemental retirement savings plan authorized under Section 457 of the Internal Revenue Code and enacted by the Mississippi State Legislature. Participation in the Plan is available to all state employees, elected officials, and employees of participating political subdivisions and independent contractors of the State or its participating political subdivisions. The MDCPT provides you with an opportunity to reduce your current taxes while investing in a variety of investment options to save for your future retirement needs.

Employees interested in this program should contact the Office of Human Resources or the Public Employees Retirement System for details.

FLEXIBLE BENEFITS/CAFETERIA PLAN

The university has a flexible/cafeteria plan which was established under provisions of Section 125 of the Internal Revenue Code. The Cafeteria Plan allows employees to pay certain insurance premiums, major un-reimbursed medical expenses before tax rather than after tax dollars. Employees may choose to participate in the plan at the time of employment or at the annual enrollment that is held in October each year.

Employees who choose to participate in the Flexible Benefits/Cafeteria Plan must agree to remain in the plan for the plan year (January 1through December 31). The only exception to this rule involves having a major change in family status such as employment, marriage, divorce, death, or ineligible dependents.

TAX-SHELTERED ANNUITIES

Employees of the University are eligible to participate in a Tax-Sheltered annuity plan provided by Section 403 (b) of the Internal Revenue Code of 1954, as mended. The amount of annuities that an employee may authorize the university to purchase for him/her in lieu of a portion of which salary otherwise payable directly to him/her is determined by a formula prescribe by the Internal Revenue Code and Regulations.

The amount of such annuity premiums is not reported annually as taxable income on the employee's Form W-2, and payment of Federal/State income tax on these funds is not required until the annuity contract matures, is canceled, or is determined to be taxable under the regulations.

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 servicemember 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.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 • Revised February 2013

MISSISSIPPI VALLEY STATE UNIVERSITY

FAMILY AND MEDICAL LEAVE ACT NOTICES

VERIFICATION OF RECEIPT

By signing below, I verify that I have received a copy of the Employee Rights and Responsibilities Under the Family and Medical Leave Act.

____

Receipt

____

Date

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Mississippi Valley State University, Office of Human Resources, MVSU7260, Itta Bena, MS 38941 (662)254-3531.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Mississippi Valley State University		4. Employer Identification Number (EIN) 64-6001395
5. Employer address MVSU 7260, 14000 Highway 82W		6. Employer phone number (662) 254-3531
7. City Itta Bena	8. State MS	9. ZIP code 38941
10. Who can we contact about employee health coverage at this job? Office of Human Resources, Benefits Office		
11. Phone number (if different from above)	12. Email address dgbanks@mvsu.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    A full-time employee who receives compensation directly from the university. An employee making contributions to a retirement plan approved by the Mississippi Public Employees Retirement System is considered a full-time employee.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    The employee's legal spouse as defined by Mississippi law, unless the spouse is also an eligible employee under the Plan. The employee's natural child, stepchild, legally adopted child, foster child, child placed in the employee's home in anticipation of adoption, child for whom the employee is legal guardian, child for whom the employee has legal custody, or child of the employee who is required to be covered by reason of Qualifi
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☑ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_______________ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $0
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☑ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_______________
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_______________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

MISSISSIPPI VALLEY STATE UNIVERSITY

AFFORDABLE CARE ACT NOTICES

VERIFICATION OF RECEIPT

By signing below, I verify that I have received a copy of the Health Insurance Exchange Notice Requirements for Employers.

____

Receipt

____

Date

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

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

Employer Name			

Social Security Number	First Name	MI	Last Name
Home Address		City	State / ZIP
Primary Telephone Number	Secondary Telephone Number	Personal Email Address	
Marital Status ❑ Single ❑ Married	Gender ❑ Male ❑ Female	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement

Were you ever a full-time employee of a covered entity under the 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 Plan participant? ☐ Yes ☐ No If yes, Spouse Name and SSN: ____________________

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 policy, 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		Medicare Number: ____________
❑ Employee - Horizon	❑ Enrollee + Spouse	❑ Select	❑ "A" Effective Date: ____________
❑ Retiree	❑ Enrollee + Child	OR	❑ "B" Effective Date: ____________
❑ COBRA	❑ Enrollee + Children	❑ Base (HIGH DEDUCTIBLE)	Reason for Entitlement:
❑ Surviving Spouse	❑ Enrollee + Spouse & Child(ren)		❑ Age ❑ ESRD ❑ Disability

Are you a tobacco user? ☐ Yes ☐ No If yes, are you interested in participating in the Plan's free cessation program? ☐ Yes ☐ No

Section D: Other Coverage Information

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

	1.	2.	3.	4.
Name of Individual Covered:	______	______	______	______
Policyholder's Name:	______	______	______	______
Policyholder's Date of Birth:	______	______	______	______
Policyholder's Insurance Effective Date:	______	______	______	______
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 (mm/dd/yyyy)	Address (if different from Enrollee)	Current Status
1.	Spouse ❑ Male ❑ Female				Employed? ❑ Yes ❑ No
2.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
3.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
4.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled

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

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason

Section F: Change Information

❑ **Add Enrollee**: ❑ Open Enrollment ❑ Marriage ❑ Birth ❑ Adoption ❑ Loss of Coverage due to Divorce
❑ Other: ____________ Requested Effective Date: ____________

❑ **Add Dependent(s)**: ❑ Open Enrollment ❑ Marriage ❑ Birth ❑ Adoption ❑ Other: ____________
(List all dependents in Section E.) Qualifying Event/ Effective Date: ____________

❑ **Change Coverage:** ❑ Base Coverage ❑ Select Coverage

❑ **Drop Dependent(s)**: ❑ Divorce ❑ Deceased ❑ Other: ____________
Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date

❑ **Other Changes** (Explain):

FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER: ____________
❑ New Legacy Employee, Requested Effective Date: ____________
❑ New Horizon Employee, Requested Effective Date: ____________
❑ Retiree, Requested Effective Date: ____________
❑ COBRA, Requested Effective Date: ____________
❑ Surviving Spouse, Requested Effective Date: ____________
❑ Change(s), Requested Effective Date: ____________

ENTERED BY: ____________
DATE: ____________

VERIFIED BY: ____________
DATE: ____________

MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
Tobacco Use Attestation Form

All sections of the form below must be completed in order for the form to be processed. Please print in blue or black ink.

LAST NAME: FIRST NAME: MI:		LAST FOUR OF SSN:	
HOME ADDRESS:	CITY:	STATE:	ZIP:
PERSONAL TELEPHONE NUMBER:	PERSONAL EMAIL ADDRESS:		

- **Please initial the appropriate box below to indicate whether or not you use tobacco on a regular basis.**
- **If you are a regular user of tobacco, please indicate whether or not you are interested in receiving information about the Mississippi State and School Employees' Health Insurance Plan's (Plan) free tobacco cessation programs.**

NON-TOBACCO USER

☐ I attest that I do not regularly use a tobacco product in any form (cigarettes, cigars, pipe, oral tobacco products, etc.).

I certify that all information provided by me on this form is complete and accurate.

______________________________ ______________________________

Signature Date

TOBACCO USER

☐ I acknowledge that I regularly use a tobacco product in some form (cigarettes, cigars, pipe, oral tobacco products, etc.).

☐ **I am interested** in receiving information about tobacco cessation programs offered by the Plan.

I certify that all information provided by me on this form is complete and accurate.

______________________________ ______________________________

Signature Date

Form Submission:

- **If you are an active employee, please return your form to your employer's Human Resources Department.**
- If you are a non-Medicare retiree or COBRA participant, please mail or fax your form to:

Blue Cross & Blue Shield of Mississippi
P.O. Box 23734
Jackson, MS 39225-3734
Fax: (601) 664-5342

For more information visit KnowYourBenefits.dfa.ms.gov

STATE OF MISSISSIPPI
STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM
Underwritten by Minnesota Life Insurance Company – Policy 33683-G

Employee/Retiree Last Name:	First Name:	MI:	Social Security No.:	Birthdate (MMDDYYYY):	Sex ☐ Male ☐ Female
Employee/Retiree Home Address:			Home Telephone No.:	E-Mail Address:	
Employer Name:				Date of Employment:	
Employer Address:				Employer Telephone No.:	

SECTION B: Waiver/Request to Cancel Coverage (Only Complete This Section To Waive Or Cancel Coverage)

☐ **Waiver of Coverage** – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

☐ **Cancellation of Coverage** – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date. **SIGN HERE ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE!**

______________________________ **Employee/Retiree Signature** ______________ **Date**

SECTION C: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)

ACTIVE EMPLOYEE: Life benefits and AD&D maximums based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to $30,000 minimum, $100,000 maximum. Employee and employer each pay 50% of the monthly premium.

☐ New Employee – applying within 31 days of employment; coverage will become effective on the first day of employment.

☐ Late Enrollee Applicant – applying after initial 31 days of employment; will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life Insurance Company. **(Employee Must Also Complete the Minnesota Life *GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY* form.)**

Date of Employment: ____________________

☐ **RETIRED EMPLOYEE:** Life benefit amounts limited to $5,000, $10,000, or $20,000. Retired Employees are not eligible for AD&D benefits. A Retired Employee should apply prior to, but no later than 31 days after, the date Active Employee coverage terminates. Retiree pays 100% of the monthly premium.

Date of Retirement: ____________________ **COVERAGE AMOUNT REQUESTED:** ☐ $5,000 ☐ $10,000 ☐ $20,000

☐ **DISABLED EMPLOYEE:** Life benefit amount is equal to employee's current benefit level at the time coverage ceases as an Active Employee. Disabled Employee must apply no later than 31 days from the date Active Employee coverage terminates. Minnesota Life Insurance Company is solely responsible for evaluating applications for coverage continuation. Premium is waived after 1st 9 months.
(Employee Must Also Complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)

Date of Disability: ____________________

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Telephone #
				( )

SECTION D: Beneficiary Information

NOTE: You cannot designate your life insurance beneficiary on this form. To designate your life insurance beneficiary, please follow the instructions below:

1. Log into your *my*Blue site, **https://myblue.bcbsms.com**, and click on the My Benefits tab.
2. Click the Life Benefits section, which is right below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on Minnesota Life's site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through your *my*Blue portal.

If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the Policy.

If you do not have internet access, please contact Minnesota Life toll free at **877-348-9217** to request a paper form.

SECTION E: Authorization and Certification

I apply for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life Insurance Company. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Group Policy #33683-G and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life Insurance Company as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

______________________________ ____________________

Employee/Retiree Signature (Required) **Date**

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT HTTP://KNOWYOURBENEFITS.DFA.STATE.MS.US, OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	GROUP NUMBER:	INFORMATION VERIFIED: (INITIAL AND DATE)

STATE OF MISSISSIPPI
GOVERNOR PHIL BRYANT

DEPARTMENT OF FINANCE AND ADMINISTRATION

KEVIN J. UPCHURCH
EXECUTIVE DIRECTOR

State and School Employees' Life Insurance Plan
Underwritten by Minnesota Life Insurance Company

Active Employee Life Insurance Beneficiary Designation

Designating a life insurance beneficiary is an important step that will allow you to determine who will receive your policy benefits. As you experience changes in your life, you should review your beneficiary designations to ensure that they still reflect how you want your benefits to be paid. With the implementation of the new online beneficiary management tool, you will now be able to make and/or change designations confidentially and conveniently, 24/7, simply by following the instructions below:

1. Log into the *my*Blue site, https://myblue.bcbsms.com (if you have not registered previously, please have your medical ID card handy)
2. Click on the **My Benefits** tab
3. Click on the link in the **Life Benefits** section and you will be directed to Minnesota Life's online beneficiary management tool
4. Enter the name and address, and the respective benefit percentages for each beneficiary you wish to name

After this information has been entered, you will receive an email acknowledgement, as well as a paper confirmation statement in the mail for your records, reflecting your beneficiary designation, and any applicable benefit percentages. Make sure that the information on your email acknowledgment/confirmation is exactly how you want your benefits to be paid. If any of the information is incorrect, log back into *my*Blue and repeat the steps above.

We are very excited about this new online option and encourage you to visit the *my*Blue site today to start the process for designating your life insurance beneficiary. Please note that if you do not execute the new beneficiary designation, any resulting life insurance proceeds will be paid according to the defaults described in the policy, which may not necessarily be according to your wishes.

Should you have any questions about your beneficiary designation, please call Minnesota Life at 1-877-348-9217.

Membership Application

Form 1 – Revised 12/1/2013

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 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: ________________ Employer No.: ________ - ________

Employer Representative's Name: ________________ Employer Representative's Title: ________________

Employer Representative's Phone: ________________ Fax: ________________ 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 12/1/2013

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: ______________________ Employer No.: ______________ - ______________

Employer Representative's Name: ______________________ Employer Representative's Title: ______________________

Employer Representative's Phone: ______________ Fax: ______________ E-Mail: ______________________

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

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

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 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 some of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Four out of five 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®

HL_PPO_2col #63452 (6/11)

Plan Benefit Highlights for: Mississippi Valley State University
Group No: 06166 **Effective Date:** 1/1/2016

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26	
Deductibles*	$50 per person / $150 per family each plan year	
Deductibles waived for D & P?	Yes	
Maximums*	Low- $750 per person each plan year High $1,500 per person each plan year	
D & P counts toward maximum?	No	
Waiting Period(s)	Major Benefits 12 Months	Orthodontics 12 Months

Benefits and Covered Services**	Low Plan		High Plan	
	Delta Dental PPO dentists†	Non-DeltaDental dentists†	Delta Dental PPO dentists†	Non-DeltaDental dentists†
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays, space maintainers, sealants	100 %	100 %	100 %	100 %
Basic Services Fillings, simple tooth extractions, denture repairs	50 %	50 %	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	50 %	50 %	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	50 %	50 %	80 %	80 %
Oral Surgery Covered Under Major Services	25 %	25 %	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures	25 %	25 %	50 %	50 %
Orthodontic Benefits dependent children only to age 19	Not a benefit	Not a benefit	50 %	50 %
Orthodontic Maximums Lifetime	Not a benefit	Not a benefit	$ 1,000	$ 1,000
Monthly Rates Rates guaranteed for 1 year January 1, 2016 - December 31, 2017	Employee Only: $14.41 Employee + 1 Dependent: $28.06 Employee + 2 or more Dep: $41.31		Employee Only: $22.85 Employee + 1 Dependent: $44.50 Employee + 2 or more Dep: $65.56	

* If you switch plans during the calendar year your Deducible and Annual Maximum may be adjusted accordingly.

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

† Fees are based on based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance 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

www.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. 1 6/10)

Delta Dental PPO℠

Benefit Highlights

Delta Dental Insurance Company

ENROLLMENT/CHANGE FORM

P.O. Box 1809
Alpharetta, GA 30023-1809
1-800-521-2651
Fax: 770-641-5393

12 Mo EEs: ()High Plan div 01001 / () Low Plan div 02001
10 Mo EEs: ()High Plan div 01002 / () Low Plan div 02002
9 Mo EEs: ()High Plan div 01003 / () Low Plan div 02003

For Employer Use Only	
Effective Date: / /	Group No. 25-06166
Full Time Hire Date: / /	Sublocation

Check One (**Enrollees can change plans only during open enrollment)

- ☐ New Hire
- ☐ Open Enrollment
- ☐ Change Dental Plans**
- ☐ COBRA
- ☐ Add/Delete Dependent
- ☐ Terminate Employee Coverage
- ☐ Spouse Employment Change
- ☐ Marital Change
- ☐ Other ____________

Indicate qualifying date: (Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event

- ☐ Termination
- ☐ Reduction in Hours
- ☐ Divorce
- ☐ Widowed/Surviving Dependent
- ☐ Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last, First)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. ____________ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group MS Valley State University Location

Marital Status: Single ☐ Married ☐ Gender: Male ☐ Female ☐ Phone # ( ) –

Do you have dependent children? Yes ☐ No ☐ Are you or your dependents covered under another dental plan? Yes ☐ No ☐

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF
(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth: (Month) (Day) (Year)
Spouse:	☐	☐	☐	☐	Date of Birth:
Dependent:	☐	☐	☐	☐	Date of Birth:
Dependent:	☐	☐	☐	☐	Date of Birth:
Dependent:	☐	☐	☐	☐	Date of Birth:
Dependent:	☐	☐	☐	☐	Date of Birth:
Dependent:	☐	☐	☐	☐	Date of Birth:
Dependent:	☐	☐	☐	☐	Date of Birth:
Dependent:	☐	☐	☐	☐	Date of Birth:

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

☐ I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee ____________ Date ____________

Mississippi Valley State University

More, for less...

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $40
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	$35 Copay, Paid in full fit and two follow-up visits	Up to $20
Premium Contact Lens Fit & Follow-Up	$35 Copay, 10% off retail price, then apply $20 Allowance	Up to $20
Frames	$0 Copay, $130 Allowance, 20% off balance over $130	Up to $46
Standard Plastic Lenses		
Single Vision	$15 Copay	Up to $40
Bifocal	$15 Copay	Up to $60
Trifocal	$15 Copay	Up to $80
Lenticular	$15 Copay	Up to $78
Lens Options (paid by the member in addition to the price of the lenses)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $5
Standard Polycarbonate–Adults	$40	N/A
Standard Polycarbonate–Kids under 19	$0	Up to $5
Standard Anti-Reflective Coating	$45	N/A
Standard Progressive Lens	$65	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	$0 Copay, $135 Allowance, 15% off balance over $135	Up to $105
Disposable	$0 Copay, $135 Allowance, plus balance over $135	Up to $105
Medically Necessary	$0 Copay, Paid in Full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

Hello, Neighbor

- You're on the ACCESS Network
- For a complete list of providers near you, use our Provider Locator on eyemed.com or call 1-866-723-0596.
- For Lasik providers, call 1-877-5LASER6, or visit eyemedlasik.com.

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

EMPLOYER INFORMATION: To be Completed by Employer					
Group Number 9732314	**Employer Name** MISSISSIPPI VALLEY STATE UNIVERSITY	**Location Code**	**Division Code**	**Client Co Code**	**Effective Date**

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)						
☐ADD ☐TERM ☐CHG	**Sex** ☐ M ☐ F	**Member ID**	**Last Name (Employee or subscriber)**	**First Name**	**M.I.**	**Date of Birth**
Social Security Number	**Home Street Address**			**City/State/Zip**		**Home Phone** ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)						
☐A ☐T ☐C	**Sex** ☐ M ☐ F	**Last Name (spouse)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐A ☐T ☐C	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐A ☐T ☐C	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐A ☐T ☐C	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐A ☐T ☐C	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**

Employee Signature: ______________________________ Date: ____________________

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date.
Deductions are adjusted according to payroll frequency.

To: All Employees of **Mississippi Valley State University**

In compliance with the requirements of IRC §403(b)(12(A)(ii) this Notice will advise you of the voluntary 403(b) program established and maintained for the benefit of our employees. The following information provides details of the Plan and outlines the procedures for enrollment.

Eligibility

All employees who are employed by the Employer.

Contributions

When you enroll in the program, the amounts you designate as salary deferrals are withheld from your wages and forwarded to an investment provider of your choice. Several types of contributions are available in your Plan:

Pre-Tax Salary Deferrals. These are amounts contributed into a 403(b) plan that are deferred from your paycheck before federal income taxes are applied. State income taxes may or may not be applicable.

Roth Salary Deferrals. These amounts are also deferred from your paycheck, but are subject to federal and state income taxes. When you withdraw monies, however, the funds may be excluded from taxation. Special rules apply to Roth contributions and you should contact your tax advisor before electing this option.

- For **2016**, you may defer from your wages, a maximum of $18,000 to all 403(b) and 401(k) plans unless you will reach 50 years of age during the year. In that case, you would be eligible to contribute an additional $6,000. Deferrals may not exceed 100% of your wages.

Rollovers. You may also rollover funds from another employer's plan if you receive an eligible rollover distribution. Before you can complete a rollover into this Plan, you must first receive an acceptance authorization before the monies to be applied to your account.

Plan Investment Options

Your contributions to the 403(b) Plan must be made to an investment provider approved by your Employer. Before enrolling in the Plan, you should first establish an account with one of the Providers listed in this Notice. Once you have executed an investment contract, you should establish an account through the Plan's web site and create a secure login and password.

Assistance

You may enroll in the Plan or receive assistance with these provisions by contacting the Plan's Third Party Administrator, your Employer's Benefit Administrator or a representative for one of the Investment Companies listed in this Notice. Additional information about the provisions and options in your Plan are available by contacting PenServ Plan Services, Inc. at (800) 849-4001 or from the Plan's web site (see below).

Investment Provider Options

Provider and Product Name	Product Type	Contact
American Fidelity	Annuities	(800) 654-8489 / www.afadvantage.com
Ameriprise Financial Services	Annuities	(724) 434-1545 / www.ameriprise.com
AXA Equitable	Annuities	(800) 628-6673 / www.axaonline.com
ING Life Insurance & Annuity Company	Annuities	(800) 525-4225 / http://www.ingretirementplans.com
TIAA CREF	Annuities	(800) 842-2776 / http://www.tiaa-cref.org
Variable Annuity Life Ins. Co. (VALIC)	Annuities	(800) 548-9651 / www.valic.com

Third Party Administrator
PenServ Plan Services, Inc.
Plan Recordkeeper
Phone 800.849.4001
www.penserv.com
Email: 403badministration@penserv.com

Employer Benefits Administrator
Mississippi Valley State University
Deneen Banks
Phone: 662.254.3530
Email: dgbanks@mvsu.edu

Plan Web Site is available at:
www.penserv.com
Select: Login to Your Account

403(b) Salary Deferral and Investment Election Agreement

Mississippi Valley State University

Participant Name	Social Security No.

Address

City	State	Zip

Date of Birth	Date of Employment	Email Address

Evening Phone	Day Phone

Position/Title	☐ Married ☐ Unmarried	☐ Full Time ☐ Part Time

PARTICIPATION ELECTIONS

Salary Deferral Elections ☐

I hereby apply for Participation in the above-named 403(b) Plan and direct my employer to withhold through payroll reduction the following amounts from each pay. I understand this election will be applied to future contributions only and will remain in effect until I direct new elections through the Plan's Internet or Voice Response System.

NOTE: I understand that if I am 50 years of age or will reach the age of 50 during this calendar year any contribution deferrals in excess of the traditional salary will be applied to the Age 50 Catch-up option.

Election to Defer Participation ☐

I do not want to participate in the Plan at this time. I understand that I may change this election by completing a new Enrollment Form prior to the next Plan Entry Date.

Election to Revoke Participation ☐

Please discontinue my Salary Deferral Contributions to the Plan. I understand that I will be able to resume participation by completing a new Enrollment Form prior to the next Plan Entry Date.

I direct my new money to be invested in the funds selected below. I understand these investment directions will remain in effect until I direct new elections through the Plan's web site or voice response system.

Investment Elections

Fund Name	Amount to Roth 403(b) (Per Pay Period)	Amount to Traditional 403(b) (Per Pay Period)
AXA Equitable		
American Fidelity Assurance Company		
Ameriprise Financial Services		
ING Life and Annuity Company (ILIAC)		
TIAA-CREF		
Variable Annuity Life Insurance Company (VALIC)		
Total		

Participant Name	Social Security No.

By signing this Agreement, Employee agrees to modify his/her salary as indicated above and Employer agrees to contribute this amount on Employee's behalf into the 403(b) annuity(ies) or custodial account(s) selected by Employee and authorized by the Employer. It is intended that the requirements of all applicable state and federal tax rules and regulations (Applicable Law) will be met. Employee understands and agrees that this Agreement:

1. Is legally binding and irrevocable with respect to amounts paid or available while it is in effect; however, is effective only for amounts not yet earned or made available.
2. May be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new salary reduction agreement is submitted;

Employee further agrees that:

- In conjunction with his/her Employer, he/she is responsible for determining that his/her salary reduction amount does not exceed the limits of the Applicable Law;
- He/she is responsible for the accuracy of information provided by Employee, which is used in determining Employee's maximum annual contribution limit;
- Employer has no liability for any losses suffered by Employee that result from his/her participation in the 403(b) plan;
- He/she acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness or tax consequences of the purchase of the 403(b) plan. Nothing herein shall affect the terms of employment between Employer and Employee;
- This agreement supersedes all prior 403(b) salary reduction and/or deduction agreements and shall automatically terminate if employment with Employer is terminated.

Important Information

- Although Employer must authorize Service Providers, Employer does not choose the annuity contract(s) or custodial account(s) in which 403(b) contributions are invested.
- Employees are responsible for setting up and signing the legal documents to establish the annuity contract or custodial account, except for certain group annuity contracts under which Employer may be required to establish the contract.
- In order to receive the expected tax results, Employees are responsible for investing in annuity contracts or custodial accounts that meet the requirements of Section 403(b) of the Internal Revenue Code.
- Employees are responsible for naming a death beneficiary under the 403(b) plan. This is normally done at the time the annuity contract or custodial account is established. Beneficiary designations should be reviewed periodically.
- Employers are responsible for all distributions and any other transactions with the Service Provider. All rights under the annuity contracts or custodial accounts are enforceable solely by Employee, Employee's beneficiary or Employee's authorized representative. However Employer has certain responsibilities under the 403(b) Plan with respect to the integrity of the transactions for the Plan and may require an authorized representative from the Employer (or their Designee) to approve any requested transaction by Employees.
- Employee must cooperate directly with Service Provider, Employer, or their Designee, as directed by Employer to transfer contract(s) or custodial account(s) to another Service Provider, begin distributions, make loans, exchanges or otherwise access 403(b) plan assets.
- Employees are responsible for determining that salary reductions do not exceed the allowable contribution limits under Applicable Law. References herein to elective deferral limits are based on the 2008 limits. In subsequent years, the basic limit and the age 50+ catch up option are indexed in $500 increments and will increase over time.

Participant Name	Social Security No.

EMPLOYEE SIGNATURE

☐ Check here if you control another consulting or other business or company.

I understand that all rights under the annuity(s) or custodial accounts established by me under the 403(b) plan are enforceable solely by me, my beneficiary or my authorized representative. I also understand that no later than January 1, 2009, my Employer will have a 403(b) Plan in place that will require my Employer, or their designee to authorize certain distributions and loans, and that it will not be solely my responsibility to authorize such transactions. By signing this Agreement, I authorize any Service Provider, or their delegee to provide information on my Account to Employer or another Service Provider if such information is necessary for compliance purposes or to effectuate such transactions as I may request.

SIGNATURES

Under penalties of perjury, I certify that the above information (including my social security number) is correct and I am an employee of the Employer. I also: (1) acknowledge receipt of the current prospectus; (2) agree to promptly give Instructions to the Sponsor necessary to enable the Custodian to carry out its duties under the Group Custodial Agreement; (3) represent that whenever information as to any taxable year is required to be filed with the Internal Revenue Service, the individual will file such information with Internal Revenue Service unless filed by the Custodian; (4) accept responsibility for computing the annual Exclusion Allowance and the limitations on Elective Deferrals under the Internal Revenue Code; and (5) acknowledge that this Group Custodial Agreement operates in conjunction with the Employer's 403(b) Plan document. I hereby agree to participate in the 403(b)(7) Group Custodial Account offered by the Custodian. I acknowledge receipt of a copy of the custodial account document under which this 403(b)(7) Group Custodial Account is established, and a copy of this Participation Agreement. I direct that my contribution be invested as indicated on my enrollment form, and I direct that all benefits upon my death be paid as indicated above. In the event that this is a rollover contribution, the undersigned hereby irrevocably elects, pursuant to the requirements of Section 1.402(a)(5)-1T of the IRS regulations, to treat this contribution as a rollover contribution.

Sponsor: PenServ Plan Services, Inc.

Participant Signature: ______________________ Date: ____________

Employer Name Mississippi Valley State University

ELECTION AND SALARY REDUCTION AGREEMENT

(PLEASE PRINT)

EMPLOYER: ______________________________

PLAN YEAR: ____________________ **thru** ____________________

ELIGIBILITY DATE:________________ **FIRST PAY DATE:** ______________

PAY MODE (M-Monthly, S-Semi Monthly, Bi-Biweekly or W-Weekly): ____________

LOCATION NAME & NO.: ______________________________

NAME:______________________________ **SSN:** ______________________

ADDRESS:____________________________ **DOB:** ______________________

______________________________ **DOH:** ______________________

______________________________ **SALARY (Per Pay Period): $** __________

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary necessary to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform with a cafeteria plan in accordance with Sections 125, 79, 105, 106 and 126 of the Internal Revenue Code.

INSURANCE ELECTIONS:	**CAFETERIA** (Per Deduction)	**NON CAFETERIA** (Per Deduction)	**Deduction Mode**
PRE-TAXED			
______________	______________		______
______________	______________		______
______________	______________		
______________	______________		
______________	______________		
POST TAXED			
______________		______________	______
______________		______________	
______________		______________	

M - Monthly = 12
S - Semi Monthly = 24
Bi - Bi Weekly = 26
W - Weekly = 52

FLEXIBLE SPENDING:	**AMOUNT** (Per Deduction)	**PLAN YEAR AMOUNT**
Dependent Care Expenses:	______________	
Unreimbursed Medical Expenses:	______________	

Please sign only one line.

YES **I WISH TO PARTICIPATE -** I agree that my salary will be reduced by the amount(s)shown for the benefit option(s) I have elected under the Cafeteria Plan. I have read and understand the information on the reverse side of this document.

EMPLOYEE SIGNATURE: ______________________ DATE: ______________________

NO **I DO NOT WISH to Participate -** I have been explained the benefits of the Cafeteria Plan and given the opportunity to participate, but I DECLINE. I understand that I may only participate at the start of the next Plan Year or in the event of a Status Change.

EMPLOYEE SIGNATURE: ______________________ DATE: ______________________

Southern Administrators and Benefit Consultants, Inc.
P.O. Box 2449 • Madison, Mississippi 39130-2449
WWW.SABCFLEX.COM

As a participant, I understand the following:

My salary will be reduced by the amount shown on the reverse side of this page for the benefit option(s) I have elected under the Cafeteria Plan.

- My social security benefits may be reduced due to my participation in the Cafeteria Plan.
- Elections made will be irrevocable for the plan year except for modifications due to a qualified Change in Status (divorce, marriage, death of spouse or dependent, birth or adoption of a child, or the change of employment status of a spouse).
- If my salary reduction for the elected insurance benefit(s) are increased or decreased while this agreement remains in effect, my salary will automatically be adjusted to reflect the change.
- Prior to each plan year, I will be given the opportunity to change my benefit election. If I fail to complete and return a new election form within the regular enrollment period, preceding each plan year, I understand my election will remain the same.
- My employer may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Code.
- If I participate for dependent care expenses, I will be reimbursed up to the amount incurred during the plan year, not to exceed the amount of my dependent care balance.
- If I participate for the Unreimbursed Medical (URM) expenses, I will be reimbursed for out-of-pocket medical expenses up to the amount incurred (date service was provided, not paid) during the plan year, not to exceed my plan year election.
- If I participate for the Dependent Care and/or Unreimbursed medical expense spending account(s), any funds remaining after the end of the sixty (60) days grace period, following the end of the plan year, will be forfeited to my employer.
- I have been explained the flexible spending reimbursement procedures and the requirements of the plan, I understand my reimbursements will be based on certain required third party documentation and eligibility of the expense. I understand that upon submission of each claim, I certify that the documentation submitted is valid and eligible under the guidelines of the plan. Submission of falsified and/or inaccurate information may result in disciplinary action and/or penalties.

TERMINATION OF EMPLOYMENT:
Please refer to your plans Summary Plan Description or contact your Plan Administrator and/or SABC for the following plan design information:

I understand that if I terminate my employment, my elected benefits under the Cafeteria Plan will cease. Depending on my Employer's Plan design, my Unreimbursed Medical election may:

- Continue, in lieu of COBRA, my Employer will deduct from my salary (pre-taxed) any unpaid URM elections for the plan year.
- Terminate, and I will only be able to claim for expenses that incurred prior to my termination. If I have a positive URM balance at the time of termination, I can extend my election due to a COBRA qualifying event and I will be given the opportunity to continue on a self pay basis.

MY ELECTION AND SALARY REDUCTION AGREEMENT IS SUBJECT TO THE TERMS OF MY EMPLOYER'S CAFETERIA PLAN DOCUMENT.

Mississippi Valley State University

Human Resources New Hire Demographics

2015-2016

NEW EMPLOYEE DATA FORM

The information collected in this form is treated as highly confidential. It is used for statistical purposes to assist you in the transfer of benefit entitlements related to prior state service and/or for obtaining services in a medical emergency. Your cooperation in completing the data is appreciated.

NAME: ____ ____________
(First) (Middle) (Last) (Suffix) (Maiden)

ADDRESS: ______________________________ **PHONE:** ______________

CITY: ______________________ **STATE:** __________ **ZIP CODE:** __________

SSN: ______________ **DEPARTMENT:** ______________ **DEPT. PHONE:** __________

Ethnic Background (Select <u>ONE</u>)
___ 1. White (non-Hispanic)
___ 2. Black (non-Hispanic)
___ 3. Hispanic
___ 4. Asian/Pacific Islander
___ 5. American Indian or Alaskan Native

Marital Status: ☐ Married ☐ Single

Gender: ☐ Male ☐ Female

Birth date: ______________

DO YOU HAVE A DISABILITY? ☐ Yes ☐ No

If **Yes**, please state the disability, and any accommodations that may be necessary for you to perform the essential duties of your position: ____
____

Veteran Status:
___1. Pre-1950
___2. Korean Conflict
___3. Cold War
___4. Vietnam Conflict
___5. Post-Vietnam ('73-'91)
___6. Gulf War
___7. '92-Present
___8. Unknown
___9. **Not Applicable**

Military Reserve:
_____1. Active
_____2. Inactive Reserve (Recall)
_____3. Inactive Reserve (No Recall)

Education Level
*Please <u>circle</u> the highest level **completed**:*

Grade School: 1 2 3 4 5 6 7 8
High School: 9 10 11
High School Graduate: 12
College: 13 14 15
College Graduate: 16
Post-Graduate work: 17
Master's Degree: 18
Ph.D.: 19

- **Are you currently enrolled as a student at Mississippi Valley State University?** ☐ Yes ☐ No;

If **Yes**, for what term? ☐ Fall ☐ Spring (Year) __________

<u>EMERGENCY NOTIFICATION</u>

In the event of a medical emergency I authorize the following contacts:

Name: ____

Address: ______________________ City/State/Zip ______________

Phone Number: ______________ Relationship: ______________

Physician's Name: ______________________________________

Dr.'s Office Phone: ______________ Dr.'s Emergency Phone: ______________

Please see back page for more information

PRIOR STATE SERVICE

- List all prior employment with Mississippi Valley **State University** *(Includes employment as a Student Worker)*

Department	**Dates of Employment**	**Name at time of Service** *(If different)*

- List any **Non-MVSU prior state service in the State of Mississippi**

Agency/University Address/City	**Dates of Employment**	**Name at time of Service**

- **Please indicate the retirement plan in which you participated as a State employee:**
  - ☐ **PERS** - State Employee Retirement System;
  - ☐ **ORP** - Optional Retirement System Company/Vendor: ______________________

- **Are you *transferring* to MVSU directly from another Mississippi State Agency, University or College?**
  ☐ Yes ☐ No If **Yes**, please answer the following:
  A. Date of separation from previous Agency: ___/___/___
  B. List any Tax Deferred Annuities in effect (amount and company/vendor)
  ____

- **Are you currently *participating* in PERS?** ☐ Yes ☐ No

  If **Yes**, through which educational institution? ______________________

- **Are you currently *receiving* PERS Benefits?** ☐ Yes ☐ No; If **Yes**, Date of Retirement: ___/___/___

☐ **I have no prior service with MVSU or with any Mississippi State Agency.**

Have you ever been convicted of anything other than minor traffic violations? ☐Yes ☐No If yes, **Explain.** ____

I affirm that to the best of my knowledge, the information provided on this form is true and correct. I am aware that at any time during my employment I may change my emergency notification designees, and I may request reasonable accommodation for any disability that may arise.

______________________________ ______________

Signature of Employee Date

rev. 9/30/2015

Mississippi Valley State University
Employee Emergency Contact Information

NAME (Last, First, Middle): ______________________________

HOME ADDRESS: ______________________________

EMPLOYEE ID #: ________ - ______ - ________

PHONE NUMBER (Include home and cellular #'s): ______________ **HOME**
______________ **CELL**

IN CASE OF AN EMERGENCY

PRIMARY CONTACT: ______________________________

RELATIONSHIP: ______________________________

PRIMARY ADDRESS: ______________________________

CITY ______________ **STATE** ________ **ZIP** ________

PHONE: **HOME** ______________ **CELL** ______________ **WORK** ______________

SECONDARY CONTACT: ______________________________

RELATIONSHIP: ______________________________

SECONDARY ADDRESS: ______________________________

CITY ______________ **STATE** ________ **ZIP** ________

PHONE: **HOME** ______________ **CELL** ______________ **WORK** ______________

PHYSICIAN'S NAME & NUMBER: ______________________ **NAME**

______________________ **NUMBER**

(OPTIONAL)

ADDITIONAL INFORMATION THAT MAY BE HELPFUL IN THE EVENT OF AN EMERGENCY:

____

____

MISS. CODE ANN. § 25-1-113
EMPLOYEE CERTIFICATION AND AUTHORIZATION STATEMENT

NOTICE

Section 25-1-113, Mississippi Code of 1972, as amended, prohibits the hiring for public employment of individuals who have been convicted of or plead guilty to the unlawful taking or misappropriation of public funds effective July 1, 2013. Effective July 1, 2014, the State cannot continue to employ a person who has been convicted or pled guilty to the unlawful misappropriation of public funds. Specifically, Section 25-1-113, has been amended to read as follows:

The State and any county, municipality, or any other political subdivision may not employ or continue to employ a person who has been convicted or pled guilty in any court of this state, another state, or in federal court of any felony in which public funds were unlawfully taken, obtained or misappropriated in the abuse or misuse of the person's office or employment or money coming into the person's hands by virtue of the person's office or employment.

EMPLOYEE CERTIFICATION AND AUTHORIZATION

I have been notified that as an employee of the State of Mississippi I cannot have been convicted of or pled guilty in any court of this state, another state, or in federal court of any felony in which public funds were unlawfully taken, obtained or misappropriated in the abuse or misuse of my office or employment or money coming into my hands by virtue of my office or employment. I understand that any conviction of embezzlement will disqualify me from employment with the State of Mississippi and result in my termination.

I swear or affirm that I have never been convicted or pled guilty in any court of this state, another state, or in federal court of *any felony* in which public funds were unlawfully taken, obtained or misappropriated by the abuse or misuse of any office or employment or money coming into my hands by virtue of my office or employment.

I hereby authorize Mississippi Valley State University to conduct a background check of my criminal history at any time as a condition of and/or subsequent to my employment. **I understand and acknowledge that I may revoke my permission for such background check. In such case, no background check investigation will be done and my employment may be terminated.** *I further understand and acknowledge that should the criminal background check occur and it establishes that I have been convicted or plead guilty to misuse of public funds in violation of Section 25-1-113 my employment will terminate and I will have no recourse against Mississippi Valley State University.*

____________________________ _______________
Signature of Employee Date

____________________________ _______________ __________________
Employee's Name – Printed Date of Birth Social Security Number

____________________________ _______________
Signature of Witness Date

____
Name of Witness - Printed

MISSISSIPPI VALLEY STATE UNIVERSITY

OFFICE OF COMMUNICATIONS AND MARKETING

New Hire Information

Name ____

Department ______________________________________

Job Title ____

Job Description ___________________________________

____

____

____

Hire Date ____

Contact # ____

Hometown ____

Email Address _____________________________________

Signature ____

Memorandum

To: All MVSU Employees

From: Human Resources

Re: Personnel Campus Directory Information

Your assistance in providing current information for a personnel directory is requested. Please complete the form below and return to Human Resources immediately. Your cooperation is greatly appreciated.

Name:________________________________
Date:________________

Title: (circle one) **Dr.** **Mr.** **Mrs.** **Ms.**

Department:____

Position:____
Home
Address:____
Street

____
City, State Zip

Home Phone: ____________________ **Work Phone:**______________

☐ **I do not want to have my personal information published in the directory.**

Signed, ___________________________
Date___________________

☐☐**An emergency telephone # is**
MANDATORY:__________________________
Emergency Phone #

☐☐**Note: If you are an area Administrator, list the number to be used as the department's main phone number.**

Department
Name:____
Department Main Telephone
Number:________________________________

Mississippi Valley State University
Email Account Request Form

Please submit a fully completed form to the Department of Academic Computing Services along with a photo copy of you University ID Card. Please allow 5-7 days for the account(s) to be created. You may call 662-254-3744 to check the status of your account(s). Before this form will be PROCESSED, you must have a SIGNED MVSU APPROPRIATE USE POLICY form on file (below).

Mr. Mrs. Ms. Dr. (Circle one)

Last Name **First Name** **Middle Initial**

SSN OR Student ID # **Today s Date**

UNIVERSITY CLASSIFICATION (check one) undergraduate☐ graduate☐ faculty☐ staff☐ other☐ non-university☐

***Estimated graduation date** (if student) or* ______ ***Expiration date** (if non-permanent faculty/staff)* ______

Institution **Department** **Title** **Major (if student)**

Phone number **Fax number** **E-Mail**

Mailing Address (campus or home)

Applicant Signature Required Here

I have read the MVSU Appropriate Use Policy, understand I have read the r to comply with it.

Name (please print)

Signature Date

DO NOT WRITE IN THIS SPACE ACS USE ONLY

USER ID ______

PASSWORD ______

PROCESSED BY ______

PICKED UP ON ______

SIGNED POLICY ON FILE ______

Appropriate Use Policy Version 1.0

This policy governs the use of computers, computer-based networks, and all related equipment administered by Mississippi Valley State University. Under the federal statutes and the sections of the Mississippi code that regulate the use of these resources, MVSU is required to ensure that this equipment is used properly and for the purpose for which state funds were expended. The intent of this policy is to allow maximum freedom of use consistent with state and federal law, IHL/University policy and a productive work environment.

General Principle

Appropriate use reflects academic honesty and ethical behavior, and demonstrates consideration in the consumption of shared resources. It shows respect for intellectual property, ownership of data, system security mechanisms, and the rights of others to privacy and to freedom from intimidation, harassment, and unwarranted annoyance.

Authorized Use

Individuals may use MVSU computing facilities only with the express authority of MVSU. Using an account that belongs to another individual or giving an individual other than the owner access to an MVSU account is prohibited. MVSU management authorizes system accounts and the use of lab facilities. In certain cases, such as with remote visualization facilities, MVSU management may designate an appropriate agent to authorize accounts. Authorized users of MVSU computing facilities include:

1. The faculty, staff, and students of the state supported universities governed by the Mississippi Board of Trustees of Institutions of Higher Learning (IHL).
2. Pre-approved individuals associated with other state supported educational institutions (e.g. high school teachers and students working on special projects).
3. Other outside, pre-approved clients.

Appropriate use of MVSU computing facilities includes:

1. The support of instructional activities (e.g., to complete class projects or conduct activities relevant to class work).
2. The support of institutionally sponsored research by authorized users.
3. The facilitation of official work of state and university offices, departments, agencies, and sanctioned campus organizations.
4. MVSU computing facilities are not to be used for commercial purposes of financial gain except in pre-approved circumstances. MVSU computing facilities are not to be used for partisan political purposes.
5. MVSU computing facilities serve diverse purposes and diverse constituencies, and rules for use may vary somewhat across systems and labs. Activities having valid educational benefits, but which are however, they may be limited or banned on certain systems at the discretion of MVSU management, according to system load and system function. For example, due to the limited number of stations, game playing and computer chatting in MVSU labs is strictly prohibited, unless the activity is required as part of a university course. System and lab dependent policies are communicated to users through on-line messages, news items, and lab postings. Compliance with the MVSU Appropriate Use Policy requires compliance with all system and lab dependent policies.
6. Misuse or abuse of MVSU computing facilities is a violation of the MVSU Appropriate Use Policy; violators are subject to the suspension or revoking of computing privileges, disciplinary action, and criminal prosecution in case of violations of state or federal law.

Computer Software Usage

MVSU computing facilities utilize many software applications, with a wide range of license and copyright provisions. Users are responsible for availing themselves of appropriate information and complying with the license and copyright provisions of the software that they use.
Mississippi Valley State University prohibits the unauthorized copying or electronic
transmission of copyrighted computer software, computer data, and software manuals at Mississippi Valley State University unless appropriate written consent is obtained from the software vendor or licensor.
Such unauthorized duplication is grounds for disciplinary action by the University and is subject to criminal prosecution under Mississippi Computer Statutes, as well as under the Federal Computer Fraud and Abuse Act of 1986.

Users Responsibilities

Respect the integrity of MVSU computing environments and computing environments reachable by MVSU network connections.

1. No individual shall, without authorization, access, use, destroy, alter, dismantle or disfigure MVSU technologies, properties or facilities. If an individual encounters or observes a vulnerability in system or network security, then that individual must report the vulnerability to MVSU management. Individuals must refrain from exploiting any vulnerabilities in security.
2. No individual shall use MVSU computing facilities to gain illegal access or entry into other computers. MVSU users must follow any policies governing the use of any remote hosts accessed.
3. Respect the privacy of other individuals.
4. Files belonging to individuals are to be considered private property unless explicit authorization is given by the owner of the files. That a user can read a file does not mean that a user may read a file. The ability to alter a file does not give a user the right to alter a file.
5. Respect the finite capacity of systems.
6. No individual shall monopolize or hoard resources, including lab stations (PC, Workstations, Terminals), printing facilities, dial-in connections, limited - use software licenses , and system resources such as CPU, disk, memory, and Cray Solid state Storage Device(SSD).
7. Use computing facilities in a manner that promotes a productive and professional working environment - locally, nationally, and internationally.

Computer communications systems and networks promote the free exchange of ideas and information, thus enhancing teaching and research.

8. Individuals should not use electronic communications systems such as E-mail to harass others or to interfere with their work. Other examples of misuse include: sending messages, mail or communications of any kind to persons who have not requested it or who cannot be reasonably expected to welcome such communications; printing or displaying materials that are unsuitable for public display or that could create an atmosphere of discomfort or harassment for others.
9. MVSU computing facilities are not to be used in a wasteful or frivolous manner (e.g., tying up system or network resources with computer based game playing, sending trivial or excessive messages, printing excess copies of documents, files, data, or programs, running grossly inefficient programs when efficient alternatives are available, etc.).
10. Protect Your Account. Even the best computer systems cannot protect the individual who fails to conceal his or her password. To prevent abuse of your account, physically protect you session, never record a password where it can be found, and never reveal your password. Follow MVSU guidelines for password selection and change your password often. Inform MVSU when you leave you institution so that your account may be properly closed. Failure to act responsibly in the use of MVSU computing facilities is a violation of the MVSU Appropriate Use Policy; violators are subject to the suspension or revoking of computing privileges, disciplinary action, and criminal prosecution in cases of violations of state of federal law.

MVSU Rights and Responsibilities

Acknowledgment of this policy statement authorizes appropriate MVSU system or network personnel, under the direction of MVSU management, to examine user files and activities, if necessary. No guarantee of complete privacy is made. MVSU management reserves the right to stop any process, restrict any individual s use, inspect, copy, remove or otherwise alter any data, file, or system resource that may undermine or adversely affect the overall performance or integrity of the computing facilities. MVSU system and network administrators have taken reasonable precautions to ensure that potentially offensive materials does not reside on local facilities; however, MVSU cannot be held responsible for materials residing on remote sites. Individuals are cautioned to exercise judgment in accessing such materials.

CONSEQUENCES

Violation of MVSU Appropriate Use Policy may result in the following penalties:

1. Suspension for varying amounts of time or the permanent revoking of computing privileges.
2. MVSU management reserves the right to revoke the computing privileges of individuals who disciplinary action is determined.
3. Report of the violation to the appropriate Disciplinary Advisory Committee for the user s institution.
4. Referral to the appropriate law enforcement agency in cases of violations of state or federal law.

Mississippi Valley State University
Staff Handbook/Probationary Period

Staff Handbook
By signing below, I verify that I have received a copy of Mississippi Valley State University's Staff Handbook. I agree to read the Handbook and I understand that if I have any questions regarding it, that I should direct them to the Office of Human Resources.

Probationary Period
Each new employee will be required to serve a six (6) month probationary period. During that period, the employee's work will be observed by his/her immediate supervisor. Before the expiration of the probationary period, the supervisor will make an evaluation of the employee's general productivity, job knowledge, dependability, cooperation, initiative and general character.

If at any time prior to the completion of the probationary period the employee's performance has not been satisfactory, the supervisor may, after counseling with the employee, recommend termination of the employee's service with a (1) week notice.

I have received a MVSU Personnel Handbook.

I understand that I must complete a six (6) month probationary period.

____
Employee Signature

____
Date

MISSISSIPPI VALLEY STATE UNIVERSITY

SEXUAL HARASSMENT POLICY

I. STATEMENT OF POLICY

Mississippi Valley State University is committed to the principle that the working and learning environment be free from inappropriate conduct of a sexual nature. Sexual harassment is inappropriate, unprofessional and illegal behavior that will not be tolerated by the University. Individuals who engage in such conduct will be subject to disciplinary action.

II. SCOPE OF POLICY

This policy applies to all administrators, faculty, staff and students and is applicable regardless of the gender of the complainant or the alleged harasser.

III. DEFINTION

A. **Sexual Harassment.** Sexual harassment includes unwelcome sexual advances, requests for sexual favors, or verbal or physical conduct of a sexual nature when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of employment or student status;

2. Submission to or rejection of such conduct is used as a basis for evaluation in making personnel or academic decisions affecting that individual; or

3. Such conduct has the purpose of effect of unreasonably interfering with an individual's performance as an administrator, faculty member, staff or student, or creating an intimidating, hostile of offensive environment.

B. **Examples.** Examples of behavior that could be considered sexual harassment include but are limited to:

1. Physical contact of sexual nature including touching, patting, hugging, or brushing against a person's body;

2. Explicit or implicit proposition or offers to engage in sexual activity;

3. Comments of a sexual nature including sexually explicit statements, questions, jokes or anecdotes; remarks of a sexual nature about a person's

clothing or body; remarks about sexual activity; speculation about sexual experience;

4. Exposure to sexually oriented graffiti, pictures, posters, or materials; and/or

5. Physical interference with, or restriction of, an individual's movements.

IV. INFORMAL COMPLAINT PRECEDURES

This process may be used as a prelude to filing a formal complaint or, as an alternative. It is necessary that this option be used. Any one who believes that he or she has been subjected to sexual harassment may immediately file a formal complaint as described in Section V of this policy. An individual wishing to utilize the options under the informal process should contact the *Director of Human Resources* or if the complainant is a student, the *Vice President for Student Affairs*.

A. **Consultative Services.** are a part of the informal process and are designed to provide a member of the university community an opportunity to discuss specific concerns in a confidential setting. Assistance will be provided to help the employee understand the definition and the legal implications of sexual harassment.

B. **Informal Assistance.** The complainant is provided assistance in attempting to resolve possible sexual harassment if the complainant does not wish to file a formal complaint. Such assistance may include strategies for the complainant to inform the offending party that his or her behavior is unwelcome and should ceased, action by an appropriate University official to stop the unwelcome conduct, or informal mediation.

C. **Confidentially.** The University will endeavor to maintain confidentiality to the extent permitted by law. Where the complainant's desire to maintain anonymity constrains attempts at establishing facts and eliminating the potential harassment, the University will attempt to find the right balance between the complainant's desire for privacy and confidentiality, and the responsibility of the University to provide an environment free of sexual harassment. However, not all circumstances will allow the complete confidentiality and, the University may take more formal action in cases of egregious sexual harassment.

V. FORMAL COMPLAINT PROCEDURE

A. Reporting.

1. Mississippi Valley State University encourages any person who believes that he or she has been subjected to sexual harassment to immediately report the incident to (1) the appropriate supervisor of the accused faculty member or employee, (2) to the Director of Human Resources or, (3) when a student is complainant or the accused individual, to the Vice President for Student Affairs. In no case will a complainant be required to report such behavior to the person accused in the misconduct. The complainant will be advised of the procedures for filing a formal complaint of sexual harassment at the time he or she reports the alleged harassment. When a supervisor or the Vice President for Student Affairs receives a complaint, he or she will immediately notify the Director of Human Resources.

2. In order to initiate the investigation process, the complainant should submit a written statement setting out the details of the conduct that is the subject of the complaint. While an investigation may begin on the basis of an oral complaint, the complainant is strongly encouraged to file a written complaint. When a supervisor or the Vice President of Student Affairs receives a complaint with a written statement, he or she shall immediately notify the Director of Human Resources.

B. Compliant Investigation.

1. The Director of Human Resources and/or the Vice President for Student Affairs will investigate all complaints that are supported by a written statement, as appropriate. If the complaint is not in writing, the investigator should prepare a statement of what he or she understands the complaint to be and seek to obtain verification of the complaint from the complainant.

2. As part of the investigation process, the accused individual shall be provided with a copy of the complaint and allowed a reasonable time to respond in writing.

3. Any persons thought to have information relevant to the complaint shall be interviewed and such interviews shall be appropriately documented. Other acceptable methods for gathering information include, but are limited to, visual inspection of materials alleged to be offensive and follow-up interviews as necessary.

4. The investigation of a complaint will be concluded as soon as possible after receipt of the written complaint. The Vice President for Academic Affairs shall review investigations exceeding sixty (60) days, and justification documented. The complaint, accused individual and

supervisor will be provided an update on the progress of the Investigation after the interview.

5. Upon completion of the investigation, a written report will be submitted to the appropriate administrative head. A copy of the report shall be sent to the appropriate vice president. The report shall include: findings, a recommendation as to whether disciplinary action should or should not be pursued against the accused individual and a proposed disciplinary penalty, if disciplinary action is recommended. Recommendations for disciplinary action regarding faculty and staff will be handled in accordance with the University's policies and procedures for discipline and dismissal of faculty and employees. The Vice President of Student Affairs will proceed with the investigation and disposition of complaint against a student in accordance with the University's student disciplinary procedures.

C. **Retaliation.** A faculty member, student or employee, who retaliates in any way against an individual who has brought a complaint pursuant to this policy in good faith or, who retaliates against an individual who has participated in good faith in an investigation of such a complaint, is subject to disciplinary action, including dismissal or expulsion as appropriate.

D. **Confidentiality.** To the extent permitted by the circumstances and the law, complaints and information received during the investigation will remain confidential. Relevant information must be provided to those persons who need to know in order to achieve a timely resolution of the complaint; therefore absolute confidentiality may be impossible.

E. **False Allegations.** Any faculty member, employee or student who is found to have intentionally made false allegations of sexual harassment against another shall be subject to disciplinary action up to and including dismissal from University employment or expulsion as a student, whichever is appropriate.

F. The compliant procedures set out in this policy are intended as a guideline. Immaterial deviation from these procedures should not be considered failure on the part of the University to respond appropriately.

MISSISSIPPI VALLEY STATE UNIVERSITY
SEXUAL HARASSMENT POLICY
VERFICATION OF RECEIPT

By signing below, I verify that I have received a copy of the Mississippi Valley State University Sexual Harassment Policy. I agree to read and I understand that if I have any questions regarding it, that I should direct them to Office of Human Resources.

____
Recipient

____
Date

DRUG-FREE WORKPLACE ACKNOWLEDGMENT

MISSISSIPPI VALLEY STATE UNIVERSITY

Drug abuse and use in the workplace are subjects of immediate concern in our society. These problems are extremely complex and there are no easy solutions. From a safety perspective, the users of drugs may impair the well-being of all employees, the public at large, and result in damage to University property. Public Law 100-690, the Anti-Drug Abuse Act, was enacted by the federal government in 1988. Title V, Subtitle D, the Drug-Free Workplace Act of 1988, is part of the overall act, which requires State agencies who receive federal grants to certify that they will maintain a drug-free workplace and publish and administer specific drug-free workplace policies and drug awareness programs. Therefore, it is the position of the Mississippi Valley State University that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance in the workplace is prohibited. Any employee violating these prohibitions will be subject to discipline up to and including termination.

1. Mississippi Valley State University does not differentiate between drug users and drug pushers or sellers. Any employee who unlawfully gives or in any way transfers a controlled substance to another person or sells or manufactures or unlawfully uses a controlled substance while on the job, in the workplace, or at a site which the university's work is performed will be subject to discipline up to and including termination.

2. The term "controlled substance" means any drug listed in 21 U.S.C. 812 and other federal regulations. Generally, these are drugs which have a high potential for abuse. Such drugs include, but are not limited to, heroin, marijuana, cocaine, PP, and 'crack'. They also include 'legal drugs' which are not prescribed by a licensed physician.

3. Each employee is required to inform the university appointing authority within five (5) days after he or she is convicted for violation of any federal or state criminal drug statute where such violation occurred in the workplace. A conviction means a finding of guilt, including a plea of guilty or of nolo contender, or the imposition of a sentence by a judge or jury in any federal or state court.

4. The agency appointing authority must notify the U.S. government agency with which the grant was made within ten (10) days after receiving notice form the employee or otherwise receives actual notice of such a conviction.

5. If an employee is convicted of violating any criminal drug statute while in the workplace, he or she will be subject to discipline up to and including termination. Alternatively, the employee may be required to successfully complete an inpatient or outpatient drug abuse program sponsored by an approved private or governmental institution.

6. As a condition of further employment on any federal government grant, all employees are required to abide by these requirements.

I,______________________ , an employee of Mississippi Valley State University, hereby certify that I understand the University's requirements regarding the maintenance of a drug-free workplace. I realize that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited at my workplace. I understand that violating those prohibitions can subject me to discipline up to and including termination. I realize that as a condition of employment, I must abide by the requirements of the University in this regard and I will notify my supervisor of any criminal drug conviction for a violation occurring in the workplace no later than five (5) days after such conviction. I further realize that federal law may mandate that Mississippi Valley State University communicate this conviction to an appropriate federal agency, and I hereby waive any and all claims that may arise for conveying this information to the federal agency.

Employee Signature________________________________ Date__________________

AMERICANS WTH DISABILITIES ACT (ADA)
ACCOMMODATIONS REQUEST FORM

Mississippi Valley State University is committed to equal employment opportunity and affirmative action for the disabled. As a government contractor, the IHL Executive Office is subject to The Americans with Disabilities Act of 1990 (ADA), and therefore must comply with governmental recordkeeping, reporting, and other requirements.

A disabled person is defined as:

1. An individual who has a physical or mental impairment that substantially limits a major life activity;
2. An individual who has a record of a substantially limiting impairment; and
3. An individual who is regarded as having substantially limiting Impairment.

Those who believe themselves covered by the Act and who wish to benefit under Mississippi Valley State Univesity Affirmative Action Plan are asked to identify themselves. All information will be considered confidential except (1) supervisors may be informed regarding work restrictions or accommodations; (2) emergency response workers may be informed for first aid purposes; (3) governmental officials investigating compliance of the Act will be informed. Choosing not to provide this information will not result in adverse treatment or disciplinary action.

DATE: ____________________

NAME: ____________________ SEX: M F (Circle One)

SOCIAL SECURITY NUMBER: ____________ BIRTH DATE: ________

POSITION TITLE: ____________________

DEPARTMENT/OFFICE: ____________________

BRIEFLY DESCRIBE YOUR DISABILITY:

Please describe any reasonable accommodations that you request Mississippi Valley State University to make to enable you to perform your job in a proper and safe manner.

VIETNAM ERA AND SPECIAL DISABLED VETERANS IDENTIFICATION INVITATION

Mississippi Valley State University is committed to equal employment opportunity and affirmative action for Vietnam Era and Special Disabled Veterans. As a government contractor, Mississippi Valley State University is subject to Sections 503 and 504 of the Rehabilitation Act of 1973, The Americans with Disabilities Act of 1990 (ADA), and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974; and therefore must comply with governmental record keeping, reporting, and other requirements.

A "Veteran of the Vietnam Era" is defined as (1) an individual who served more than 180 days of active military, naval, or air service, any part of which was during the period August 5, 1964 through May 7, 1975, and was honorably discharged or released; or (2) was discharged or released because of a service-connected disability.

A "Special Disabled Veteran" is defined as (1) an individual who is entitled to compensation (including those receiving military retirement pay but who would otherwise be entitled to compensation) under laws administered by the Veterans Administration for disability rated at 30 percent or more or rated at 10 or 20 percent in the case of those determined to have a serious employment disability; or (2) an individual discharged or released from active duty because of a service-connected disability.

Veterans, as defined above, are asked to identify themselves by providing the requested information. All information will be considered confidential and will be used only in accordance with meeting the requirements and obligations of the Acts previously mentioned. Choosing not to provide this information will not result in adverse treatment or disciplinary action.

DATE: ______________________________

NAME: ______________________________

SOCIAL SECURITY NUMBER: ______________________________

POSITION TITLE: ______________________________

DEPARTMENT/OFFICE: ______________________________

VETERAN'S STATUS (CHECK ONLY ONE PLEASE):

__________VIETNAM ERA __________ DISABLED VETERAN

Policy Name: Direct Deposit of Pay
Effective Date: October 1, 2009

I. PURPOSE

To outline the policies and procedures for the direct deposit of MVSU employee payroll payments.

II. POLICY

Effective October 1, 2009, all regular full-time and part-time employees are required to participate in payroll direct deposit. Regular employees include faculty, professional, salaried and hourly staff. Temporary employees including graduate students, adjunct faculty and professionals, and other miscellaneous wage employees will be subject to this policy as well.

A. Direct Deposit Financial Institution

Each new or rehired employee, at the time of employment or return to the payroll, shall designate up to three financial institutions and associated checking or savings account for the direct deposit of pay by completing a Direct Deposit Form, available on the MVSU web site or in the Human Resources office. The designated financial institution must be a member of the National Associated Clearing House (NACHA). New employee direct deposit forms are to be sent to the Human Resources Office with other new hire paperwork.

The Direct Deposit Form may also be used by current employees to notify Human Resources of changes

B. Information on Direct Deposit

Direct deposit payments are available in employees' designated accounts at the financial institution's opening of business the morning of payday, ready for check writing or withdrawal through an automated teller machine.

Employees can access their personal payroll data on http://www.sutton2.mvsu.edu. A human resources representative can answer any questions that employees may have about accessing this information online.

MISSISSIPPI VALLEY STATE UNIVERSITY

Direct Deposit Agreement Form

Authorization Agreement

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

Further, I agree not to hold **Mississippi Valley State University** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I also understand that my first payroll check will be prenoted, and therefore mailed. Every check thereafter will be directly deposited into my account.

This agreement will remain in effect until **Mississippi Valley State University** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: ______________________________

Routing Number: ______________________________

Account Number: ____________________ ☐ Checking ☐ Savings $____Amt

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Name of Financial Institution: ______________________________

Routing Number: ______________________________

Account Number: ____________________ ☐ Checking ☐ Savings $____Amt

Signature

Authorized Signature: ______________________________ **Date:** __________

Employee Identification # ______________________________

☐ NEW ACCT ☐ ADD ACCT ☐ CHANGE ACCT ☐ CANCEL ACCT ☐ CHANGE $ AMT

Please attach a voided check and return this form to your human resources representative.

HRD Form Revised 11/11/2008

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

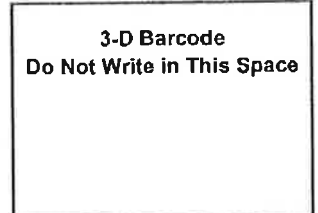
2. Form I-94 Admission Number: ____________

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

Employer Completes Next Page

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:				**3-D Barcode Do Not Write in This Space**
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

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

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
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.
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

OR

LIST B

Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

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

AND

LIST C

Documents that Establish Employment Authorization

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. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
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. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

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.

Form W-4 (2016)

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 2016 expires February 15, 2017. 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 $1,050 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 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 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 2016. 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 . . . **F** ______
(**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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

2016

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 2016, 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 2016 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, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 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 2016 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 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 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 $4,050 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 2016. 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 2016. 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 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 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 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name ______________________ SSN ____________

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

EMPLOYEE:

File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.

EMPLOYER:

Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION		
Marital Status	**Personal Exemption Allowed**	**Amount Claimed**
1. Single	☐ Enter $6,000 as exemption . . . . ▶	$
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 . . . .▶	$
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 . . . .▶		$
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..▶		____________

Military Spouses Residency Relief Act Exemption from Mississippi Withholding

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.