TOWN OF HANOVER
PAYROLL & BENEFITS OFFICE
188 BROADWAY
HANOVER, MASSACHUSETTS 02339
(781) 878-0786

Welcome to the Town of Hanover!

The Payroll and Benefits Office for the Town of Hanover would like to congratulate and welcome you on your new position. The staff is available and prepared to offer assistance with the numerous options offered to all benefit eligible employees.

Please complete all of the enclosed documents. As soon as you complete all of the paperwork, call Audrey Barresi at (781)878-0786 X 23 to set up an appointment. It is very important to bring the required documentation listed below with you to your appointment.

- Conflict of Interest Law Summary and Training **(must bring completed certificate with you when you bring in your new hire paperwork.) Use this link to complete the required training http://www.muniprog.eth.state.ma.us/**
- Voided check or bank authorization form for direct deposit.
- Valid Driver's License and either a social security card or copy of your birth certificate, or a valid U.S. Passport.
- Copy of your birth certificate (for all employees hired for 20+ hours per week)
- Social Security numbers and birthdates for any dependents or beneficiaries you may be including on health, life, or retirement documents.
- Birth Certificates for any dependents you are adding to your health insurance.
- Primary Care Physician (PCP) #'s for health insurance forms.

Prior to beginning your employment, all new employees are required to review the following documents listed below. These notices can be found on our website at http://www.hanover-ma.gov/payrollbenefits-office/pages/required-notices

Children's Health Insurance Program (CHIP) Notice
HIPAA Notice of Privacy Practices
HIPAA Notice of Special Enrollment Rights
Creditable Coverage Disclosure Notice
Health Insurance Marketplace Information
Sexual Harassment Policy

For more information please feel free to contact the office with any questions or concerns at 781-878-0786.

Payroll/Benefits Supervisor	**Lisa Keefe**	**Ext. 14**
Benefits Specialist:	**Audrey Barresi**	**Ext. 23**
Payroll Assistant:	**Lisa Feeney**	**Ext. 18**

Please sign below in acknowledgment that you have been notified of the required employee documents listed.

_____	_____	_____
Employee signature	Benefits Administrator	Date

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)

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q Form **W-4** (2016)

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
M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 1/12

Print full name ..... Social Security no. .....

Print home address ..... City..... State ..... Zip .....

Employee:
File this form or Form W-4 with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:
Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" .....
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C..... .....
3. Write the number of your qualified dependents. See Instruction D..... .....
4. Add the number of exemptions which you have claimed above and write the total..... ☐
5. Additional withholding per pay period under agreement with employer $ _____

   A. ☐ Check if you will file as head of household on your tax return.

   B. ☐ Check if you are blind. C. ☐ Check if spouse is blind and not subject to withholding.

   D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed $8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

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

Date..... Signed .....

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. If you claim **more** than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions **increases**. You **must** file a new certificate within 10 days if the number of exemptions previously claimed by you **decreases**. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a wife or husband, write "4" in line 2. Using "4" is the withholding system adjustment for the $4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

IF THE ALLOWABLE MASSACHUSETTS WITHHOLDING EXEMPTIONS ARE THE SAME AS YOU ARE CLAIMING FOR U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.

TOWN OF HANOVER

PAYROLL & BENEFITS OFFICE
188 BROADWAY
HANOVER, MASSACHUSETTS 02339
(781) 878-0786
Website: www.hanover-ma.gov

DIRECT DEPOSIT

The Town of Hanover offers the use of direct deposit for all employees. This benefit allows you to have your paycheck deposited electronically to any bank account(s) YOU specify. There are no restrictions on your choice of financial institutions.

Direct deposit will benefit you in many ways. There is no need to stand in line at the bank and there will be no hold on your money until your payroll check clears. Your money is available for immediate use each Thursday at 12:01 a.m. To sign up for direct deposit, please complete the information requested below. If your funds will be deposited into a checking account please attach a voided check and return it to the Payroll/Benefits Department.

Name: _____

Department: _____

Primary Direct Deposit

Financial Institution 1: _____

Routing Number _____ Account Number _____

Checking account $ _____ ☐ Savings account $_____

*Net Balance $*_____

Additional Accounts (Savings, Christmas Club, etc.)

Financial Institution 2: _____

Routing Number _____ Account Number _____

Checking account $ _____ ☐ Savings account $_____

Financial Institution 3: _____

Routing Number _____ Account Number _____

Checking account $ _____ ☐ Savings account $_____

I hereby authorize the Town of Hanover to electronically deposit my paycheck to the financial institutions noted above.

Signature_____ Date_____

Please attach either a voided check or a bank authorization form for all direct deposits.

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

Signature of Employer or Authorized Representative	Today's Date*(mm/dd/yyyy)*	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

TOWN OF HANOVER
PAYROLL & BENEFITS OFFICE
188 BROADWAY
HANOVER, MA 02339
(781)878-0876 X23

EMPLOYEE EMERGENCY CONTACT INFORMATION FORM

EMPLOYEE PERSONAL INFORMATION

LAST NAME:	**FIRST NAME:**	**MIDDLE INITIAL**
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
CELL PHONE:	**HOME PHONE:**	
PERSONAL E-MAIL ADDRESS:		

TOWN INFORMATION

WORK PHONE:	**E-MAIL ADDRESS:**

PRIMARY EMERGENCY CONTACT INFORMATION

(emergency contacts should be local)

LAST NAME:	**FIRST NAME:**
CELL PHONE #	**HOME PHONE #:**

SECONDARY EMERGENCY CONTACT INFORMATION

LAST NAME:	**FIRST NAME:**
CELL PHONE #	**HOME PHONE #:**

☐ I CHOOSE NOT TO PROVIDE PERSONAL CONTACT INFORMATION.

ACKNOWLEDGE THAT BY NOT DOING SO THERE MAY BE CRITICAL INFORMATION NOT ABLE TO BE SENT TO ME IN A TIMELY FASHION.

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name Town Of Hanover **Employer ID#** 04-6001171

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945
Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/form1945. Paper copies can be requested by email at oplm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

Criminal Offender Record Information (CORI) Acknowledgement Form

To be used by organizations conducting CORI checks for employment, volunteer, subcontractor, licensing, and housing purposes.

Hanover Public Schools/ Town of Hanover is registered under the
(Organization)
provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for the rental or lease of housing.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to Hanover Public Schools/ Town of Hanover
(Organization)
to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing Hanover Public Schools/ Town of Hanover
(Organization)
with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

The Hanover Public Schools/ Town of Hanover may conduct
(Organization)
subsequent CORI checks within one year of the date this Form was signed by me, provided, however, that
Hanover Public Schools/ Town of Hanover, must first provide me
(Organization)
with written notice of this check.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____
Signature of CORI Subject *Date*

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: ___ ___ -- ___ ___ ___ ___ ☐ No Social Security Number

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION

The above information was verified by reviewing the following form(s) of government-issued identification:

_____

_____

_____

Verified by:

_____

Print Name of Verifying Employee

_____ _____

Signature of Verifying Employee *Date*

TO: ALL TOWN ELIGIBLE EMPLOYEES
FROM: PAYROLL & BENEFITS OFFICE
payroll-benefits@hanoverschools.org

FY 17 INSURANCE RATES

PLAN NAME	GROUP	WEEKLY	BI WEEKLY	21 PAY*	42 PAY*	39 PAY*	39 PAY* - LTS- 10 MONTH	EMPLOYEE MONTHLY COST
BCBS- **Blue Care Elect Rate Saver**	Individual	$129.50	$259.00	$296.00	$148.00	$159.38	$132.82	$518.00
	Family	$307.00	$614.00	$701.71	$350.86	$377.85	$314.87	$1,228.00
BCBS- **Blue Care Elect Benchmark**	Individual	$120.75	$241.50	$276.00	$138.00	$148.62	$123.85	$483.00
	Family	$286.50	$573.00	$654.86	$327.43	$352.62	$293.85	$1,146.00
BCBS- **Network Blue Rate Saver**	Individual	$89.00	$178.00	$203.43	$101.71	$109.54	$91.28	$356.00
	Family	$237.25	$474.50	$542.29	$271.14	$292.00	$243.33	$949.00
BCBS- **Network Blue Benchmark**	Individual	$85.25	$170.50	$194.86	$97.43	$104.92	$87.44	$341.00
	Family	$227.13	$454.25	$519.14	$259.57	$279.54	$232.95	$908.50
HARVARD PILGRIM - **HMO Rate Saver**	Individual	$96.00	$192.00	$219.43	$109.71	$118.15	$98.46	$384.00
	Family	$255.63	$511.25	$584.29	$292.14	$314.62	$262.18	$1,022.50
HARVARD PILGRIM - **Benchmark**	Individual	$92.00	$184.00	$210.29	$105.14	$113.23	$94.36	$368.00
	Family	$245.00	$490.00	$560.00	$280.00	$301.54	$251.28	$980.00
RETIREES								
BCBS-Medex	Individual Only							$218.50
HPHC Medicare Enhance	Individual Only							$241.50

Dental Insurance (Active Employees Only)

Dental is offered as an optional insurance with no Town contribution. There is NO increase for the FY17 year.

Plan Name	Group	Weekly	Bi Weekly	21 Pay*	42 Pay*	39 Pay*	39 LTS Pay* 10 month	Employee's Monthly Cost
Delta Dental Premier	Individual	$9.75	$19.50	$22.29	$11.14	$12.00	$10.00	$39.00
Delta Dental Premier	Family	$24.25	$48.50	$55.43	$27.71	$29.85	$24.87	$97.00

*21 -Pay applies to Teachers only
*42- Pay applies to paraprofessionals and tutors
*39- Pay applies to cafeteria employees
*39 LTS Pay- applies to 10 Month coverage

Employee Acknowledgement:
(Employees with MMHG health insurance must sign and return to employer)

- I understand that I am required to notify my employer within thirty (30) days of the following events:

  a. marriage
  b. birth of a child
  c. adoption of a child or placement for adoption
  d. legal guardianship
  e. divorce
  f. death of a dependent
  g. dependent's loss of status as a dependent (except for turning age 26)
  h. myself, my spouse or dependent becoming eligible for Medicare and/or enrolling in Medicare
  i. divorced spouse's re-marriage
  j. change of address

Caution: Failure to notify your employer that your dependent(s) is/are no longer eligible may result in being financially responsible for any claims that were paid for an ineligible dependent. Your contract may be cancelled retroactively if you have committed fraud or misrepresented yourself and/or dependent(s).

- I understand that I may cancel health insurance for myself and/or dependent(s) voluntarily at any time with 30 days advance notice.

- If I refuse health insurance or cancel coverage I understand that I may only enroll during the next open enrollment period (effective July 1st) unless a valid qualifying event occurs.

- I have received the comparison of benefits, Summary of Benefits and Coverage (SBC) and/or other benefit plan summary information that explain my health insurance benefits, HIPAA notice of privacy practices **or** have gone online to receive this information at www.MMHG.org

Mayflower Municipal Health Group reserves the right to request additional information to support eligibility in accordance with G.L. c.32B section 6.

In order to process your Health Insurance enrollment please read this form, sign, and date. Attach this document to your completed enrollment application. Please keep a copy of this form for your records.

VISIT US ON THE WEB AT: WWW.MMHG.ORG

_____ _____
Signature (subscriber) **Date**

Print Name:_____ / Employer/Governmental Unit:_____

Email address _____ (you will receive wellness email updates with important incentive programs and your email address will not be shared with anyone)

Insurance plan selected (circle one): BCBS HP / Type of plan (circle one): IND FAM

TOWN OF HANOVER
PAYROLL & BENEFITS OFFICE
188 BROADWAY
HANOVER, MASSACHUSETTS 02339
781-878-0786

HEALTH-LIFE-DENTAL INSURANCE – DENIAL FORM

I have been offered Health Insurance Benefits with the Town of Hanover and do not accept any at this time. I understand that if I am eligible, I have the option of joining at the time of open enrollment.

Signed: _____ Date: _____

I have been offered Life Insurance Benefits with the Town of Hanover and do not accept the benefit at this time. I understand that if I opt for Life Insurance in the future, I must complete a physical exam to be accepted by the Insurance Company.

Signed: _____ Date: _____

I have been offered Dental Insurance Benefits with the Town of Hanover and do not accept the benefit at this time. I understand that if I am eligible, I have the option of joining at the time of open enrollment.

Signed: _____ Date: _____

BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE ***Please refer to your Administration Kit for enrollment and mailing instructions***

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

Employer/Policyholder _____ Dept. ID _____

Employee Name *(Last, First, Middle)* _____ Social Security Number ☐☐☐☐☐☐☐☐☐

Home Address *(Street, City, State, Zip)* _____ ( ) Telephone # _____

Gender *(M/F)* _____ Occupation or Job Title _____ Date of Birth _____ Age _____ PAYROLL TYPE: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Annual Earnings: $ _____

Average Hours Worked _____ Date of Hire _____ or Date of Full Time Employment if different _____ Effective Date _____ State _____ Class _____

Spouse *(Last, First, Middle)* _____ Gender *(M/F)* _____ Date of Birth _____ Age _____ No. of Dependents _____

LIFE

You Must Have Basic Coverage to Elect Voluntary Coverage

BASIC:

Group # _____ **Div.** _____

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$ _____

You Must Have Voluntary Coverage to Elect Dependent Coverage

VOLUNTARY:

Group # _____ **Div.** _____

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$ _____
SPOUSE	❑	❑	$ _____

DEPENDENT LIFE:

CHILD(REN)	❑	❑	$ _____

BENEFICIARY

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: *(Total Percentage of Benefit must equal 100%)* **List Additional Beneficiaries on separate sheet**

Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit
Contingent Beneficiary(ies):						

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

ACCEPTANCE OF INSURANCE - *Employee Signature Required*

SIGNATURE

I apply for the insurance for which I am now eligible *(or for which I may become eligible)* under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. *I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ **Date** _____

REFUSAL OF INSURANCE

Employee Name _____ *(Last, First, Middle)* Employee/Policyholder _____ Group No. _____

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer *(or the Association with whom I am affiliated)* and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

❑ Basic Life & AD&D ❑ Voluntary Life & AD&D ❑ Dependent Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

BOSTON MUTUAL LIFE INSURANCE PROGRAM

TOWN OF HANOVER

BASIC LIFE AND AD&D INSURANCE GROUP # G-25937 DIV 1

	Life	AD&D
Active Employees	$2,000	$2,000
Municipal Employees	$5,000	$5,000
Upon retirement	$2,000	$2,000

VOLUNTARY LIFE & AD&D INSURANCE GROUP # G-25937 DIV 3

You must be enrolled in the Basic Life Insurance to join this plan

Active Employees: Choice of $5,000 to $50,000 in increments of $5,000 (All Guarantee Issue)

Cost: $.80 per $1,000 per month (100% employee paid)

		(Cost per month)
Active Employees:	$ 5,000	$ 4.00
	$10,000	$ 8.00
	$15,000	$12.00
	$20,000	$16.00
	$25,000	$20.00
	$30,000	$24.00
	$35,000	$28.00
	$40,000	$32.00
	$45,000	$36.00
	$50,000	$40.00

Dependent Life:	**Spouse:**	**$5,000**
(Employee must have voluntary coverage to elect dependent coverage)	**Children:**	
	14 days to 6 months	**$ 400**
	6 months to age 19; (to age 25, if full-time student)	**$2,000**

Cost for Dependent Life coverage: $2.16 per family per month

Retirees: Upon retirement, Life and Accidental Death and Dismemberment benefits reduce to $5,000.

All benefits, including dependent life, for Active employees and Retirees shall terminate at age 75.

Basic & Voluntary Life Insurance Includes:
Accidental Death & Dismemberment Insurance (AD&D)
Waiver of Premium
Right to Convert

TOWN HANOVER VOLUNTARY TERM LIFE AND D RATES

Must have Basic Life to sign up for Optional Life

GUARANTEED ISSUE AMOUNTS			
AGE	Under 60	60 - 69	70 & Over
Employee	$ 100,000	$ 50,000	$10,000
Spouse	$ 30,000	$ 20,000	Not Eligible
Dependent	$ 5,000		

MONTHLY PREMIUM

Age	Monthly Premium Rate per 1,000	10,000	20,000	30,000	40,000	50,000	60,000	70,000	80,000	90,000	**100,000**
<35	*$0.11*	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	***$11.00***
35-39	*$0.15*	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00	$13.50	***$15.00***
40-44	*$0.22*	$2.20	$4.40	$6.60	$8.80	$11.00	$13.20	$15.40	$17.60	$19.80	***$22.00***
45-49	*$0.34*	$3.40	$6.80	$10.20	$13.60	$17.00	$20.40	$23.80	$27.20	$30.60	***$34.00***
50-54	*$0.54*	$5.40	$10.80	$16.20	$21.60	$27.00	$32.40	$37.80	$43.20	$48.60	***$54.00***
55-59	*$0.80*	$8.00	$16.00	$24.00	$32.00	$40.00	$48.00	$56.00	$64.00	$72.00	***$80.00***
60-64	*$1.24*	$12.40	$24.80	$37.20	$49.60	$62.00	$74.40	$86.80	$99.20	$111.60	***$124.00***
65-69	*$1.98*	$19.80	$39.60	$59.40	$79.20	$99.00	$118.80	$138.60	$158.40	$178.20	***$198.00***
70-74	*$3.14*	$31.40	$62.80	$94.20	$125.60	$157.00	$188.40	$219.80	$251.20	$282.60	***$314.00***
75>	*$5.39*	$53.90	$107.80	$161.70	$215.60	$269.50	$323.40	$377.30	$431.20	$485.10	***$539.00***

****EMPLOYEE MUST HAVE COVERAGE IN ORDER TO INSURE SPOUSE AND/OR CHILDREN****

* EMPLOYEE LIFE & AD&D = $10,000 TO A MAXIMUM OF $500,000 (NOT TO EXCEED 5 TIMES SALARY)
* SPOUSE LIFE & AD&D = $5,000 TO A MAXIMUM OF $100,000 (NOT TO EXCEED 50% OF EMPLOYEE BENEFIT)
* DEPENDENT (LIFE ONLY) - $500 AGE 14 DAYS TO 1 YEAR; $5,000 AGE 1 YEAR TO AGE 19 OR 25 IF FULL TIME STUDENT ($.95/MONTH)
* DEPENDENT CHILD(REN) - (LIFE ONLY) COVERAGE ALL GUARANTEE ISSUE

AMOUNTS OVER THE GUARANTEE ISSUE LIMITS REQUIRE EVIDENCE OF INSURABILITY FORM AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION FORM BE COMPLETED AND SUBMITTED WITH THE ENROLLMENT FORM.

NEW MEMBER ENROLLMENT FORM

Plymouth County Retirement Association
10 Cordage Park Circle, Suite 234
Plymouth, MA 02360
Phone: (508) 830-1803
Fax: (508) 830-1875

EMPLOYEE NAME _____ SSN _____ SEX_____
(Last) (First) (Middle)

ADDRESS_____
(Street and Number) (City/Town) (State) (Zip Code)
BIRTH NAME (If Different)_____

MARITAL STATUS

DATE OF BIRTH*_____ AGE_____ # OF CHILDREN _____ M (__) S (__) W (__) D (__) SPOUSE DATE OF BIRTH _____
GOVERNMENTAL ENTITY_____
AGENCY OR DEPARTMENT_____ TITLE/POSITION_____
STARTING DATE OF PRESENT SERVICE_____ RATE OF REGULAR COMPENSATION _____Per_____

Please list any previous or concurrent employment with the Commonwealth of Massachusetts or with any other City/Town or County. (State place of employment, dates and name if different from above)

_____

_____

Were you ever a member of any other Retirement System? _____ If "Yes", did you withdraw your funds? _____
(If your funds were withdrawn and you wish to redeposit same at this time, you must submit a written request to this Board.
Are you currently or have you ever received a retirement allowance from another retirement system? _____
Are you a Veteran?* _____ Dates of Active Service _____

***A COPY OF BIRTH RECORD, MILITARY DISCHARGE PAPERS AND OTHER PERTINENT DATA WILL BE REQUESTED BY THE RETIREMENT BOARD**

I have carefully and truthfully filled out this form. I hereby authorize the Treasurer to withhold the proper percent of my regular compensation due on each pay day and to deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with compound interest if provided by the retirement act, will be returned to me upon request if I terminate my service before becoming eligible for retirement, unless to accept a position which would entitle me to become a member of any other similar contributory retirement system in the Commonwealth of will be paid to my beneficiary or beneficiaries if provided by the retirement act in case of death.

The above statements are true and correctly recorded to the best of my knowledge and belief and are made under the penalties of perjury.

DATE:_____ EMPLOYEE'S SIGNATURE_____

TO BE COMPLETED BY PAYROLL DEPARTMENT:
Check base rate to be deducted for retirement:
5% ( ) 7% ( ) 8% ( ) 9% ( ) 2% ( )
(Check all which apply) Permanent ( ) Temporary ( ) Full-Time ( ) Part-time: 50% ( ) 75% ( ) Other_____

DATE:_____ Authorized Signature_____

TO BE COMPLETED BY THE RETIREMENT BOARD:

Membership Date: _____ Annual Compensation_____ % to be deducted_____ Group _____

FORM MUST BE COMPLETED IN ITS ENTIRETY AND BENEFICIARY DESIGNATED ON THE REVERSE SIDE

NOMINATION OF BENEFICIARY

G. L. Chapter 32, Section 11(2)(c). Any member, upon his written notice on a prescribed form filed with the board prior to his death, may nominate, and from time to time change, one or more beneficiaries to receive in designated proportions any sum becoming payable under the provisions of this subdivision on his death; provided, that any such beneficiary nominated by a minor shall be of his kindred. The payment of any such sum or portion thereof to his beneficiary or beneficiaries of record surviving at his death shall bar the recovery of such payment by any other person. If there is no beneficiary of record or if any beneficiary of record is not living at the death of such member, such sum or the amount which would have been paid to such beneficiary if he had survived such member, as the case may be, shall be paid to the legal representatives of such member; provided, that if any such sum or amount does not exceed three hundred dollars, and if there has been no written demand upon the Board for payment thereof by a duly appointed executor or administrator of the estate of such member and the Board has not otherwise been informed that probate proceedings relative to such estate have been commenced, such sum or amount may be paid after the expiration of ninety days from the date of death of such member, to the person or persons appearing in the judgment of the Board to be entitled thereto. The payment of any such sum or amount in such a manner, or to the natural or legal guardian or conservator of a minor or incompetent beneficiary, shall constitute a legal settlement of all claims on account thereof to the extent of such payment and shall bar recovery of such payment by any other person.

Payment shall not be made under this subdivision if the deceased member is survived by a beneficiary appointed under Option (d) of subdivision (2) of Section 12 who is eligible to receive the allowance provided by said option, nor if the deceased member is survived by a person eligible to receive the allowance provided for in Section 12B, or is survived by a child eligible to receive the allowance provided for in Section 12B, unless the widow or person acting for such child elects, in lieu of receiving allowances provided for in said Section 12B, to have payment of any monies due made in accordance with the provisions of this paragraph.

Beneficiary or beneficiaries nominated will receive in the proportion designated any sum due at your death. The right to change any nominated beneficiary is reserved by the member.

A BENEFICIARY BLANK WITH CORRECTIONS OR ERASURES IS NOT ACCEPTABLE

NAME AND ADDRESS OF BENEFICIARY	BENEFICIARY DATE OF BIRTH	RELATIONSHIP TO MEMBER	PROPORTION OF BENEFIT

DATE:_____ SIGNATURE OF EMPLOYEE:_____

SIGNATURE OF WITNESS:_____

(A CHANGE OF BENEFICIARY FORM must be used if you wish to change your designated beneficiary/beneficiaries. You may obtain said form from your payroll department or from your Board of Retirement)

What Are "Life Problems"?

Life problems affect our personal lives and can affect our job performance. Among typical problems **EAP Network** can help you or a loved one with include:

- marital problems
- family problems
- couples conflict
- alcohol and other drug issues
- legal concerns
- financial issues
- problems with children
- problems with parents
- aging issues
- child care issues
- stress
- mental illness
- depression
- grief
- anxiety
- crisis intervention
- workplace crisis
- traumatic events
- domestic violence
- smoking cessation
- health or weight concerns
- gender problems

(partial list)

Employees

...in their own words...

"I was desperate when I called EAP Network and an appointment was arranged the next day. It was a huge relief."

"I would recommend EAP Network to anyone."

"After my divorce I thought everything would be better, but it got worse. Money problems mounted, the kids acted up and their school work suffered. I called EAP Network and now have a clear financial plan. They also helped me, and family counseling has improved things for me and the kids."

"I called EAP Network for legal help. They were right here when I needed them."

EAP Network

For Confidential Assistance Call:

EAP Network

1-800-333-6624

www.eapnetwork.com

EAP Network

Your Employer Has Provided This Employee Assistance Program

We All Have "Life Problems"

...legal, financial and emotional... that leave us uncertain. Sometimes we are able to solve these problems ourselves, especially if they are simple. Often we need the help of an experienced professional. Now comes more uncertainty. Where do you turn for help? Who can you trust? How much will it cost?

Your employer has provided a FREE, CONFIDENTIAL benefit to help you during those uncertain times.

EAP Network is here to help you when life presents problems. We have been helping employees and those they love for decades and with successful outcomes. But we know you have more questions about EAP, so here we answer some common questions.

What is an Employee Assistance Program?

EAP Network, your employee assistance program (EAP), provides you and your loved ones with counseling or consultations to help you with "life problems" whether they are legal, financial or emotional.

Always completely confidential, your EAP is available 24 hours a day, 7 days a week. Your employer has put this program in place for the health and well being of each and every employee. Neither your employer nor co-workers will know of your request for help.

How Does It Work?

By calling **EAP Network** at:

1-800-333-6624

anytime day or night, you or a family member can speak in confidence with a trained professional about any personal issue and arrange to meet with a counselor face to face. Your "family" can be anyone you decide needs help. Your loved one will get the same benefit, same professional service and can call on his/her own. No special ID's or numbers are needed... just a call.

Who Will Be Helping Me?

The professionals who are part of EAP Network are licensed and degreed. They are among the most experienced in their field. The lawyers, therapists or financial planners you will meet with are located close to your work or home.

For legal problems, a face to face legal consultation with a qualified lawyer is provided at no cost and with no obligation. For financial help, a meeting with an adviser is arranged. Whether you need help to get out of debt or start a savings plan, the financial planning is personalized and free. If an emotional problem has you or a family member confused, our counselors can provide free, short term counseling. In many cases, that is all that is needed. If more counseling is necessary, your full insurance benefit is available for you to continue with your current counselor or another of your choice.

No Conflict of Interest

Rest assured that any recommendations made to you by EAP Network staff are with your best interests in mind. Your employer pays an annual, fixed fee for this benefit and EAP Network receives no money for any referral it makes. Our only obligation is to provide you with the best help available.

EAP Network