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PLEASE INCLUDE DIRECT DEPOSIT INFORMATION AND A COPY OF YOUR SOCIAL SECURITY CARDS FOR ALL AND YOUR DRIVERS LICENSE.

IF OPTING FOR HEALTH INSURANCE AND ADDING A SPOUSE PLEASE HAVE A COPY OF THE MARRIAGE CERTIFICATE FROM THE CITY/TOWN

IF ADDING CHILDREN TO HEALTH INSURANCE PLEASE HAVE THE CITY/TOWN BIRTH CERTIFICATES

Please contact Deb Kuhn @ 413-685-1014 or [dkuhn@grsd.org](mailto:dkuhn@grsd.org) after you have completed all paperwork to set up an appointment to complete the hiring process.

## G.R.S.D. FACULTY/STAFF PARKING PERMIT

Parking Decal # \_\_\_\_\_

Name \_\_\_\_\_ Department \_\_\_\_\_

Make/Model #1 \_\_\_\_\_ Year \_\_\_\_\_ Color \_\_\_\_\_

Registration No. \_\_\_\_\_

Make/Model #2 \_\_\_\_\_ Year \_\_\_\_\_ Color \_\_\_\_\_

Registration No. \_\_\_\_\_

Make/Model #3 \_\_\_\_\_ Year \_\_\_\_\_ Color \_\_\_\_\_

Registration No. \_\_\_\_\_

Staff Signature \_\_\_\_\_

Date \_\_\_\_\_

### Memorandum

To: Gateway Regional School District Employees

From: Kelly Sudnick, MSN, RN Nurse Leader

Re: Varicella (Chicken Pox)

Per the Massachusetts Department of Public Health, staff and students must be excluded in the event of a Chicken Pox outbreak if they have no history of having the Varicella immunization or if they have not had the disease. Please check which one applies to you:

Name of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

☐ I have had Chicken Pox

☐ I have had the Varicella (Chicken Pox) vaccine

☐ I have proof of immunity

☐ I have never had Chicken Pox or the Varicella vaccine

(Central Office Personnel Only)

\*Submit a copy to Nurse Leader

***Gateway Regional School District***

12 Littleville Road  
Huntington, MA 01050

(413) 685-1000 - Telephone  
(413) 667-8739 - FAX

***Kristen Smidy***  
***Superintendent***

***Stephanie Fisk***  
***Business & Finance Officer***

I \_\_\_\_\_

WILL REVIEW AND COMPLY WITH THE GATEWAY REGIONAL SCHOOL DISTRICT  
POLICIES ON THE GATEWAY REGIONAL SCHOOL DISTRICT WEBSITE

PLEASE GO TO: [WWW.GRSD.ORG](http://WWW.GRSD.ORG)

CLICK ON:

SCHOOL COMMITTEE/POLICIES

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

## Employee's Withholding Certificate

OMB No. 1545-0074

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.  
Give Form W-4 to your employer.  
Your withholding is subject to review by the IRS.

**2023**

<b>Step 1:</b> <b>Enter Personal Information</b>	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 **ONLY** if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

**Step 2:**  
**Multiple Jobs or Spouse Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

**TIP:** If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only **ONE** of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 \$		
	Multiply the number of other dependents by \$500 . . . . . \$		
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . .	<b>3</b>	\$
<b>Step 4 (optional):</b> <b>Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . .	<b>4(a)</b>	\$
	(b) <b>Deductions.</b> If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . .	<b>4(b)</b>	\$
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . .	<b>4(c)</b>	\$

<b>Step 5:</b> <b>Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)

## General Instructions

Section references are to the Internal Revenue Code.

### Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

### Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

**Exemption from withholding.** You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 and you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

**Your privacy.** If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

**Self-employment.** Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

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

## Specific Instructions

**Step 1(c).** Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

**Step 2.** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



**Multiple jobs.** Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

**Step 3.** This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Step 4 (optional).

**Step 4(a).** Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

**Step 4(c).** Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

**Step 2(b) — Multiple Jobs Worksheet** (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

**Note:** If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** \$ \_\_\_\_\_
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
  - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** \$ \_\_\_\_\_
  - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** \$ \_\_\_\_\_
  - c** Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** \$ \_\_\_\_\_
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** \_\_\_\_\_
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** \$ \_\_\_\_\_

**Step 4(b) — Deductions Worksheet** (Keep for your records.)

- 1** Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** \$ \_\_\_\_\_
- 2** Enter: 

{	• \$27,700 if you're married filing jointly or a qualifying surviving spouse	}	. . . . .	<b>2</b>	\$ _____
	• \$20,800 if you're head of household				
	• \$13,850 if you're single or married filing separately				

 . . . . .
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** \$ \_\_\_\_\_
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . . **4** \$ \_\_\_\_\_
- 5** Add lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** \$ \_\_\_\_\_

**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 with no other entries on the form; 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 territories 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.

**Married Filing Jointly or Qualifying Surviving Spouse**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 89,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

**Single or Married Filing Separately**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

**Head of Household**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600



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 elect to 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 IF YOU CLAIM THE SAME NUMBER OF EXEMPTIONS FOR MASSACHUSETTS AND U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.

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.

150M 7/97 CRP0198



# Request for Taxpayer Identification Number and Certification

Give Form to the  
requester. Do not  
send to the IRS.

► Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Print or type.  
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► \_\_\_\_\_  
**Note:** Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ► \_\_\_\_\_

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) \_\_\_\_\_

Exemption from FATCA reporting code (if any) \_\_\_\_\_

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

				-			-				
--	--	--	--	---	--	--	---	--	--	--	--

or

Employer identification number

				-							
--	--	--	--	---	--	--	--	--	--	--	--

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign  
Here

Signature of  
U.S. person ►

Date ►

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.



**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 10/31/2022

► **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):**

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
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: _____ <b>OR</b> 2. Form I-94 Admission Number: _____ <b>OR</b> 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):**

<input type="checkbox"/> I did not use a preparer or translator.	<input type="checkbox"/> A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
<i>(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)</i>	

**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



**Employer Completes Next Page**





**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 10/31/2022

**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.")

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
-------------------------------------	-------------------------	-------------------------	------	--------------------------------

<b>List A</b> Identity and Employment Authorization	<b>OR</b>	<b>List B</b> Identity	<b>AND</b>	<b>List C</b> 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		<div>Additional Information</div> <div>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
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		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.)**

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>
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 report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:  a. Foreign passport; and  b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
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		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 the Handbook for Employers (M-274).**

**Refer to the instructions for more information about acceptable receipts.**

GATEWAY REGIONAL SCHOOL DISTRICT  
BLANDFORD-CHESTER-HUNTINGTON-MIDDLEFIELD-  
MONTGOMERY-RUSSELL-WORTHINGTON

May 7, 2012 Update

**CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT  
FORM**

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR  
EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING AND HOUSING  
PURPOSES.

Gateway Regional School District is registered under the provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified employees, subcontractors, volunteers, license applicants, current licenses, and applications for the rental or lease of housing. As a prospective or current employee, subcontractor, volunteer, license applicant, current license, 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 Gateway Regional School District 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 Gateway Regional School District with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY: The Gateway Regional School District may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Gateway Regional School District must first provide me with written notice of this check.

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

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

(SEE BACK)

---District Vision Statement---

The Gateway Regional School District will provide an exemplary education that challenges all students in an instructional setting appropriate to their needs.

## SUBJECT INFORMATION

Reason for submitting this form (please circle one): Employment, Volunteer/Chaperone, Intern,  
Other: \_\_\_\_\_

_____	_____	_____	_____
Last Name	First Name	Middle Name	Suffix

\_\_\_\_\_

Maiden Name (or other name(s) by which you have been known)

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Place of Birth

\_\_\_\_\_

Last Six Digits of Your Social Security Number: (XXX-\_\_\_\_-\_\_\_\_)

Sex: \_\_\_\_\_ Height: \_\_\_\_ ft. \_\_\_\_ in. Eye Color: \_\_\_\_\_ Race: \_\_\_\_\_

Driver's License/ID Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

(please provide a copy)

\_\_\_\_\_

Mother's Full Maiden Name

\_\_\_\_\_

Father's Full Name

Current and Former Addresses:

_____	_____	_____	_____
Street Number & Name	City/Town	State	Zip

_____	_____	_____	_____
Street Number & Name	City/Town	State	Zip

\_\_\_\_\_

The above information was verified by the following form(s) of governmental issued identification.

\_\_\_\_\_

VERIFIED BY:

\_\_\_\_\_

Name of Verifying Employee (Please Print)

\_\_\_\_\_

Signature of Verifying Employee

GATEWAY REGIONAL SCHOOL DISTRICT  
BLANDFORD-CHESTER-HUNTINGTON-MIDDLEFIELD-  
MONTGOMERY-RUSSELL-WORTHINGTON

June, 2013

On January 10, 2013, Governor Deval Patrick signed into law G.L. Chapter 459 of the Acts of 2012, An Act Relative to Background Checks. The new law requires all newly hired school employees in Massachusetts, beginning in the 2013-2014 school year, to submit to national fingerprint-based criminal background checks in addition to state CORI checks.

The Commonwealth is developing regulations, policy and procedures to meet the requirements of this new law. As of today, a system is not yet in place for school employers to conduct a national fingerprint-based criminal background check.

As a new employee of the Gateway Regional School District, you will be subject to a Massachusetts criminal background check (CORI), which must be completed before you may begin work. In addition, you will be required to submit to a national criminal background check by submitting your fingerprints when that system is available. The Executive Office of Public Safety and Security and the Department of Criminal Justice Information Services, working with the Executive Office of Education, the Department of Elementary and Secondary Education, and the Department of Early Education and Care, are in the process of establishing the procedures for taking fingerprints, submitting them to the national database and returning reports to school employers. Under c. 459, the individual employee or prospective employee is responsible for the cost of the national criminal background check.

Your continued employment in the Gateway Regional School District is conditioned upon completion and assessment of a national criminal background check as well as the state CORI check already completed.

Please sign below indicating your understanding and acknowledgement of these conditions of employment and the required national criminal background check.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For more information regarding national criminal background checks, please visit <http://www.mass.gov/eopss/agencies/dcjis/>

---District Vision Statement---

The Gateway Regional School District will provide an exemplary education that challenges all students in an instructional setting appropriate to their needs.



**GATEWAY REGIONAL SCHOOL DISTRICT**  
**BLANDFORD-CHESTER-HUNTINGTON-MIDDLEFIELD-**  
**MONTGOMERY-RUSSELL**

**To: New Employee**

**From: Stacy Stewart**

**Re: National Fingerprint Instructions**

- Go to [www.identogo.com](http://www.identogo.com)
- Click on Get Fingerprinted
- Choose Massachusetts
- Click Digital Fingerprinting
- Choose Schedule a new Appointment
- Choose PreK-12<sup>th</sup> Grade Education (ESE)
- Choose either Certified Staff (anyone with DESE Certification) or All Other School Personnel
- Confirm Choice
- Provider ID 06720000
- Enter Zip Code to Determine Finger Printing Location or Choose an area
- Choose a location and date to see the schedule
- Continue on with remaining website instructions.

For more information regarding national criminal background checks, please visit <http://www.mass.gov/eopss/agencies/dcjis/>

---District Vision Statement---

The Gateway Regional School District will provide an exemplary education that challenges all students in an instructional setting appropriate to their needs.

**AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED CREDITS**

**Bank Name:** \_\_\_\_\_

**Bank Address:** \_\_\_\_\_

Depositor Account Number: \_\_\_\_\_ (City) \_\_\_\_\_ (State)

It is understood that this agreement may be terminated by me (either of us) at any time by written notification to COMPANY or BANK. Any such notification to COMPANY shall be effective only with respect to entries initiated by COMPANY after receipt of such notification and a reasonable opportunity to act on it. Any such notification to BANK shall be effective only with respect to entries credited to my (our) account by BANK after receipt of such notification and a reasonable opportunity to act on it.

Customer Name(s): \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

**To Be Completed by the Company**

Company ID No.: \_\_\_\_\_

Depositor account number information: \_\_\_\_\_

[illegible]

**NOTE:** When completing account number information, insert a hyphen ( - ) for each Dash Cue Symbol ( ||| ) contained in the field, and insert a number sign ( # ) for each "On Us" Cue Symbol ( ||| ).

The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Division of Health Care Finance and Policy

**Employee Health Insurance Responsibility Disclosure Form**

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at < [www.mahealthconnector.org](http://www.mahealthconnector.org) >.

*Employers: please complete this section. See reverse side for instructions.*

**Employer Name:** GATEWAY REGIONAL SCHOOL DISTRICT **FEIN:** 04-6006503

**Employer D/B/A:** \_\_\_\_\_

**Employer Address:** 12 Littleville Road

**City | State | ZIP Code:** Huntington, MA 01050

1. Did you offer a "Section 125 Cafeteria Plan" to this employee?

Yes ☐

No ☐

2. Did you offer employer sponsored health insurance to this employee?

Yes ☐

No ☐

3. If you offered sponsored insurance to this employee, what is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee? (If did not offer sponsored insurance, leave blank.)

\$

*Employees: please complete this section. See reverse side for instructions.*

**Employee First Name**

**Middle Initial**

**Employee Last Name**

**Suffix (e.g., Sr, Jr.)**

1. Did you accept your employer sponsored health insurance?

Yes ☐

No ☐

None ☐  
Offered ☐

2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase health insurance?

Yes ☐

No ☐

None ☐  
Offered ☐

3. Do you have other health insurance?

Yes ☐

No ☐

**Employee Affidavit**

I hereby affirm, under penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

**Employee Signature**

**Date (MM/DD/YY)**

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Department of Revenue as required by state regulation 114.5 CMR 18.00.

**Please Read the Instructions  
Before Filling Out This Form.**

Please TYPE OR PRINT CLEARLY using blue  
or black ink to avoid coverage delay or type in information



**MASSACHUSETTS**

**Enrollment and Change Form**

Please mail to: P.O. Box 986001  
Boston, MA 02298 or fax to 1-617-246-7531

**1. To Be Filled Out by Your Employer**

Company Name <b>GATEWAY REGIONAL SCHOOL DIST</b>		Current Medical Group #:		Medical Group #, Transferring To	
Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group #, Transferring To	
Type of Transaction <input type="checkbox"/> ADD <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE    Three digit termination code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TRANSFER		Remarks: (i.e., qualifying event for a new add, change to family or other instruction) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change to Family <input type="checkbox"/> New Hire <input type="checkbox"/> Add Spouse <input type="checkbox"/> COBRA <input type="checkbox"/> Add Dependent <input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter Required) <input type="checkbox"/> Other: _____			

**2. Yourself (Member 1)**

What products? <input type="checkbox"/> Access Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> Blue Choice New England	<input type="checkbox"/> Blue Medicare Rx (Part D) <input type="checkbox"/> Dental Blue <input type="checkbox"/> HMO Blue	<input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Managed Blue for Seniors <input type="checkbox"/> Medex (Group)	<input type="checkbox"/> Network Blue <input type="checkbox"/> PPO <input type="checkbox"/> Saver Blue	Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family
Your First Name	M.I.	Last Name	Sex	Date of Birth	
Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code	
Home Phone ( )	Cell Phone ( )	Email		City / State	
Social Security # (REQUIRED) <sup>1</sup>	Other Insurance? <sup>2</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	City / State		
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		
Are you covered by Medicare? <sup>2</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date
3. Member 2			Please Check One: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced Spouse (court ordered)    Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental		

First Name	M.I.	Last Name	Sex	Date of Birth	
Social Security # (REQUIRED) <sup>1</sup>	Phone ( )	Other Insurance? <sup>1</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	City / State	
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		
Are you covered by Medicare? <sup>2</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date

**4. Your Eligible Dependents (Member 3, 4, and 5)**

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth	
Social Security # (REQUIRED) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP	City / State		
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/>	Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth	
Social Security # (REQUIRED) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP	City / State		
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/>	Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth	
Social Security # (REQUIRED) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP	City / State		
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/>	Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental		

Please check if you are using separate forms for additional dependent children ☐    Total # of dependents: \_\_\_\_\_

<input type="checkbox"/> HSA: Health Savings Account	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): \$
<input type="checkbox"/> FSA: Health Flexible Spending Account	Start Date	End Date	Health: \$
<input type="checkbox"/> FSA: Dependent Care Reimbursement Account	Start Date	End Date	Dependent Care: \$

**6. Signature (Employer & Employee)**

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_ Employer's Signature \_\_\_\_\_ Date \_\_\_\_\_

**REQUIRED:** Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.  
If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

## HAMPSHIRE COUNTY GROUP INSURANCE TRUST

### Subscriber Affidavit of Marital Status

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*Please print*

Subscriber Name: \_\_\_\_\_

Address: \_\_\_\_\_

Town/City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Best Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Dependent Spouse or Former Spouse:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address (If different than above): \_\_\_\_\_

**Are you currently legally married to this dependent? YES / NO**

If YES, attach a photocopy of the City/Town Clerk's marriage certificate.

If NO, attach a copy of signature page of divorce and page relating to health insurance provision.

**Are you remarried? NO / YES**

If Yes, Date of remarriage: \_\_\_\_\_

**Is your former spouse remarried? YES / NO / Unknown**

If YES, Date of marriage: \_\_\_\_\_

*Please initial each after reading:*

\_\_\_\_\_ I hereby certify that the information provided above is true and accurate.

\_\_\_\_\_ I understand that I am obligated to inform my employer immediately if there are any changes in my status or that of my spouse/ex-spouse.

\_\_\_\_\_ I understand that should I or my ex-spouse remarry, my ex-spouse may not continue on my coverage beyond the date of marriage except by court order and must be enrolled in individual coverage for which I will be responsible for 100% of the cost.

\_\_\_\_\_ I understand that any misrepresentation in the information given may result in termination of benefit eligibility for myself and/or my spouse/ex-spouse.

\_\_\_\_\_  
Subscriber Signature

\_\_\_\_\_  
Date

## GATEWAY REGIONAL SCHOOL DISTRICT

(DEDUCTIONS BEGIN 6/02/23 PAYROLL)

# Hampshire County Election Form and Compensation Reduction Agreement

Employer \_\_\_\_\_ Social Security \_\_\_\_\_  
Employee Name \_\_\_\_\_ Date of First Deduction \_\_\_\_\_  
Address \_\_\_\_\_ No. of Pay Periods 10 \_\_\_\_\_ 12 \_\_\_\_\_ 24 \_\_\_\_\_ 26 \_\_\_\_\_  
52 \_\_\_\_\_ Other \_\_\_\_\_

## Premium Conversion

## Per Pay Period

Benefit	Annual Amount	Pre-Tax	After-Tax
→ Group Term Life			
Vol Group Term			
Dental			
Disability			
Other			

## Payroll Authorization:

My employer is authorized to deduct premium payments from my salary or share account as billed and forward the premium amount to the appropriate insurance carrier, as shown above. ✓  
Such deductions shall cease upon written notice from me cancelling this authorization or upon termination of the plan by you.

This authorization shall be null and void if the policy(ies) is/are declined or not accepted by me.

AGENT'S SIGNATURE: \_\_\_\_\_

\* PAYOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## Waiver:

I have been offered the opportunity to participate in this voluntary supplemental insurance benefit plan and I have declined. I understand that if I should later desire to apply, evidence of insurability may be required.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



PLEASE PRINT OR TYPE

## EMPLOYEE/FAMILY INFORMATION

Dept. ID

Social Security Number

Telephone #

☐ Annual Earnings \$

### Rate Basis

No. of Dependents.

## LIFE - DISABILITY

**INSURANCE AMOUNT**

6

3

**DEPENDENT LIFE:**

**\$**

§

**6**

OTHER (please specify coverage &amp; amt)

## BENEFICIARY

Relationship to you

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. Please list additional beneficiaries on separate sheet.**

**DO NOT SIGN THIS FORM UNTIL YOU HAVE READ THE FRAUD NOTICES**

**EMPLOYEE SIGNATURE REQUIRED**

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.

Date \_\_\_\_\_

## REFUSAL OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the Group Insurance plan offered by 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:

☐ Long Term Disability

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

Date \_\_\_\_\_

Date \_\_\_\_\_

**Must have Basic Life to sign up for Optional Life**

GUARANTEED ISSUE AMOUNTS			
AGE	Under 60	60-69	70 & Over
Employee	\$ 150,000	\$ 50,000	\$10,000
Spouse	\$ 30,000	\$ 20,000	Not Eligible
Dependent	\$ 5,000 or \$10,000		

Monthly Premium Rate per 1,000		Dependent										Dependent		\$ 5,000 or \$10,000		
Age		\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000	\$110,000	\$120,000	\$130,000	\$140,000	\$150,000
<35	\$0.10	\$1.00	\$2.00	\$3.00	\$4.00	\$5.00	\$6.00	\$7.00	\$8.00	\$9.00	\$10.00	\$11.00	\$12.00	\$13.00	\$14.00	\$15.00
	\$0.13	\$1.30	\$2.60	\$3.90	\$5.20	\$6.50	\$7.80	\$9.10	\$10.40	\$11.70	\$13.00	\$14.30	\$15.60	\$16.90	\$18.20	\$19.50
40-44	\$0.19	\$1.90	\$3.80	\$5.70	\$7.60	\$9.50	\$11.40	\$13.30	\$15.20	\$17.10	\$19.00	\$20.90	\$22.80	\$24.70	\$26.60	\$28.50
45-49	\$0.28	\$2.80	\$5.60	\$8.40	\$11.20	\$14.00	\$16.80	\$19.60	\$22.40	\$25.20	\$28.00	\$30.80	\$33.60	\$36.40	\$39.20	\$42.00
50-54	\$0.45	\$4.50	\$9.00	\$13.50	\$18.00	\$22.50	\$27.00	\$31.50	\$36.00	\$40.50	\$45.00	\$49.50	\$54.00	\$58.50	\$63.00	\$67.50
55-59	\$0.73	\$7.30	\$14.60	\$21.90	\$29.20	\$36.50	\$43.80	\$51.10	\$58.40	\$65.70	\$73.00	\$80.30	\$87.60	\$94.90	\$102.20	\$109.50
60-64	\$1.05	\$10.50	\$21.00	\$31.50	\$42.00	\$52.50	\$63.00	\$73.50	\$84.00	\$94.50	\$105.00	\$115.50	\$126.00	\$136.50	\$147.00	\$157.50
65-69	\$1.74	\$17.40	\$34.80	\$52.20	\$69.60	\$87.00	\$104.40	\$121.80	\$139.20	\$156.60	\$174.00	\$191.40	\$208.80	\$226.20	\$243.60	\$261.00
70-74	\$3.08	\$30.80	\$61.60	\$92.40	\$123.20	\$154.00	\$184.80	\$215.60	\$246.40	\$277.20	\$308.00	\$338.80	\$369.60	\$400.40	\$431.20	\$462.00
75-79	\$5.34	\$53.40	\$106.80	\$160.20	\$213.60	\$267.00	\$320.40	\$373.80	\$427.20	\$480.60	\$534.00	\$587.40	\$640.80	\$694.20	\$747.60	\$801.00

- 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 or \$1,000 AGE 14 DAYS TO 1 YEAR; \$5,000 (\$0.95/month) or \$10,000 (\$1.90/month) AGE 1 YEAR TO AGE 19 OR 25 IF FULL TIME STUDENT)
- DEPENDENT CHILD(REN) - (LIFE ONLY) COVERAGE ALL GUARANTEE ISSUE

\*Applicants requesting insurance over the Guaranteed Issue amount will require an Evidence of Insurability Form and Authorization to release medical information. These forms need to accompany the application.

**STATEMENT OF INSURABILITY FORM FOR GROUP INSURANCE**

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance.

**PLEASE COMPLETE IN FULL****IMPORTANT****EMPLOYEE/EMPLOYER**

Submit with completed Enrollment form.

Group #	Div. #	Employer/Group Name
Social Security #	Employee Name (Last, First, Middle Initial)	
Telephone #	Address	

**PROPOSED INSURED(S)**

Name	Relationship	Date of Birth	Height	Weight [(if pregnant, pre-pregnancy weight)]

**REASON****NEW**

- ☐ Late Applicant
- ☐ Applying for Coverage in Excess of the Guaranteed Amount
- ☐ Applying for Supplemental Coverage
- ☐ Other \_\_\_\_\_

**CHANGE**

- ☐ Increase in Coverage
- ☐ Adding Spouse
- ☐ Increasing Spouse
- ☐ Adding Dependent Child(ren)
- ☐ Other \_\_\_\_\_

**INSURANCE**

<b>YOU</b>	<b>[LIFE]</b>	<b>AD&amp;D</b>	<b>VOLUNTARY LIFE</b>	<b>VOLUNTARY AD&amp;D</b>
Current Insurance	_____	_____	_____	_____
Additional Insurance Requested	_____	_____	_____	_____
Total New Coverage	_____	_____	_____	_____
<input type="checkbox"/> [Short Term Disability	\$ _____			
	Weekly Benefit			
<input type="checkbox"/> [Long Term Disability	\$ _____		<input type="checkbox"/> Other	\$ _____
	Monthly Benefit			
<b>YOUR SPOUSE</b>	<b>[LIFE]</b>	<b>AD&amp;D</b>	<b>VOLUNTARY LIFE</b>	<b>VOLUNTARY AD&amp;D</b>
Current Insurance	_____	_____	_____	_____
Additional Insurance Requested	_____	_____	_____	_____
Total New Coverage	_____	_____	_____	_____
			<input type="checkbox"/> Other	\$ _____

# **EVIDENCE OF INSURABILITY**

Existing Coverage	Please list all life insurance and/or annuity contacts now in-force or pending on your life				
	Name of Company (if replacement include Policy No.)	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?
					<input type="checkbox"/> YES <input type="checkbox"/> NO

## **To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract**

1. Have you used any form of tobacco products (*cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches*) within the past 12 months? \*\*      **Employee** ☐ YES      ☐ NO      **Spouse** ☐ YES      ☐ NO

\*\* *I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted only for misstatement of age or sex.*

2. In the past [3-10 years], have ANY of the proposed insureds been diagnosed, treated, tested positive for or been given medical advice by a licensed medical professional that they had: A) sleep apnea, asthma or emphysema; B) high blood pressure, stroke chest pain, transient ischemic attack (TIA), heart or circulatory disease or disorder; C) intestinal disease or disorder or ulcer; D) diabetes; E) leukemia, cancer, tumor or malignancy; F) epilepsy, mental or nervous disease or disorder; G) kidney or genito-urinary disease or disorder; H) disorder of the back, muscles, bones or joints; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder? ☐ YES    ☐ NO
3. In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)? ☐ YES    ☐ NO
4. In the past 5 years, have ANY of the proposed insureds; 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results? ☐ YES    ☐ NO
5. Within the next 2 years, do you or your spouse: A) fly, or intend to fly, as pilot or crew member; B) race or test drive any form of vehicle; C) scuba dive; D) hang glide or sky dive? ☐ YES    ☐ NO
6. Have ANY of the proposed insured, within the past [3-10 years], used or are they currently using or received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? ☐ YES    ☐ NO
7. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having memory loss? ☐ YES    ☐ NO
8. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Amyotrophic Lateral Sclerosis (ALS)? ☐ YES    ☐ NO
9. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? ☐ YES    ☐ NO
10. In the past 2 years, have any of the proposed insureds been treated, examined or advised by a licensed medical professional for attempted suicide? ☐ YES    ☐ NO
11. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington's Chorea? ☐ YES    ☐ NO

## **[To be Completed if Applying for Disability Insurance**

12. Are ANY of the proposed insureds currently pregnant? ☐ YES    ☐ NO

Details for questions [2-12] answered "YES". Include question number. (*Attach additional details on a signed and dated separate sheet*)

Name	Medical Condition	Date(s)	Details/Treatment	Name & Address of Attending Physicians and Hospitals

## AUTHORIZATION TO OBTAIN INFORMATION

### MIB PRE-NOTICE

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

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

### MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

### CONSUMER REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. (*formerly Medical Information Bureau, Inc.*) on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

## REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Statement of Insurability form and represent that the statements and answers are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

**CAUTION:** Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

\_\_\_\_\_  
Signature of Proposed Insured (*Employee/Member*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed & Dated at (*City, State*)

\_\_\_\_\_  
Signature of Proposed Insured (*Other than Employee/Member*)  
(*Employee/Member if the proposed insured is under [15]*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed & Dated at (*City, State*)

**MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE**



**Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY**  
*(This authorization complies with the HIPAA Privacy Rule)*

Name of (Proposed) Insured/Patient (please print)

Date of Birth

Name of Second (Proposed) Insured/Patient (please print)

Date of Birth

**I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider ("Providers") that has provided payment, treatment or services to the person named above, or on such person's behalf, to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization**, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

**This protected health information is to be disclosed under this Authorization so that BML may:** 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

**This authorization shall remain in force for 24 months** following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing**, at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient

**• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •**

I, the undersigned, designate \_\_\_\_\_, the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured

Date

**Social Security** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of First Deduction \_\_\_\_\_

No. of Pay Periods 10 \_\_\_\_\_ 12 \_\_\_\_\_ 24 \_\_\_\_\_ 26 \_\_\_\_\_

52 \_\_\_\_\_ Other \_\_\_\_\_

## Reg Pay Period

Benefit	Annual Amount	Pre-Tax	After-Tax
Group Term Life			
Vol Group Term			
Dental			
Disability			
Other			

**Payroll Authorization:**

**My employer is authorized to deduct premium payments from my salary or share account as billed and forward the premium amount to the appropriate insurance carrier, as shown above. Such deductions shall cease upon written notice from me cancelling this authorization or upon termination of the plan by you.**

**This authorization shall be null and void if the policy(ies) is/are declined or not accepted by me.**

AGENT'S SIGNATURE: \_\_\_\_\_

PAYOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Waiver:**

I have been offered the opportunity to participate in this voluntary supplemental insurance benefit plan and I have declined. I understand that if I should later desire to apply, evidence of insurability may be required.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## **HAMPSHIRE COUNTY GROUP INSURANCE TRUST**

### **Long-Term Disability**

**Voluntary Long-Term Disability (no contribution from the member unit) is offered to employees through the convenience of payroll deduction.**

- **Eligibility Requirement** – All actively at work benefit eligible employees working 20 hours per week may sign up for the plan
- **Monthly Benefit** can not exceed 50% of your salary to a max of \$3,000
- **Benefit Duration - Own occupation 2 Years** – You are covered if you are disabled and cannot work in your occupation for the first 2 years. After that you will continue to receive benefits if you are unable to work at any occupation you are capable of by training, education, or experience
- **Elimination Period** is 90 Days - no coverage for the first 90 days of disability
- **Full Family Integration with Social Security** -Long-Term Disability benefits will be offset with benefits received from Social Security, Workers' Compensation
- **Pre-Existing Exclusion 12/6/24** -Any condition you have had 12 months prior to the policy effective date will not be covered for 24 months or until you are treatment-free for 6 continuous months
- **Progressive Partial** – If you are partially disabled and experience a 15% reduction in pay based upon your disability you will begin to receive pro-rated benefits
- **Mental Illness/Substance abuse** is covered for a period of 24 months
- **Survivor Benefit** – 3 months of benefits will be paid to your beneficiary
- **Full maternity coverage** – Pregnancy is covered like any other illness
- **Waiver of premium** included – While you are disabled and receiving benefits, you will not be required to pay the monthly premium for your plan
- **Accumulation of the elimination period** – If you are disabled for less than 90 days and attempt to come back to work, you will not be required to complete a new 90 day elimination period to start receiving benefits if you return to disabled status for the same sickness/illness
- **6-month recurrent disability** – If you are disabled and come back to work for less than 6 months and go back out on the same disability you will not be required to complete a new elimination period
- **Cost of living freeze** – If benefits received from other sources are increased, the LTD benefit will not be reduced

Please contact Jim Flynn at LifePlus Insurance Agency, Inc. with any enrollment questions.

475 School Street Suite 5

Marshfield MA 02050

James A. Flynn, LIA 781-837-9222 fax 781-837-9227

Toll Free 866 511 9222, Email [jim@lpins.com](mailto:jim@lpins.com)

**This form is for informational purposes only, please refer to the contract for specific language.**



Please refer to your Administration Kit for enrollment and mailing instructions

PLEASE PRINT OR TYPE

## GROUP BENEFITS ENROLLMENT FORM

Group Number-Division Number

Employee/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☐ Monthly☐ Bi-Weekly☐ Annual Earnings \$

Average Hours Worked

Date of Hire

or

Date of Full Time Employment if different

Effective Date

State

Class

Rate Basis

Spouse (Last, First, Middle)

Gender (M/F)

Date of  
Birth

Age

No. of Dependents

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

BASIC

YES

NO

INSURANCE AMOUNT

VOLUNTARY

YES

NO

INSURANCE AMOUNT

LIFE

☐☐

\$

LIFE

☐☐

\$

AD&amp;D

☐☐

\$

AD&amp;D

☐☐

\$

DEPENDENT LIFE:

DEPENDENT LIFE:

SPOUSE

☐☐

\$

SPOUSE

☐☐

\$

CHILD(REN)

☐☐

\$

CHILD(REN)

☐☐

\$

LONG TERM DISABILITY

☐☐

\$

LONG TERM DISABILITY

☐☐

\$

OTHER (please specify coverage &amp; amt)

OTHER (please specify coverage &amp; amt)

BENEFICIARY(IES) FOR LIFE AND/OR AD&amp;D BENEFITS:

Primary Beneficiary(ies):

% of Benefit

Relationship to you

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. Please list additional beneficiaries on separate sheet.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ THE FRAUD NOTICES

EMPLOYEE SIGNATURE REQUIRED

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

I hereby certify that I have been given an opportunity to participate in the Group Insurance plan offered by 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:

☐ All Coverages☐ Life and AD&D☐ Dependent Coverage☐ Short Term Disability☐ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with the respect to the coverage(s) 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

## Chart of Long Term Disability Benefits with Corresponding Monthly Premium

<u>Monthly Benefit</u>	<u>Age &lt;29</u>	<u>30-39</u>	<u>40-44</u>	<u>45-49</u>	<u>50-54</u>	<u>55+</u>
\$500	\$2.15	\$3.55	\$5.70	\$8.35	\$11.55	\$14.00
\$600	\$2.58	\$4.26	\$6.84	\$10.02	\$13.86	\$16.80
\$700	\$3.01	\$4.97	\$7.98	\$11.69	\$16.17	\$19.60
\$800	\$3.44	\$5.68	\$9.12	\$13.36	\$18.48	\$22.40
\$900	\$3.87	\$6.39	\$10.26	\$15.03	\$20.79	\$25.20
\$1,000	\$4.30	\$7.10	\$11.40	\$16.70	\$23.10	\$28.00
\$1,100	\$4.73	\$7.81	\$12.54	\$18.37	\$25.41	\$30.80
\$1,200	\$5.16	\$8.52	\$13.68	\$20.04	\$27.72	\$33.60
\$1,300	\$5.59	\$9.23	\$14.82	\$21.71	\$30.03	\$36.40
\$1,400	\$6.02	\$9.94	\$15.96	\$23.38	\$32.34	\$39.20
\$1,500	\$6.45	\$10.65	\$17.10	\$25.05	\$34.65	\$42.00
\$1,600	\$6.88	\$11.36	\$18.24	\$26.72	\$36.96	\$44.80
\$1,700	\$7.31	\$12.07	\$19.38	\$28.39	\$39.27	\$47.60
\$1,800	\$7.74	\$12.78	\$20.52	\$30.06	\$41.58	\$50.40
\$1,900	\$8.17	\$13.49	\$21.66	\$31.73	\$43.89	\$53.20
\$2,000	\$8.60	\$14.20	\$22.80	\$33.40	\$46.20	\$56.00
\$2,100	\$9.03	\$14.91	\$23.94	\$35.07	\$48.51	\$58.80
\$2,200	\$9.46	\$15.62	\$25.08	\$36.74	\$50.82	\$61.60
\$2,300	\$9.89	\$16.33	\$26.22	\$38.41	\$53.13	\$64.40
\$2,400	\$10.32	\$17.04	\$27.36	\$40.08	\$55.44	\$67.20
\$2,500	\$10.75	\$17.75	\$28.50	\$41.75	\$57.75	\$70.00
\$2,600	\$11.18	\$18.46	\$29.64	\$43.42	\$60.06	\$72.80
\$2,700	\$11.61	\$19.17	\$30.78	\$45.09	\$62.37	\$75.60
\$2,800	\$12.04	\$19.88	\$31.92	\$46.76	\$64.68	\$78.40
\$2,900	\$12.47	\$20.59	\$33.06	\$48.43	\$66.99	\$81.20
\$3,000	\$12.90	\$21.30	\$34.20	\$50.10	\$69.30	\$84.00

Monthly Benefit = 50% of Monthly Salary

Benefit offset = Full Family Intergration - Disability benefits will be offset by benefits received from Social Security or workers' compensatic

**Questions should be directed to LifePlus Insurance Agency, Inc.  
866-511-9222**



**Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY**

*(This authorization complies with the HIPAA Privacy Rule.)*

\_\_\_\_\_  
Name of (Proposed) Insured/Patient (please print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name of Second (Proposed) Insured/Patient (please print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider ("Providers") that has provided payment, treatment or services to the person named above; or on such person's behalf, to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc., to provide protected health information.

By my signature below, I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

**• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •**

I, the undersigned, hereby, designate the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative. This designation shall remain in force for a period of 12 months following my date of death.

\_\_\_\_\_  
Signature of Proposed Insured/Claimant/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient

\_\_\_\_\_  
Signature of Second Proposed Insured/Claimant/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient

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

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Employee Name \_\_\_\_\_ Employee ID# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer ID# \_\_\_\_\_

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 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$395.50. 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](http://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 \_\_\_\_\_

# Hampshire County Election Form and Compensation Reduction Agreement

Employer Gateway Regional School

Social Security \_\_\_\_\_

Employee Name \_\_\_\_\_

Date of First Deduction \_\_\_\_\_

Address \_\_\_\_\_

No. of Pay Periods 10 \_\_\_\_\_ 12 \_\_\_\_\_ 24 \_\_\_\_\_ 26 \_\_\_\_\_

52 \_\_\_\_\_ Other \_\_\_\_\_

## Premium Conversion

## Per Pay Period

Benefit	Annual Amount	Pre-Tax	After-Tax
Group Term Life			
Vol Group Term			
→ Dental			
Disability			
Other			

## Payroll Authorization:

My employer is authorized to deduct premium payments from my salary or share account as billed and forward the premium amount to the appropriate insurance carrier, as shown above. Such deductions shall cease upon written notice from me cancelling this authorization or upon termination of the plan by you.

This authorization shall be null and void if the policy(ies) is/are declined or not accepted by me.

AGENT'S SIGNATURE: \_\_\_\_\_

\* PAYOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## Waiver:

I have been offered the opportunity to participate in this voluntary supplemental insurance benefit plan and I have declined. I understand that if I should later desire to apply, evidence of insurability may be required.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**\*Employers:** Log In at [www.ppienroll.com](http://www.ppienroll.com) to update member enrollment; please retain this completed form for your records. Try *Express Terminations* and *Express Compensation* to easily enter multiple updates. For assistance, please contact PPI Service Team at [clientservices@ppibenefits.com](mailto:clientservices@ppibenefits.com) or (888) 674-0046

**PPI**  
Benefit Solutions  
ACSA Group  
Insurance Trust

**Please continue on the reverse side**



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**Section 4 – Waiver of Coverage (Complete and sign ONLY if waiving coverage(s) for yourself and/or your dependents)**

---

I hereby certify that I have been given an opportunity to enroll for Group Health Insurance benefits offered by my employer and have decided **NOT** to enroll in the following coverage(s):

☐ Dental ☐ Dependent Dental

I understand that if I delay enrolling more than 31 days after the date I could first become insured, the Dental benefits for myself and my dependents may be limited for a period time as determined by the plan rules.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

---

**Section 5 – Employee Signature**

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I represent that all the information supplied in this application is true and complete. I have personally designated the beneficiaries shown on this form (if applicable) and hereby request group insurance for myself and for my dependents listed on this form for selected coverages noted in Section 1. I hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if any, to apply toward the insurance costs for the insurance provided for in the policy of group insurance issued to my employer.

I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the carrier gives its written consent.

I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason the carrier does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my eligibility and my dependent's eligibility may be affected.

**Misrepresentations:** Any person who knowingly and with intent to defraud 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's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

---

**Section 6 – Employer Verification**

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_____ Employer's Signature	_____ Title	_____ Date
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**IMPORTANT:**

The benefits you have elected are provided through a group insurance policy insured by the insurance carriers listed on this form, and identified in your certificate. Billing administration services are provided to your employer by PPI Benefit Solutions, a licensed Third Party Administrator, pursuant to an agreement previously entered into by PPI and the carrier, as required by law. The carrier is responsible for eligibility and benefit determination, payment of claims, and all other administration services associated with your coverage. If you have any questions, please feel free to contact the carrier, or PPI Benefit Solutions' Client Service Center at (888-674-0046).

PPI ER #Various, Revised 02/14/2023

**DELTA VOLUNTARY DENTAL rates effective- JULY 1, 2023**

	CORE PPO Plan	12 Month Employee Biweekly Rate	10 Month Employee Biweekly Rate	Annual
Single		\$11.83	\$14.20	283.92
Emp +1		\$23.34	\$28.01	560.16
Family		\$43.61	\$52.33	1,046.64

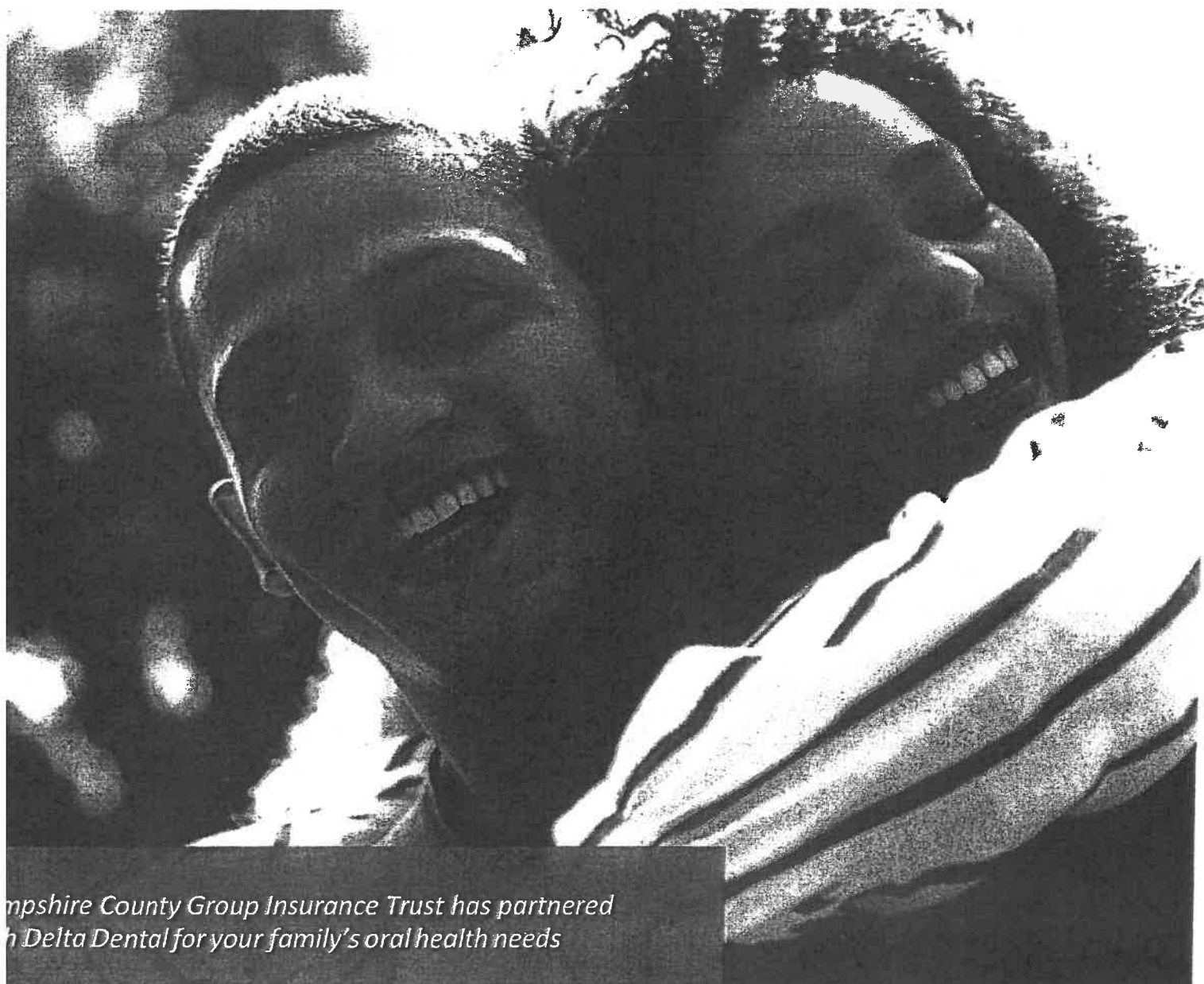
	HIGH PPO Plan	12 Month Rate Biweekly Rate	10 Month Rate Biweekly Rate	
Single		\$22.08	\$26.50	529.92
Emp +1		\$41.90	\$50.28	1,005.60
Family		\$64.87	\$77.84	1,556.88

Group # 0158160000  
Employer# 027760

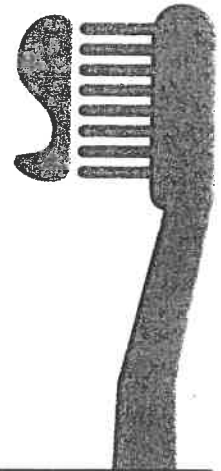
4/26/23



Delta Dental PPO *Plus* Premier  
for  
Hampshire County Group  
Insurance Trust - Core Plan



Hampshire County Group Insurance Trust has partnered  
with Delta Dental for your family's oral health needs



## Who we are

For nearly 70 years, Delta Dental has been dedicated to delivering great dental plans. Delta Dental's mission is to provide oral health for all, enhancing the overall health for all. We do this by providing comprehensive plans allowing affordable dental care for our members.

## Select a Plan

Delta Dental offers two plans to HCGIT Members to allow you to select the plan that best meets your needs.

**Delta PPO Core** covering your preventive, diagnostic and basic restorative dental needs.

**Delta PPO High** covering your preventive, diagnostic, basic and major restorative needs.

## Gain Access to Two Networks

Whether you select the Base or Premium Plan, you have the flexibility to access two different Delta Dental networks that allow you to manage your out-of-pocket costs. An estimated 95% of the providers in Massachusetts, and 75% of providers nationally participate in one or both networks, so you are covered where you live and where you may travel.

### Delta Dental PPO<sup>SM</sup>

This is a smaller network of dentists who offer dental care at a deeply discounted rate, allowing you to maximize the value of your plan.

### Delta Dental Premier<sup>®</sup>

This provides a larger network of dentists, but you will have a higher out-of-pocket cost for services not covered in full.

You can also see a dentist outside of our contracted networks – however, you will likely pay more.



## Find a provider

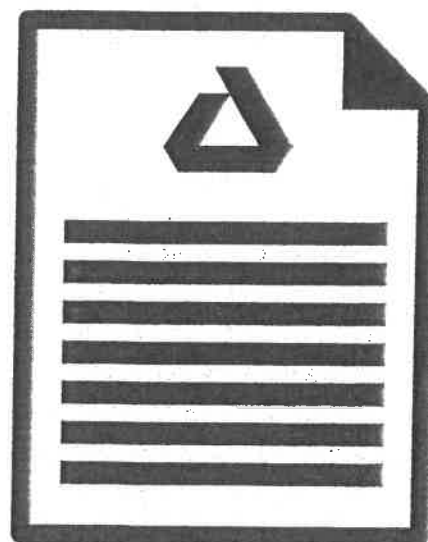
To find a provider or to see if your current provider is in one of our networks

**Visit:** [deltadentalma.com](http://deltadentalma.com) and click on "Find a Dentist"

**Call:** 800-872-0500

## Pre-Treatment Estimate

If your dentist expects that your treatment will cost more than \$300, they need to send a copy of their treatment plan to Delta Dental before you receive care. A treatment plan is a description of the procedures and how much they will cost. Delta Dental will review your treatment plan and notify your dentist regarding your available coverage for those services and notify you of your out-of-pocket amount.



Visit [deltadentalma.com](http://deltadentalma.com) for detailed benefit information

**Coverage Summary for  
Hampshire County Group Insurance  
Trust- Core Plan  
Group # 0158160000**

**Deductible: \$50 per individual / \$150 per family. Deductible does not apply for members under age 13.**  
**Deductible waived for Diagnostic and Preventive categories.**  
**Calendar Year Maximum: \$1,250 per person.**

Category / Procedure	Qualifications	Co-Insurance Members under age 13		Co-Insurance Members age 13 and older	
		PPO Network	Premier and Out of Network*	PPO Network	Premier and Out of Network*
<b>Diagnostic</b> Comprehensive Evaluation Periodic Oral Exam Panoramic or Full Mouth X-rays Bitewing X-rays Single Tooth X-rays	Once every 60 months. Twice every 12 months. Once every 60 months. Twice every 12 months. As needed.	100%	100%	100%	100%
<b>Preventive</b> Teeth Cleaning Fluoride Treatments Space Maintainers  Sealants	Twice every 12 months. Twice every 12 months for members under age 19. Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth. Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants also covered for members age 16 up to age 19 with a recent cavity and are at risk for decay.	100%	100%	100%	100%
<b>Restorative</b> Silver Fillings White Fillings (Front Teeth) Inlays and White Fillings (Back Teeth)  Protective Restorations Stainless Steel Crowns	Once every 24 months per surface per tooth. Once every 24 months per surface per tooth. Covered only for single surfaces. Once every 24 months per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental negotiated fee for white fillings, where permitted by state law. In other states, the patient may be responsible for paying up to the provider's full submitted charge for white fillings. Once per tooth. Once every 24 months per tooth (on primary teeth only).	100%	100%	100%	80%
<b>Oral Surgery</b> Extractions General Anesthesia	Once per tooth. General Anesthesia and IV sedation allowed with covered surgical impacted wisdom teeth only (up to one hour).	100%	100%	100%	80%
<b>Periodontics (on natural teeth only)</b> Periodontal Surgery Scaling and Root Planing Periodontal Cleaning  Bone Grafts/GTR	One surgical procedure per quadrant in 36 months. Once in 24 months, per quadrant. No more than 2 quadrants per date of service. 4 times every 12 months following active periodontal treatment. Not to be combined with preventive cleanings. No more than 2 teeth per quadrant per 36 months on natural teeth.	100%	100%	100%	80%
<b>Endodontics</b> Root Canal Treatment Root Canal Retreatment Vital Pulpotomy	Once per tooth. Once per tooth after 24 months have elapsed from initial treatment. Limited to deciduous teeth.	100%	100%	100%	80%
<b>Prosthetic Maintenance</b> Bridge or Denture Repair Crown or Onlay Repair Rebase or Reline of Dentures Recement of Crowns and Onlays, Bridges	Once per bridge/denture per 12 months, after 24 months of initial insertion. Once per tooth per 12 months after 24 months of initial placement. Once per denture within 36 months. Once per crown, onlay or bridge.	100%	100%	100%	80%
<b>Emergency Dental Care</b> Palliative Treatment	Three occurrences in 12 months.	100%	100%	100%	80%
<b>Prosthodontics</b> Dentures Fixed Bridges Implants (only in lieu of a 3-unit bridge)  Implant Abutments	Once within 60 months (age 16 and older). Once within 60 months (age 16 and older). Endosteal Implant: Only when replacing one missing tooth and when adjacent teeth are healthy and do not require crowns. Once per 60 months per Implant. (Pre-estimate recommended). Once per implant only when surgical implant is benefitted.	100%	100%	Not a covered benefit.	Not a covered benefit.

Category / Procedure	Qualifications	Co-insurance Members under age 13		Co-insurance Members age 13 and older	
		In Network	Out of Network*	In Network	Out of Network*
Major Restorative Crowns or Onlay	When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older).	100%	100%	Not a covered benefit.	Not a covered benefit.
Cast Posts/Buildups	Once per tooth per 60 months only benefitted to retain a crown.				
Orthodontics:					

### Additional Benefit Information

Deductible waived for periodontal cleanings.  
Dependent Eligibility - Dependents to 26

*This plan is eligible for Rollover Max. See the benefit guide for details.*

Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds \$300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that the services are covered under your dental coverage.

\*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Delta Dental PPO *Plus Premier*

 DELTA DENTAL

## Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental PPO *Plus Premier* subscriber, you have access to two of Delta Dental's extensive national networks—Delta Dental PPO, with more than 283,000 dentist locations and Delta Dental Premier, the largest dental network in the country with more than 358,000 dentist locations. Three out of four dentists nationwide participate in one or both of these networks.

You will enjoy great benefits when you receive your dental care from a participating dentist in either the Delta Dental PPO or Delta Dental Premier networks.

- Both networks offer discounted fees and a no balance billing policy.
- You will receive good value from Delta Dental Premier network dentists who generally accept discounted fees, but will be subject to the out-of-network co-insurance level shown on the front of this summary.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists and will receive the in-network co-insurance level shown on the front of this summary.

If you choose to receive services from a non-participating dentist, you will have higher out-of-pocket costs as the Delta Dental contract rates and the no balance billing policy do not apply.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at <http://www.deltadentalma.com/members/discounts-on-covered-services/>

Simply visit [www.deltadentalma.com](http://www.deltadentalma.com) to find a participating dentist in your area.

## Learn more at [deltadentalma.com](http://deltadentalma.com)

Visit the member area of [www.deltadentalma.com](http://www.deltadentalma.com) to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 1-800-872-0500.

You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at [www.deltadentalma.com](http://www.deltadentalma.com). In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:  
**Delta Dental of Massachusetts**  
1-800-872-0500  
[www.deltadentalma.com](http://www.deltadentalma.com)

465 Medford Street  
Boston, MA 02120

Delta Dental of Massachusetts, Inc. is an independent licensee of the Delta Dental Plans Association. Registered marks of the Delta Dental Plans Association. 1/12/2014

2 of 4

12/01/2014

# Rollover Maximum Benefit Summary

## Rollover Maximum Summary

**With *Rollover Max* from Delta Dental, you won't lose what you don't use.**

Thanks to the *Rollover Max* benefit from Delta Dental, you can save some of your unused benefit dollars to be applied to future services that would otherwise exceed your plan maximum.

***Rollover Max* is easy and automatic.**

- To qualify for *Rollover Max*, you must receive at least one cleaning or oral exam in the plan year. If you don't receive a cleaning or exam, you won't be eligible to rollover any of your benefit dollars to the following year.
- In addition, your paid claims must not exceed the Plan Year Maximum "threshold" amounts outlined in the chart below.
- Once you qualify, some of your unused annual Plan Year maximum benefit dollars will automatically rollover for use in your next plan year and beyond. The amounts are outlined in the chart below.
- Annual Plan Year Maximum dollars are used first. *Rollover Max* dollars are used after the annual maximum amount for your plan has been exhausted.
- *Rollover Max* dollars cannot be applied to orthodontic treatment or other lifetime benefits.
- You must be enrolled for dental coverage before the 4th quarter of the plan (10/1-12/31) to qualify for the rollover that year.

## How *Rollover Max* works.

The chart below shows how *Rollover Max* is calculated based on your plan's annual Plan Year Maximum level.

### ***Rollover Max* increases your dental benefit value.**

You get more flexibility in planning and paying for your dental care, as well as the peace of mind knowing you have more benefits—if you need them, when you need them. Best of all, *Rollover Max* comes as part of your Delta Dental coverage.

	Your Plan Year Maximum benefit amount.	If your total yearly claims don't exceed this threshold amount.	Then you can roll over this amount to use next year, and beyond.	Your accumulated rollover total will not exceed this amount.
<b>Core</b>	<b>\$1250</b>	<b>\$600</b>	<b>\$450</b>	<b>\$1250</b>

## How to check your *Rollover Max* balance online:

- Log on to your account at [deltadentalma.com](http://deltadentalma.com) (You'll need to register if this will be your first visit.)
- Click on Benefit Maximums.
- The rollover amount for each member will be listed under *Rollover Maximum*.

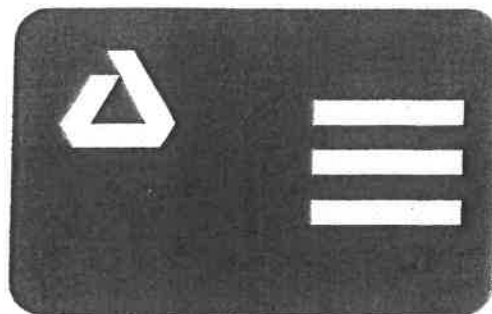


## Member Discounts

As a member of Delta Dental, you can take advantage of discounts on Sonic toothbrushes and replacement heads.

Discounts are also available for hearing tests, diagnostics and hearing aids through Amplifon.

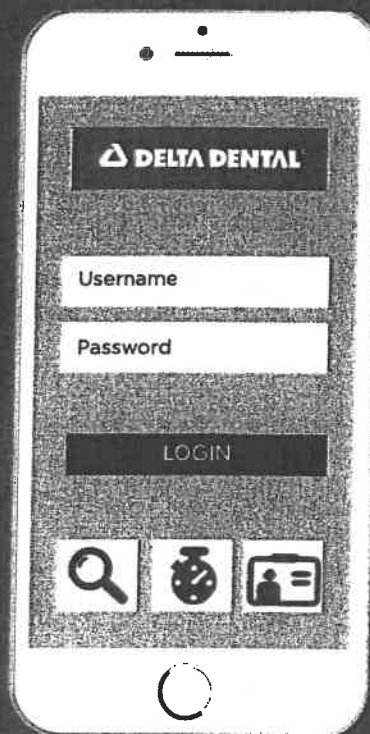
Details and discounts are available **deltadentalma.com**.



## Use our app to access your dental plan anytime, anywhere.

Download our Delta Dental mobile app and get instant access to:

- Mobile ID card
- Dentist search
- Cost estimator



Download on the  
**App Store**

ANDROID APP ON  
**Google play**



**Contact us with any questions.**

Email us at [customer.care@deltadentalma.com](mailto:customer.care@deltadentalma.com)

**Customer Service** Call 800-872-0500

Mon. - Thurs. 8:30 a.m. - 8:00 p.m.

Fri. 8:30 a.m. - 4:30 p.m.

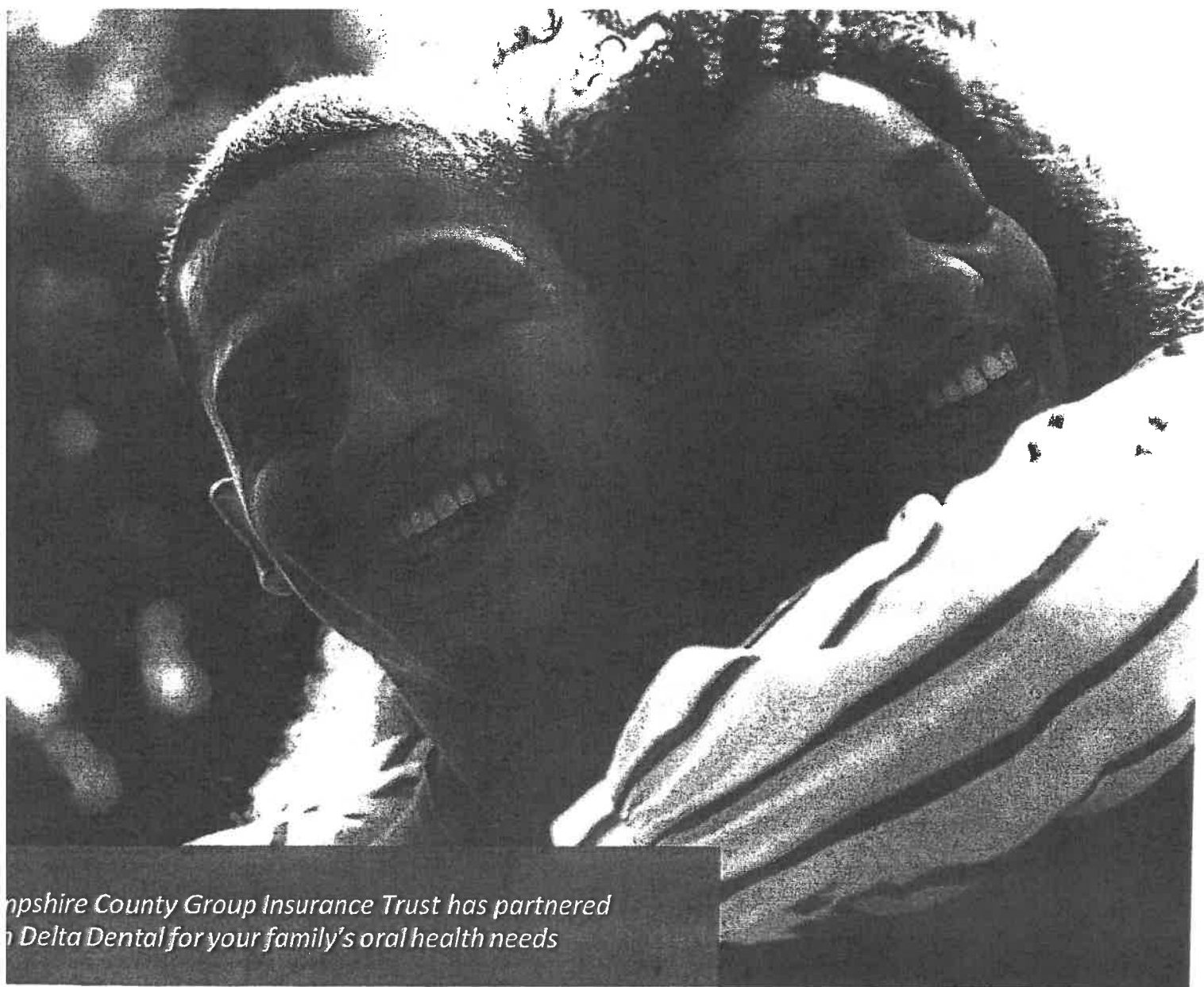
A 24-hour automated voice response is also available after hours and on weekends.

[deltadentalma.com](http://deltadentalma.com)

**Need Translation Services?** We offer a foreign language translation service through AT&T Language Line to assist with non-English speaking members in 140 languages.



Delta Dental PPO *Plus* Premier  
for  
Hampshire County Group  
Insurance Trust - High Plan



Hampshire County Group Insurance Trust has partnered  
with Delta Dental for your family's oral health needs



## Who we are

For nearly 70 years, Delta Dental has been dedicated to delivering great dental plans. Delta Dental's mission is to provide oral health for all, enhancing the overall health for all. We do this by providing comprehensive plans allowing affordable dental care for our members.

## Select a Plan

Delta Dental offers two plans to HCGIT Members to allow you to select the plan that best meets your needs.

**Delta PPO Core** covering your preventive, diagnostic and basic restorative dental needs.

**Delta PPO High** covering your preventive, diagnostic, basic and major restorative needs.

## Gain Access to Two Networks

Whether you select the Base or Premium Plan, you have the flexibility to access two different Delta Dental networks that allow you to manage your out-of-pocket costs. An estimated 95% of the providers in Massachusetts, and 75% of providers nationally participate in one or both networks, so you are covered where you live and where you may travel.

### Delta Dental PPO<sup>SM</sup>

This is a smaller network of dentists who offer dental care at a deeply discounted rate, allowing you to maximize the value of your plan.

### Delta Dental Premier®

This provides a larger network of dentists, but you will have a higher out-of-pocket cost for services not covered in full.

You can also see a dentist outside of our contracted networks – however, you will likely pay more.



## Find a provider

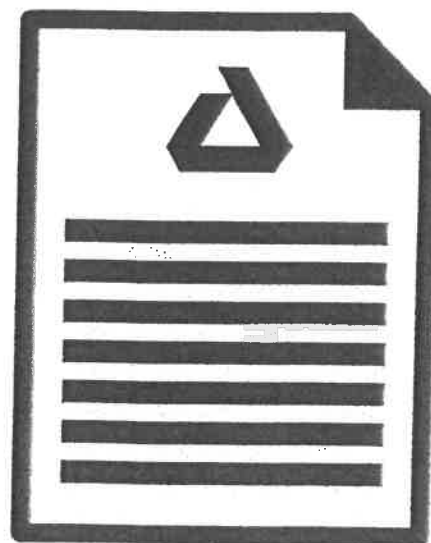
To find a provider or to see if your current provider is in one of our networks

**Visit:** [deltadentalma.com](http://deltadentalma.com) and click on "Find a Dentist"

**Call:** 800-872-0500

## Pre-Treatment Estimate

If your dentist expects that your treatment will cost more than \$300, they need to send a copy of their treatment plan to Delta Dental before you receive care. A treatment plan is a description of the procedures and how much they will cost. Delta Dental will review your treatment plan and notify your dentist regarding your available coverage for those services and notify you of your out-of-pocket amount.





Visit [deltadentalma.com](http://deltadentalma.com) for detailed benefit information.

**Coverage Summary for  
Hampshire County Group Insurance  
Trust- High Plan  
Group # 0158160000**

**Deductible: \$50 per individual / \$150 per family. Deductible does not apply for members under age 13.**

**Deductible waived for Diagnostic and Preventive categories.**

**Calendar Year Maximum: \$1,500 per person.**

Category / Procedure	Qualifications	Co-insurance Members under age 13		Co-insurance Members age 13 and older	
		PPO Network	Premier and Out of Network*	PPO Network	Premier and Out of Network*
<b>Diagnostic</b> Comprehensive Evaluation Periodic Oral Exam Panoramic or Full Mouth X-rays Bitewing X-rays Single Tooth X-rays	Once every 60 months. Twice every 12 months. Once every 60 months. Twice every 12 months. As needed.	100%	100%	100%	100%
<b>Preventive</b> Teeth Cleaning Fluoride Treatments Space Maintainers  Sealants	Twice every 12 months. Twice every 12 months for members under age 19. Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth. Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants also covered for members age 16 up to age 19 with a recent cavity and are at risk for decay.	100%	100%	100%	100%
<b>Restorative</b> Silver Fillings White Fillings (Front Teeth) Inlays and White Fillings (Back Teeth)  Protective Restorations Stainless Steel Crowns	Once every 24 months per surface per tooth. Once every 24 months per surface per tooth. Covered only for single surfaces. Once every 24 months per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental negotiated fee for white fillings, where permitted by state law. In other states, the patient may be responsible for paying up to the provider's full submitted charge for white fillings. Once per tooth. Once every 24 months per tooth (on primary teeth only).	100%	100%	100%	80%
<b>Oral Surgery</b> Extractions General Anesthesia	Once per tooth. General Anesthesia and IV sedation allowed with covered surgical impacted wisdom teeth only (up to one hour).	100%	100%	100%	80%
<b>Periodontics (on natural teeth only)</b> Periodontal Surgery Scaling and Root Planing Periodontal Cleaning  Bone Grafts/GTR	One surgical procedure per quadrant in 36 months. Once in 24 months, per quadrant. No more than 2 quadrants per date of service. 4 times every 12 months following active periodontal treatment. Not to be combined with preventive cleanings. No more than 2 teeth per quadrant per 36 months on natural teeth.	100%	100%	100%	80%
<b>Endodontics</b> Root Canal Treatment Root Canal Retreatment Vital Pulpotomy	Once per tooth. Once per tooth after 24 months have elapsed from initial treatment. Limited to deciduous teeth.	100%	100%	100%	80%
<b>Prosthetic Maintenance</b> Bridge or Denture Repair Crown or Onlay Repair Rebase or Reline of Dentures Recement of Crowns and Onlays, Bridges	Once per bridge/denture per 12 months, after 24 months of initial insertion. Once per tooth per 12 months after 24 months of initial placement. Once per denture within 36 months. Once per crown, onlay or bridge.	100%	100%	100%	80%
<b>Emergency Dental Care</b> Palliative Treatment	Three occurrences in 12 months.	100%	100%	100%	80%
<b>Prostodontics</b> Dentures Fixed Bridges Implants (only in lieu of a 3-unit bridge)  Implant Abutments	<b>12 Month Waiting Period Applies</b> Once within 60 months (age 16 and older). Once within 60 months (age 16 and older). Endosteal Implant: Only when replacing one missing tooth and when adjacent teeth are healthy and do not require crowns. Once per 60 months per Implant. (Pre-estimate recommended). Once per implant only when surgical implant is benefitted.	100%	100%	50%	50%

Category / Procedure	Qualifications	Co-insurance Members under age 13		Co-insurance Members age 13 and older	
		In Network	Out of Network*	In Network	Out of Network*
<b>Major Restorative</b> Crowns or Onlay	<b>12 Month Waiting Period Applies</b> When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older).	100%	100%	50%	50%
Cast Posts/Buildups	Once per tooth per 60 months only benefitted to retain a crown.				
<b>Orthodontics:</b>					

### Additional Benefit Information

Deductible waived for periodontal cleanings.  
Dependent Eligibility - Dependents to 26

*This plan is eligible for Rollover Max. See the benefit guide for details.*

Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds \$300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that the services are covered under your dental coverage.

\*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Delta Dental PPO *Plus Premier*

 **DELTA DENTAL**

## Easy Access and Great Value - Your Delta Dental Networks

As a Delta Dental PPO *Plus Premier* subscriber, you have access to two of Delta Dental's extensive national networks—Delta Dental PPO, with more than 283,000 dentist locations and Delta Dental Premier, the largest dental network in the country with more than 358,000 dentist locations. Three out of four dentists nationwide participate in one or both of these networks.

You will enjoy great benefits when you receive your dental care from a participating dentist in either the Delta Dental PPO or Delta Dental Premier networks.

- Both networks offer discounted fees and a no balance billing policy.
- You will receive good value from Delta Dental Premier network dentists who generally accept discounted fees, but will be subject to the out-of-network co-insurance level shown on the front of this summary.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists and will receive the in-network co-insurance level shown on the front of this summary.

If you choose to receive services from a non-participating dentist, you will have higher out-of-pocket costs as the Delta Dental contract rates and the no balance billing policy do not apply.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at <http://www.deltadentalma.com/members/discounts-on-covered-services/>

Simply visit [www.deltadentalma.com](http://www.deltadentalma.com) to find a participating dentist in your area.

## Learn more at [deltadentalma.com](http://deltadentalma.com)

Visit the member area of [www.deltadentalma.com](http://www.deltadentalma.com) to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 1-800-872-0500.

You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at [www.deltadentalma.com](http://www.deltadentalma.com). In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:  
**Delta Dental of Massachusetts**  
1-800-872-0500  
[www.deltadentalma.com](http://www.deltadentalma.com)

465 Medford Street  
Boston, MA 02129

# Rollover Maximum Benefit Summary

## Rollover Maximum Summary

**With *Rollover Max* from Delta Dental, you won't lose what you don't use.**

Thanks to the *Rollover Max* benefit from Delta Dental, you can save some of your unused benefit dollars to be applied to future services that would otherwise exceed your plan maximum.

***Rollover Max* is easy and automatic.**

- To qualify for *Rollover Max*, you must receive at least one cleaning or oral exam in the plan year. If you don't receive a cleaning or exam, you won't be eligible to rollover any of your benefit dollars to the following year.
- In addition, your paid claims must not exceed the Plan Year Maximum "threshold" amounts outlined in the chart below.
- Once you qualify, some of your unused annual Plan Year maximum benefit dollars will automatically rollover for use in your next plan year and beyond. The amounts are outlined in the chart below.
- Annual Plan Year Maximum dollars are used first. *Rollover Max* dollars are used after the annual maximum amount for your plan has been exhausted.
- *Rollover Max* dollars cannot be applied to orthodontic treatment or other lifetime benefits.
- You must be enrolled for dental coverage before the 4th quarter of the plan (10/1-12/31) to qualify for the rollover that year.

**How *Rollover Max* works.**

The chart below shows how *Rollover Max* is calculated based on your plan's annual Plan Year Maximum level.

***Rollover Max* increases your dental benefit value.**

You get more flexibility in planning and paying for your dental care, as well as the peace of mind knowing you have more benefits—if you need them, when you need them. Best of all, *Rollover Max* comes as part of your Delta Dental coverage.

	Your Plan Year Maximum benefit amount.	If your total yearly claims don't exceed this threshold amount.	Then you can roll over this amount to use next year, and beyond.	Your accumulated rollover total will not exceed this amount.
High	\$1500	\$700	\$500	\$1250

**How to check your *Rollover Max* balance online:**

- Log on to your account at [deltadentalma.com](http://deltadentalma.com) (You'll need to register if this will be your first visit.)
- Click on Benefit Maximums.
- The rollover amount for each member will be listed under *Rollover Maximum*.

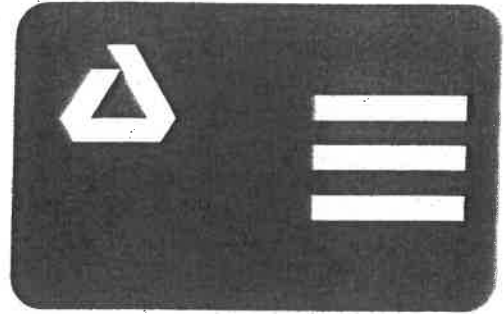


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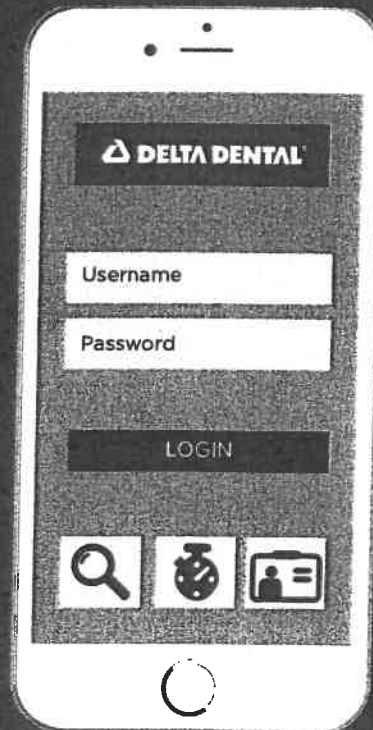
Details and discounts are available [deltadentalma.com](http://deltadentalma.com).



## Use our app to access your dental plan anytime, anywhere.

Download our Delta Dental mobile app and get instant access to:

- Mobile ID card
- Dentist search
- Cost estimator



Download on the  
**App Store**

ANDROID APP ON  
**Google play**



**Contact us with any questions.**

Email us at [customer.care@deltadentalma.com](mailto:customer.care@deltadentalma.com)

**Customer Service** Call 800-872-0500

Mon. - Thurs. 8:30 a.m. - 8:00 p.m.

Fri. 8:30 a.m. - 4:30 p.m.

A 24-hour automated voice response is also available after hours and on weekends.

[deltadentalma.com](http://deltadentalma.com)

**Need Translation Services?** We offer a foreign language translation service through AT&T Language Line to assist with non-English speaking members in 140 languages.

**GATEWAY REGIONAL SCHOOL DISTRICT  
TECHNOLOGY DEPARTMENT  
USER ACCOUNT FORM**

Employee Last Name:	Employee First Name:	Employee Middle Name
---------------------	----------------------	----------------------

Job Title:  
Email Address:  
Start Date:  
Employed at:

End Date:

Central Office <input type="checkbox"/>	High School <input type="checkbox"/>	Middle School <input type="checkbox"/>	Littleville <input type="checkbox"/>	Chester <input type="checkbox"/>
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Copier Codes: Telephone Extension:

Google Apps User Information: \_\_\_\_\_

Account Created: ☐ Date: Password Set: ☐  
Activated: ☐ Date: Deactivated: ☐ Date:

Powerschool: \_\_\_\_\_ Unique Id \_\_\_\_\_ Check here if employee needs administrative access: ☐

Account Created: ☐ Date: Password Set: ☐  
Activated: ☐ Date: Deactivated: ☐ Date:

Sendit (Schoolpointe): (administrators only) \_\_\_\_\_

Account Created: ☐ Date: Password Set: ☐  
Activated: ☐ Date: Deactivated: ☐ Date:

Frontline: \_\_\_\_\_

Account Created: ☐ Date: Password Set: ☐  
Activated: ☐ Date: Deactivated: ☐ Date:

SRSD Website User Information: \_\_\_\_\_

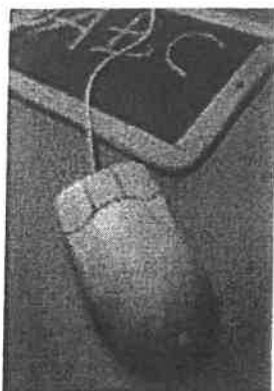
Account Created: ☐ Date: Password Set: ☐  
Activated: ☐ Date: Deactivated: ☐ Date:

Forwarded to Stacy Stewart on \_\_\_\_\_ by \_\_\_\_\_

Forwarded to Kurt Zinnack on \_\_\_\_\_ by \_\_\_\_\_

Forwarded to Chris Parker on \_\_\_\_\_ by \_\_\_\_\_

Forwarded to Tammy Paiva on \_\_\_\_\_ by \_\_\_\_\_



Version 4.0 ■ July 2006

## MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

# MTRS Enrollment Registration Form

THIS SECTION TO BE COMPLETED BY PAYROLL ADMINISTRATOR AND SUBMITTED ONLINE

*NOTE: For everyone's protection, this data will be submitted via a secure online connection directly to the MTRS's on-site server.*

Employee Name <input type="text"/>	Employee SSN <input type="text"/> - <input type="text"/> - <input type="text"/>
Employer Contact <input type="text"/>	Employer Phone <input type="text"/>
Employer Title <input type="text"/>	Employer E-mail <input type="text"/>
Date <input type="text"/>	

Enrollment is a benefit and a very important part of your financial future—the MTRS is your employer's retirement plan.

1) School district's four-digit MTRS agency code .....	<input type="text"/>
<i>Be sure to enter your district's four-digit MTRS code, not your DOE code. Please see our web site for the complete listing of district codes.</i>	
2) Employee's start date as a teacher or administrator mm/dd/yyyy ..	<input type="text"/>
3) Job title .....	Teacher (Daytime)
4) If "other," please enter other position title .....	<input type="text"/>
5) Employment status as a percentage of full-time .....	100
<i>Note: Less than half-time is ineligible for membership unless employee is also employed by another district. Also, part-time and temporary employees are subject to a six-month waiting period, unless they have funds on account with the MTRS or another Massachusetts retirement system.</i>	
6) Number of days in contract .....	<input type="text"/>
7) Annual contract salary .....	<input type="text"/>
8) Percentage of salary paid by federal grant, if any .....	<input type="text"/>
9) Date of first payroll deduction, if known mm/dd/yyyy .....	<input type="text"/>
10) Additional employment information:	
■ Temporary employee? .....	<input type="checkbox"/> No <input type="checkbox"/> Yes
■ Long-term substitute? .....	<input type="checkbox"/> No <input type="checkbox"/> Yes



**Cambridge Office**  
One Charles Park  
Cambridge, MA 02142-1206  
617-679-MTRS (6877)  
Fax 617-679-1661

**Western Regional Office**  
101 State Street  
Springfield, MA 01103-2066  
413-784-1711  
Fax 413-784-1707

**Questions or problems?**  
617-679-6895  
enrollsupport@trb.state.ma.us

**Online** [mass.gov/mtrs](http://mass.gov/mtrs)

Form ERU-F0010-PERF-07182006

## You will need...

- 1) Your certification number, name of issuing authority and date of issue.
- 2) If you have ever been employed by a Massachusetts public school and/or another Massachusetts city, town, county or authority: your position or title, your dates of employment and the status of that account (e.g., whether you withdrew or rolled it over, left it on deposit, or transferred it to another account).

## What you need to do...

- 1) Using a computer that has Internet access and that is connected to a printer, **go to** <https://mtrs.trb.state.ma.us/eep/59enroll.htm>. Allow yourself 10 minutes to complete the online process.
- 2) **Provide and submit your data online.**
- 3) **Return your printed MTRS Enrollment Confirmation Form to your school payroll official as soon as possible**, so that your employer may process your MTRS payroll deductions and the MTRS may maintain your retirement account.

*Thank you for your cooperation!*

Mass.gov

[mass.gov home](#) • [online services](#) • [state agencies](#)

SEARCH MASS.GOV



MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

[Home](#) > Enrollment process**MTRS Enrollment process**

We know you are here to complete your mandatory enrollment process—and we hope to take you through this quickly, painlessly and in about 10 minutes. A note to **Mac users**: Our online process is best completed using either **Safari** or **Netscape**. Before you proceed to Step 1, please have the following at hand:

- your **enrollment registration form from your school district**, completed with the necessary data;
- if you have received your certification, please have your certification number, and the date of issue;
- if you have ever been employed by a Massachusetts public school and/or another Massachusetts city, town, county or authority, your position title, your dates of employment and what you did with the funds in that account; and,
- a printer.

**Ready?**

Once you begin, we recommend that you continue through all of the steps at one sitting. If you have any questions, feel free to send us an e-mail at [enrollsupport@trb.state.ma.us](mailto:enrollsupport@trb.state.ma.us), or call us at 617-679-6895.

First, please give us

- 1) Your SSN:
- 2) Your new school:
- 3) Your start date:

[Go to step 1](#)

© Commonwealth of Massachusetts

**GATEWAY REGIONAL SCHOOL DISTRICT  
POLICY ON SEXUAL HARASSMENT**

**Written and edited by:**

**Carol Doss  
Sue Everett  
Jeff Fisk  
Margery Gerard  
Jan Gormley  
Darlene Grady  
Jim Hughes  
Nancy Marek  
Ron Peloquin  
Dawn Piers-Gamble  
Gerrie Richards  
Nancy Shutt  
Sue Ulrich  
Richard White  
Gail Ziemba  
John Zmud**

**May 1996**

***Approved by Gateway Regional School District School Committee  
July 1996***

## **GATEWAY REGIONAL SCHOOL DISTRICT POLICY ON SEXUAL HARASSMENT**

### **POLICY**

It is the policy of the Gateway Regional School District to maintain a learning and working environment free from sexual harassment. No employee or student will be subjected to sexual harassment (as defined by Title VII of the 1964 Civil Rights Act and/or by Title IX of the 1972 Education Act).

It will be a violation of this policy for any student or staff member to harass another student or staff member through contact or communication as defined below.

### **DEFINITION**

Sexual harassment is defined as any unwelcome advance, request, or conduct which has the purpose or effect of unreasonably interfering with an individual's right to live and learn in an environment void of intimidating, hostile, humiliating, or sexually offensive behavior.

This definition applies to explicit or implicit sexual harassment occurring within the school environment between student to student, staff to student, student to staff, or staff to staff.

### **IDENTIFICATION OF BEHAVIORS AND ACTIVITIES AS DEFINED**

- Repeated remarks or written comments with sexual or demeaning implications
- Subtle or direct pressure for sexual activity
- Unwelcome touching or physical contact
- Suggestions or demands for sexual involvement accompanied by implied or explicit threats concerning one's performance evaluation or grade as a student
- Nonverbal sexual intimidation

## **Policy on Sexual Harassment**

### **COMPLAINT/INVESTIGATION PROCEDURE**

This procedure applies to all Gateway faculty, employees and students.

Any student, employee or individual on school property who believes that he or she has been subjected to sexual harassment should make a complaint to the building principal or designee(s) so that appropriate action may be taken.

All employees are charged with the responsibility of discouraging any sexually harassing behaviors within their areas of supervision or assignment. This includes discussing the incident with the individual(s) involved and/or reporting the activity to the appropriate person.

Complaints will be investigated promptly, and corrective action will be taken where appropriate. No person will suffer retaliation or intimidation as a result of using the internal complaint procedure.

#### **Informal Process**

Efforts shall be made by the principal or designee(s) to reach a settlement between the parties. Should this process prove to be unsuccessful, a formal written complaint may be filed by the complainant.

#### **Formal Process**

The complaint will state clearly and concisely the complainant's description of the incident, and he/she will also indicate any remedy sought. The complaint must be signed by the complainant. The principal's office will send the respondent a copy of the complaint within three working days after it is received. A separate file system shall be maintained as to all matters relating to the complaint. Confidentiality shall be respected to the extent possible.

The respondent will be given an opportunity within three working days to respond in writing. If a statement is given, it should contain full and specific references to each claim in the complaint admitting, denying or explaining the complainant's allegations. The respondent must sign his or her statement which will then be



## **Policy on Sexual Harassment**

appended to the original complaint. Within three working days, the principal's or investigator's office will forward any and all statements to the complainant and the respondent.

There will be two modes of resolution for formal complaints. A complaint may be settled through (1) mediation or (2) a hearing.

**Mediation:** The principal or designee(s) shall act as the mediator at this session. If the complainant and respondent agree to pursue mediation, a date mutually acceptable to both parties will be set within five working days. If the mediation results in a mutually acceptable agreement, copies of the agreement will be forwarded to both parties. If the mediation does not result in an agreement or if mediation is not requested, the case will be scheduled for hearing before the Superintendent.

**Hearing:** When a hearing is requested by either the complainant or respondent, the principal or designee(s) will inform the school committee; and the case will be heard as soon as reasonably possible.

The Superintendent, building principal or designee(s) will act as the presiding officer(s) of the hearing and may have counsel present for purposes of assisting in the orderly conduct of the hearing and the questioning of witnesses.

The purpose of the hearing will be to determine whether the school system's policy on sexual harassment has been violated.

Both parties will be given a full and fair hearing which will be held in closed session. The proceeding, although formal, is not a court proceeding and will not be bound by the procedures and rules of evidence of a court of law.

If a criminal complaint has been filed, this process will be held in abeyance until the conclusion of the criminal proceedings.

### **Decision of the Superintendent, Principal or Designee(s)**

After all evidence, testimony, and written arguments have been presented, the Superintendent will determine whether the school system's policy on sexual harassment has been violated.

## **Policy on Sexual Harassment**

If the Superintendent, principal or designee(s) finds that the charge of violating the school system's policy on sexual harassment has been substantiated, he/she will prepare findings and will determine a penalty for the respondent and relief for the complainant.

The penalty should reflect the severity of the harassment. For students the penalties may include, but will not be limited to, any one or combination of the following:

- verbal admonition

- written warning placed in the respondent's student file

- suspension or expulsion (per Serious Offenses Policy)

For staff the penalties may include, but will not be limited to, any one or combination of the following:

- verbal admonition

- written warning placed in the respondent's personnel file

- probation

- suspension without pay

- demotion

- dismissal

- removal from administrative duties within a department

- professional counseling

Any penalty imposed upon an employee must be in accordance with State and Federal Law and/or any collective bargaining agreement.

The written decision will be forwarded to the complainant and the respondent no later than ten working days after completion of the hearing.

### **The School Committee**

If the complainant has allegedly been sexually harassed by a School Committee member or the Superintendent of Schools, the School Committee will hear the case other than the Superintendent. The School Committee member charged with the violation will not be a voting member of the School Committee or be part of the deliberations resulting in the determination from the School Committee.

At the event the hearing occurs before the School Committee, the requirements of the Education Reform Act of 1993 and the Open Meeting Law will be observed.

**ADDENDUM TO GATEWAY REGIONAL SCHOOL DISTRICT  
SEXUAL HARASSMENT POLICY/COMPLAINT PROCEDURE**

The State and Federal Agencies Primarily Responsible For Processing Claims of Sexual Harassment are listed below. You may either call the Agency or write to them.

The Commonwealth of Massachusetts  
Commission Against Discrimination  
436 Dwight Street, Suite 315  
Springfield, MA 01103  
(413) 739-2145

Equal Employment Opportunity Commission  
1 Congress Street  
Boston, MA 02114  
(617) 565-3200