WWW.GRSD.ORG

CLICK ON GENERAL INFORMATION

CLICK ON CAF, CUS, PARA, NON-UNION, SECR INFORMATION

DOWNLOAD PACKET-PLEASE PRINT OFF SINGLE SIDED

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 after you have completed the paperwork to set up an appointment to complete the hiring process. Please do not hesitate to reach out if you have questions. Thank you!

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

CLICK ON:

SCHOOL COMMITTEE/POLICIES

Signature

_____

Date

_____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number

Address

City or town, state, and ZIP code

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 *www.ssa.gov*.

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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.)

Step 3: Claim Dependent and Other Credits

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 . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). 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 . . . . . **4(a)** $

(b) Deductions. 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 . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

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
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . 2 $

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.

FORM
M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 7/98

Print full name ..... Social Security No. .....

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

EMPLOYEE:

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

EMPLOYER:

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

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

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

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

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

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

EMPLOYER: DO NOT withhold if Box D is checked.

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

(Date) ..... (Signed).....

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS • DEPARTMENT OF REVENUE

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

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

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

IF YOU WORK FOR MORE THAN ONE EMPLOYER AT THE SAME TIME, YOU MUST NOT CLAIM ANY EXEMPTIONS WITH EMPLOYERS OTHER THAN YOUR PRINCIPAL EMPLOYER.

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

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

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

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

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

YOU ARE NOT ALLOWED TO CLAIM "FEDERAL WITHHOLDING DEDUCTIONS AND ADJUSTMENTS" UNDER THE MASSACHUSETTS WITHHOLDING SYSTEM.

IF YOU HAVE INCOME NOT SUBJECT TO WITHHOLDING, YOU ARE URGED TO HAVE ADDITIONAL AMOUNTS WITHHELD TO COVER YOUR TAX LIABILITY ON SUCH INCOME. SEE LINE 5.

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

150M 7/97 CRP0198

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

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.*

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):

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

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 HOUSEING 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)

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/

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
- Click on Get Fingerprinted
- Choose Massachusetts
- Click Digital Fingerprinting
- Choose Schedule a new Appointment
- Choose PreK-12th 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/

* PLEASE ATTACH A COPY OF A VOID CHECK OR CANCELLED CHECK!

AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED CREDITS

I (we) hereby authorize and request GATEWAY REGIONAL SCHOOL DISTRICT hereinafter called COMPANY, to make payment of any amounts owing to me (either of us) for payroll by initiating credit entries to my (our) account indicated below in the bank named below, hereinafter called BANK, and I (we) authorize and request BANK to accept any credit entries initiated by COMPANY to such account and to credit the same to such account without responsibility for the correctness thereof:

Bank Name: _____

Bank Address: _____
(City) (State)

Depositor Account Number: _____

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 time to act on it.

Customer Name(s): _____
(Please Print)

Date: _____ Signed: _____ Signed: _____

To Be Completed by the Company

Company ID No.: _____

Depositor account number information:

TRANSIT ROUTING NUMBER | Transit/ABA Check Digit | ACCOUNT NUMBER INFORMATION

TRANSIT ABA Designated by Federal Reserve

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 (⑆).

PR-507-75

1 – COMPANY INPUT COPY 2 – COMPANY FILE COPY 3 – EMPLOYEE COPY

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 >.

Employer

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.) $

Employee

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	Current Medical Group #:	Medical Group #, Transferring To
GATEWAY REGIONAL SCHOOL DIST		

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

☐ ADD ☐ CANCEL
☐ CHANGE Three digit termination code ☐☐☐
☐ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

☐ Open Enrollment ☐ New Hire ☐ COBRA

Change to Family ☐ Add Spouse ☐ Add Dependent

☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)

☐ Other: _____

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice ☐ Blue Choice New England ☐ Blue Medicare Rx (Part D) ☐ Dental Blue ☐ HMO Blue ☐ HMO Blue New England ☐ Managed Blue for Seniors ☐ Medex (Group) ☐ Network Blue ☐ PPO ☐ Saver Blue

Membership Type (Medical) ☐ Individual ☐ Family

Membership Type (Dental) ☐ Individual ☐ 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

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ☐ / N ☐	Other Insurance Company Name	City / State

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ☐ / N ☐

Are you covered by Medicare?[2] Y ☐ / N ☐	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #	☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐	If Retired, Date

3. Member 2

Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered)

Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ☐ / N ☐	Other Insurance Company Name	City / State

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ☐ / N ☐

Are you covered by Medicare?[2] Y ☐ / N ☐	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #	☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐	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)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

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

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ HSA: Health Savings Account			
☐ FSA: Health Flexible Spending Account	Start Date	End Date	Health: $
☐ 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 _____

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

HAMPSHIRE COUNTY GROUP INSURANCE TRUST

Subscriber Affidavit of Marital Status

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

HEALTH INSURANCE RATES - BENEFITS EFFECTIVE 7/1/23

(DEDUCTIONS BEGIN 6/02/23 PAYROLL)

	New Rate Per Month	Gateway Contribution Per Month	Employee Contribution Per Month	12 Month Employees Bi-Weekly Deduction	10 Month Employees Bi-Weekly Deduction	ADM,TEACHERS,CUS,SEC 12 MONTH EMPLOYEE *EMPLOYER PORTION BIWEEKLY 24 DEDUCTIONS*	AIDE,CAF,SEC 10 MONTH EMPLOYEE *EMPLOYER PORTION BIWEEKLY 20 DEDUCTIONS*
Blue Care Elect (BCBS-PPO)		**70%**	**30%**				
Single-with dental	$781.75	$547.23	$234.52	$117.26	$140.71	$273.62	$328.34
Family-with dental	$2,138.96	$1,497.27	$641.69	$320.85	$385.02	$748.64	$898.37
Single-without dental	$758.00	$530.60	$227.40	$113.70	$136.44	$265.30	$318.36
Family-without dental	$2,071.00	$1,449.70	$621.30	$310.65	$372.78	$724.85	$869.82
Network Blue New England (BCBS-HMO)		**75%**	**25%**				
Single	$658.00	$493.50	$164.50	$82.25	$98.70	$246.75	$296.10
Employee +1	$1,532.00	$1,149.00	$383.00	$191.50	$229.80	$574.50	$689.40
Family	$1,889.00	$1,416.75	$472.25	$236.13	$283.35	$708.38	$850.05
MEDEX	$342.00						

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 oppurtunity 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: _____

BOSTON MUTUAL LIFE INSURANCE COMPANY 1-800-669-2668 x 700

120 ROYALL STREET • CANTON, MA 02021

Please refer to your Administration Kit for enrollment and mailing instructions

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE/FAMILY INFORMATION

GroupNumber-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 ☐ Bi-Weekly ☐ Monthly ☐ 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

LIFE - DISABILITY

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&D	☐	☐	$	AD&D	☐	☐	$
DEPENDENT LIFE:				DEPENDENT LIFE:			
SPOUSE	☐	☐	$	SPOUSE	☐	☐	$
CHILD(REN)	☐	☐	$	CHILD(REN)	☐	☐	$
LONG TERM DISABILITY	☐	☐	$	LONG TERM DISABILITY	☐	☐	$
OTHER *(please specify coverage & amt)*				OTHER *(please specify coverage & amt)*			

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&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.

SIGNATURE

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 _____

HAMPSHIRE/FRANKLIN COUNTY VOLUNTARY TERM LIFE AND AD&D RATES

Must have Basic Life to sign up for Optional Life

*****ISSUE AGE OPTION*****

MONTHLY PREMIUM

Age	Monthly Premium Rate per 1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$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
35-39	$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

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		

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

- EMPLOYEE LIFE & AD&D = $10,000 TO A MAXIMUM OF $500,000 (NOT TO EXCEED 5 TIMES SALARY)
- SPOUSE LIFE & AD&D = $5,000 TO A MAXIMUM OF $100,000 (NOT TO EXCEED 50% OF EMPLOYEE BENEFIT)
- DEPENDENT (LIFE ONLY) = $500 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.

BOSTON MUTUAL LIFE INSURANCE COMPANY

[120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473]

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
Submit with completed Enrollment form.

EMPLOYEE/EMPLOYER

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

YOU	**[LIFE**	**AD&D**	**VOLUNTARY LIFE**	**VOLUNTARY AD&D]**
Current Insurance	[			]
Additional Insurance Requested	[			]
Total New Coverage	[			]

❑ [Short Term Disability $ _____] *Weekly Benefit*

❑ [Long Term Disability $ _____] *Monthly Benefit*

❑ Other $ _____

YOUR SPOUSE	**[LIFE**	**AD&D**	**VOLUNTARY LIFE**	**VOLUNTARY AD&D]**
Current Insurance	[			]
Additional Insurance Requested	[			]
Total New Coverage	[			]

❑ 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?
					❑ YES ❑ NO
					❑ YES ❑ 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) scubadive; 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 Amytrophic 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

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

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 _____

LTD

Hampshire County Election Form and Compensation Reduction Agreement

Employer Gateway Regional School

Employee Name _____

Address _____

_____

Social Security ___-___-___

Date of First Deduction _____

No. of Pay Periods 10____ 12____ 24____ 26____

52____ Other____

Premium Conversion

	Benefit		Annual Amount	Per Pay Period: 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 oppurtunity 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
- Wavier 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

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

BOSTON MUTUAL LIFE INSURANCE COMPANY 1-800-669-2668 x 700

120 ROYALL STREET • CANTON, MA 02021

Please refer to your Administration Kit for enrollment and mailing instructions

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE/FAMILY INFORMATION

GroupNumber-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 ☐ Bi-Weekly ☐ Monthly ☐ 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

LIFE - DISABILITY

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&D	☐	☐	$	AD&D	☐	☐	$
DEPENDENT LIFE:				DEPENDENT LIFE:			
SPOUSE	☐	☐	$	SPOUSE	☐	☐	$
CHILD(REN)	☐	☐	$	CHILD(REN)	☐	☐	$
LONG TERM DISABILITY	☐	☐	$	LONG TERM DISABILITY	☐	☐	$
OTHER *(please specify coverage & amt)*				OTHER *(please specify coverage & amt)*			

BENEFICIARY

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

	% of Benefit	Relationship to you
Primary Beneficiary(ies):		
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.

SIGNATURE

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

Monthly Benefit	Age <29	30-39	40-44	45-49	50-54	55+
$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 - Disabilty 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

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET • CANTON, MASSACHUSETTS 02021 • 800-669-2668

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 inforce 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 _____

Social Security Administration

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

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. 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

Employee Name _____

Address _____

_____

Social Security ___ - ___ - ___

Date of First Deduction _____

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 oppurtunity 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: _____

*Employees: Return this completed form to your employer. Incomplete forms will cause a delay in processing
*Employers: Log in at 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 or (888) 674-0046

Hampshire County Group Insurance Trust
ENROLLMENT/CHANGE FORM
PPI Employer No. 027760

PPI Benefit Solutions
ACSA Group Insurance Trust

Section 1 – Plan Options

Employer Use Only:

Payroll/Benefit Deduction Frequency: _____

Department Code: ☐ Active ☐ Retirees

Please fill in the name of your municipality below:

Employer Name Gateway Regional School District

Please select a dental plan option:

☐ **Delta Dental Core Plan**
☐ **Delta Dental High Plan**
☐ **Delta Dental PPO $750 Plan**

BRFOX

Section 2 – Type of Activity

*Employer ***must*** complete *both* of the following if enrolling or changing coverage:
***Date of Hire or Rehire:**
		-			-				

***Effective Date of Coverage:**
		-			-				

1. ENROLL FOR COVERAGE (List all enrollees in Section 3):
☐ New/Rehire
☐ Open Enrollment
☐ Part-time to Full-time status
☐ Loss of other coverage (HIPAA Cert from prior carrier required)
Date of Loss of Coverage: _____

2. CHANGES TO COVERAGE
A. Add Dependents (List Deps in Section 3):
☐ Birth/Adoption
☐ Marriage
☐ Other (**specify**):_____
Date of Event: _____

PLEASE NOTE THE FOLLOWING:
Provider Changes after your initial election must be reported directly to the insurance carrier.

B. Other Changes (Specify on form)
☐ Open Enrollment Plan Change
☐ Name Change
☐ Address Change
☐ Beneficiary Change

3. REMOVE COVERAGE
A. Cancel Dependents (List Deps in Section 3):
☐ Loss of Student Status
☐ Divorce/Separation
☐ Gained Other Coverage
☐ Death
☐ Other (**specify**):_____
Date of Loss: _____

B. Term Employee Coverage
☐ Reduced Hours
☐ Gained Other Coverage
☐ Retirement
☐ Other (**specify**):_____
Date of Loss: _____

Section 3 – Individuals Covered (A=Add C=Change R=Remove)

EMPLOYEE (SSN Required if Electing Dental):

Last Name	First Name	SS#
Home Address	City	State / Zip
Date of Birth / /	Gender: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other
Job Title:		
Phone: ( ) -	Email:	
Dental: ☐ A ☐ C ☐ R		

SPOUSE (SSN Required if Electing Dental):

Last Name	First Name	SS#
Date of Birth / /	Gender: ☐ M ☐ F	
Dental: ☐ A ☐ C ☐ R		

CHILD (SSN Required if Electing Dental):

Last Name	First Name	SS#
Date of Birth / /	Gender: ☐ M ☐ F	
Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R		

CHILD (SSN Required If Electing Dental):

Last Name	First Name	SS#
Date of Birth / /	Gender: ☐ M ☐ F	
Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R		

CHILD (SSN Required if Electing Dental):

Last Name	First Name	SS#
Date of Birth / /	Gender: ☐ M ☐ F	
Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R		

Please use a separate sheet of paper for additional dependents.

Please continue on the reverse side

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

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

Employer's Signature	Title	Date

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).

DELTAL 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

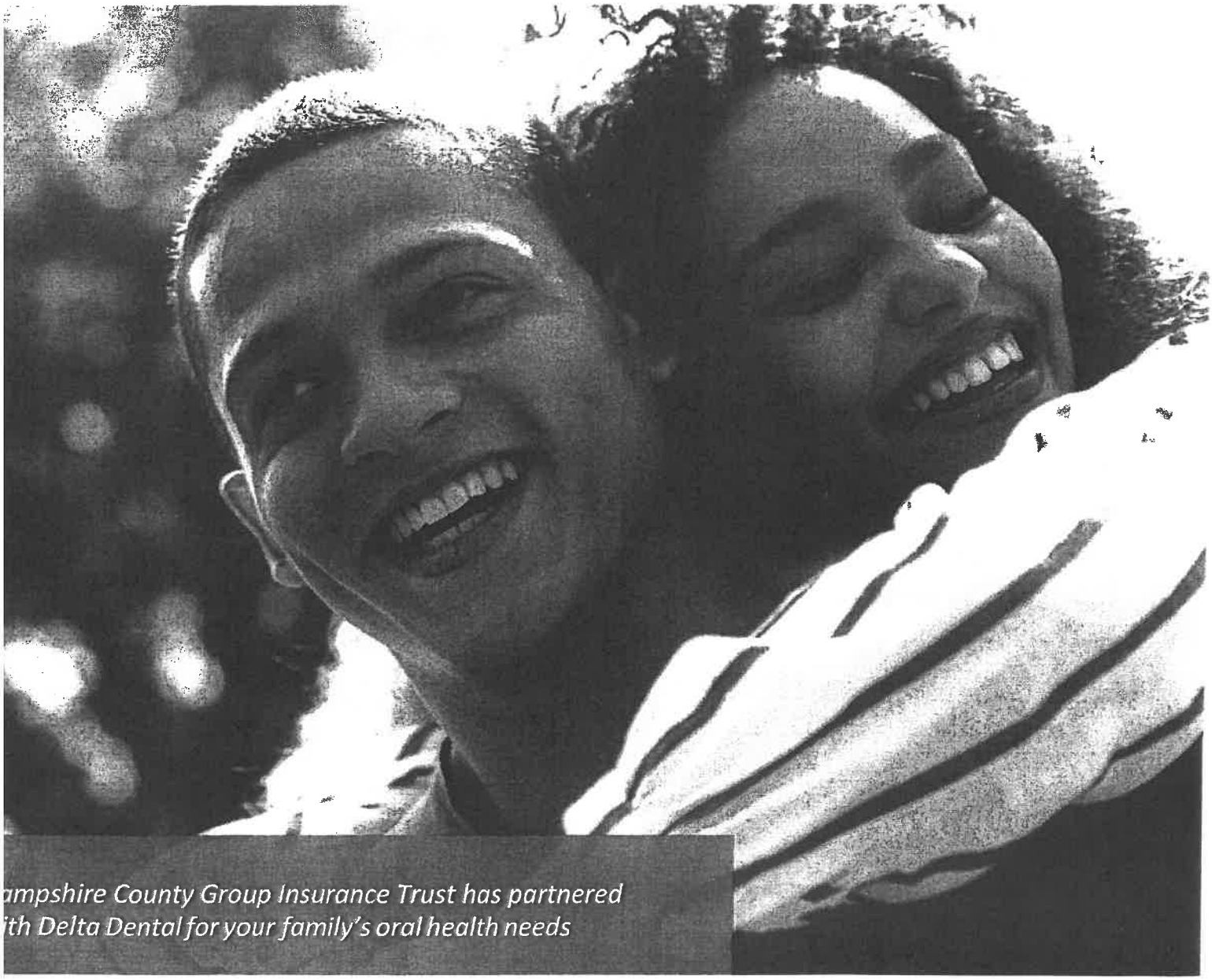
	HIGH PPO Plan	12 Month Rate Biweekly Rate	10 Month Rate Biweekly Rate	
Single		$22.08	$26.50	529.92
Emp +1		$41.90	$50.28	1,005.60
Family		$64.87	$77.84	1,556.88

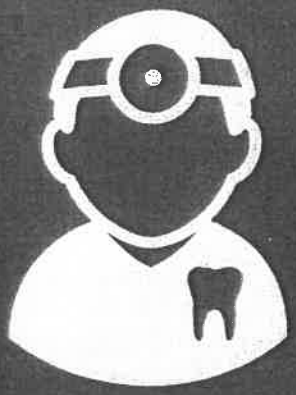
Group # 0158160000
Employer# 027760

4/26/23

DELTA DENTAL®

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





Find a provider

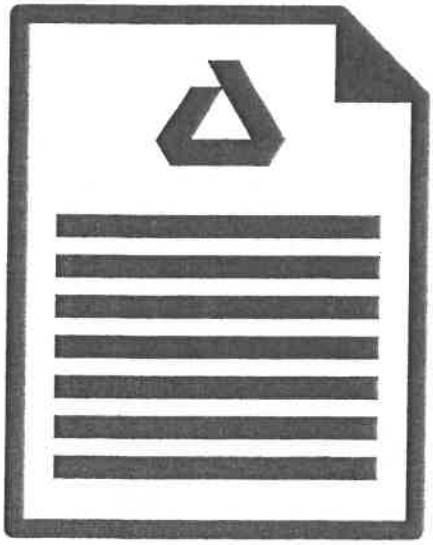
To find a provider or to see if your current provider is in one of our networks

Visit: 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.



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		100%	100%	Not a covered benefit.	Not a covered benefit.
Crowns or Onlay	When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older).				
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** to find a participating dentist in your area.

Learn more at deltadentalma.com

Visit the member area of **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**. 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.

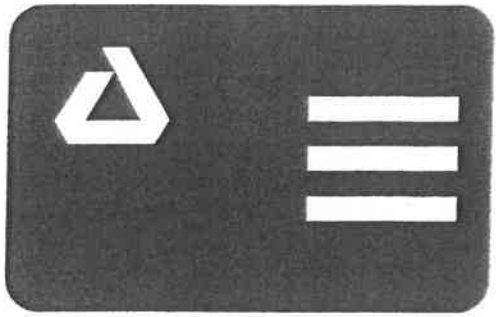
The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits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

Your Plan is Administered by:
Delta Dental of Massachusetts
1-800-872-0500
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

SD2388 (0210)

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:

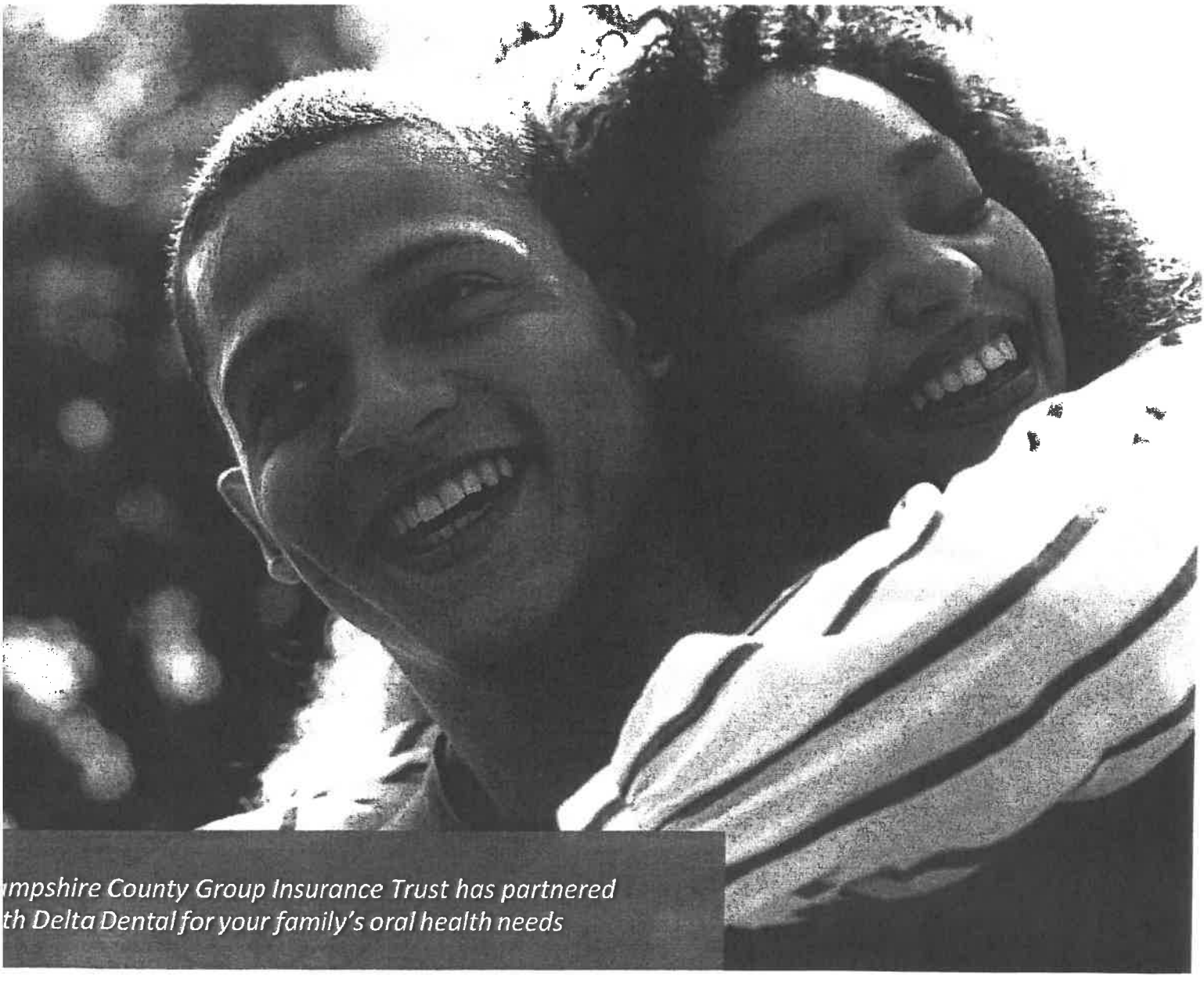
- Mobile ID card
- Dentist search
- Cost estimator

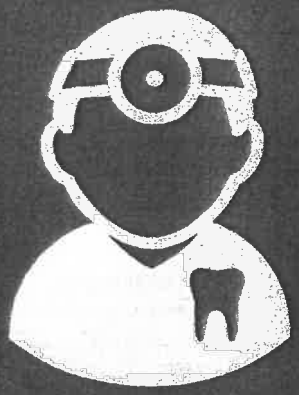
Download on the App Store

ANDROID APP ON Google play

DELTA DENTAL®

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





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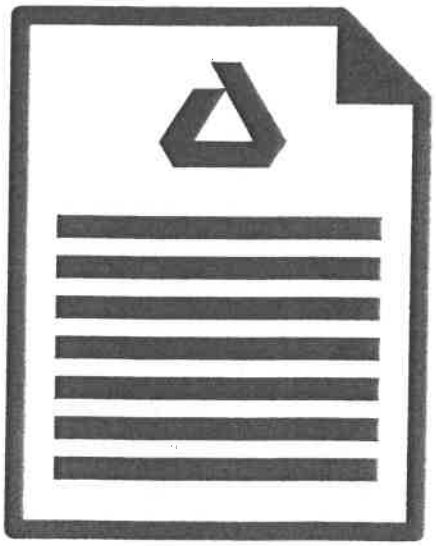

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		In Network	Out of Network*	In Network	Out of Network*
Major Restorative	**12 Month Waiting Period Applies**	100%	100%	50%.	50%
Crowns or Onlay	When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older).				
Cast Posts/Buildups	Once per tooth per 60 months only benefitted to retain a crown.				
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Delta Dental PPO *Plus Premier*

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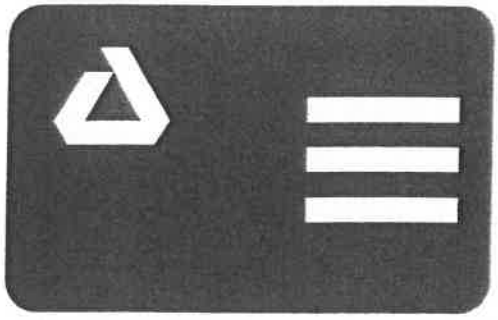
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

SP1309 (10-21)

Member Discounts



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- Dentist search
- Cost estimator

Download on the App Store

ANDROID APP ON Google play

GATEWAY REGIONAL SCHOOL DISTRICT
TECHNOLOGY DEPARTMENT
USER ACCOUNT FORM

Employee Last Name:	Employee First Name:	Employee Middle Name

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

Central Office ☐	High School ☐	Middle School ☐	Littleville ☐	Chester ☐

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:

GRSD 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_____

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
New Member Enrollment
Form Last Revised: February, 2020

The *New Member Enrollment* Form allows a newly hired employee to apply for membership in a public retirement system. The form must be completed by any new employee regardless of his or her past employment with any governmental entity. Certain information on this form must be provided by the Payroll/Personnel Department and verified by the retirement board.

A new member must also complete the *Beneficiary Selection Form for Refund of Accumulated Deductions* and, if applicable, the *Beneficiary Selection Form (Option D)*.

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board: Hampshire County Retirement System
Address: 99 Industrial Drive, Suite 2
City/Town: Northampton, MA **Zip Code:** 01060
Telephone: (413) 584-9100 **Fax:** (413) 587-9396

Employee Information

Employee Last Name: **First Name:.** **M.I.:**
Social Security # (Entire #): **Phone #:** **Sex:**
Street Address:
City/Town: **State:** **Zip Code:**
Birth/Former Name *(if different)* **Email:**
Date of Birth*: **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced***
Spouse's Name: **Spouse's DOB:** **# of Children:**

Your Retirement Board will request a copy of birth records, military discharge papers and other pertinent data.
***If Divorced and you have a Qualified Domestic Relations Order (QDRO), please attach a copy.**

Current/Prior Retirement System Membership

List prior or current public retirement system membership:

Are you retired from any other Massachusetts public retirement system? ☐ YES ☐ NO

Were you ever a member of any other Massachusetts public retirement system? ☐ YES ☐ NO

List prior or current public retirement system membership:

SYSTEM	DATES OF MEMBERSHIP From:	To:	ARE YOUR FUNDS STILL ON DEPOSIT?
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

If you wish to purchase past creditable service, please ask your Retirement Board about your options.

Did you ever work for or do you currently work for the Commonwealth or one of its political subdivisions for which you were not/are not a contributing member of a a retirement system? ☐ YES ☐ NO

Member Last Name: **First Name:** **SSN:** ***-**-____

Other Public Employment in Massachusetts

List prior or current public employment in Massachusetts or one of its political subdivisions (Non-membership):

EMPLOYER	DATES OF EMPLOYMENT From:	To:

Veteran Status

Are you a veteran? ☐ YES ☐ NO

DATES OF ACTIVE SERVICE From: To:

If **YES**, please enter dates of service and attach a copy of your military discharge papers, Forms DD-214, DD-215, DD-256, NGB 22, or NGB 22A.

I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and to deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular interest as provided by law, will be returned to me upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor benefits **OR** a refund of my accumulated total deductions as allowed by law.

I sign this application under the penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

Applicant's Signature:

Print Employee's Name:

Employee's Signature: **Date:**

Member Last Name: **First Name:** **SSN:** ***-**-____

Payroll/Personnel Department

To be completed by Payroll/Personnel Department and verified by Retirement Board:

Check base rate to be deducted for retirement:

☐ 5% ☐ 7% ☐ 8% ☐ 9% ☐ Additional 2%

If 5%, 7%, or 8%, state reason:

Current Rate of Regular Compensation per Pay Period: $

Employment Status (Check ALL that apply):

☐ Permanent ☐ Temporary ☐ Full-time ☐ Part-time ☐ 50% ☐ 75% ☐ Other:

Agency/Dept: Title/Position:

Starting Date of Present Position:

Authorized Signature: Date:

Print Name:

Retirement Board

To be completed by Retirement Board:

Membership Date: Annual Regular Compensation: $

% to be Deducted Current Group Classification:

The member should also complete the *Beneficiary Selection Form (Refund)* or if applicable, the *Beneficiary Selection Form (Option D).*

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Beneficiary Selection Form for Refund of Accumulated Deductions
(If Member Dies Before Retirement)
Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Form Last Revised: February, 2020

The *Beneficiary Selection Form for Refund of Accumulated Deductions* allows a member to select a beneficiary or beneficiaries to receive payment of accumulated deductions and other payments due a member if the member dies before retirement, as described at Massachusetts General Laws, Chapter 32, Section 11(2)(c).

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you have designated an eligible beneficiary who is alive at the time of your death on the *Beneficiary Selection Form for Option D*, then the money in your annuity account will not be disbursed to anyone in a one-time lump-sum payment, even if you have designated them on this form.
- Any person or entity may be designated as your Refund of Accumulated Deductions beneficiary under Section 11(2)(c). You may designate multiple beneficiaries and must indicate the percentage of the annuity account that you wish each beneficiary to receive. The percentages must total 100%.
- Your selection of a beneficiary on this form also may be superseded by an eligible spouse under the provisions of Option D.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Section 11(2)(c) form with your retirement board, it will supersede any and all prior Section 11(2)(c) forms filed previously by you.
- When you sign this form, it should be witnessed by a disinterested party.
- This form becomes void upon your retirement.

Beneficiary Selection Form for Refund of Accumulated Deductions
(If Member Dies Before Retirement)
Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board: Hampshire County Retirement System
Address: 99 Industrial Drive, Suite 2
City/Town: Northampton, MA **Zip Code:** 01060
Telephone: (413) 584-9100 **Fax:** (413) 587-9396

Member's Information:

Member's Last Name	Member's First Name		***-**-____ ____ ____ ____ Social Security # (last four)
Street Address:			
City/Town:		**State:**	**Zip Code:**
Email:			
Phone:			

Choice of Beneficiary or Beneficiaries to Receive a Refund of Accumulated Total Deductions at Member's Death:

- Any person or entity may be a beneficiary under Massachusetts General Laws, Chapter 32, Section 11(2)(c). Give complete name and address of each beneficiary on the next page.

I, (Print Name) , a member of the Retirement System hereby request the Retirement Board to pay any sum referred to in Massachusetts General Laws, Chapter 32, Section 11(2)(c) due at my death to the following beneficiary or beneficiaries in the proportions designated on the next pages.

Beneficiary Selection Form for Refund of Accumulated Deductions

Member Last Name: **First Name:** **SSN:** ***-**-____

PRIMARY LUMP-SUM BENEFICIARY(IES)

Do NOT name any one person or entity as a beneficiary more than ONCE in this section.

Primary Lump-Sum Beneficiary Information:

% of Benefit**

Full Name: (First, MI, Last): **SSN/EIN*:**
Relationship to You: **Phone:** **Date of Birth:**
Address:

Full Name: (First, MI, Last): **SSN/EIN*:**
Relationship to You: **Phone:** **Date of Birth:**
Address:

Full Name: (First, MI, Last): **SSN/EIN*:**
Relationship to You: **Phone:** **Date of Birth:**
Address:

Full Name: (First, MI, Last): **SSN/EIN*:**
Relationship to You: **Phone:** **Date of Birth:**
Address:

Full Name: (First, MI, Last): **SSN/EIN*:**
Relationship to You: **Phone:** **Date of Birth:**
Address:

*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.
**Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficaries.

0%

CONTINGENT LUMP-SUM BENEFICIARY(IES)

In the event that none of the named primary lump-sum beneficiary(ies) above, are alive, or, if an organization, still operating, as of your death.

Contingent Lump-Sum Beneficiary Information:

% of Benefit**

Full Name: (First, MI, Last): **SSN/EIN*:**
Relationship to You: **Phone:** **Date of Birth:**
Address:

Full Name: (First, MI, Last): **SSN/EIN*:**
Relationship to You: **Phone:** **Date of Birth:**
Address:

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Relationship to You: **Phone:** **Date of Birth:**
Address:

*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.
**Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficaries.

0%

Beneficiary Selection Form for Refund of Accumulated Deductions

Member Last Name: **First Name:** **SSN:** ***-**-____

I understand that my selection may be superseded if I die with an eligible beneficiary under Option D.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement, this form becomes void.

The types of payments covered under Massachusetts General Laws, Chapter 32, Section 11(2)(c) include:

- The one-time payment of the accumulated deductions credited to a member's account in the annuity savings fund at the date of death when the member's death occurs prior to his/her retirement.
- Any amounts payable to a member at his or her death.

Member's Signature:

Print Name:

Signature: **Date:**

To Be Completed By Witness (should be disinterested party):

Name (Print):

Street Address:

City/Town: **State:** **Zip Code:**

Signature: **Date:**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction

Beneficiary Selection Form - Option D (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 12(2)(d)

Form Last Revised: February, 2020

The *Beneficiary Selection Form - Option D* allows a member to select an eligible beneficiary to receive an allowance if the member dies before retirement. This is the Member Survivor allowance described at Massachusetts General Laws, Chapter 32, Section 12(2)(d) ("Option D").

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you designate an eligible beneficiary on this form, and that beneficiary is living at the time of your death, the money in your annuity account will not be disbursed to anyone in a one-time, lump-sum payment, even if you have named them to receive such money on your *Beneficiary Selection Form for Refund of Accumulated Deductions*.
- You may name only one person as the Option D beneficiary. That one person may be your spouse, your former spouse who is not remarried at the time of your death, your child, your father, your mother, your sister or your brother.
- If you select a beneficiary other than the spouse to whom you are married at the time of your death, your selection on this form may be superseded by the eligible spouse under the provisions of Option D if you die before retirement.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Option D form with your retirement board, it will supersede any and all prior Option D forms previously filed by you.
- When you sign this form, it should be witnessed by a disinterested party.
- To cancel an Option D beneficiary designation prior to retirement, your written notice must be filed with the retirement board.
- This form becomes void upon your retirement.

Beneficiary Selection Form - Option D (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 12(2)(d)

Form Last Revised: July, 2019

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board: Hampshire County Retirement System

Address: 99 Industrial Drive, Suite 2

City/Town: Northampton, MA **Zip Code:** 01060

Telephone: (413) 584-9100 **Fax:** (413) 587-9396

Member's Information:

***-**-____ ____ ____ ____

Member's Last Name **Member's First Name** **Social Security # (last four)**

Street Address:

City/Town: **State:** **Zip Code:**

Email:

Phone:

Choice of Option D Beneficiary

I, (Print Name) , a member of the Retirement System, hereby nominate the beneficiary listed below, under the provisions of Massachusetts General Laws, Chapter 32, Section 12(2)(d) to receive from the retirement system a benefit equal to the Option C retirement allowance which would otherwise have been payable to me, in the event that I die before being retired.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement this form becomes void.

I understand that this choice of Option D Beneficiary can be superceded if, at my death, I have at least two years of creditable service and leave a spouse to whom I have been married for over one year and with whom I am living on the date of my death, or if living apart, doing so for justifiable cause as determined by the Retirement Board.

Beneficiary

This person is my: ☐ Parent ☐ Sibling ☐ Unmarried Former Spouse* ☐ Spouse* ☐ Child

Name of Eligible Beneficiary:

Beneficiary's Date of Birth: *(attach birth record)* **Beneficiary's Social Security #:**

Beneficiary's Street Address:

City/Town: **State:** **Zip Code:**

*If beneficiary is your spouse or former spouse, a copy of your marriage certificate is required

Member's Signature:

Print Name:

Signature: **Date:**

To Be Completed By Witness (should be disinterested party):

Print Name:

Street Address:

City/Town: **State:** **Zip Code:**

Signature: **Date:**

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

Fourth draft 5/7/96

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**

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

All reasonable 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

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.

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 rather 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.

In 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 Aencies 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