Dr. Shundera Stallings, Business Manager
Mrs. Ronda Cook, Payroll
Mrs. Angela Thompson, Human Resources
Ms. Alexia Montgomery, Accounts Payable

Dr. Sandra R. Nash
Superintendent
Mrs. Trena Warren, Deputy
Superintendent/Director of Federal Programs

Business & Finance

www.claiborne.k12.ms.us • 404 Market Street • P. O. Box 337 • Port Gibson, MS 39150 • Ph: 601.437.4232 • Fax: 401.437.3036

Dear New Employee,

We welcome you to the Claiborne County School District with great pleasure! We are delighted that you have chosen to accept our offer of employment.

Enclosed are forms that you must complete to finalize your employment. You must also return the original documents to our office immediately. Below are some items needed to complete your personnel and payroll files.

- Ensure you have submitted an online application at https://ccsdjobs.claiborne.k12.ms.us/
- A copy of any previous teaching experience and Mississippi teacher license (before a contract can be issued).
- Emergency Contact Form
- Employment Eligibility Verification Form (I-9)
- A copy of your driver's license/picture ID and social security card
- Federal and State Tax Forms
- Direct Deposit Authorization Form (Please be sure to attach a voided check, direct deposit letter/card from the bank)
- Benefits Election Forms
    - Health Insurance
    - Life Insurance
    - Dental Insurance
    - Vision Insurance
    - American Fidelity (additional benefits)
- PERS Form(s)
    - Forms 1 and 1B for New Hires, Rehires, and Part-time/Substitute employees who currently contribute to PERS at another place of employment
    - Form 4A for Non-covered employees (Substitute employees)
    - Form 4B for Retirees
- Drug-Free Schools and Workplace Policy Acknowledgement Form
- Code of Ethics and Standards of Conduct Acknowledgement Form
- Fair Labor Standards and Family and Medical Leave Acts Acknowledgment Form
- Job Description
- $32.00 (exact cash amount, check, or money order made payable to the Claiborne County School District) for a background check. You should submit the payment to the Business Office. You will then contact the District's Resource Officer to complete the fingerprinting process.

We are excited about you joining us and want to ensure you succeed in your new role. Please do not hesitate to contact the Business Office at (601)-437-4232 with any questions or concerns. We look forward to a positive working relationship!

Respectfully,

The Business Department

CLAIBORNE COUNTY SCHOOL DISTRICT

Employee Information

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Spouse's Work Phone: _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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		**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*.
City or town, state, and ZIP code		

(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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

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

Specific Instructions

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

1	Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	**1**	$
2	Enter: • $27,700 if you're married filing jointly or a qualifying surviving spouse • $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.

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

Form 89-350-20-8-1-000 (Rev. 08/20)

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name _____ SSN _____

Employee's Residence _____ _____ _____ _____

Number and Street | City or Town | State | Zip Code

	CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION		
	Marital Status	Personal Exemption Allowed	Amount Claimed
EMPLOYEE:	1. Single	☐ Enter $6,000 as exemption . . . . ▸	$
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	2. Marital Status (Check One)	(a) ☐ Spouse **NOT** employed: Enter $12,000 ▸	$
		(b) ☐ Spouse **IS** employed: Enter that part of $12,000 claimed by you in multiples of $500. See instructions 2(b) below. ▸	$
	3. Head of Family	☐ Enter $9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d)below . . . . . ▸	$
EMPLOYER:	4. Dependents Number Claimed	You may claim $1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim $1,500 for each dependent excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by $1,500. Enter amount claimed. . . ▸	$
Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	5. Age and blindness	• Age 65 or older ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ Single Multiply the number of blocks checked by $1,500. Enter the amount claimed . . . . . ▸ * **Note**: No exemption allowed for age or blindness for dependents.	$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5... ▸		$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer . . . . . ▸		$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write **"Exempt"** on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▸		_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ **Date:** _____

INSTRUCTIONS

1. The personal exemptions allowed:

(a) Single Individuals	$6,000	(d) Dependents	$1,500
(b) Married Individuals (Jointly)	$12,000	(e) Age 65 and Over	$1,500
(c) Head of family	$9,500	(f) Blindness	$1,500

2. Claiming personal exemptions:

(a) Single Individuals enter $6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of $12,000.

If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of $500. For example, the taxpayer may claim $6,500 and the spouse claims $5,500; or the taxpayer may claim $8,000 and the spouse claims $4,000. The total claimed by the taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter $9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. Total Exemption Claimed:

Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION.

6. IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENIFIT OF EXEMPTION.

To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.

CLAIBORNE COUNTY SCHOOL DISTRICT
ACH Payment Authorization

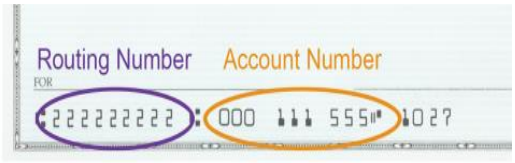
I (we) do hereby authorize the above-named company, hereinafter called Company, to initiate credit entries and to initiate. If necessary, debit entries and adjustments for any credits entries in error to my account (our) account/s indicated below and the depository named hereinafter called DEPOSITORY, to credit and /or debit the same to such account/s.

1. **Bank Name/City State: _____**
2. **Routing Transit#**: _____
   Account Number#: _____
   - Checking
   - Savings
   - **Entire Net Amount**
   - Other
     I wish to deposit $_____or Percentage%_____
3. **Bank Name/City State**_____
   Routing Transit#: _____
   Account Number#: _____
   - Checking
   - Savings
   - Entire Net Amount
   - Other
     I wish to deposit $_____or Percentage%_____

_____

This authorization is to remain in effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the COMPANY and DEPOSITORY a reasonable opportunity to act upon it.

Bank Details



☐Checking ☐Savings
Account Number _____
Routing Number _____

EMPLOYEE NAME: _____
SIGNATURE _____ ***DATE*** _____
(Account Holder's Signature)

AFFIX VOIDED CHECK OR OTHER DEPOSITORY DOCUMENT BELOW:

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

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

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

Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? ☐ No (Horizon) ☐ Yes (Legacy)

If yes, please list your most recent (pre-1/1/06) employer and dates of employment: _____

If married, is your spouse a Plan participant? ☐ Yes ☐ No If yes, Spouse Name and SSN: _____

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

☐ **I hereby apply to ADD, CONTINUE AND/OR CHANGE COVERAGE** for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the *Plan Document*. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

☐ **I hereby WAIVE COVERAGE in the State and School Employees' Health Insurance Plan.** I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. **If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.**

Enrollee Signature: _____ Date: _____

Section C: Coverage

Enrollee Type:	**Coverage Type**:	**Coverage Option:** (Choose Only One)	**Do you have Medicare?** ☐ Yes ☐ No
☐ Employee - Legacy	☐ Enrollee Only	☐ Base	**Medicare Number:** _____
☐ Employee - Horizon	☐ Enrollee + Spouse	☐ Choice	☐ "A" Effective Date: _____
☐ Retiree	☐ Enrollee + Child	☐ Select	☐ "B" Effective Date: _____
☐ COBRA	☐ Enrollee + Children		**Reason for Entitlement:**
☐ Surviving Spouse	☐ Enrollee + Spouse & Child(ren)		☐ Age ☐ ESRD ☐ Disability

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

Section D: Other Coverage Information

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

	1.	2.	3.	4.
Name of Individual Covered:				
Policyholder's Name:				
Policyholder's Date of Birth:				
Policyholder's Insurance Effective Date:				
Policy Number:				
Policyholder's Employment Status:	☐ Active, ☐ Retiree or ☐ COBRA	☐ Active, ☐ Retiree or ☐ COBRA	☐ Active, ☐ Retiree or ☐ COBRA	☐ Active, ☐ Retiree or ☐ COBRA
Insurance Company Name address & phone #:				
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:

Section E: Dependents

Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security Number	Date of Birth (mm/dd/yyyy)	Address (if different from Enrollee)	Current Status
1.	Spouse ☐ Male ☐ Female				Employed? ☐ Yes ☐ No
2.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
3.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
4.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled

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

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

Section F: Change Information

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

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

☐ **Change Coverage:** ☐ Base Coverage ☐ Choice Coverage ☐ Select Coverage

Drop Dependent(s): ☐ Divorce ☐ Deceased ☐ Other: _____
Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date

Other Changes (Explain):

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

ENTERED BY: _____
DATE: _____

VERIFIED BY: _____
DATE: _____

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
Effective January 1, 2023

Legacy - Initially hired before 1/1/2006

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

	LEGACY EMPLOYEES				HORIZON EMPLOYEES			
	BASE		SELECT		BASE		SELECT	
ACTIVE EMPLOYEE	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	$437	$0	$457	$20	$437	$0	$483	$46
Employee + Spouse	$915	$478	$1,001	$564	$915	$478	$1,027	$590
Employee + Spouse & Child(ren)	$1,165	$728	$1,251	$814	$1,165	$728	$1,277	$840
Employee + Child	$561	$124	$648	$211	$561	$124	$674	$237
Employee + Children	$754	$317	$840	$403	$754	$317	$866	$429

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

	LEGACY RETIREES		HORIZON RETIREES	
RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	BASE	SELECT	BASE	SELECT
Retiree	$502	$525	$802	$830
Retiree + Spouse (Non-Medicare)	$1,052	$1,151	$1,608	$1,712
Retiree + Spouse & Child(ren) (Non-Medicare)	$1,339	$1,438	$1,797	$1,902
Retiree + Child	$645	$716	$945	$1,021
Retiree + Children	$866	$908	$1,166	$1,213
Retiree + Spouse (Medicare)	N/A	$738	N/A	$1,043
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$929	N/A	$1,234
RETIRED EMPLOYEE - MEDICARE ELIGIBLE	**BASE**	**SELECT**	**BASE**	**SELECT**
Retiree	N/A	$213	N/A	$213
Retiree + Spouse (Non-Medicare)	N/A	$839	N/A	$1,095
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	$1,126	N/A	$1,285
Retiree + Child	N/A	$404	N/A	$404
Retiree + Children	N/A	$596	N/A	$596
Retiree + Spouse (Medicare)	N/A	$426	N/A	$426
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$617	N/A	$617

	LEGACY		HORIZON	
COBRA	BASE	SELECT	BASE	SELECT
Participant	$445	$466	$445	$492
Participant + Spouse	$933	$1,021	$933	$1,047
Participant + Spouse & Child(ren)	$1,188	$1,276	$1,188	$1,302
Participant + Child	$572	$660	$572	$687
Participant + Children	$769	$856	$769	$883
COBRA DISABILITY EXTENSION	**BASE**	**SELECT**	**BASE**	**SELECT**
Participant	$655	$685	$655	$724
Participant + Spouse	$1,372	$1,501	$1,372	$1,540
Participant + Spouse & Child(ren)	$1,747	$1,876	$1,747	$1,915
Participant + Child	$841	$972	$841	$1,011
Participant + Children	$1,131	$1,260	$1,131	$1,299

STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.

Policy 33683-G

SECTION A: Employee/Employer Information

Employee/Retiree Last Name:	First Name:	MI:	Social Security Number:	Birthdate: (MM/DD/YYYY):
Employee/Retiree Home Address:			Email Address:	Home Phone: Alternate Phone:
Employer Name:				Employer Phone:
Employer Address:				

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

ACTIVE FULL-TIME EMPLOYEE: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of $30,000 and a maximum of $100,000. The employee and employer each pay 50 percent of the monthly premium.

☐ **New Employee** – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.

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

Date of Employment: _____

☐ **RETIRED EMPLOYEE:** Life benefit amounts are limited to $5,000, $10,000 or $20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

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

☐ **DISABLED EMPLOYEE:** Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months.

(Employee must also complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

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

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

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

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

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

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone

SECTION D: Authorization and Certification

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

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

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

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

_____ _____

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

SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)

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

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

SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.

_____ _____

Employee/Retiree Signature **Date**

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT http://KnowYourBenefits.dfa.ms.gov/ OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

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

State & School Employees' Life Insurance Plan
Active Employee Premiums Effective 1/1/23

Insurance Amount	Employee Premium	Employer Premium	Total Premium	Insurance Amount	Employee Premium	Employer Premium	Total Premium
$30,000	$3.00	$3.00	$6.00	$66,000	$6.60	$6.60	$13.20
$31,000	$3.10	$3.10	$6.20	$67,000	$6.70	$6.70	$13.40
$32,000	$3.20	$3.20	$6.40	$68,000	$6.80	$6.80	$13.60
$33,000	$3.30	$3.30	$6.60	$69,000	$6.90	$6.90	$13.80
$34,000	$3.40	$3.40	$6.80	$70,000	$7.00	$7.00	$14.00
$35,000	$3.50	$3.50	$7.00	$71,000	$7.10	$7.10	$14.20
$36,000	$3.60	$3.60	$7.20	$72,000	$7.20	$7.20	$14.40
$37,000	$3.70	$3.70	$7.40	$73,000	$7.30	$7.30	$14.60
$38,000	$3.80	$3.80	$7.60	$74,000	$7.40	$7.40	$14.80
$39,000	$3.90	$3.90	$7.80	$75,000	$7.50	$7.50	$15.00
$40,000	$4.00	$4.00	$8.00	$76,000	$7.60	$7.60	$15.20
$41,000	$4.10	$4.10	$8.20	$77,000	$7.70	$7.70	$15.40
$42,000	$4.20	$4.20	$8.40	$78,000	$7.80	$7.80	$15.60
$43,000	$4.30	$4.30	$8.60	$79,000	$7.90	$7.90	$15.80
$44,000	$4.40	$4.40	$8.80	$80,000	$8.00	$8.00	$16.00
$45,000	$4.50	$4.50	$9.00	$81,000	$8.10	$8.10	$16.20
$46,000	$4.60	$4.60	$9.20	$82,000	$8.20	$8.20	$16.40
$47,000	$4.70	$4.70	$9.40	$83,000	$8.30	$8.30	$16.60
$48,000	$4.80	$4.80	$9.60	$84,000	$8.40	$8.40	$16.80
$49,000	$4.90	$4.90	$9.80	$85,000	$8.50	$8.50	$17.00
$50,000	$5.00	$5.00	$10.00	$86,000	$8.60	$8.60	$17.20
$51,000	$5.10	$5.10	$10.20	$87,000	$8.70	$8.70	$17.40
$52,000	$5.20	$5.20	$10.40	$88,000	$8.80	$8.80	$17.60
$53,000	$5.30	$5.30	$10.60	$89,000	$8.90	$8.90	$17.80
$54,000	$5.40	$5.40	$10.80	$90,000	$9.00	$9.00	$18.00
$55,000	$5.50	$5.50	$11.00	$91,000	$9.10	$9.10	$18.20
$56,000	$5.60	$5.60	$11.20	$92,000	$9.20	$9.20	$18.40
$57,000	$5.70	$5.70	$11.40	$93,000	$9.30	$9.30	$18.60
$58,000	$5.80	$5.80	$11.60	$94,000	$9.40	$9.40	$18.80
$59,000	$5.90	$5.90	$11.80	$95,000	$9.50	$9.50	$19.00
$60,000	$6.00	$6.00	$12.00	$96,000	$9.60	$9.60	$19.20
$61,000	$6.10	$6.10	$12.20	$97,000	$9.70	$9.70	$19.40
$62,000	$6.20	$6.20	$12.40	$98,000	$9.80	$9.80	$19.60
$63,000	$6.30	$6.30	$12.60	$99,000	$9.90	$9.90	$19.80
$64,000	$6.40	$6.40	$12.80	$100,000	$10.00	$10.00	$20.00
$65,000	$6.50	$6.50	$13.00				

CLEAR FORM

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop: _____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-3797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Note for Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Maryland Insureds: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico and Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: 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.

Note for Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Note for Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Note for Washington, D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number –** to make sure plan members are added to the correct group.
- **Department/Division Numbers –** so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers –** the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.

CLAIBORNE COUNTY SCHOOL DISTRICT

Policy #: 010-28492

Ameritas
fulfilling life.

Dental Plan Benefits

Networks: Classic

Type 1 Preventive No Waiting Period	100%
	Routine Exam (2 per Benefit Period) Bitewing X-rays (1 per Benefit Period) Cleaning (2 per Benefit Period)
Type 2 Basic No Waiting Period	100%
	Restorative Amalgams Restorative Composites Simple Extractions
Type 3 Major 12 Month Waiting Period	100%
	Surgical Extractions Endodontics (nonsurgical) Periodontics (nonsurgical) Crowns (1 in 5 years per tooth) Endodontics (surgical) Periodontics (surgical) Prosthodontics (Bridges, Dentures) (1 in 5 years)

Deductible

Type 1	$0
Type 2 and 3	$50 per person, per calendar year
Family Maximum	When 3 family members satisfy their Deductible Amounts for this Calendar Year, no additional Deductibles will apply to any family members for the rest of this Calendar Year.

Benefit Year Maximum

Type 1, 2, and 3 (per person, per calendar year)	$1,250

Claims Allowance

Type 1, 2 and 3	Maximum Covered Expense

In network allowance is discounted fee

Tenthly Rates

Employee only	$25.00
Employee & Spouse	$48.76
Employee & Child(ren)	$59.08
Employee & Spouse & Child(ren)	$81.40

Rates are effective from 8/1/2023 to 8/1/2025.

Open Enrollment

If you do not elect to participate when initially eligible, you may elect to participate at the policyholder's next enrollment period, which normally coincides with the policy anniversary date.

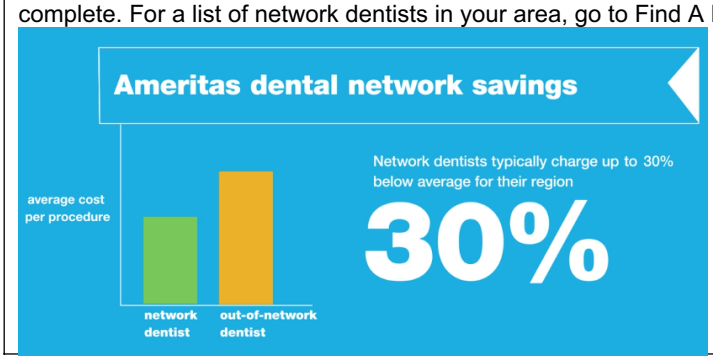
Dental Rewards

Your dental plan includes Dental Rewards as a way to grow your annual maximum benefit. Simply by visiting a dental provider each year and submitting a claim, you can increase your annual maximum benefit over time. After your initial benefit is used, accumulated rewards are there to help pay for more expensive procedures, such as root canals or crowns.

Here's how it works. For each year, you submit at least one dental claim and your total dental benefits paid for the year are at or under $500 you qualify to carry over $250 in rewards to the following year. You may accumulate rewards up to the maximum amount of $1000. Please note, if you do not submit a dental claim during the year, no rewards are earned and accumulated rewards are reset to zero. However, you can start qualifying for rewards again the very next year.

Provider Flexibility and Network Savings

Members aren't limited to one particular dentist, or a small group of providers, who may or may not be taking new patients. Each plan member is free to visit any provider they choose, including your current dentist, regardless if they are in- or out-of-network. And family members do not have to see the same dentist. When yo visit an in-network dentist there are no claim forms to complete. For a list of network dentists in your area, go to Find A Provider at Ameritas.com.



The Ameritas dental network is one of the **5 largest networks** in the nation for access points. Source: NetMinder 2016

Ameritas Network: These plans give you more than 428,000 access points across the nation for dental care.

Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declined, you and/or your eligible dependents will be considered a Late Entrant. Covered expenses will not include and benefits will not be payable in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application. After 12 months, you will have access to all of the plan's benefits.

Member Savings

Prescription savings

Just for participating in our dental, vision or hearing care plans, members can save big on prescription medications through one of the world's largest retailers. **No additional cost. Only savings.**

Extra Value

Our plan members, their covered dependents can **save on prescription medications at over 60,000 pharmacies across the nation** including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

Participating pharmacies will give Ameritas plan members their normal health care pharmacy benefit, or the prescription discount, whichever saves them more. Even if the employees already have health insurance pharmacy benefits, they are welcome to check out this Rx discount.

Find a pharmacy near you – http://www.emsmed.com/vendors/pharmacy.aspx

Look up a price – http://www.emsmed.com/vendors/rxpricing.aspx?groupid=Ameritas

Rx Savings

Members can receive up to 65% savings on generic prescriptions, and overall average savings of 40% across brand name and generic prescription combined.

Save on frames and lenses

Save up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. This is available to you without any additional cost to your plan premium.

You may receive savings on the following vision care products at Walmart Vision Centers:

- top quality frames for the entire family including today's most popular brands.
- wide selection of lens options; all lenses come with scratch resistant coating for no additional charge.
- safety eyewear.

Guarantees

Walmart Vision Centers stand behind their products and workmanship by offering:

- 60-day frame and lens satisfaction guarantee.
- 12-month replacement guarantee on broken or damaged frames or lenses.
- lifetime adjustments and cleanings.

Customer Service

Customer Connections 800-487-5553 www.Ameritas.com
Monday - Thursday 7am-12am CST, Friday 7am-6:30pm CST

CLAIBORNE COUNTY SCHOOL DISTRICT

Policy #: 010-28492

Ameritas
fulfilling life.

Dental Plan Benefits

Networks: Classic

Type 1 Preventive No Waiting Period	100%
	Routine Exam (2 per Benefit Period) Bitewing X-rays (1 per Benefit Period) Cleaning (2 per Benefit Period)
Type 2 Basic No Waiting Period	80%
	Restorative Amalgams Restorative Composites Simple Extractions
Type 3 Major 12 Month Waiting Period	50%
	Surgical Extractions Endodontics (nonsurgical) Periodontics (nonsurgical) Crowns (1 in 5 years per tooth) Endodontics (surgical) Periodontics (surgical) Prosthodontics (Bridges, Dentures) (1 in 5 years)

Deductible

Type 1	$0
Type 2 and 3	$50 per person, per calendar year
Family Maximum	When 3 family members satisfy their Deductible Amounts for this Calendar Year, no additional Deductibles will apply to any family members for the rest of this Calendar Year.

Benefit Year Maximum

Type 1, 2, and 3 (per person, per calendar year)	$1,250

Orthodontia Benefits (adult ortho included)

12 month waiting period

Plan Benefit	50%
Lifetime Deductible	$0
Lifetime Maximum (per person)	$1,000

Claims Allowance

Type 1, 2 and 3	75th U&C

In network allowance is discounted fee

Tenthly Rates

Employee only	$42.14
Employee & Spouse	$88.41
Employee & Child(ren)	$98.64
Employee & Spouse & Child(ren)	$140.49

Rates are effective from 8/1/2023 to 8/1/2025.

CLAIBORNE COUNTY SCHOOL DISTRICT

Policy #: 010-28492

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Open Enrollment

If you do not elect to participate when initially eligible, you may elect to participate at the policyholder's next enrollment period, which normally coincides with the policy anniversary date.

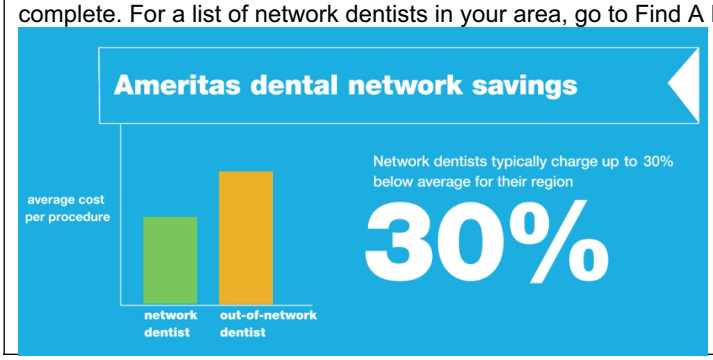
Dental Rewards

Your dental plan includes Dental Rewards as a way to grow your annual maximum benefit. Simply by visiting a dental provider each year and submitting a claim, you can increase your annual maximum benefit over time. After your initial benefit is used, accumulated rewards are there to help pay for more expensive procedures, such as root canals or crowns.

Here's how it works. For each year, you submit at least one dental claim and your total dental benefits paid for the year are at or under $500 you qualify to carry over $250 in rewards to the following year. You may accumulate rewards up to the maximum amount of $1000. Please note, if you do not submit a dental claim during the year, no rewards are earned and accumulated rewards are reset to zero. However, you can start qualifying for rewards again the very next year.

Provider Flexibility and Network Savings

Members aren't limited to one particular dentist, or a small group of providers, who may or may not be taking new patients. Each plan member is free to visit any provider they choose, including your current dentist, regardless if they are in- or out-of-network. And family members do not have to see the same dentist. When yo visit an in-network dentist there are no claim forms to complete. For a list of network dentists in your area, go to Find A Provider at Ameritas.com.



The Ameritas dental network is one of the **5 largest networks** in the nation for access points. Source: NetMinder 2016

Ameritas Network: These plans give you more than 428,000 access points across the nation for dental care.

Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declined, you and/or your eligible dependents will be considered a Late Entrant. Covered expenses will not include and benefits will not be payable in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application. After 12 months, you will have access to all of the plan's benefits.

Member Savings

Prescription savings

Just for participating in our dental, vision or hearing care plans, members can save big on prescription medications through one of the world's largest retailers. **No additional cost. Only savings.**

Extra Value

Our plan members, their covered dependents can **save on prescription medications at over 60,000 pharmacies across the nation** including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

Participating pharmacies will give Ameritas plan members their normal health care pharmacy benefit, or the prescription discount, whichever saves them more. Even if the employees already have health insurance pharmacy benefits, they are welcome to check out this Rx discount.

Find a pharmacy near you – http://www.emsmed.com/vendors/pharmacy.aspx

Look up a price – http://www.emsmed.com/vendors/rxpricing.aspx?groupid=Ameritas

Rx Savings

Members can receive up to 65% savings on generic prescriptions, and overall average savings of 40% across brand name and generic prescription combined.

Save on frames and lenses

Save up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. This is available to you without any additional cost to your plan premium.

You may receive savings on the following vision care products at Walmart Vision Centers:

- top quality frames for the entire family including today's most popular brands.
- wide selection of lens options; all lenses come with scratch resistant coating for no additional charge.
- safety eyewear.

Guarantees

Walmart Vision Centers stand behind their products and workmanship by offering:

- 60-day frame and lens satisfaction guarantee.
- 12-month replacement guarantee on broken or damaged frames or lenses.
- lifetime adjustments and cleanings.

Customer Service

Customer Connections 800-487-5553 www.Ameritas.com
Monday - Thursday 7am-12am CST, Friday 7am-6:30pm CST

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

CITIZENS SECURITY LIFE INSURANCE COMPANY
P.O. BOX 436149 • Louisville, KY 40253-6149
www.thecsbenefits.com
800.843.7752

GROUP EMPLOYEE ENROLLMENT / CHANGE FORM

ENROLLMENT / CHANGE TYPE			**CITIZENS SECURITY USE ONLY**	
☐ **New Applicant**			Dental Plan:	Dental Prem:
☐ **Change in Coverage:**			Vision Plan:	Vision Prem:
☐ Change Address ☐ Change Name ☐ Add Dependent	☐ Terminate effective: / / ☐ Reinstate effective: / / ☐ COBRA effective: / /		Waiting Period:	PID:
			Takeover: ❑ Y ❑ N Date: / /	
COVERAGE REQUESTED			**EMPLOYER USE ONLY**	
☐ **Dental**	**Dual Choice ONLY:**	☐ **High Option** ☐ **Low Option**	Group #:	Acct#:
☐ **Vision**	**Dual Choice ONLY:**	☐ **High Option** ☐ **Low Option**	Effective Date:	

APPLICANT INFORMATION

Last Name: First Name: M.I.:			Social Security #: XXX – XX -	
Address:			Phone #: ( ) -	
City:	State:	Zip Code:	Gender: ☐M ☐F	Married? ☐Y ☐N
Date of Birth: / /	Age:	Coverage Type: EE Only ☐ EE + Spouse ☐ EE + Child(ren) ☐ Family ☐		

EMPLOYER INFORMATION

Employer:	Location:	Phone #: ( ) -
Occupation / Title:	Hours Worked Per Week:	Full Time Employment Date: / /

DEPENDENT INFORMATION

All information must be completed for each dependent(s) to be covered. Select what coverage you want for each dependent(s) by placing a "Y" for Yes or "N" for No under the Dental and Vision columns. *(Child(ren) Ages 0-25)*

Name	Relation	Date of Birth	Sex (M/F)	Dental (Y/N)	Vision (Y/N)	If covered under another Dental Policy list the carrier

AUTHORIZATION

I hereby request coverage under the group policy(ies) issued by CITIZENS SECURITY LIFE INSURANCE COMPANY and authorize my employer to deduct from my earnings any required contribution for the insurance to which I am or may become entitled. I am employed by the employer listed above and regularly work and, at present I am working at least 30 hours per week for this employer at a regular place of business or other location to which I am required to travel to perform my regular duties for this employer. I hereby represent that all answers above are true and complete to the best of my knowledge and belief.

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.

Applicant's Signature:	Date:

The Collection

Our plans offer members a generous frame allowance to use toward any frame of their choice or the option to choose their frame from our exclusive Collection of over 200 name brand frames. Each comprehensive plan includes a selection of Collection frames that are covered in full (retail value up to $225).

Covered-In-Full Contact Lenses

Contact lens wearers will find the same outstanding value and quality with CS Benefits and Davis Vision's Contact Lens Collections, our value-added option to the contact lens allowance. Members who select from our popular Collection of contact lenses receive their evaluations, fitting, follow-up care, and contact lenses — covered up to $130! To see the full Formulary List of Contacts, please visit us at www.mycsbenefits.com.

Unparalleled Value on Lens Options

Standard lenses such as singe vision, bifocals, trifocals, and lenticular lenses are covered in full, and many extras are included at no cost for members. Plus, many of the most popular lens options are offered at significantly reduced prices.

Value Added Benefit

Digital Progressive Lens now available at a discounted rates.

Network Choice

Freedom of choice in selecting a vision provider is a core value to us. We offer out-of-network options to all members. The member is responsible for the difference between the out-of-network provider's charge and the negotiated schedule of a network provider. If a Davis network provider is not available within 30 miles of a member's home or there is no provider that adequately meets the particular health care needs of a member, we allow access to a non-participating provider. In this case, there is no additional cost beyond what the member would normally pay for the same in-network service. To learn more about your network choices, contact us at www.davisvision.com.

Monthly Rates Effective 9/1/2019	
Employee	$9.94
Employee + One	$17.95
Employee + Family	$27.10

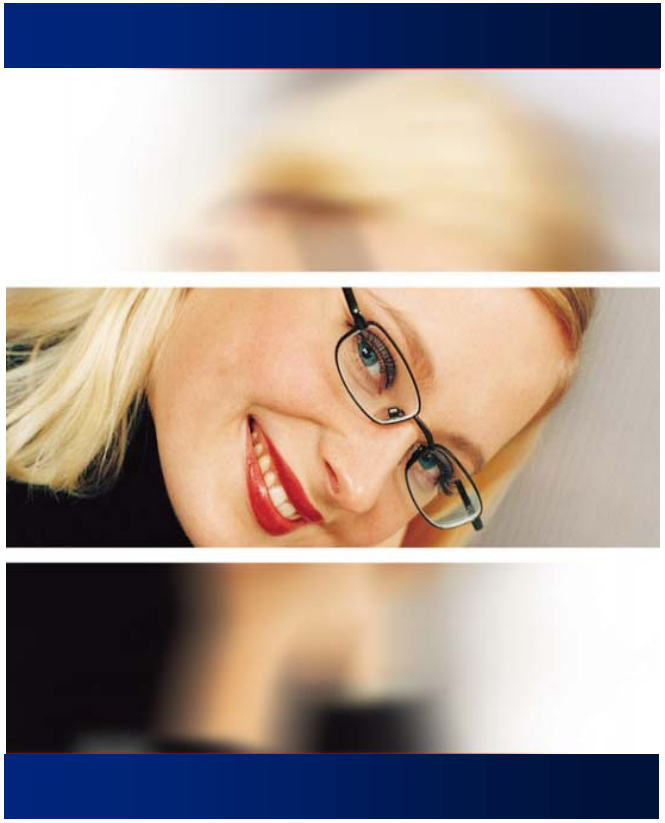
The industry's only one-year eyeglass breakage warranty!

CS Benefits
Service with a Human Touch.

12910 Shelbyville Road
Louisville, KY 40243
800.843.7752
www.citizensgroup.com

CS Benefits
Service with a Human Touch.

OUR FOCUS



IS YOUR VISION

Vision Care Plan Benefit Description for

Claiborne County

School District

Vision Plan Services & Benefits

Special Features of Your Davis Vision Plan

Low Vision Services:

You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up care visits will be covered during the five year period.

Laser Vision Correction Services:

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts of up to 25% off a participating providers normal charges, or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the participating provider. For more information, please visit **www.DavisVision.com** or call 800.999.5431.

Contact Replacements by Mail

Free membership and access to Lens 123, a mail order replacement contact lens service, providing a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the Lens 123 website at www.Lens123.com.

This is only a brief summary of the benefits in the Vision Plan. Refer to the Certificate of Insurance for complete details.
** Contact Lenses are available in lieu of frames and lenses. Once lenses are fitted, they cannot be exchanged. Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.*
*** Additional discount does not apply at participating Walmart and Sam's Club locations.* *Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses; however, the co-payment is not refundable.*

CS Benefits
Service with a Human Touch.

DAVISVISION
SEE LIFE

Benefits	In-Network	Out-Of-Network
Exams (Includes dilation when medically necessary) Co-Pay Frequency	$10 Co-Pay Once Every 12 months	Reimbursed up to $40 Once every 12 months
Eyeglass Lenses Co-Pay Frequency Single Bifocal Trifocal Lenticular	$25 Co-Pay Once Every 12 months Paid in Full Paid in Full Paid in Full Paid in Full	Once Every 12 months Reimbursed up to $40 Reimbursed up to $60 Reimbursed up to $80 Reimbursed up to $80
Optional Lenses: Oversize Lenses Ultraviolet Coating Scratch-Resistant Blended Segment Polycarbonate Photochromic Glass Intermediate Progressive Multifocal Std Glass Grey#3 Prescription Sunglass Lenses Anti-Reflective Std Anti- Reflective Prem Anti-Reflective Ultra High Index Progressive Multifocal Prem+ Plastic Photosensitive Polarized	 Paid in Full $12 Co-Pay $20 Co-Pay $20 Co-Pay *$0 or $30 Co-Pay* $20 Co-Pay $30 Co-Pay $50 Co-Pay Paid in Full $35 Co-Pay $48 Co-Pay $60 Co-Pay $55 Co-Pay $90 Co-Pay $65 Co-Pay $75 Co-Pay	 n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a
Frames Frequency Fashion Collection Designer Collection Premier Collection All Other	Once Every 24 months Paid in Full Paid in Full $25 Co-Pay $130 allowance and 20% discount on excess**	Once Every 24 months n/a n/a n/a $65 allowance
Contact Lenses Frequency Medically Necessary (With Prior Approval) Davis Vision Collection Disposable Planned Replacement Retail Allowance Evaluation, Fitting, and Follow-Up Davis Vision Collection Non-Collection Standard Non-Collection Specialty	 Once Every 12 months Paid in Full Paid in Full 4 multi-packs 2 multi-packs $130 allowance and 15% discount on excess** Paid in Full 15% discount 15% discount	 Once Every 12 months Reimbursed up to $225 Reimbursed up to $105 Reimbursed up to $105 Reimbursed up to $105 Reimbursed up to $105 n/a n/a n/a

Polycarbonate lenses COVERED-IN-FULL for dependent children monocular patients and patients with prescriptions ≥ +/- 6.00 diopters

Eligible Dependents are all children who are not married, who are less than 26 years of age and who live with you and are dependent on you for principal support and maintenance.

Vision Q & A

How do I receive services from a provider in the network?

Simply, call the network provider of your choice and schedule an appointment. Identify yourself as a Davis Vision plan participant. You will be asked to provide the name(s) and date of birth of any covered member needing service. No claim forms are required. Be prepared with your personal I.D. number when you call.

Who are the network providers?

The Davis Vision network have licensed providers in both private practice and retail locations who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. To Find a Provider, go to **www.mycsbenefits.com,** click on Vision or call **800.999.5431** to be directed to the network providers nearest you.

Can I access care at a retail location?

In order to provide our members with the greatest flexibility and convenience, Davis Vision has a number of retail establishments in the provider network. Benefits at retail locations may vary slightly from other locations, as noted in this benefit description.

What about out-of-network provider benefits?

Although you can receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network, you can choose an out-of-network provider. You must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
PO Box 1525
Latham, NY 12110

Only one claim per service may be submitted for reimbursement each benefit cycle. To obtain a claim form, please visit our website at **www.mycsbenefits.com**.

Are there any exclusions?

The following items are not covered by this vision program:
- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
- Replacement of lost eyewear.
- Non-prescription (plano) lenses.
- Contact lenses and eyeglasses in the same benefit cycle.
- Services not performed by licensed personnel.
- Two pairs of eyeglasses in lieu of a bifocal.

PERS of MISSISSIPPI

Membership Application

Form 1 – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member Information – *Attach a copy of the member's Social Security card.*

First Name: _____ MI: _____ Last Name: _____ Gender: ☐ M ☐ F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

Have you previously served on active duty in the U.S. Armed Forces? *If yes, attach Form(s) DD214* ..... ☐ Yes ☐ No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? ..... ☐ Yes ☐ No

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Family Information – *Use additional* Membership Applications *if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B,* Beneficiary Designation, *to officially designate any and all beneficiaries.*

Marital Status – *Select one. Add date for last three.* ☐ Single ☐ Married ☐ Divorced ☐ Widowed Effective Date *mm/dd/ccyy:* _____

Spouse's Full Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Wedding Date** *mm/dd/ccyy*	**Gender**
				☐ M ☐ F

Dependent Child's Full Name – *Up to age 19, or 23 if unmarried and a full-time student*	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Gender**
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

❹ Member Certification – *If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

Member's Signature: _____ Date *mm/dd/ccyy*: _____

❺ Employer Certification – *This section must be completed by an authorized employer representative, not the member.*

Member's Position Held/Job Title: _____ **Member's Hire Date** *mm/dd/ccyy:* _____

Member's Status: Elected Official: ☐ Yes ☐ No Fee Paid Official: ☐ Yes ☐ No Public Safety Employee: ☐ Yes ☐ No

Employer Name: _____ Employer No.: _____ - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, *Eligibility of Part-time Employees for State Retirement Annuity Service Credit*, and PERS Board of Trustees Regulation 36, *Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS)*.

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

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, *fax* www.pers.ms.gov

Reset Form Print

PERS of MISSISSIPPI

Beneficiary Designation

Form 1B – Revised 08/30/2022

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ ☐ Member ☐ Retiree

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ Gender: ☐ M ☐ F

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Beneficiary Information – *Use additional Form 1B,* Beneficiary Designation, *to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary beneficiaries must equal 100 percent, and total secondary beneficiaries must equal 100 percent. Secondary beneficiaries will only receive payment if all listed primary beneficiaries are deceased.*

Beneficiary Name	Social Security No.	Birth Date *mm/dd/ccyy*	Relationship	Beneficiary Percentage *P=Primary, S=Secondary Use whole numbers*	Gender
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F

❹ Member/Retiree Certification – *Check applicable acknowledgement then sign. If an authorized representative signs this form, 📎 attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

☐ **Member** – I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).

☐ **Retiree –** I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date *mm/dd/ccyy*: _____

❺ Employer Certification – *This section must be completed by an authorized employer representative, not the member. Only complete for active members.*

Employer Name: _____ Employer No.: _____ - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

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

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, *fax* www.pers.ms.gov

Reset Form Print

VEFIFICATION OF RECEIVING DRUG FREE POLICY

Policy Code: GBRL - Drug Free Schools and Workplace

DRUG FREE SCHOOLS AND WORKPLACE

No employee engaged in work in connection with the Claiborne County School District shall unlawfully manufacture, distribute, dispense, possess or use on or in the workplace any narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana or any other controlled substance, as defined in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation at 21 CFR 1300.11 through 1300.15.

"Workplace" is defined to mean the site for the performance of work done in connection the Claiborne County School District. That includes any school building or any school premises; any school-owned vehicle or any other school approved vehicle used to transport students to and from school or school activities; off school property during any school-sponsored or school-approved activity, event or function, such as a field trip or athletic event, where students are under the jurisdiction of the school district.

As a condition of employment in the Claiborne County School District, each employee shall notify his or her supervisor of his or her conviction of any criminal drug statute for a violation occurring in the workplace as defined above, no later than 5 days after such conviction.

As a condition of employment in the Claiborne County School District, each employee shall abide by the terms of the school district policy respecting a drug-free workplace.

An employee who violates the terms of this policy may be nonrenewed or his or her employment may be suspended or terminated, at the discretion of the superintendent and/or board in accordance with applicable law. Sanctions against employees, including non-renewal, suspension, and termination shall be in accordance with prescribed school district administrative regulations and procedures.

DENIAL OF LICENSE

The State Board of Education, acting through the commission, may deny an application for any teacher or administrator license if the applicant is actively addicted to or actively dependent on alcohol or other habit-forming drugs or is a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having a similar effect, at the time of application for a license. ' 37-3-2 (11) (c)

SUSPENSION OF LICENSE

The State Board of Education, acting on the recommendation of the commission, may revoke or suspend any teacher or administrator license for specified periods of time if the teacher or administrator has been convicted, has pled guilty or entered a plea of nolo contendere to a felony, as defined by federal or state law. ' 37-3-2 (12) (d)

Dismissal or suspension of a licensed employee by a local school board pursuant to Section 37-959 may result in the suspension or revocation of a license for a length of time which shall be determined by the commission and based upon the severity of the offense. ' 37-3-2 (13) (a)

LEGAL REF.: MS CODE as cited 21 U.S.C. 812

CROSS REF.: Policy GBRM-2 C Drug and Alcohol Testing Policy

NOTICE TO EMPLOYEES ENGAGED IN WORK ON FEDERAL GRANTS

YOU ARE HEREBY NOTIFIED that it is a violation of the policy of this school district for any employee to unlawfully manufacture, distribute, dispense, possess or use on or in the workplace any narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana or any other controlled substance, as defined in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation at 21 CFR 1300.11 through 1300.15.

"Workplace" is defined as the site for the performance of work done in connection with a federal grant. That includes any place where work on a school district federal grant is performed, including a school building or other school premises; any school-owned vehicle or any other school-approved vehicle used to transport students to and from school or school activities; off school property during any school-sponsored or school-approved activity, event or function, such as a field trip or athletic event, where students are under the jurisdiction of the school district.

YOU ARE FURTHER NOTIFIED that it is a condition of your continued employment on any federal grant that you will comply with the above policy of the school district and will notify your supervisor of your conviction of any criminal statute for a violation occurring in the workplace, no later than 5 days after such conviction.

Any employee who violates the terms of the school district's drug-free workplace policy may be non-renewed or his or her employment may be suspended or terminated, at the discretion of the school district.

My signature affixed below is verification that I have received a copy of the Drug Free Policy of the Claiborne County School District.

_____ _____

Signature of Employee Date

CLAIBORNE COUNTY SCHOOL DISTRICT

Statement of Understanding

Professional Educators'

Code of Ethics and Standards of Conduct

Directions: Attached to your contract is a copy of the Mississippi Educator Code of Ethics and Standards of Conduct that was adopted by the Mississippi Board of Education and is referenced in your employment contract. It is important for you to review the Code of Ethics and Standards of Conduct as all licensed employees are expected to comply with its requirements.

Please sign this document on the signature line below and return this signed statement along with your contract to your principal. Your signature on this form indicates that you have received a copy of the Mississippi Educators' Code of Ethics and Standards of Conduct and that you have read and understand the stipulations of such Code and Standards.

STATEMENT

This is to verify that I have received a copy of the *Mississippi Educator Code of Ethics and Standards of Conduct.* I have read the *Mississippi Educator Code of Ethics and Standards of Conduct* and understand and agree to abide by all stipulations of such Code and Standards.

_____ _____

Signature of Employee *Date*

EMPLOYEE RIGHTS

UNDER THE FAIR LABOR STANDARDS ACT

FEDERAL MINIMUM WAGE

$7.25 PER HOUR

BEGINNING JULY 24, 2009

The law requires employers to display this poster where employees can readily see it.

OVERTIME PAY

At least 1½ times the regular rate of pay for all hours worked over 40 in a workweek.

CHILD LABOR

An employee must be at least 16 years old to work in most non-farm jobs and at least 18 to work in non-farm jobs declared hazardous by the Secretary of Labor. Youths 14 and 15 years old may work outside school hours in various non-manufacturing, non-mining, non-hazardous jobs with certain work hours restrictions. Different rules apply in agricultural employment.

TIP CREDIT

Employers of "tipped employees" who meet certain conditions may claim a partial wage credit based on tips received by their employees. Employers must pay tipped employees a cash wage of at least $2.13 per hour if they claim a tip credit against their minimum wage obligation. If an employee's tips combined with the employer's cash wage of at least $2.13 per hour do not equal the minimum hourly wage, the employer must make up the difference.

PUMP AT WORK

The FLSA requires employers to provide reasonable break time for a nursing employee to express breast milk for their nursing child for one year after the child's birth each time the employee needs to express breast milk. Employers must provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by the employee to express breast milk.

ENFORCEMENT

The Department has authority to recover back wages and an equal amount in liquidated damages in instances of minimum wage, overtime, and other violations. The Department may litigate and/or recommend criminal prosecution. Employers may be assessed civil money penalties for each willful or repeated violation of the minimum wage or overtime pay provisions of the law. Civil money penalties may also be assessed for violations of the FLSA's child labor provisions. Heightened civil money penalties may be assessed for each child labor violation that results in the death or serious injury of any minor employee, and such assessments may be doubled when the violations are determined to be willful or repeated. The law also prohibits retaliating against or discharging workers who file a complaint or participate in any proceeding under the FLSA.

ADDITIONAL INFORMATION

- Certain occupations and establishments are exempt from the minimum wage, and/or overtime pay provisions.
- Special provisions apply to workers in American Samoa, the Commonwealth of the Northern Mariana Islands, and the Commonwealth of Puerto Rico.
- Some state laws provide greater employee protections; employers must comply with both.
- Some employers incorrectly classify workers as "independent contractors" when they are actually employees under the FLSA. It is important to know the difference between the two because employees (unless exempt) are entitled to the FLSA's minimum wage and overtime pay protections and correctly classified independent contractors are not.
- Certain full-time students, student learners, apprentices, and workers with disabilities may be paid less than the minimum wage under special certificates issued by the Department of Labor.

WHD
WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR
1-866-487-9243
www.dol.gov/agencies/whd
WH1088 REV 0423

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

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