Hattiesburg Public Schools

301 Mamie Street
Hattiesburg, MS 39401
Phone: 601-582-5078
Fax: 601-583-7339

Dear New Employee,

It is with great pleasure that we welcome you to the Hattiesburg Public School District. We are pleased that you have chosen to accept our offer of employment.

Enclosed you will find forms that must be completed and submitted to Human Resources on or before the day of your scheduled onboarding. Once you have completed the onboarding process and received a favorable result from your background screening, you will receive a call from a Personnel Specialist providing you with an official start date.

The following fillable forms are included:

- Fleet Safety Program Verification Form
- W-4 Federal Tax Withholding Form
- Mississippi State Tax Withholding Form
- Public Employee' Retirement System (PERS Form 1-Membership Application)
- Public Employee's Retirement System Beneficiary Designation Form (PERS Form 1B)
- Retirement Status Form
- Employment Eligibility Verification (I-9 Form). Must attach a copy of your Social Security Card and Driver's License
- State and School Employee's Health Insurance Form
- State and School Employee's Life Insurance Enrollment Form
- Direct Deposit Form (provide a voided check or letter from bank with routing/account number listed)
- Non-Covered Employment Acknowledgement Form (Part-Time Employees only)
- Instructions for Active Resources Set-up (On-line Payroll Information Access)
- Verification of Experience Form (Certified email to audrey.smith@hattiesburgpsd.com)
- Verification of Experience Form (Classified email to robyn.moore@hattiesburgpsd.com)

We are excited about you joining the team and want to ensure that you are successful in your new role. Please do not hesitate to contact Human Resources at 601-582-5078 with any questions or concerns. If you are a classified employee, please contact Human Resources Specialist Robyn Moore. If you are a certified employee, please contact Human Resources Specialist Audrey Smith.

Thank you again for choosing Hattiesburg Public Schools.

Hattiesburg Public Schools

Fleet Safety Program

All employees of Hattiesburg Public Schools are expected to operate vehicles safely to prevent accidents that may result in injuries and property loss. It is the policy of Hattiesburg Public Schools to provide and maintain a safe working environment to protect our employees and the citizens of the communities where we conduct business from injury and property loss. Hattiesburg Public Schools considers the use of automobiles as part of the working environment. As such, the Board of Trustees is committed to promoting a heightened level of safety awareness and responsible driving behavior in its employees. The following statements reflect our commitment to safety:

- Safety takes precedence over expedience and shortcuts.
- We will strive to prevent the possibility of an accident.
- We will strive to operate all vehicles in accordance with federal, state, and local laws.
- We pledge to demonstrate defensive driving practices at all times.

Responsibility

The Superintendent or designee is responsible for the successful implementation and ongoing execution of this program. Supervisors and employees are responsible for meeting and maintaining the standards set forth in this program.

Scope

This policy applies to employees who operate vehicles on company business and will be reviewed annually to ensure implementation and compliance. The following rules are meant to serve as a guideline and do not cover every possible item or situation. Contact your immediate supervisor if you have any questions or concerns.

Statement of Acknowledgement

I have read the Hattiesburg Public School District Drivers Fleet Safety Program guidance and understand the information contained in this document. I acknowledge that I will be held accountable for complying with the rules and policies stated here. Additionally, my compliance with these rules and policies is a part of my job and is a condition of my employment.

____________________________	________________________	__________
Driver Name	**Driver Signature**	**Date**

Organization and Responsibilities

- Everyone is responsible for the implementation of the vehicle safety program.
- The superintendent (or designee) will provide the resources necessary to implement and maintain the program.
- All accidents invoving motor vehicles will be reported to the immediate superintendent immediately (or a soon as it is safe to do so).
- All accident reports will be forwarded to the superintendent's office and the business office.
- Revisions to the Fleet Safety Program guidance will be forwarded to all employees.

Driver Qualification/ Eligibility

- Driver must possess the required license to operate the vehicle assigned to perform the job (i.e., proper class or CDL if required)
- Driver must maintain an acceptable motor vehicle driving record (MVR)
    - ❖ No drug or alcohol-related violations, such as driving under the influence (DUI) or driving while intoxicated (DWI) in the last year resulting in charge of a felony
- No major violations within the last year
    - ❖ Excessive speeding resulting in charge of a felony
    - ❖ Careless/reckless/ imprudent driving
    - ❖ Vehicular homicide, manslaughter or assault resulting from a vehicle-related incident

Note:

- Drivers must immediately report license suspensions, revocations, and other restrictions and cease driving to the personnel office.

Use of Private Vehicles for School Purposes

Hattiesburg Public Schools discourages the use of privately owned vehicles on behalf of the district. Should occasions arise when a privately owned vehicle must be used, the following provisions must be met.

- The school district employee must provide the district with proof of liability insurance to cover all risks associated with driving an automobile.
- Each use of the automobile must be approved in writing by the principal and/or the superintendent or his/her designee. The preferred mode of transportation is HPS-owned vehicles.
- No one shall be permitted to operate the vehicle other than the school district employee.
- Students should not be transported unless authorized by the principal and/or superintendent or his/her designee.
- Possess a valid driver's license in the state of Mississippi to operate the vehicle.
- Operate vehicle in accordance with federal, state, and local laws.
- There shall be a check of the driving record of each school employee permitted to operate a school-owned vehicle or privately owned vehicle on behalf of the school district. No employee shall be allowed to operate a vehicle in order to transport students if their driving record contains, but is not limited to, a DUI or reckless driving charge.
- Under no circumstances will the operator allow more than six (6) elementary school age or four (4) junior high school students to ride in the vehicle at any one time.
- Maintain their own vehicle in a safe operating condition when driving on company business.

- Maintain current state vehicle inspections when required.
- Drivers are required to conduct daily inspections of their vehicle with special emphasis on lights, turn signals, and tires.

Rental Vehicles

- Rental vehicles will be leased from an approved vendor by the district.

Unauthorized Use of Vehicles

- If unauthorized use results in an accident, the responsible employee will be required to make restitution for the damages.

Distracted Driving

No employee or volunteer driver of Hattiesburg Public Schools shall operate any district motor vehicle or operate a personal vehicle in the course of their responsibilities and duties with the district in a manner that allows them to knowingly drive distracted *(See Board Policy ECIA: District Staff use of Electronic Devices While Driving on District Business)*

The primary responsibility of the driver is to operate the motor vehicle safely. The task of driving requires full attention and focus. Drivers should resist engaging in any activity that takes their attention and eyes off the road for more than a couple of seconds. There are three main types of distractions:

- Visual-taking eyes off the road
- Manual- taking hands off the wheel
- Cognitive-taking mind off what you're doing

Examples of Distracted driving include, but are not limited to:

- Utilizing a wireless communication device for writing, sending, and/or receiving a message (s), posting to social media, internet usage, viewing photos, playing games, and other such activities.
- Watching a video
- Eating or drinking
- Engaging with passengers
- Grooming
- Reading
- Retrieving items from the floor, purse, glove box, computer, etc.

When operating a district vehicle, employees are required to:

- Pull over to a safe place to send or receive a call or to complete any task that might distract attention from the road.

Violations

- Violations of this policy may lead to disciplinary action, including denial of use of school vehicles and district cellphones and up to and including termination. Certain violations are punishable by law. Any fines or penalties incurred shall be the responsibility of the employee.

Statement of Acknowledgement

Please read and sign the Statement of Acknowledgment and return it to your supervisor. If you have any questions regarding this Policy ECIA, please contact your supervisor.

I am aware of the policy prohibiting distracted driving while operating a district vehicle or a personal vehicle in the course of my responsibilities and duties with the district. I fully understand the terms of this policy and agree to abide by them.

Employee Signature______________________________ Date___________

Fatigue/Illness/Drugs and Alcohol _________ Initials

- Drivers should be well-rested, healthy, and alert before beginning any trip.
- Drivers should plan periodic rest breaks into their schedules to reduce fatigue. Generally, a driver should not drive more than two hours without taking a short break.
- Drivers should be aware of their total time on-the-job and stop driving when they become drowsy or fatigued.
- DOT-regulated drivers must comply with applicable hours-of-service requirements.
- Drivers should stop driving and find a safe place to park if an illness or stressor renders them incapable of driving safely.
- Drivers should be aware of the impact of an over-the-counter drug or prescribed medications on theirr driving and follow the precautions outlined, including not driving. Inform doctors of your driving responsibilities when receiving any new medical recommendations.
- Being under the influence of alcohol or controlled substance is prohibited while operating a district vehicle or in a personal vehicle on company business.
- Possessing controlled substances or open containers of alcohol in a district vehicle is prohibited.
- All drivers/employees must comply with the district's drug and alcohol program.
- The driver and all occupants are required to wear safety belts when the vehicle is in operation or while riding in a district vehicle or in a personal vehicle on district business. The driver is responsible for ensuring passengers wear their safety belts. Students/children under four years of age or under 40 pounds in weight must be secured in a DOT-approved child safety seat.

Defensive Driving __________ Initials

Drivers should drive in a defensive manner, including the following:

- Maintain a safe speed, adjusting for traffic, road and weather conditions.
- Maintain a cushion of safety around your vehicle with an emphasis on following the proper distance.
- Scan ahead to identify hazardous conditions or actions of others and be prepared to stop.
- Yield to the right-of-way of others. This includes stopping at intersections and not pulling out in front of others. Anticipate unsafe actions of others, such as: not stopping where required, pulling out in front of you, or driving distracted.
- Be extremely cautious when driving around pedestrians and bicyclists.
- Limit lane changes and passing

Vehicle Inspection and Maintenance _________ Initials

- Drivers are required to conduct a daily inspection of their vehicle with a speak emphasis on lights. Turn, signals, and tires. Periodic inspections are required of all district vehicles.

- Defects should be reported immediately and discussed with the superintendent's designee to determine the vehicle's status for safe operation. Drivers should not operate vehicles deemed unsafe until repairs are completed.
- Drivers should ensure their designated vehicles are maintained in accordance with the manufacturer's requirements.
- In addition, DOT-regulated vehicle drivers are required to:
    - ❖ Complete daily pre-trip and post-trip inspections.
    - ❖ Ensure their vehicle and trailer, if applicable, have valid annual inspection stickers.
    - ❖ Not operate a vehicle that has been placed out-of-service by the DOT until repairs or conditions have been corrected.

Additional Driver Rules and Responsibilities __________ Initials

- Drivers will operate the vehicle in a manner consistent with reasonable practices to avoid abuse, theft, neglect or disrespect of the equipment.
- Seatbelt and shoulder harness use is required for all drivers and passengers.
- Drivers should adhere to local, state and federal traffic laws.
- Drivers are required to pay fines for any violations received.
- Smoking is prohibited in district-owned vehicles.
- Drivers are required to attend all driver safety meetings and review safe driving materials provided by the district.
- Vehicles should be parked in safe locations and keys removed and locked. Valuable cargo should be removed or adequately secured from theft

Road Emergency Stops

Stopping along a roadway is dangerous and should only be done in an emergency, such as a breakdown.

- When possible, get off the roadway as soon as possible using four-way flashers to warn other vehicles of your reduced vehicle speed.
- If you must stop:
    - ❖ Move as far off the roadway as safely possible, being aware of soft or sloped shoulders.
    - ❖ Try not to stop on a curve or other areas where it will be difficult to be seen by other motorists.
- Turn on your emergency flashers and put out reflective safety triangles, if applicable.
- Contact the Business Office or Human Resources for directions on what to do,
- Do not work on the vehicle. After contact either the Business Office or Human Resources, have the vehicle towed to s safer location to complete the repairs.

Employee Accident Reporting Procdures _____ Initials

Drivers are required to report all accidents and vhhicle/cargo vandalism or theft immediately. Employees will take the following actions when there are injuries to persons and/or damage to other vehicles or property:

- Report to Hattiesburg Public Schools Human Resource Representative. In the event you cannot reach a Human Resrouce Representative, please contact a representative from the Business Office.

Follow these at -scene instructions.

- Stop, turn off your engine, set your brake, and turn on you emergency flashers.
- If the accident is minor and there are no serious injuries, move your vehice to a safe location out of the way of traffice.
- Call 911 to alert police and other emergency personnel.

- Give the police complete and accurate information; do not guess. Do not discuss the specifics of the accident with other drivers or anyone else without the district approval.
- Secure the names and addresses of drivers an occupants of any vehicles involved their operator's license number, insurance company names and policy numbers, as well as the names and addresses of injured persons and witnesses.
- Do not admit fault or accept offers to settle.
- Do not sign anthing without district approval.
- Stay at the scene until police or a district representative releases you,

Accident scene photos:

  - Accident photos should be taken of the scene as soon as practical to help substantate what happened, preferable before vehicles are moved. However, they should only be taken if it is safe to do so, depending on road conditions.
  - Photos document vehicle damage can be taken after vehicles are moved to a sfe location.
- Photo Tips:
  - Get the entire scene and surrounding area
  - Take photos from all directions
  - Take photos from all sides of the vehicles to include damaged areas, license plates, company name, DOT #
  - Skid marks, traffic control devices and signs etc..

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- Safety takes precedence over expedience and shortcuts.
- We will strive to prevent the possibility of an accident.
- We will strive to operate all vehicles in accordance with federal, state, and local laws.
- We pledge to demonstrate defensive driving practices at all times.

Please review the assigned vehicle safety videos as a part of our district's efforts to educate employees on the importance of maintaining a safe work environment.

I acknowledge that I viewed the assigned vehicle safety video.

____________________________________ ____________________

Employee Signature Date

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

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.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(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 . . . . ☐

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 unless otherwise noted.

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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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 these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, 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 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 2025 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; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

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 2025 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:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 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	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

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

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

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

Military Spouses Residency Relief Act Exemption from Mississippi Withholding

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

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.

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*: ____________

Beneficiary Designation

Form 1B – 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/Retiree Information

First Name: _______________________________________ MI: ______ Last Name: ___________________________________ ☐ Member ☐ Retiree

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

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

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

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Beneficiary Information – *Use additional Form 1B,* Beneficiary Designation, *to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary and secondary beneficiary percentages must equal 100 percent.*

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

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

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

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

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

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

Employer Name: ____ Employer No.:________________ - ___________________

Employer Representative's Name:_________________________________ Employer Representative's Title: _____________________________________

Employer Representative's Phone: _________________________ Fax:__________________________ E-Mail: __________________________________

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

Hattiesburg Public Schools

301 Mamie Street
Hattiesburg, MS 39401
Phone: 601-582-5078
Fax: 601-583-7339

Date: ________________________________

Instructions for Determining Your Retirement Status

1. ______ I am currently an active member of the MS Public Employees Retirement System, and I am employed by __________________________
   - Complete PERS Form 1.

2. ______ I am retired and receive monthly benefits from the MS Public Employees Retirement System.
   - Complete PERS Form 4B.

3. ______ I am not a member of the MS Public Employees Retirement System.
   - Complete PERS Form 4A.

____
Print

____
Signature

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

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)			**Additional Information**		
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)			☐ 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 **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa **4.** Employment Authorization Document that contains a photograph (Form I-766) **5.** For 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. **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		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address **3.** School ID card with a photograph **4.** Voter's registration card **5.** U.S. Military card or draft record **6.** Military dependent's ID card **7.** U.S. Coast Guard Merchant Mariner Card **8.** Native American tribal document **9.** Driver's license issued by a Canadian government authority **For persons under age 18 who are unable to present a document listed above:** **10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION **2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) **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.** Native American tribal document **5.** U.S. Citizen ID Card (Form I-197) **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) **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.

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

List A	OR	List B		List C
• 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 05/31/2027

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 05/31/2027

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.

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

PLEASE PRINT Section A: Enrollee Information (all fields are required)		Employer Name		
Social Security Number	First Name	MI	Last Name	
Home Address		City	State	ZIP
Primary Telephone Number	Secondary Telephone Number	Personal Email Address		
Marital Status Single Married	Gender Male Female	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement	

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

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

____

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

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

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

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

Enrollee Signature: ____________________ Date: ____________________

Section C: Coverage

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

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

Section D: Other Coverage Information

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

Name of Individual Covered:	1.__________	2.__________	3.__________	4.__________
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 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' 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)

HATTIESBURG PUBLIC SCHOOL DISTRICT

Employee Pay Selection Form

Select One: _______ENROLLMENT _______CHANGE

You have two options to receive your pay, as listed below. Please review them and make your selection by initialing your choice and signing below.

☐ _____ Initials	**DIRECT DEPOSIT** I hereby authorize my employer Hattiesburg Public School District to initiate deposits of my net pay into the account at the financial institution shown on the attached personal check and further authorize Financial Institution to credit the account indicated with the deposits. If funds to which I am not entitled are deposited to my account, I authorize debits from my account and the return of such funds. This authority is to remain in effect until Company or Financial Institution has received notification from me of termination of such authorization in such time and such manner as to afford Company and Financial Institution a reasonable opportunity to act on those instructions or until Company or Financial Institution cancels the direct deposit arrangement. **MUST ATTACH AN ORIGINAL VOIDED CHECK** **or** **INFORMATION ON LETTERHEAD FROM MY FINANCIAL INSTITUTION** **Bank/Financial Institution Name:**___________________________________ **Routing/Transit #:**____________________________ **Account #:**______________________________ **Account Type:** ☐ **Checking or** ☐ **Savings**

I authorize Hattiesburg Public School District to disburse my pay by direct deposit or Money Network Service debit card according to the selection I initialed above. If I don't make a selection within 7 days of payroll date, I agree that my pay will be disbursed using Money Network Service debit card. I understand that I can change my pay selection at any time in the future.

Employee Printed Name: ________________________ Employee Work Location: ______________________________

____________________________ ____________________________

Employee Signature Social Security Number

____

Date

Non-Covered Employment Acknowledgment

Form 4A – Revised 06/14/2023

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

❶ Employee Status

First Name: ______________________ MI: ______ Last Name: ______________________ Gender: ☐ M ☐ F

Is employee currently receiving PERS service retirement benefits? *Choose yes or no and follow related instructions.*

- ☐ Yes – *Do not complete form. Instead, complete PERS Form 4B,* Reemployment of PERS Retiree Certification/Acknowledgement.
- ☐ No – *Continue to next question.*

Is employee currently employed with a PERS-covered employer other than the employer to be listed in Section 4? *Choose yes or no and follow related instructions.*

- ☐ Yes – *Choose type of employee for the employer to be listed in Section 4 and follow related instructions.*
  - ☐ Temporary or Intermittent Part-Time Employee – *Continue to Section 2.*
  - ☐ Eligible Part-Time Employee (meeting eligibility requirements listed in Section 105 of PERS Board of Trustees Regulation 36 as it relates to dual employment) – *Do not complete this form. Instead, complete PERS Form 1,* Membership Application.
- ☐ No – *Continue to Section 2.*

❷ Employee Information

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

Mailing Address: ______________________ City: ______________ State: ______ Zip: ______

Phone: ______________ ☐ Cellular ☐ Home ☐ Work Phone: ______________ ☐ Cellular ☐ Home ☐ Work

❸ Employee Acknowledgment

I hereby acknowledge that I am not receiving service retirement benefits from PERS and that my employment does not meet 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)*, and that I, therefore, am not eligible for coverage for this employment under the provisions of PERS. *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.*

Employee's Signature: ______________________ Date *mm/dd/ccyy*: ______________

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

Employee's Position Held/Job Title: ______________________

Employee's Hire Date *mm/dd/ccyy*: ______________ **Employee's Termination Date** *mm/dd/ccyy*: ______________

Employer Name: Hattiesburg Public Schools Employer No.: 0032 - 001

Employer Representative's Name: ______________ Employer Representative's Title: ______________

Employer Representative's Phone: (601) 582-5078 Fax: (601) 582-2501 E-Mail: payroll@hattiesburgpsd.com

As employer representative, I understand that wages earned and paid to the above-named individual during this period of employment **will not** be subject to withholding for state retirement. I further understand that any person who makes a false statement or shall falsify or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution. With that understanding, I certify that the above information is true and correct and that employment in this position does not meet 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*: ______________

To Access your Direct Deposit Statement:

Go to: www.hattiesburgpsd.com

Step 1: **Click on "Employee Links" and from the drop down box, click on "Active Resources"**

Home	Leadership	Schools	Departments	Employee Links	Parent Links

Step 2: Click on "**Sign up for an Account**!", complete "**Create an Account**" information and click "**Create Account**".

User Name:

Password:

Login

Forgot Password? | Forgot User Name? | Sign up for an Account!

Create an Account	
Desired User Name:	
Password:	
Confirm Password:	
Employee Last Name:	
SSN (without hyphens):	
Security Question:	
Security Answer:	
Email Address:	

Create Account

Step 3: Once your account has been successfully created, enter your "**User Name**" and "**Password**" above and then click "**Login**".

User Name:

Password:

Login

Forgot Password? | Forgot User Name? | Sign up for an Account!

Step 4: To view and/or print your Direct Deposit Statement, click "**Employee**" tab. A drop down box will appear. Click on the "Check/Direct Deposit" tab and your checks by date, will be listed. Click on the Direct Deposit Statement you wish to view and/or print to continue.

Doe, Jane|Logout

Information
Leave
Checks/Direct Deposits
W-2
Help
Clocked Time
Substitute Statement
Tax Wages
Work Schedules

HATTIESBURG PUBLIC SCHOOLS
301 Mamie Street
Hattiesburg, MS 39401
Phone: 601.582.5078
Website: hattiesburgpsd.com

HPS 1885

TO:

____

____

DATE: ______________________

I have been requested to furnish verification of my years of service as an employee at your place of establishment. Please complete the information below and return the form to:

Organizational Support: Dr. Michael Battle, Assistant Superintendent
Hattiesburg Public Schools
P.O. Box 1569
Hattiesburg, MS 39403-1569
Phone: (601) 582-5078 Fax: (601) 582-6654
ATTN: *Robyn Moore, HR Personnel Specialist* @ robyn.moore@hattiesburgpsd.com

....

____________	____________	____________	XXX-XX-____________
LAST NAME	FIRST NAME	MIDDLE/MAIDEN	SOCIAL SECURITY NUMBER

____

SIGNATURE

THIS IS TO VERIFY THAT ____________________ WAS EMPLOYED AT ____________________ FOR THE FOLLOWING YEARS:

Dates of Employment Beginning Date Mo/day/year	End Date Mo/day/year	**Position**	**Full-time or Part-time**	**Part-time # Hours daily**

Total number of years of employment: ____________

____

Signature of Authorized Official | Title | Date

Address: ____________________ **Phone #:** ____________________ SEAL

____

VERIFICATION OF EXPERIENCE
HATTIESBURG PUBLIC SCHOOL DISTRICT
P.O. BOX 1569
HATTIESBURG, MS 39403-1569
(601) 582-5078

To: Office of Superintendent

____

____

I have been requested to furnish verification of my services as a teacher and/or administrator in your school system. Please complete the information below and return it to:

Audrey Smith, Personnel Specialist
Hattiesburg Public School District
P.O. Box 1569
Hattiesburg, MS 39403-1569
audrey.smith@hattiesburgpsd.com

My employment in your school system was during the following sessions: _____-_____ _____-_____ _____-_____
_____-_____ _____-_____ _____-_____ _____-_____ _____-_____ _____-_____ _____-_____ _____-_____

The name under which I taught was:

____

Printed Name **Signature** **Date**

**************************************FOR OFFICIAL USE ONLY**************************************

THIS IS TO VERIFY THAT ______________________ WAS EMPLOYED FULL-TIME IN THE ______________ PUBLIC SCHOOL DISTRICT AS FOLLOWS:

Dates of Employment (List each year separately)	Job Title	Full-time/Part-time	Begin Date	End Date	# of Days on Contract	# of Days Worked	% of Days Worked

PLEASE AFFIX SCHOOL DISTRICT'S OFFICIAL SEAL

The above school, school system, college or university was fully approved or accredited by the ______________________ at the time service was performed. **Check one of the following**: [ ] Public School [ ] Private [ ] Non-public ______________________

CODE OF ETHICS STANDARDS OF CONDUCT DISCLOSURE STATEMENT: Hattiesburg Public School District request the disclosure of any and all information related to allegations and/or charges of violations by the applicant of any code of conduct or code of ethics of your school district or State Department of Education. By signing this form, the applicant has released previous and current employer from any liability or damages because of such disclosure. Please mark the appropriate statement that applies to the above applicant. Check one:

_____ We have no information as to any allegations or charges of violations by this applicant for any code of conduct or code of ethics while employed at this school district.

_____ Allegations and/or charges of violations of the code of conduct or code of ethics by the applicant have been reported and/or documented by this school district.

____

Printed Name Signature Title Phone Number Date