MRSD SAU 93
600 OLD HOMESTEAD HIGHWAY
SWANZEY, NEW HAMPSHIRE 03446

# Name and Address Change Form

If you have an address and name change, please fill out the forms following this cover letter.

Employee name_____

Building _____

Effective Date _____

(Complete below ONLY what is applicable)

## MARRIAGE/DIVORCE

- **Update your W-4 for payroll if needed.**
- **If you need to change the Medical Membership (Single, Two-person, Family) Use the Medical/Dental Application and Change Form.**
  **NOTE: If you also are using CVS/Caremark's mail service program for prescription drug orders, you will need to contact CVS/Caremark Customer Care at 888-726-1631 and notify them of your address change.**
- **Make sure you sign and date all the forms that would apply to your current benefit situation, as well as the SAU Name & Address Change Form. Return them to the SAU Office Attention Personnel and Payroll Coordinator.**

New Name _____

Reason for change _____ Marriage _____ Divorce _____ Other

- Your Marriage Certificate or Divorce Decree is required with this paperwork within 30 days of the event.

## ADDRESS CHANGE _____ Check if address **no** change is needed.

Street _____

Town _____

State _____ Zip Code _____

Phone _____

EMPLOYEE'S SIGNATURE _____ DATE _____

---

SAU Use Only - Please initial steps completed.

| | | |
|---|---|---|
| ____ Infinite Visions | ____ I9 (marriage/divorce) | ____ Medical/Dental |
| ____ Notify school | ____ NH Retirement | ____ Frontline |
| Admin/Admin asst. | ____ Help Desk Ticket (Alma) | ____ Accounts Payable/Payroll/PC |

New Hampshire Retirement System
54 Regional Drive, Concord, NH 03301
Phone: (603) 410-3500 - Fax: (603) 410-3501
Website: www.nhrs.org - Email: info@nhrs.org

# PERSONAL INFORMATION CHANGE FORM

**Please Complete the Applicable Areas:**

| SECTION I – CHANGE OF ADDRESS | |
|---|---|
| Name (if retired, as it appears on check or non-negotiable) | Social Security Number (last four digits) |
| Are you currently receiving an NHRS monthly benefit? ☐ Yes ☐ No | Employer's Name (if you are currently employed) |
| Old Address | New Address |
| City, State, Zip | City, State, Zip |
| Old Telephone | New Telephone |
| Old Email Address | New Email Address |
| For Email changes: ☐ Also update this address for *NHRS Email Updates* ☐ Sign me up for *NHRS Email Updates*<br>Note: *My Account* users must log in to their personal account and manually change their email address for account authentication purposes. | |

| SECTION II – CHANGE OF NAME | |
|---|---|
| Please provide proof of name change (marriage certificate, legal document, etc.) | |
| Former Name | |
| Current Name | Effective Date |

| SECTION III – SIGNATURE | |
|---|---|
| Please provide your signature to authorize the requested change. | |
| Printed Name | |
| Signature | Date |

| SECTION IV – FOR OFFICE USE ONLY | |
|---|---|
| **ANNUITANT** | **ACTIVE** |
| Retirement # | By |
| Employer # | Date |
| By | |
| Date | |

# HealthTrust

# INFORMATION UPDATE/CORRECTION FORM

DATE: _____

**ENROLLEE INFORMATION:**

NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____

☐ Check here if you are a participant in a Flexible Spending Account (FSA) plan offered through HealthTrust.

**ACTION REQUESTED:**

| | |
|---|---|
| ☐ **Change/Update Address** | **New Address:**<br>Street: _____<br>City: _____ State: _____ Zip: _____<br>Phone:(____)_____ Email: _____ |
| ☐ **Correct DOB** | **Name of Individual:** _____<br>Relationship to Enrollee: ☐ Self ☐ Spouse ☐ Child<br>Correct DOB: _____/_____/_____ |
| ☐ **Correct Name Spelling** | **Incorrect Spelling:** _____<br>Relationship to Enrollee: ☐ Self ☐ Spouse ☐ Child<br>Correct Spelling: _____ |
| ☐ **Change Name*** | **Name of Individual:** _____<br>Relationship to Enrollee: ☐ Self ☐ Spouse ☐ Child<br>New Name: _____<br>Reason for Name Change: ☐ Marriage ☐ Divorce ☐ Other_____ *Please Explain* |
| ☐ **Gender Change** | **Name of Individual:** _____<br>Relationship to Enrollee: ☐ Self ☐ Spouse ☐ Child<br>Gender Change: From: ☐ Male ☐ Female To: ☐ Male ☐ Female |

*HealthTrust may request additional documentation.

**EMPLOYER INFORMATION:**

BENEFITS ADMINISTRATOR: _____ GROUP NAME: _____

SIGNATURE: _____ PHONE NUMBER: _____

**Please Note:** If you are using CVS Caremark®'s mail service program, you will need to update/correct your prescription drug mail order address directly with CVS Caremark by calling **888.726.1631** or visiting ***www.caremark.com*** and entering your login ID and password.

Please submit this form to HealthTrust using one of the following methods.

**Mail:** HealthTrust, PO Box 617, Concord, NH 03302-0617
**Email:** enrolleeservices@healthtrustnh.org
**Secure Enrollee Portal (SEP) Message Center:**
Log in to your SEP account and click Message Center.

HealthTrust

# NOTICE OF DIVORCE OR LEGAL SEPARATION

**THIS FORM MUST BE COMPLETED AND SIGNED BY THE ENROLLEE AS NOTIFICATION OF A COURT DECREE REGARDING DIVORCE OR LEGAL SEPARATION. HEALTHTRUST MAY REQUEST A COPY OF THE DECREE.**

**Enrollee Name:** _____ **Date:** _____

**Enrollee Mailing Address:** _____ **Enrollee Date of Birth:** _____

**Group Name:** _____

**I hereby notify HealthTrust of the following event affecting my medical and/or dental plan coverage (check one):** ☐ Divorce ☐ Legal Separation **Date of Decree:** _____

**Former Spouse:** My former spouse was covered as an eligible dependent under my group plan through my employer immediately prior to the issuance of such decree. The decree provides as follows with respect to the nature and payment terms of my former spouse's medical and/or dental plan coverage:

_____

_____

_____

**Children:** The children listed below were covered as eligible dependents under my group plan through my employer immediately prior to the issuance of such decree. The decree provides as follows with respect to these dependent children's medical and/or dental plan coverage:

_____

_____

_____

**I understand that my former spouse and child(ren) may be entitled to continue coverage under my employer's medical and/or dental plan in certain situations pursuant to state or federal law.**

_____ _____

**Enrollee Signature** **Date**

Name of Former Spouse: _____

Date of Birth: _____

Current Mailing Address: _____

| Name(s) of covered child(ren) | Date(s) of Birth | Address |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

HealthTrust

# LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

**WELCOME TO HEALTHTRUST**

Use this form to change your beneficiary(ies) as well as to enroll in or change your disability and/or life insurance coverage. If you only need to change your mailing address, do not complete this form; instead, call HealthTrust's Enrollee Services Department at 800.527.5001 and notify your employer.

**BE SURE TO FILL OUT EACH SECTION COMPLETELY.** Failure to complete each section in full could delay the start of coverage.

## HOW TO COMPLETE THIS FORM

| | |
|---|---|
| STEP 1 | **EMPLOYEE INFORMATION**<br><br>Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored life and/or disability coverage you are requesting. Please limit your selection to only those coverages offered by your employer and for which you are eligible.<br><br>Some life and disability coverages may require evidence of insurability. You will not be eligible for any amount greater than the evidence of insurability requirement if you do not submit an Evidence of Insurability form; this form may be obtained from your employer or HealthTrust. You will be added for an amount greater than the evidence of insurability requirement once approved. For more information, refer to your certificate of coverage. |
| STEP 2 | **REASON FOR COMPLETING APPLICATION**<br><br>Use this section to indicate the reason(s) for completing form. |
| STEP 3 | **BENEFICIARY INFORMATION**<br><br>Please name your beneficiary(ies) for your life and/or disability coverages. If you wish to name a different beneficiary(ies) for your life, long-term disability (LTD), and/or short-term disability (STD) coverages, attach a separate piece of paper containing all necessary information. Otherwise, your beneficiary(ies) will be the same for all coverages.<br><br>You may name more than one beneficiary. If you specify benefit percentages, the total must equal 100 percent. If you do not specify benefit percentages, benefits will be paid in equal shares.<br><br>If you do not name a beneficiary(ies) – or if neither your primary nor contingent beneficiary(ies) survive you – benefits will be paid in order of survivorship shown in your certificate of coverage. Your primary beneficiary(ies) are the person(s) you name to receive benefits. Your contingent beneficiary(ies) are the person(s) you name to receive benefits if your primary beneficiary(ies) do not survive you. |
| STEP 4 | **EMPLOYEE SIGNATURE**<br><br>Sign and date this form; return completed form to your employer. |
| STEP 5 | **EMPLOYER USE ONLY**<br><br>Employer must complete this section and send via a secure message to HealthTrust Enrollee Services by logging in to their account on HealthTrust's Secure Member Portal and clicking on Message Center; forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302; email to: *enrolleeservices@healthtrustnh.org*; or fax to: 603.226.2988 |

**Questions?** Please call us at 800.527.5001, Monday through Friday, 8:30 a.m. to 4:30 p.m.

# LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

## STEP 1: EMPLOYEE INFORMATION

| First Name | MI | Last Name | |
|---|---|---|---|
| Social Security # | Date of Birth | | Gender ☐ Male ☐ Female |
| Mailing Address | | | Telephone |
| City | State | | ZIP |
| Employer Name | | | |
| Marital Status<br>☐ Single ☐ Married ☐ Divorced/Legally Separated ☐ Widowed<br>☐ Other _____ | **TYPE OF COVERAGE REQUESTED (check)**<br>**Life Coverage:**<br>☐ Basic Life ☐ Supplemental Life ☐ Dependent Life | | **Disability Coverage:**<br>☐ Long-Term Disability ☐ Short-Term Disability |

## STEP 2: REASON FOR COMPLETING FORM

| Reason/Qualifying Event<br>☐ New Enrollee ☐ Benefit Change ☐ Part-Time to Full-Time ☐ Name Change ☐ Change in Beneficiary ONLY ☐ Other _____ | Actual Date of Event |
|---|---|

## STEP 3: BENEFICIARY INFORMATION

| Name of Beneficiary | Date of Birth | Relation to Employee | Social Security # | Benefit Percentage |
|---|---|---|---|---|
| Primary Beneficiary* | | | | % |
| Primary Beneficiary* | | | | % |
| Primary Beneficiary* | | | | % |
| | | | | Total: 100% |
| Contingent Beneficiary* | | | | % |
| Contingent Beneficiary* | | | | % |

**Please note: Madison National Life cannot issue benefits directly to a minor. Should benefits be payable to a minor, we will require documents confirming who is the court appointed legal guardian of the minor. If a legal guardian is not appointed, benefits due to be paid to the minor will remain on deposit with the insurance company and earn interest until the minor is of legal age.**

Total: 100%

## STEP 4: ENROLLEE SIGNATURE

I hereby authorize HealthTrust and my employer to institute the action(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the effective date and termination date of my membership will be determined by HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed and beneficiary designation(s) to be made valid. By signing this application, I attest to the accuracy and truthfulness and will provide documentation to HealthTrust upon request.

**Enrollee Signature**_____ Date _____

## STEP 5: EMPLOYER USE ONLY

| Date of Hire | Date of Rehire | Billing Group Name | |
|---|---|---|---|
| Full-Time Number of Hours | Part-Time Number of Hours | Base Annual Salary | Employee Job Title |

| Basic Life Coverage | Additional Life Coverage | Long-Term Disability Coverage | Short-Term Disability Coverage |
|---|---|---|---|
| Class Number | ☐ Supplemental | Class Number | Class Number |
| Effective Date of Coverage | ☐ Dependent | Effective Date of Coverage | Effective Date of Coverage |
| Basic Life Benefit Amount | | Benefits Administrator Signature/Stamp | Date |
| Supplemental Life Benefit Amount | | | |

**Questions?** Please call us at 800.527.5001, Monday through Friday, 8:30 a.m. to 4:30 p.m.

HealthTrust

# MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

Please use this form to enroll in or change your medical and/or dental coverage. Be sure to complete this entire form. If you only need to change your mailing address, do not complete this form; instead, log in to your account on HealthTrust's Secure Enrollee Portal (SEP), click on "Enrollment/ Membership Info" and scroll to the bottom of the page and click on "Update your Membership Information."

**BE SURE TO FILL OUT EACH SECTION COMPLETELY.** Include information on all your eligible family members at initial enrollment and when making changes. Failure to complete each section in full could delay the start of coverage.

**PRIMARY CARE PROVIDER (PCP) SELECTION**

When you enroll in a BlueChoice® or Access Blue New England℠ medical plan, each member of your family must choose their own PCP to coordinate medical care. Your PCP can be a family or general practitioner, an internist, or a pediatrician (for children). To access a Provider Directory, visit *www.healthtrustnh.org* and click on the medical icon, then click on the orange button with your plan type. Should you decide to change your PCP after initially enrolling with HealthTrust, do not fill out this form. Instead, call the Anthem Member Services number on the back of your medical ID card.

**DENTAL COVERAGE**

- Dependent children are generally eligible for coverage as of the first of the month following their second birthday. In order for your children to be covered, you must enroll them at that time; coverage is not automatic.
- You are required to enroll for a 12-month period. Voluntary cancellations or membership downgrades are not allowed during this period unless you terminate employment, your dependent is no longer eligible, or you experience a qualified family status change.

## HOW TO COMPLETE THIS FORM

| | |
|---|---|
| STEP 1 | **ENROLLEE (EMPLOYEE) INFORMATION**<br>Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored medical and/or dental coverage you are requesting and the membership type for each. Please limit your selection to only those coverages offered by your employer and for which you are eligible. If you are applying for the MCNRX or MAPD plan, please complete the *Retiree Medical and/or Dental Application and Change Form.* |
| STEP 2 | **REASON FOR COMPLETING FORM**<br>Use this section to indicate the reason(s) for completing form. If you are a current HealthTrust Enrollee making a change to your existing membership, you must include the actual date of event. Please see your employer or call HealthTrust to obtain additional forms that are required for divorce/legal separation or retirement. |
| STEP 3 | **ENROLLEE AND DEPENDENT INFORMATION**<br>Complete this section as your membership should appear at HealthTrust. If you need additional space, use the *Additional Dependent(s) Information* section on the last page of this form.<br>• If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at *www.healthtrustnh.org*. **Your dependent child will not be added to your coverage until approval of incapacitated status has been received by HealthTrust.**<br>• If your HealthTrust-sponsored medical plan requires a PCP, you must provide a PCP name and PCP ID number (including all characters) for you and each of your covered dependents. |
| STEP 4 | **OTHER INSURANCE COVERAGE INFORMATION**<br>Complete this section if you or a covered family member will have other coverage along with this plan or are transferring from another group medical or dental plan. If you choose to cover some, but not all of your eligible dependents, proof of other group coverage for those dependents you are not covering may be required. |
| STEP 5 | **ENROLLEE SIGNATURE**<br>Sign and date this form; return completed form to your employer. |
| STEP 6 | **EMPLOYER USE ONLY**<br>Employer must review form and verify that steps 1-5 are completed. Employer must complete this section and send via a secure message to HealthTrust Enrollee Services by logging in to their account on HealthTrust's Secure Member Portal and clicking on Message Center; forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302; email to: *enrolleeservices@healthtrustnh.org*; or fax to: 603.226.2988 |

**Questions?** Please call us at 800.527.5001, Monday through Friday, 8:30 a.m. to 4:30 p.m.

# MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

## STEP 1: ENROLLEE (EMPLOYEE) INFORMATION

| First Name | MI | Last Name | |
|---|---|---|---|
| Mailing Address | City | State | ZIP |
| Telephone / Employer Name | Marital Status ☐ Single ☐ Married ☐ Divorced/Legally Separated ☐ Widowed ☐ Other _____ | | |

**TYPE OF COVERAGE AND MEMBERSHIP REQUESTED**

| Medical Plan Type | Medical Membership | Dental Option # | Dental Membership |
|---|---|---|---|
| ☐ Access Blue HDHP* ☐ Lumenos Preferred Blue HDHP ☐ Open Access HDHP ☐ Access Blue New England HMO<br>☐ Site of Service Access Blue New England HMO ☐ Open Access PPO ☐ BlueChoice POS* | ☐ Single ☐ Two-Person<br>☐ Family ☐ Opt Out | | ☐ Single ☐ Two-Person<br>☐ Family ☐ Opt Out |

***A PCP must be selected for HMO and is strongly recommended for POS.**

## STEP 2: REASON FOR COMPLETING FORM

| | | |
|---|---|---|
| ☐ New Enrollee<br>☐ Open Enrollment<br>☐ Marriage<br>☐ Death<br>☐ Benefit Change<br>☐ Name Change | ☐ Birth/Adoption<br>☐ Dependent No Longer Eligible (Dependent Name & **complete step 4**): _____<br>☐ Divorce/Legal Separation<br>☐ Loss of Other Coverage (explain & **complete step 4**): _____<br>☐ Part-Time to Full-Time<br>☐ Election of COBRA Coverage | ☐ Other (explain):<br>**Actual Date of Event** |

## STEP 3: ENROLLEE AND DEPENDENT INFORMATION (Complete this section as your membership should appear.)

| NAME (First, MI, Last) | SOCIAL SECURITY NUMBER | Date of Birth Month/Day/Year | Relation to Enrollee | Gender | Enroll(ed) in | | Primary Care Provider (for HMO or POS Medical Type) | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Medical | Dental | PCP ID# *(Find on www.healthtrustnh.org)* | First/Last Name/City/State |
| Employee Name | | | Self | ☐M ☐F | ☐ | ☐ | | |
| Spouse Name | | | Spouse | ☐M ☐F | ☐ | ☐ | | |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |

****If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at *www.healthtrustnh.org.***

## STEP 4: OTHER INSURANCE

### OTHER MEDICAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)

Do you or your family have medical coverage through another group or employer? ☐ Yes ☐ No

Are you or another dependent transferring coverage from another medical carrier? ☐ Yes ☐ No

Name of Insurance Company

Effective Date | Termination Date

Are you or any of your dependents eligible for Medicare? ☐ Yes ☐ No

Member Name _____

Part A (Hospital) Effective Date

Part B (Medical) Effective Date

### OTHER DENTAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)

Do you or your family have dental coverage through another group or employer? ☐ Yes ☐ No

Are you or another dependent transferring coverage from another dental carrier? ☐ Yes ☐ No

Name of Insurance Company

Effective Date | Termination Date

Medicare Claim Number _____

Is coverage due to end-stage renal disease? ☐ Yes ☐ No

## STEP 5: ENROLLEE SIGNATURE

I hereby authorize HealthTrust and my employer to institute the enrollment(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the effective date and termination date of my membership will be determined by HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed. By signing this application, I attest to the accuracy and truthfulness and will provide documentation to HealthTrust upon request. I understand that any misrepresentation affecting the above named Enrollee's and/or Dependents' eligibility may result in retroactive cancellation of the medical and/or dental coverage and any charges incurred will be my liability. I understand it is my responsibility to notify my employer immediately when any Dependent no longer meets eligibility requirements of the plan.

**Enrollee Signature** _____ Date _____

## STEP 6: EMPLOYER USE ONLY

Date of Hire | Date of Rehire | ☐ Full-Time | ☐ Part-Time Number of Hours Weekly _____ | ☐ COBRA

Billing Group Name | Employee Job Title

Medical Group/Carrier Number ☐ HRA | Effective Date of Coverage

Dental Group/Carrier Number | Effective Date of Coverage

Benefits Administrator Signature/Stamp

Date _____

Please complete section A, as necessary, and return with your application.

**Enrollee Name** _____ **Employer Name**_____

**A. ADDITIONAL DEPENDENT(S) INFORMATION** – If you are enrolling more than three dependent children, please complete the information below.

| NAME (First, MI, Last) | SOCIAL SECURITY NUMBER | Date of Birth Month/Day/Year | Relation to Enrollee | Gender | Enroll(ed) in | | Primary Care Provider (for HMO or POS Medical Plan Type) | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Medical | Dental | PCP ID# *(Find on www.healthtrustnh.org)* | First/Last Name/City/State |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |
| Dependent Child Name** | | | | ☐M ☐F | ☐ | ☐ | | |

****If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at www.healthtrustnh.org.**

**Enrollee 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) |
|---|---|---|
| | | |