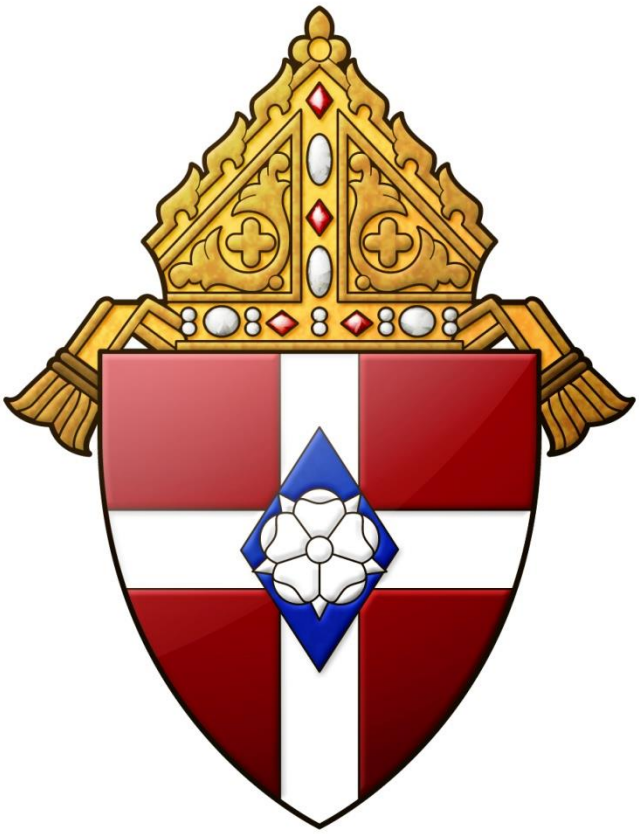
Employee Benefits Guide for Parish Administrators



Diocese of
Winona-Rochester

55 West Sanborn
PO Box 588
Winona, MN 55987
507-454-4643

July 2022

DIOCESE OF WINONA-ROCHESTER
Employee Benefits Guide Overview for Administrators

This book is an outline of the procedures and forms that need to be completed when hiring new employees, when employees are terminating, or when an employee is making changes in the Diocese of Winona-Rochester benefit programs. Enrollment, termination and changes for each benefit program are summarized separately and the corresponding forms to use are located in the back of each section. This guide should be your "master copy" of the forms and information; photocopies should be made for your use. Forms are frequently updated and may be found on the website at:

https://www.dowr.org/offices/human-resources/index.html

Upon hiring new employees and terminating employees, it is necessary to notify the Employee Benefits Coordinator at the Diocese of Winona-Rochester within 5 days of such event. Notification forms for this purpose are in the Hire/Term tab of this guide. Notification forms should be completed as soon as you are aware of a new hire or a termination.

Benefit forms for **New Employees** need to be sent to the Diocese of Winona-Rochester Pastoral Center within 30 days of the date of hire, preferably uploaded to Dropbox.

There are two checklists in the Hire/Term tab that you can use to quickly reference what forms and information are needed for new employees and terminating employees.

If you have any questions, please do not hesitate to contact the Diocese of Winona-Rochester Employee Benefits Coordinator at 507-858-1268.

The Benefits Manual is also on the diocesan website at:

DOW-R Employee Benefits Manual for Administrators
(https://www.dowr.org/offices/human-resources/benefits.html)

DIOCESE OF WINONA-ROCHESTER EMPLOYEE BENEFITS SUMMARY

Eligibility: All Diocese of Winona-Rochester employee benefits are written as corporate plans and are available to be adopted by any parish, school, or other institution under the jurisdiction of the Bishop of Winona-Rochester. Persons working for these employers are eligible for diocesan benefits if they work at least 20 hours a week or work at least half-time during the academic year, regardless of job title. Employees hired on a temporary basis working 30 or more hours per week are eligible for health insurance on the first of the month following 60 days of continuous employment (call HR/Benefits for further explanation). In addition, the (403)b Lay Retirement and Flexible Benefits Account (FSA) Plans require employees to be age 21 or over to participate.

Medical/Dental/Life/Accidental Death & Dismemberment/Long Term Disability Insurance Plans

The following policy is in effect in the Diocese of Winona-Rochester: That all eligible lay employees, employed by parishes and institutions in the Diocese of Winona-Rochester, be enrolled in the Diocese of Winona-Rochester group insurance plan.

A. Medical: Eligible employees have two deductible plans to choose from - $2,500 and $5,000. The plans pay for eligible medical expenses at a rate 80% after the applicable deductible is met. Each plan has an annual out-of-pocket maximum for the participant. The $5,000 deductible plan is Health Savings Plan Account (HSA) plan. The $2,500 deductible plan has a co-pay program for prescription drugs; the co-pay amount is determined by the Medica Formulary Drug listing and is not an eligible HSA plan. Coverage is available in either single or family plans. The plans are administered by Medica and take advantage of the Medica network of participating medical providers. The use of non-participating providers may result in a benefit reduction.

B. Dental: Eligible employees who enroll in the medical plan are also provided with a dental plan. The dental plan pays for eligible dental expenses, with a maximum annual benefit of $1,500. Preventative services are paid at 100%. Basic procedures are paid at a rate of 80% after a $50 annual deductible. Major procedures are paid at a rate of 50% after the same $50 deductible. There is also an orthodontia benefit for dependents ages 8-19 (if on family coverage). The orthodontia benefit is 50% of eligible charges with a lifetime maximum benefit of $1,000. The plan is administered by Delta Dental of Minnesota and takes advantage of the Delta PPO network of participating dental providers. The use of non-participating providers may result in a benefit reduction.

C. Life and Long-Term Disability (LTD): Each eligible employee is covered by a term life insurance policy equal to 1½ times the employee's annual salary, up to a maximum benefit of $50,000. Employees who become disabled will receive a monthly benefit equal to 60% of salary, after a 90-day waiting period. Life and LTD contracts are written by Unum and the premiums are paid by the employer.

D. Accidental Death and Dismemberment (AD&D) Life Insurance: In the event of an accidental death, the employee will receive an additional death benefit equal to the life benefit. AD&D insurance contracts are written by Mutual of Omaha and the premium is paid by the employer.

403 (b) Lay Retirement Plan

Type of Plan:	Tax Deferred 403(b) - Lincoln Alliance®
Eligibility:	Employees, age 21 or older, who are normally scheduled to work 20 or more hours per week. Participation is effective at date of hire for eligible employees.
Employer Discretionary Contribution:	3% of employee's wages.
Employee Elective Deferral:	Participant may contribute, via payroll deduction, from 1% to 100% of his/her wages up to the annual IRS limits (whole numbers only). Participant may change his/her elective deferral percentage effective the first day of any given month.
Employer Matching Contribution:	1% of employee's wages if the employee contributes 1%; 2% of employee's wages if the employee contributes 2%; 3% of the employee's wages if the employee contributes 3% or more; otherwise 0%.
Vesting - Employer Contributions:	20% vesting (ownership) per full year of eligible employment. Participant is 100% vested after 5 years.
Vesting - Employee Contributions:	Participant is always 100% vested in his/her elective deferral contributions.
Investments Options:	Participant directs all contributions to a variety of widely-recognized mutual funds. Participant also has the option to select a *LifeSpan*® asset allocation model, which provides allocation among the various investment options, based on a targeted retirement date. Participant may change investment options at any time.
Default Investment Election:	Participants who do NOT make individual investment elections for their contributions will automatically be invested in a LifeSpan® Target Date Model based on the participant's date of birth and the date closest to when the participant will reach the plan's normal retirement age of 65.
Withdrawal of Funds:	Participant may be eligible to withdraw money from the vested account balance when the following events occur: - Reach age 59½ - Upon retirement - Upon death - Upon total and permanent disability - A financial hardship, as defined by IRS guideline - No longer employed within the Diocese of Winona-Rochester Please note that distribution restrictions may apply to certain accounts under each of the above events. Taxes will be due upon distribution and if taken before age 59½, may be subject to an additional 10% federal tax penalty.
Loans:	Participant may borrow from his/her elective deferral account balance. Minimum loan amount is $1,000 and only one loan may be outstanding at a time. Loan must be repaid within 5 years, except loans used to purchase primary residence.
Fees:	The mutual funds in this program contain operating expenses just like all mutual funds.

Flexible Spending Account Medical and Dependent Care Benefit Plans (Administered by "Further")

Purpose:	To allow employees to reduce their taxable income and to use that deferred amount to purchase qualified benefits. New employees have 30 days from their date of employment to enroll in the plan.
Qualified Benefits:	Family medical expenses up to maximum of $2,750 per plan year (calendar year) with a minimum of $150. Dependent care expenses up to maximum allowed by IRS per plan year with a minimum of $150.
Administration:	Total amount deferred for the plan year is deducted from employee's gross pay. The medical expense and dependent care portion is forwarded to the Diocese of Winona-Rochester to be held in a separate fund. When an employee has qualified expenses, the employee files a claim form with Further, the Flexible Benefits Plan third party administrator.
Employee Savings:	The amount of employee-deferred wages is not subject to state or federal income taxes or Social Security/Medicare taxes. The W-2 form issued to the employee will be total annual salary minus flex plan deferrals.
Employer Savings:	Because deferred amounts are not subject to the Social Security/Medicare tax, the employer also saves their share of the tax, which is currently 7.65%.
Social Security:	It should be noted that any amount deducted from wages in this plan are not subject to Social Security/Medicare tax, and may affect the employee's social security benefits upon retirement.
Unused Accounts:	Employees should be very conservative when they decide on their income deferrals for the plan year. Amounts not incurred for qualified expenses cannot be returned to the employee.
Fees:	There are no fees paid by the employees. The Diocese of Winona-Rochester charges an annual fee to each participating employer based on the cost to administer the plan.

Note: This document is a summary of the various employee benefit programs offered by the Diocese of Winona-Rochester. In the case of an inconsistency between this and the "Plan" document or other policy related document will take precedence.

Supplemental Life Insurance (Administered by Unum)

Coverage Amounts	
Employee	Up to 5 times salary in increments of $10,000. Up to a maximum of the lesser of 5x salary or $500,000.
Spouse	Up to 100% of employee amount in increments of $5,000. Not to exceed $500,000. Benefits will be paid to the employee.
Child(ren)	Up to 100% of employee coverage amount in increments of $2,000. Not to exceed $10,000 (up to age 26). The maximum death benefit for a child between the ages of live birth and 6 months is $1,000. Benefits will be paid to the employee. The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.
Increase in Coverage	Once you enroll, you are able to increase the coverage amount at annual enrollment or a qualifying event. You and your eligible dependents may purchase additional life coverage up to the guarantee issue amount without evidence of insurability. Coverage over the guarantee issue amount requires evidence of insurability.
Guarantee Issue	If you and your eligible dependents enroll within 30 days of your eligibility date, you may apply for any amount of life coverage up to $200,000 for yourself and any amount of coverage up to $25,000 for your spouse. Any life coverage over the guarantee issue amount is subject to evidence of insurability.
30 days of eligibility	You have 30 days to enroll you and your dependents in life insurance. Once the 30 days are up you will be able to enroll at yearly enrollment of January 1 or if you have a qualifying event, but you are required to furnish the evidence of insurability for the entire amount of coverage.

CONTACT INFORMATION

Blue Cross Blue Shield of Minnesota – Senior Gold Health Plan – Senior Priests/Retired Lay

Customer Service 888-878-0136
Main Website ..... www.bluecrossmn.com
Members online access to health plan..... www.bluecrossmnonline.com

Catholic Mutual/Ryan Christianson – Risk Manager

Phone 800-228-6108

Delta Dental of Minnesota – Dental Plan

Customer Service 800-553-9536
Main Website ..... www.DeltaDentalMN.org

Diocese of Winona-Rochester

Phone 507-454-4643
Fax..... 507-454-8106
Main Website .....www.dowr.org
Mailing Address ..... 55 W. Sanborn P.O. Box 588 Winona, MN 55987

Staff

Andrew Brannon..... Chief Finance and Administrative Officer
Email..... abrannon@dowr.org
Phone 507-858-1248

David Fricke ..... Director of Human Resources
Email..... dfricke@dowr.org
Phone 507-858-1250

Julia Sandsness..... Employee Benefits Coordinator
Email..... benefits@dowr.org
Phone 507-858-1268

Beth Buswell..... Finance/HR Administrative Assistant
Email..... bbuswell@dowr.org
Phone 507-858-1241

Ann Ringlien ..... Accounting Assistant
Email..... aringlien@dowr.org
Phone 507-858-1247

Sandy Todd..... Controller
Email..... stodd@dowr.org
Phone 507-858-1245

Lincoln Alliance – 403(b) Lay Retirement and Multi-Fund

Customer Service 800-234-3500
Website ..... www.lfg.com

Medica – Health Plan – Lay, Active Priests, Seminary Students

Customer Service 877-347-0282
Main Website ..... www.medica.com
Members online access to health plan..... www.medica.com/login

Please note: All documents can be accessed online at https://www.dowr.org/offices/human-resources/index.html and are current, whereas your previously printed documents may not be current.

Information: Accessing Flexible Spending Account Information Online	10/25/18		
Form: FSA Enrollment Form	For 2022	Y	D-2
Form: Medical Expense Reimbursement Account Claim - Online only	2/18		F8503R09
Form: Daycare Expense Reimbursement Claim - Online only	2/18		F8420R10
Form: Qualifying Event Notification Form - Online only	2/18		F3927R07
Form: Authorization for Direct Deposit (ONLY for Medical Flex or Dependent Care) - Online only	2/18		F7415R17
Section E – Supplemental Life Insurance			
Supplemental Life Insurance Participation and Form Directions	6/30/22	Y	
Benefits at a Glance - Supplemental Life	8/1/21	Y	
Supplemental Life – Term Life Insurance Coverage Highlights			ADR1879-2001
Summary Plan Booklet – Supplement Life Insurance – Online only			
Information: "What Would Your Family Do Without Your Income" flyer - Online only			
Information: "Group term life insurance" flyer - Online only			
Form: Supplemental Life Term Life Insurance Enrollment	10/25/18		E-1
Form: Evidence of Insurability (only if exceeding limits) – ***Email benefits for online form link***			
Section F – Family Medical Leave (FMLA) – Online only			
Family and Medical Leave Act Text			
Employer Notification Requirements under the Family Medical Leave Act			FS 28D
FMLA – Who is Covered			FS 28
Notice of Eligibility & Rights	Exp 6/30/23		
Designation Notice	Exp 6/30/23		
Certification of Health Care Provider for Employee's Serious Health Condition	Exp 6/30/23		
Certification of Health Care Provider for Family Member's Serious Health Condition	Exp 6/30/23		

Revised 7/6/2022

PLEASE USE CURRENT FORM, WHICH MAY BE FOUND ON WEBSITE

DOW-R

⇨ BENEFIT ELIGIBLE ☐ YES ☐ NO -Complete form up to *

NOTICE OF

☐ **NEW EMPLOYEE HIRE OR INCREASE IN HOURS**

☐ **EMPLOYEE TERMINATION OR REDUCTION IN HOURS**

☐ **NAME CHANGE** - (COMPLETE THROUGH CITY/STATE/ZIP)

Dow-R to complete SCANNED

Pension No Pension

Insurance LDS LDF HDS HDF

Effective Date: _____

Date to BCBS: _____

Date to DD: _____

Date: _____ Parish/School Name: _____

Employee Information (For Non-Benefit eligible employees – You do not have to complete the Qualifying Event information)

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

Employee name must match your accounting/payroll & DOW-R No period in MI

Address: _____

City, State, Zip: _____ Home Phone # _____

Date of Birth: _____ Social Security #: _____

Start date or date hours increased: _____ Work Email address: _____

Job Title: _____ If teaching, license #: _____

Will the new employee work with children or young adults: ☐ Yes ☐ No

Has the new employee worked at a Catholic school/church/institution within the Diocese of Winona-Rochester in the last 5 years: ☐ No ☐ Yes Where: _____

*Qualifying Event Information (check one)

New hire or increase in hours:

☐ New Hire or ☐ Increase in hours

(from less than 20 to 20 or more per week

⇨ Transfer from DOW-R location: _____

⇨ Exempt employee ☐ No ☐ Yes (attach job description)

⇨FTE _____ or

Number of hours per week employee will work _____

Number of months per fiscal year _____

⇨ Annual salary _____

⇨ Date employee will receive first paycheck

Termination or decrease in hours (attach term/resign letter)

⇨ Effective date _____ ⇨ Last day worked _____

☐ Employee hired at different DOW-R location:

Hired at _____

☐ Termination of employment – involuntary ☐ Retirement

☐ Voluntary separation of employment, resignation or quit

☐ Reduction in hours less than benefit-eligible

⇨ Date of employee's final paycheck _____

⇨Date parish/school ends contribution to insurance

Diocesan Benefit Plan(s) Employee is Enrolled in:

(Check all that apply for term)

☐ Health/Dental Insurance ☐ Waived

Coverage: ☐ Single ☐ Family

Plan/Deductible: ☐ $2,500 ☐ $5,000

☐ Life Insurance

☐ Supplemental Life Ins

☐ Waived

☐ Employee

☐ Spouse

☐ Child(ren)

☐ Lay Pension Plan P___% R___%

Ineligible for pension:

☐ Age – under 21

☐ Temp and under 1000 hrs/yr

☐ Flex ☐ Waived ☐ Medical ☐ Dependent Care

DOW-R Use: ☐ To Safe Environment

Term: New Hire:

☐ Census

☐ Alerus: NA E D

BC DD FLX Life Supp Life E S D

☐Retirement # years ____

Vested _____% F

Life # Units ___ Mo $_____

Flex __# Mo Mo $ _____

Supp Life:

Emp _____

Spouse _____

Child(ren) _____

H - Needs N Y

☐ Census COBRA: E S

L - Needs N Y NA

P - Needs N Y NA

F - Needs Waived Y NA

S - Needs Waived Y NA

Invoice NA CR DB

☐ Health ☐ Med/Dental

☐ Life/ADD/LTD

☐ Flex ☐ Sup Life

#_____ Mo___

COBRA period:

Parish/school representative X _____ _____

Signature Date

Place form in your Dropbox within 5 days of hire/termination – Do Not Email

or mail/fax to: Diocese of Winona-Rochester, Employee Benefits Coordinator, PO Box 588, Winona, MN 55987

Fax 507.454.8106 Questions? - Email: benefits@dowr.org or call 507-858-1268 ☐ **Uploaded to Dropbox**

ACCUFUND Emp_____ LOC _____

Diocese of Winona-Rochester

NEW HIRE EMPLOYEE BENEFITS CHECKLIST*

EMPLOYEE'S NAME: _____

HIRE/TERM:

- Send completed form to Diocese of Winona-Rochester
  - ☐ Notice of New Employee Hire/Increase of Hours Form 001
  - ☐ Please note name format must match what you have in your accounting/payroll system, contains no titles (you can designate title in a non-name area). The format is full legal first and last name, along with the middle initial, no period.

HEALTH/DENTAL INSURANCE

- Send completed form to Diocese of Winona-Rochester
  - ☐ Health/Dental Enrollment Group Coverage Form A-1
  - ☐ Waiver for Health/Dental Group Coverage Form A-2 (used only for new hires/open enrollment)
- Information to Give to Employee
  - ☐ New Health Insurance Marketplace Coverage Options and Your Health Coverage
  - ☐ Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
  - ☐ FAQS about Health/Dental Insurance Enrollment and Change Form
  - ☐ Summary of Benefits and Coverage for $2500 and $5000 Deductibles
  - ☐ Lay Employee Dental Plan Summary
- If enrolling
  - ☐ Directions for Online Access to Medica and Delta Dental
    - Employees can print their own identification card replacements
    - Access to coverage information and other vital plan information
  - ☐ Employee receives their "Summary Plan Booklet" by registering online
    - See instructions on form above

LIFE/LTD/AD&D

- Send completed form to Diocese of Winona-Rochester
  - Insurance Enrollment For: Basic Group (Term) Life, Long Term Disability (LTD), Accidental Death and Dismemberment (AD&D) – Form B-1
- Information to Give to Employee
  - ☐ Benefits at a Glance
    - Life Insurance Plan (Basic Life)
    - LTD Plan
    - AD&D 24-Hour Accident Insurance
- Direct employee to DOW-R benefit website Section B
  - ☐ Summary Plan Booklet - Basic Group Life Insurance Plan
  - ☐ Summary Plan Booklet - LTD
  - ☐ Summary Plan Booklet – AD&D

RETIREMENT – 403(b) Lay Employees Retirement Plan

- Send completed form to Diocese of Winona-Rochester
  - ☐ Salary Reduction Agreement Form C-2
- Information to Give to Employee
  - ☐ 403(b) Lay employees Retirement Plan Information
  - ☐ Lincoln Enrollment Booklet – Direct employee to DOW-R HR/Benefit website Section B or give employee booklet which you can obtain from the diocese

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FLEXIBLE BENEFITS

- Send completed form to Diocese of Winona-Rochester
  - ☐ Flexible Spending Account Enrollment Form D-2
- Information to Give to Employee
  - ☐ FSA - The Medical Flexible Spending Account
  - ☐ Medical FSA Worksheet
  - ☐ FSA - The Dependent Care Spending Account
  - ☐ Getting Reimbursed for Dependent Care Expenses
  - ☐ Accessing Flexible Spending Account Information Online
- If enrolling, direct employee to DOW-R HR/Benefit website Section D
  - ☐ Summary Plan Booklet
    - Medical FSA
    - Dependent Care FSA

SUPPLEMENTAL LIFE

- Send completed form(s) to Diocese of Winona-Rochester
  - ☐ Insurance Enrollment Form for Supplemental (Term) Life Form E-1
  - ☐ **Complete only if** employee chose life coverage over the Guarantee Issue amount of $200,000 for self or $25,000 for spouse Evidence of Insurability (EOI) – contact benefits@dowr.org for online form information.
- Information to Give to Employee
  - ☐ Benefits at a Glance – (Supplemental) Life Insurance Plan
  - ☐ Supplemental Life - Term Life Insurance Coverage Highlights
  - ☐ "Beneficiary Guide for Term Life Insurance" flyer
  - ☐ "What Would Your Family Do Without Your Income" flyer
  - ☐ "Group term life insurance" flyer
  - ☐ Benefits at a Glance – Supplemental Life Insurance
- If enrolling, direct employee to DOW-R HR/Benefit website Section E
  - ☐ Summary Plan Booklet - Supplemental Life Insurance

***This checklist is for parish/school/cemetery/institution only and does not need to be sent to the Diocese of Winona-Rochester.**

Employment Eligibility Verification

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

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

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
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		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		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Instructions for Form I-9, Employment Eligibility Verification

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

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

Anti-Discrimination Notice. It is illegal to discriminate against work-authorized individuals in hiring, firing, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers CANNOT specify which document(s) the employee may present to establish employment authorization. The employer must allow the employee to choose the documents to be presented from the Lists of Acceptable Documents, found on the last page of Form I-9. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, contact the Immigrant and Employee Rights Section (IER) in the Department of Justice's Civil Rights Division at **https://www.justice.gov/ier**.

What is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011.

General Instructions

Both employers and employees are responsible for completing their respective sections of Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors, as defined in section 3 of the Migrant and Seasonal Agricultural Worker Protection Act, Public Law 97-470 (29 U.S.C. 1802). An "employee" is a person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term "Employee" does not include those who do not receive any form of remuneration (volunteers), independent contractors or those engaged in certain casual domestic employment. Form I-9 has three sections. Employees complete Section 1. Employers complete Section 2 and, when applicable, Section 3. Employers may be fined if the form is not properly completed. See 8 USC § 1324a and 8 CFR § 274a.10. Individuals may be prosecuted for knowingly and willfully entering false information on the form. Employers are responsible for retaining completed forms. **Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).**

These instructions will assist you in properly completing Form I-9. The employer must ensure that all pages of the instructions and Lists of Acceptable Documents are available, either in print or electronically, to all employees completing this form. When completing the form on a computer, the English version of the form includes specific instructions for each field and drop-down lists for universally used abbreviations and acceptable documents. To access these instructions, move the cursor over each field or click on the question mark symbol (ⓘ) within the field. Employers and employees can also access this full set of instructions at any time by clicking the Instructions button at the top of each page when completing the form on a computer that is connected to the Internet.

Employers and employees may choose to complete any or all sections of the form on paper or using a computer, or a combination of both. Forms I-9 obtained from the USCIS website are not considered electronic Forms I-9 under DHS regulations and, therefore, cannot be electronically signed. Therefore, regardless of the method you used to enter information into each field, you must print a hard copy of the form, then sign and date the hard copy by hand where required.

Employers can obtain a blank copy of Form I-9 from the USCIS website at https://www.uscis.gov/i-9. This form is in portable document format (.pdf) that is fillable and savable. That means that you may download it, or simply print out a blank copy to enter information by hand. You may also request paper Forms I-9 from USCIS.

Certain features of Form I-9 that allow for data entry on personal computers may make the form appear to be more than two pages. When using a computer, Form I-9 has been designed to print as two pages. Using more than one preparer and/or translator will add an additional page to the form, regardless of your method of completion. You are not required to print, retain or store the page containing the Lists of Acceptable Documents.

The form will also populate certain fields with N/A when certain user choices ensure that particular fields will not be completed. The Print button located at the top of each page that will print any number of pages the user selects. Also, the Start Over button located at the top of each page will clear all the fields on the form.

The Spanish version of Form I-9 does not include the additional instructions and drop-down lists described above. Employers in Puerto Rico may use either the Spanish or English version of the form. Employers outside of Puerto Rico must retain the English version of the form for their records, but may use the Spanish form as a translation tool. Additional guidance to complete the form may be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274) and on USCIS' Form I-9 website, I-9 Central.

Completing Section I: Employee Information and Attestation

You, the employee, must complete each field in Section 1 as described below. Newly hired employees must complete and sign Section 1 no later than the first day of employment. Section 1 should never be completed before you have accepted a job offer.

Entering Your Employee Information

Last Name *(Family Name)*: Enter your full legal last name. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the Last Name field. *Examples of correctly entered last names include: De La Cruz, O'Neill, Garcia Lopez, Smith-Johnson, Nguyen.* If you only have one name, enter it in this field, then enter "Unknown" in the First Name field. You may not enter "Unknown" in both the Last Name field and the First Name field.

First Name *(Given Name)*: Enter your full legal first name. Your first name is your given name. *Some examples of correctly entered first names include: Jessica, John-Paul, Tae Young, D'Shaun, Mai.* If you only have one name, enter it in the Last Name field, then enter "Unknown" in this field. You may not enter "Unknown" in both the First Name field and the Last Name field.

Middle Initial: Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any. If you have more than one middle name, enter the first letter of your first middle name. If you do not have a middle name, enter N/A in this field.

Other Last Names Used: Provide all other last names used, if any (e.g., maiden name). Enter N/A if you have not used other last names. For example, if you legally changed your last name from Smith to Jones, you should enter the name Smith in this field.

Address (*Street Name and Number*): Enter the street name and number of the current address of your residence. If you are a border commuter from Canada or Mexico, you may enter your Canada or Mexico address in this field. If your residence does not have a physical address, enter a description of the location of your residence, such as "3 miles southwest of Anytown post office near water tower."

Apartment: Enter the number(s) or letter(s) that identify(ies) your apartment. If you do not live in an apartment, enter N/A.

City or Town: Enter your city, town or village in this field. If your residence is not located in a city, town or village, enter your county, township, reservation, etc., in this field. If you are a border commuter from Canada, enter your city and province in this field. If you are a border commuter from Mexico, enter your city and state in this field.

State: Enter the abbreviation of your state or territory in this field. If you are a border commuter from Canada or Mexico, enter your country abbreviation in this field.

ZIP Code: Enter your 5-digit ZIP code. If you are a border commuter from Canada or Mexico, enter your 5- or 6-digit postal code in this field.

Date of Birth (*mm/dd/yyyy*): Enter your date of birth as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 1980 as 01/08/1980.

U.S. Social Security Number: Providing your 9-digit Social Security number is voluntary on Form I-9 unless your employer participates in E-Verify. If your employer participates in E-Verify and:

1. You have been issued a Social Security number, you must provide it in this field; or
2. You have applied for, but have not yet received a Social Security number, leave this field blank until you receive a Social Security number.

Employee's E-mail Address (*Optional*): Providing your e-mail address is optional on Form I-9, but the field cannot be left blank. To enter your e-mail address, use this format: name@site.domain. One reason Department of Homeland Security (DHS) may e-mail you is if your employer uses E-Verify and DHS learns of a potential mismatch between the information provided and the information in government records. This e-mail would contain information on how to begin to resolve the potential mismatch. You may use either your personal or work e-mail address in this field. Enter N/A if you do not enter your e-mail address.

Employee's Telephone Number (*Optional*): Providing your telephone number is optional on Form I-9, but the field cannot be left blank. If you enter your area code and telephone number, use this format: 000-000-0000. Enter N/A if you do not enter your telephone number.

Attesting to Your Citizenship or Immigration Status

You must select one box to attest to your citizenship or immigration status.

1. **A citizen of the United States.**

2. **A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

3. **A lawful permanent resident:** An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. This term includes conditional residents. Asylees and refugees should not select this status, but should instead select "An Alien authorized to work" below.

   If you select "lawful permanent resident," enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or USCIS Number in the space provided. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

4. **An alien authorized to work:** An individual who is not a citizen or national of the United States, or a lawful permanent resident, but is authorized to work in the United States.

   If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the document(s) evidencing your employment authorization. Refugees, asylees and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other aliens whose employment authorization does not have an expiration date should enter N/A in the Expiration Date field. In some cases, such as if you have Temporary Protected Status, your employment authorization may have been automatically extended; in these cases, you should enter the expiration date of the automatic extension in this space.

   Aliens authorized to work must enter one of the following to complete Section 1:

   1. Alien Registration Number (A-Number)/USCIS Number; or
   2. Form I-94 Admission Number; or
   3. Foreign Passport Number and the Country of Issuance.

   Your employer may not ask you to present the document from which you supplied this information.

   Alien Registration Number/USCIS Number: Enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or your USCIS Number in this field. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. If you do not provide an A-Number or USCIS Number, enter N/A in this field then enter either a Form I-94 Admission Number, or a Foreign Passport and Country of Issuance in the fields provided.

   Form I-94 Admission Number: Enter your 11-digit I-94 Admission Number in this field. If you do not provide an I-94 Admission Number, enter N/A in this field, then enter either an Alien Registration Number/USCIS Number or a Foreign Passport Number and Country of Issuance in the fields provided.

   Foreign Passport Number: Enter your Foreign Passport Number in this field. If you do not provide a Foreign Passport Number, enter N/A in this field, then enter either an Alien Number/USCIS Number or a I-94 Admission Number in the fields provided.

   Country of Issuance: If you entered your Foreign Passport Number, enter your Foreign Passport's Country of Issuance. If you did not enter your Foreign Passport Number, enter N/A.

Signature of Employee: After completing Section 1, sign your name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing this form, you attest under penalty of perjury (28 U.S.C. § 1746) that the information you provided, along with the citizenship or immigration status you selected, and all information and documentation you provide to your employer, is complete, true and correct, and you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties, removal proceedings and may adversely affect an employee's ability to seek future immigration benefits. If you cannot sign your name, you may place a mark in this field to indicate your signature. Employees who use a preparer or translator to help them complete the form must still sign or place a mark in the Signature of Employee field on the printed form.

If you used a preparer, translator, and other individual to assist you in completing Form I-9:

- Both you and your preparer(s) and/or translator(s) must complete the appropriate areas of Section 1, and then sign Section 1. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to sign these fields. You and your preparer(s) and/or translator(s) also should review the instructions for **Completing the Preparer and/or Translator Certification** below.
- If the employee is a minor (individual under 18) who cannot present an identity document, the employee's parent or legal guardian can complete Section 1 for the employee and enter "minor under age 18" in the signature field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The minor's parent or legal guardian should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on completion of Form I-9 for minors. If the minor's employer participates in E-Verify, the employee must present a list B identity document with a photograph to complete Form I-9.
- If the employee is a person with a disability (who is placed in employment by a nonprofit organization, association or as part of a rehabilitation program) who cannot present an identity document, the employee's parent, legal guardian or a representative of the nonprofit organization, association or rehabilitation program can complete Section 1 for the employee and enter "Special Placement" in this field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The parent, legal guardian or representative of the nonprofit organization, association or rehabilitation program completing Section 1 for the employee should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on completion of Form I-9 for certain employees with disabilities.

Today's Date: Enter the date you signed Section 1 in this field. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014. A preparer or translator who assists the employee in completing Section 1 may enter the date the employee signed or made a mark to sign Section 1 in this field. Parents or legal guardians assisting minors (individuals under age 18) and parents, legal guardians or representatives of a nonprofit organization, association or rehabilitation program assisting certain employees with disabilities must enter the date they completed Section 1 for the employee.

Completing the Preparer and/or Translator Certification

If you did not use a preparer or translator to assist you in completing Section 1, you, the employee, must check the box marked **I did not use a Preparer or Translator.** If you check this box, leave the rest of the fields in this area blank.

If one or more preparers and/or translators assist the employee in completing the form using a computer, the preparer and/or translator must check the box marked **"A preparer(s) and/or translator(s) assisted the employee in completing Section 1"**, then select the number of Certification areas needed from the dropdown provided. Any additional Certification areas generated will result in an additional page. The Form I-9 Supplement, Section 1 Preparer and/or Translator Certification, can be separately downloaded from the USCIS Form I-9 webpage, which provides additional Certification areas for those completing Form I-9 using a computer who need more Certification areas than the 5 provided or those who are completing Form I-9 on paper. The first preparer and/or translator must complete all the fields in the Certification area on the same page the employee has signed. There is no limit to the number of preparers and/or translators an employee can use, but each additional preparer and/or translator must complete and sign a separate Certification area. Ensure the employee's last name, first name and middle initial are entered at the top of any additional pages. The employer must ensure that any additional pages are retained with the employee's completed Form I-9.

Signature of Preparer or Translator: Any person who helped to prepare or translate Section 1of Form I-9 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. The Preparer and/or Translator Certification must also be completed if "Individual under Age 18" or "Special Placement" is entered in lieu of the employee's signature in Section 1.

Today's Date: The person who signs the Preparer and/or Translator Certification must enter the date he or she signs in this field on the printed form. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Last Name *(Family Name):* Enter the full legal last name of the person who helped the employee in preparing or translating Section 1 in this field. The last name is also the family name or surname. If the preparer or translator has two last names or a hyphenated last name, include both names in this field.

First Name (*Given Name*): Enter the full legal first name of the person who helped the employee in preparing or translating Section 1 in this field. The first name is also the given name.

Address (*Street Name and Number*): Enter the street name and number of the current address of the residence of the person who helped the employee in preparing or translating Section 1 in this field. Addresses for residences in Canada or Mexico may be entered in this field. If the residence does not have a physical address, enter a description of the location of the residence, such as "3 miles southwest of Anytown post office near water tower." If the residence is an apartment, enter the apartment number in this field.

City or Town: Enter the city, town or village of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the residence is not located in a city, town or village, enter the name of the county, township, reservation, etc., in this field. If the residence is in Canada, enter the city and province in this field. If the residence is in Mexico, enter the city and state in this field.

State: Enter the abbreviation of the state, territory or country of the preparer or translator's residence in this field.

ZIP Code: Enter the 5-digit ZIP code of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the preparer or translator's residence is in Canada or Mexico, enter the 5- or 6-digit postal code.

Presenting Form I-9 Documents

Within 3 business days of starting work for pay, you must present to your employer documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before Thursday of that week. However, if you were hired to work for less than 3 business days, you must present documentation no later than the first day of employment.

Choose which unexpired document(s) to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which document(s) you may present from the Lists of Acceptable Documents. You may present either one selection from List A or a combination of one selection from List B and one selection from List C. Some List A documents, which show both identity and employment authorization, are combination documents that must be presented together to be considered a List A document: for example, the foreign passport together with a Form I-94 containing an endorsement of the alien's nonimmigrant status and employment authorization with a specific employer incident to such status. List B documents show identity only and List C documents show employment authorization only. If your employer participates in E-Verify and you present a List B document, the document must contain a photograph. If you present acceptable List A documentation, you should not be asked to present, nor should you provide, List B and List C documentation. If you present acceptable List B and List C documentation, you should not be asked to present, nor should you provide, List A documentation. If you are unable to present a document(s) from these lists, you may be able to present an acceptable receipt. Refer to the Receipts section below.

Your employer must review the document(s) you present to complete Form I-9. If your document(s) reasonably appears to be genuine and to relate to you, your employer must accept the documents. If your document(s) does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documents from the Lists of Acceptable Documents. Your employer may choose to make copies of your document(s), but must return the original(s) to you. Your employer must review your documents in your physical presence.

Your employer will complete the other parts of this form, as well as review your entries in Section 1. Your employer may ask you to correct any errors found. Your employer is responsible for ensuring all parts of Form I-9 are properly completed and is subject to penalties under federal law if the form is not completed correctly.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on minors and certain individuals with disabilities.

Receipts

If you do not have unexpired documentation from the Lists of Acceptable Documents, you may be able to present a receipt(s) in lieu of an acceptable document(s). New employees who choose to present a receipt(s) must do so within three business days of their first day of employment. If your employer is reverifying your employment authorization, and you choose to present a receipt for reverification, you must present the receipt by the date your employment authorization expires. Receipts are not acceptable if employment lasts fewer than three business days.

There are three types of acceptable receipts:

1. A receipt showing that you have applied to replace a document that was lost, stolen or damaged. You must present the actual document within 90 days from the date of hire or, in the case of reverification, within 90 days from the date your original employment authorization expires.
2. The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and a photograph of the individual. You must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of admission.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. You must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security Card within 90 days from the date of hire or, in the case of reverification, within 90 days from the date your original employment authorization expires.

Receipts showing that you have applied for an initial grant of employment authorization, or for renewal of your expiring or expired employment authorization, are not acceptable.

Completing Section 2: Employer or Authorized Representative Review and Verification

You, the employer, must ensure that all parts of Form I-9 are properly completed and may be subject to penalties under federal law if the form is not completed correctly. Section 1 must be completed no later than the employee's first day of employment. You may not ask an individual to complete Section 1 before he or she has accepted a job offer. Before completing Section 2, you should review Section 1 to ensure the employee completed it properly. If you find any errors in Section 1, have the employee make corrections, as necessary and initial and date any corrections made.

You may designate an authorized representative to act on your behalf to complete Section 2. An authorized representative can be any person you designate to complete and sign Form I-9 on your behalf. You are liable for any violations in connection with the form or the verification process, including any violations of the employer sanctions laws committed by the person designated to act on your behalf.

You or your authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete Section 2 on or before Thursday of that week. However, if you hire an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment.

Entering Employee Information from Section 1

This area, titled, "Employee Info from Section 1" contains fields to enter the employee's last name, first name, middle initial exactly as he or she entered them in Section 1. This area also includes a Citizenship/Immigration Status field to enter the number of the citizenship or immigration status checkbox the employee selected in Section 1. These fields help to ensure that the two pages of an employee's Form I-9 remain together. When completing Section 2 using a computer, the number entered in the Citizenship/Immigration Status field provides drop-downs that directly relate to the employee's selected citizenship or immigration status.

Entering Documents the Employee Presents

You, the employer or authorized representative, must physically examine, in the employee's physical presence, the unexpired document(s) the employee presents from the Lists of Acceptable Documents to complete the Document fields in Section 2.

You cannot specify which document(s) an employee may present from these lists. If you discriminate in the Form I-9 process based on an individual's citizenship status, immigration status, or national origin, you may be in violation of the law and subject to sanctions such as civil penalties and be required to pay back pay to discrimination victims. A document is acceptable as long as it reasonably appears to be genuine and to relate to the person presenting it. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

List A documents show both identity and employment authorization. Some List A documents are combination documents that must be presented together to be considered a List A document, such as a foreign passport together with a Form I-94 containing an endorsement of the alien's nonimmigrant status.

List B documents show identity only, and List C documents show employment authorization only. If an employee presents a List A document, do not ask or require the employee to present List B and List C documents, and vice versa. If an employer participates in E-Verify and the employee presents a List B document, the List B document must include a photograph.

If an employee presents a receipt for the application to replace a lost, stolen or damaged document, the employee must present the replacement document to you within 90 days of the first day of work for pay, or in the case of reverification, within 90 days of the date the employee's employment authorization expired. Enter the word "Receipt" followed by the title of the receipt in Section 2 under the list that relates to the receipt.

When your employee presents the replacement document, draw a line through the receipt, then enter the information from the new document into Section 2. Other receipts may be valid for longer or shorter periods, such as the arrival portion of Form I-94/ I-94A containing a temporary I-551 stamp and a photograph of the individual, which is valid until the expiration date of the temporary I-551 stamp or, if there is no expiration date, valid for one year from the date of admission.

Ensure that each document is an unexpired, original (no photocopies, except for certified copies of birth certificates) document. Certain employees may present an expired employment authorization document, which may be considered unexpired, if the employee's employment authorization has been extended by regulation or a Federal Register Notice. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) or I-9 Central for more guidance on these special situations.

Refer to the M-274 for guidance on how to handle special situations, such as students (who may present additional documents not specified on the Lists) and H-1B and H-2A nonimmigrants changing employers.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the M-274 for more guidance on minors and certain persons with disabilities. If the minor's employer participates in E-Verify, the minor employee also must present a List B identity document with a photograph to complete Form I-9.

You must return original document(s) to the employee, but may make photocopies of the document(s) reviewed. Photocopying documents is voluntary unless you participate in E-Verify. E-Verify employers are only required to photocopy certain documents. If you are an E-Verify employer who chooses to photocopy documents other than those you are required to photocopy, you should apply this policy consistently with respect to Form I-9 completion for all employees. For more information on the types of documents that an employer must photocopy if the employer uses E-Verify, visit E-Verify's website at www.everify.gov. For non-E-Verify employers, if photocopies are made, they should be made consistently for ALL new hires and reverified employees.

Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or another federal government agency. You must always complete Section 2 by reviewing original documentation, even if you photocopy an employee's document(s) after reviewing the documentation. Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. You are still responsible for completing and retaining Form I-9.

List A - Identity and Employment Authorization: If the employee presented an acceptable document(s) from List A or an acceptable receipt for a List A document, enter the document(s) information in this column. If the employee presented a List A document that consists of a combination of documents, enter information from each document in that combination in a separate area under List A as described below. All documents must be unexpired. If you enter document information in the List A column, you should not enter document information or N/A in the List B or List C columns. If you complete Section 2 using a computer, a selection in List A will fill all the fields in the Lists B and C columns with N/A.

Document Title: If the employee presented a document from List A, enter the title of the List A document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviation to enter the document title or issuing authority. If the employee presented a combination of documents, use the second and third Document Title fields as necessary.

Full name of List A Document	Abbreviations
U.S. Passport	U.S. Passport
U.S. Passport Card	U.S. Passport Card
Permanent Resident Card (Form I-551)	Perm. Resident Card (Form I-551)
Alien Registration Receipt Card (Form I-551)	Alien Reg. Receipt Card (Form I-551)
Foreign passport containing a temporary I-551 stamp	1. Foreign Passport 2. Temporary I-551 Stamp
Foreign passport containing a temporary I-551 printed notation on a machine-readable immigrant visa (MRIV)	1. Foreign Passport 2. Machine-readable immigrant visa (MRIV)
Employment Authorization Document (Form I-766)	Employment Auth. Document (Form I-766)
For a nonimmigrant alien authorized to work for a specific employer because of his or her status, a foreign passport with Form I/94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Foreign Passport, work-authorized non-immigrant 2. Form I-94/I94A 3. Form I-20 or Form DS-2019 Note: In limited circumstances, certain J-1 students may be required to present a letter from their Responsible Officer in order to work. Enter the document title, issuing authority, document number and expiration date from this document in the Additional Information field.
Passport from the Federated States of Micronesia (FSM) with Form I-94/I-94A	1. FSM Passport with Form I-94 2. Form I-94/I94A
Passport from the Republic of the Marshall Islands (RMI) with Form I-94/I94A	1. RMI Passport with Form I-94 2. Form I-94/I94A
Receipt: The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and photograph	Receipt: Form I-94/I-94A w/I-551 stamp, photo
Receipt: The departure portion of Form I-94/I-94A with an unexpired refugee admission stamp	Receipt: Form I-94/I-94A w/refugee stamp
Receipt for an application to replace a lost, stolen or damaged Permanent Resident Card (Form I-551)	Receipt replacement Perm. Res. Card (Form I-551)
Receipt for an application to replace a lost, stolen or damaged Employment Authorization Document (Form I-766)	Receipt replacement EAD (Form I-766)
Receipt for an application to replace a lost, stolen or damaged foreign passport with Form I-94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Receipt: Replacement Foreign Passport, work-authorized nonimmigrant 2. Receipt: Replacement Form I-94/I-94A 3. Form I-20 or Form DS-2019 (if presented)
Receipt for an application to replace a lost, stolen or damaged passport from the Federated States of Micronesia with Form I-94/I-94A	1. Receipt: Replacement FSM Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A
Receipt for an application to replace a lost, stolen or damaged passport from the Republic of the Marshall Islands with Form I-94/ I-94A	1. Receipt: Replacement RMI Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A

Issuing Authority: Enter the issuing authority of the List A document or receipt. The issuing authority is the specific entity that issued the document. If the employee presented a combination of documents, use the second and third Issuing Authority fields as necessary.

Document Number: Enter the document number, if any, of the List A document or receipt presented. If the document does not contain a number, enter N/A in this field. If the employee presented a combination of documents, use the second and third Document Number fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the Student and Exchange Visitor Information System (SEVIS) number in the third Document Number field exactly as it appears on the Form I-20 or the DS-2019.

Expiration Date (*if any*) (*mm/dd/yyyy*): Enter the expiration date, if any, of the List A document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. If the document uses text rather than a date to indicate when it expires, enter the text as shown on the document, such as "D/S" (which means, "duration of status"). For a receipt, enter the expiration date of the receipt validity period as described above. If the employee presented a combination of documents, use the second and third Expiration Date fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the program end date here.

List B - Identity: If the employee presented an acceptable document from List B or an acceptable receipt for the application to replace a lost, stolen, or destroyed List B document, enter the document information in this column. If a parent or legal guardian attested to the identity of an employee who is an individual under age 18 or certain employees with disabilities in Section 1, enter either "Individual under age 18" or "Special Placement" in this field. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on individuals under age 18 and certain person with disabilities.

If you enter document information in the List B column, you must also enter document information in the List C column. If an employee presents acceptable List B and List C documents, do not ask the employees to present a List A document. If you enter document information in List B, you should not enter document information or N/A in List A. If you complete Section 2 using a computer, a selection in List B will fill all the fields in the List A column with N/A.

Document Title: If the employee presented a document from List B, enter the title of the List B document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority.

Full name of List B Document	Abbreviations
Driver's license issued by a State or outlying possession of the United States	Driver's license issued by state/territory
ID card issued by a State or outlying possession of the United States	ID card issued by state/territory
ID card issued by federal, state, or local government agencies or entities (Note: This selection does not include the driver's license or ID card issued by a State or outlying possession of the United States as described in B1 of the List of Acceptable Documents.)	Government ID
School ID card with photograph	School ID
Voter's registration card	Voter registration card
U.S. Military card	U.S. Military card
U.S. Military draft record	U.S. Military draft record
Military dependent's ID card	Military dependent's ID card
U.S. Coast Guard Merchant Mariner Card	USCG Merchant Mariner card
Native American tribal document	Native American tribal document
Driver's license issued by a Canadian government authority	Canadian driver's license
School record (for persons under age 18 who are unable to present a document listed above)	School record (under age 18)
Report card (for persons under age 18 who are unable to present a document listed above)	Report card (under age 18)
Clinic record (for persons under age 18 who are unable to present a document listed above)	Clinic record (under age 18)
Doctor record (for persons under age 18 who are unable to present a document listed above)	Doctor record (under age 18)
Hospital record (for persons under age 18 who are unable to present a document listed above)	Hospital record (under age 18)
Day-care record (for persons under age 18 who are unable to present a document listed above)	Day-care record (under age 18)
Nursery school record (for persons under age 18 who are unable to present a document listed above)	Nursery school record (under age 18)

Full name of List B Document	Abbreviations
Individual under age 18 endorsement by parent or guardian	Individual under Age 18
Special placement endorsement for persons with disabilities	Special Placement
Receipt for the application to replace a lost, stolen or damaged Driver's License issued by a State or outlying possession of the United States	Receipt: Replacement driver's license
Receipt for the application to replace a lost, stolen or damaged ID card issued by a State or outlying possession of the United States	Receipt: Replacement ID card
Receipt for the application to replace a lost, stolen or damaged ID card issued by federal, state, or local government agencies or entities	Receipt: Replacement Gov't ID
Receipt for the application to replace a lost, stolen or damaged School ID card with photograph	Receipt: Replacement School ID
Receipt for the application to replace a lost, stolen or damaged Voter's registration card	Receipt: Replacement Voter reg. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military card	Receipt: Replacement U.S. Military card
Receipt for the application to replace a lost, stolen or damaged Military dependent's ID card	Receipt: Replacement U.S. Military dep. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military draft record	Receipt: Replacement Military draft record
Receipt for the application to replace a lost, stolen or damaged U.S. Coast Guard Merchant Mariner Card	Receipt: Replacement Merchant Mariner card
Receipt for the application to replace a lost, stolen or damaged Driver's license issued by a Canadian government authority	Receipt: Replacement Canadian DL
Receipt for the application to replace a lost, stolen or damaged Native American tribal document	Receipt: Replacement Native American tribal doc
Receipt for the application to replace a lost, stolen or damaged School record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement School record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Report card (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Report card (under age 18)
Receipt for the application to replace a lost, stolen or damaged Clinic record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Clinic record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Doctor record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Doctor record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Hospital record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Hospital record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Day-care record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Day-care record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Nursery school record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Nursery school record (under age 18)

Issuing Authority: Enter the issuing authority of the List B document or receipt. The issuing authority is the entity that issued the document. If the employee presented a document that is issued by a state agency, include the state as part of the issuing authority.

Document Number: Enter the document number, if any, of the List B document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (*if any*) (*mm/dd/yyyy*): Enter the expiration date, if any, of the List B document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

List C - Employment Authorization: If the employee presented an acceptable document from List C, or an acceptable receipt for the application to replace a lost, stolen, or destroyed List C document, enter the document information in this column. If you enter document information in the List C column, you must also enter document information in the List B column. If an employee presents acceptable List B and List C documents, do not ask the employee to present a list A document. If you enter document information in List C, you should not enter document information or N/A in List A. If you complete Section 2 using a computer, a selection in List C will fill all the fields in the List A column with N/A.

Document Title: If the employee presented a document from List C, enter the title of the List C document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority. If you are completing the form on a computer, and you select an Employment authorization document issued by DHS, the field will populate with List C #7 and provide a space for you to enter a description of the documentation the employee presented. Refer to the M-274 for guidance on entering List C #7 documentation.

Full name of List C Document	Abbreviations
Social Security Account Number card without restrictions	(Unrestricted) Social Security Card
Certification of Birth Abroad (Form FS-545)	Form FS-545
Certification of Report of Birth (Form DS-1350)	Form DS-1350
Consular Report of Birth Abroad (Form FS-240)	Form FS-240
Original or certified copy of a U.S. birth certificate bearing an official seal	Birth Certificate
Native American tribal document	Native American tribal document
U.S. Citizen ID Card (Form I-197)	Form I-197
Identification Card for use of Resident Citizen in the United States (Form I-179)	Form I-179
Employment authorization document issued by DHS (List C #7) (Note: This selection does not include the Employment Authorization Document (Form I-766) from List A.)	Employment Auth. document (DHS) List C #7
Receipt for the application to replace a lost, stolen or damaged Social Security Account Number Card without restrictions	Receipt: Replacement Unrestricted SS Card
Receipt for the application to replace a lost, stolen or damaged Original or certified copy of a U.S. birth certificate bearing an official seal	Receipt: Replacement Birth Certificate
Receipt for the application to replace a lost, stolen or damaged Native American Tribal Document	Receipt: Replacement Native American Tribal Doc.
Receipt for the application to replace a lost, stolen or damaged Employment Authorization Document issued by DHS	Receipt: Replacement Employment Auth. Doc. (DHS)

Issuing Authority: Enter the issuing authority of the List C document or receipt. The issuing authority is the entity that issued the document.

Document Number: Enter the document number, if any, of the List C document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (*if any*) (*mm/dd/yyyy*): Enter the expiration date, if any, of the List C document. The document is not acceptable if it has already expired, unless USCIS has extended the expiration date on the document. For instance, if a conditional resident presents a Form I-797 extending his or her conditional resident status with the employee's expired Form I-551, enter the future expiration date as indicated on the Form I-797. If the document has no expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

Additional Information: Use this space to notate any additional information required for Form I-9 such as:

- Employment authorization extensions for Temporary Protected Status beneficiaries, F-1 OPT STEM students, CAP-GAP, H-1B and H-2A employees continuing employment with the same employer or changing employers, and other nonimmigrant categories that may receive extensions of stay
- Additional document(s) that certain nonimmigrant employees may present
- Discrepancies that E-Verify employers must notate when participating in the IMAGE program
- Employee termination dates and form retention dates
- E-Verify case number, which may also be entered in the margin or attached as a separate sheet per E-Verify requirements and your chosen business process
- Any other comments or notations necessary for the employer's business process

You may leave this field blank if the employee's circumstances do not require additional notations.

Entering Information in the Employer Certification

Employee's First Day of Employment: Enter the employee's first day of employment as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy).

Signature of Employer or Authorized Representative: Review the form for accuracy and completeness. The person who physically examines the employee's original document(s) and completes Section 2 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing Section 2, you attest under penalty of perjury (28 U.S.C. § 1746) that you have physically examined the documents presented by the employee, the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 2 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who signs Section 2 must enter the date he or she signed Section 2 in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print the form to write the date in this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Title of Employer or Authorized Representative: Enter the title, position or role of the person who physically examines the employee's original document(s), completes and signs Section 2.

Last Name of the Employer or Authorized Representative: Enter the full legal last name of the person who physically examines the employee's original documents, completes and signs Section 2. Last name refers to family name or surname. If the person has two last names or a hyphenated last name, include both names in this field.

First Name of the Employer or Authorized Representative: Enter the full legal first name of the person who physically examines the employee's original documents, completes, and signs Section 2. First name refers to the given name.

Employer's Business or Organization Name: Enter the name of the employer's business or organization in this field.

Employer's Business or Organization Address (*Street Name and Number*): Enter an actual, physical address of the employer. If your company has multiple locations, use the most appropriate address that identifies the location of the employer. Do not provide a P.O. Box address.

City or Town: Enter the city or town for the employer's business or organization address. If the location is not a city or town, you may enter the name of the village, county, township, reservation, etc, that applies.

State: Enter the two-character abbreviation of the state for the employer's business or organization address.

ZIP Code: Enter the 5-digit ZIP code for the employer's business or organization address.

Completing Section 3: Reverification and Rehires

Section 3 applies to both reverification and rehires. When completing this section, you must also complete the Last Name, First Name and Middle Initial fields in the Employee Info from Section 1 area at the top of Section 2, leaving the Citizenship/ Immigration Status field blank. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the new name in Block A.

Reverification

Reverification in Section 3 must be completed prior to the earlier of:

- The expiration date, if any, of the employment authorization stated in Section 1, or
- The expiration date, if any, of the List A or List C employment authorization document recorded in Section 2 (with some exceptions listed below).

Some employees may have entered "N/A" in the expiration date field in Section 1 if they are aliens whose employment authorization does not expire, e.g. asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau. Reverification does not apply for such employees unless they choose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

You should not reverify U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551). Reverification does not apply to List B documents.

For reverification, an employee must present an unexpired document(s) (or a receipt) from either List A or List C showing he or she is still authorized to work. You CANNOT require the employee to present a particular document from List A or List C. The employee is also not required to show the same type of document that he or she presented previously. See specific instructions on how to complete Section 3 below.

Rehires

If you rehire an employee within three years from the date that the Form I-9 was previously executed, you may either rely on the employee's previously executed Form I-9 or complete a new Form I-9.

If you choose to rely on a previously completed Form I-9, follow these guidelines.

- If the employee remains employment authorized as indicated on the previously executed Form I-9, the employee does not need to provide any additional documentation. Provide in Section 3 the employee's rehire date, any name changes if applicable, and sign and date the form.
- If the previously executed Form I-9 indicates that the employee's employment authorization from Section 1 or employment authorization documentation from Section 2 that is subject to reverification has expired, then reverification of employment authorization is required in Section 3 in addition to providing the rehire date. If the previously executed Form I-9 is not the current version of the form, you must complete Section 3 on the current version of the form.
- If you already used Section 3 of the employee's previously executed Form I-9, but are rehiring the employee within three years of the original execution of Form I-9, you may complete Section 3 on a new Form I-9 and attach it to the previously executed form.

Employees rehired after three years of original execution of the Form I-9 must complete a new Form I-9.

Complete each block in Section 3 as follows:

Block A - New Name: If an employee who is being reverified or rehired has also changed his or her name since originally completing Section 1 of this form, complete this block with the employee's new name. Enter only the part of the name that has changed, for example: if the employee changed only his or her last name, enter the last name in the Last Name field in this Block, then enter N/A in the First Name and Middle Initial fields. If the employee has not changed his or her name, enter N/A in each field of Block A.

Block B - Date of Rehire: Complete this block if you are rehiring an employee within three years of the date Form I-9 was originally executed. Enter the date of rehire in this field. Enter N/A in this field if the employee is not being rehired.

Block C - Complete this block if you are reverifying expiring or expired employment authorization or employment authorization documentation of a current or rehired employee. Enter the information from the List A or List C document(s) (or receipt) that the employee presented to reverify his or her employment authorization. All documents must be unexpired.

Document Title: Enter the title of the List A or C document (or receipt) the employee has presented to show continuing employment authorization in this field.

Document Number: Enter the document number, if any, of the document you entered in the Document Title field exactly as it appears on the document. Enter N/A if the document does not have a number.

Expiration Date (*if any*) (*mm/dd/yyyy*): Enter the expiration date, if any, of the document you entered in the Document Title field as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). If the document does not contain an expiration date, enter N/A in this field.

Signature of Employer or Authorized Representative: The person who completes Section 3 must sign in this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to sign your name in this field. By signing Section 3, you attest under penalty of perjury (28 U.S.C. §1746) that you have examined the documents presented by the employee, that the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 3 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who completes Section 3 must enter the date Section 3 was completed and signed in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to enter the date in this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Name of Employer or Authorized Representative: The person who completed, signed and dated Section 3 must enter his or her name in this field.

What is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the "DHS Privacy Notice" below.

USCIS Forms and Information

For additional guidance about Form I-9, employers and employees should refer to the *Handbook for Employers: Guidance for Completing Form I-9 (M-274)* or USCIS' Form I-9 website at https://www.uscis.gov/i-9-central.

You can also obtain information about Form I-9 by e-mailing USCIS at I-9Central@dhs.gov, or by calling 1-888-464-4218 or 1-877-875-6028 (TTY).

You may download and obtain the English and Spanish versions of Form I-9, the *Handbook for Employers*, or the instructions to Form I-9 from the USCIS website at https://www.uscis.gov/i-9. To complete Form I-9 on a computer, you will need the latest version of Adobe Reader, which can be downloaded for free at http://get.adobe.com/reader/. You may order paper forms at https://www.uscis.gov/forms/forms-by-mail or by contacting the USCIS Contact Center at 1-800-375-5283 or 1-800-767-1833 (TTY).

Information about E-Verify, a web-based system that allows employers to confirm the eligibility of their employees to work in the United States, can be obtained at https://www.e-verify.gov or by contacting E-Verify at https://www.e-verify.gov/contact-us.

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling 1-888-897-7781 or 1-877-875-6028 (TTY).

Photocopying Blank and Completed Forms I-9 and Retaining Completed Forms I-9

Employers may photocopy or print blank Forms I-9 for future use. All pages of the instructions and Lists of Acceptable Documents must be available, either in print or electronically, to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer and for a specified period after employment has ended. Employers are required to retain the pages of the form on which the employee and employer entered data. If copies of documentation presented by the employee are made, those copies must also be retained. Once the individual's employment ends, the employer must retain this form and attachments for either 3 years after the date of hire (i.e., first day of work for pay) or 1 year after the date employment ended, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is 3 years after the date of hire (i.e., first day of work for pay).

Forms I-9 obtained from the USCIS website that are not printed and signed manually (by hand) are not considered complete. In the event of an inspection, retaining incomplete forms may make you subject to fines and penalties associated with incomplete forms.

Employers should ensure that information employees provide on Form I-9 is used only for Form I-9 purposes. Completed Forms I-9 and all accompanying documents should be stored in a safe, secure location.

Form I-9 may be generated, signed, and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

DHS Privacy Notice

AUTHORITIES: The information requested on this form, and the associated documents, are collected under the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

PURPOSE: The primary purpose for providing the requested information on this form is for employers to verify your identity and employment authorization. Consistent with the requirements of the Immigration Reform and Control Act of 1986, employers use the Form I-9 to document the verification of the identity and employment authorization for new employees to prevent the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States. This form is completed by both the employer and employee, and is ultimately retained by the employer.

DISCLOSURE: The information you provide is voluntary. However, failure to provide the requested information, including your Social Security number (if applicable), and any requested evidence, may result in termination of employment. Failure of the employer to ensure proper completion of this form may result in the imposition of civil or criminal penalties against the employer. In addition, knowingly employing individuals who are not authorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an individual to work in the United States. The employer must retain this completed form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section. DHS may also share this information, as appropriate, for law enforcement purposes or in the interest of national security.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, when completing the form manually, and 26 minutes per response when using a computer to aid in completion of the form, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

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

2022

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 widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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 and enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

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

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ ▶ _____

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

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

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.

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

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

CAUTION *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 2022 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.

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 2022 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:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 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 possessions 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 Widow(er)

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	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

DEPARTMENT OF REVENUE

2022 W-4MN, Minnesota Withholding Allowance/Exemption Certificate

Employees

Complete Form W-4MN so that your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year and when your personal or financial situation changes.

First Name and Initial | Last Name | Social Security Number

Permanent Address | Marital Status *(Check one)*:
- ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
- ☐ Married
- ☐ Married, but withhold at higher Single rate

City | State | ZIP Code

Complete Section 1 OR Section 2, then sign the bottom and give the completed form to your employer.

☐ **Section 1 — Determining Minnesota Allowances**

A Enter "1" if no one else can claim you as a dependent ..... A _____

B Enter "1" if any of the following apply: ..... B _____
- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are $1500 or less

C Enter "1" if you are married. Or choose to enter "0" if you are married and have either a working spouse or more than one job. *(Entering "0" may help you avoid having too little tax withheld.)* . C _____

D Enter the number of dependents (other than your spouse or yourself) you will claim on your tax return. ..... D _____

E Enter "1" if you will use the filing status Head of Household *(see instructions)*..... E _____

F Add steps A through E. If you plan to itemize deductions on your 2022 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet..... F _____

1 **Minnesota Allowances.** Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet ..... 1 _____

2 Additional Minnesota withholding you want deducted for each pay period *(see instructions)* ..... 2 $_____

☐ **Section 2 — Exemption From Minnesota Withholding**

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate why you believe you are exempt:

☐ **A** I meet the requirements and claim exempt from both federal and Minnesota income tax withholding

☐ **B** Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:
- I had no Minnesota income tax liability last year
- I received a refund of all Minnesota income tax withheld
- I expect to have no Minnesota income tax liability this year

☐ **C** All of these apply:
- My spouse is a military service member assigned to a military location in Minnesota
- My domicile (legal residence) is in another state
- I am in Minnesota solely to be with my spouse. My state of domicile is _____

☐ **D** I am an American Indian that resides and works on a reservation.
Enter the reservation name: _____
Enter your Certificate of Degree of Indian Blood (CDIB)/Enrollment number: _____

☐ **E** I am a member of the Minnesota National Guard or an active duty U.S. military member and claim exempt from Minnesota withholding on my military pay

☐ **F** I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay

I certify that all information provided in Section 1 OR Section 2 is correct. I understand there is a $500 penalty for filing a false Form W-4MN.

Employee's Signature | Date | Daytime Phone Number

Employees: Give the completed form to your employer.

Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. (Incomplete forms are considered invalid.) We may assess a $50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer | Minnesota Tax ID Number | Federal Employer ID Number (FEIN)

Address | City | State | ZIP Code

DEPARTMENT OF REVENUE

Form W-4MN Instructions for Employees and Pension/Annuity Recipients

Complete this form for your employer to calculate the amount of Minnesota income tax to be withheld from your pay.

When should I complete Form W-4MN?

Complete Form W-4MN if any of these apply:

- You begin employment
- You change your filing status
- You reasonably expect to change your filing status in the next calendar year
- Your personal or financial situation changes
- You claim exempt from Minnesota withholding (see Section 2 instructions for qualifications)
- You receive distributions from an annuity or pension

If you have not had sufficient Minnesota income tax withheld from your wages, we may assess penalty and interest when you file your state income tax return.

Note: Your employer may be required to submit a copy of your Form W-4MN to the Minnesota Department of Revenue. You may be subject to a $500 penalty if you provide a false Form W-4MN.

You must enter your Social Security Number for this Form W-4MN to be valid.

What if I have completed federal Form W-4?

If you completed a 2022 Form W-4, you must complete Form W-4MN to determine your Minnesota withholding allowances.

What if I am exempt from Minnesota withholding?

If you claim exempt from Minnesota withholding, complete only Section 2 of Form W-4MN and sign and date the form to validate it. If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year in which you claim an exemption from Minnesota withholding.

You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

What if I am a nonresident alien for U.S. income taxes?

If you are a nonresident alien, you are not allowed to claim exempt from withholding. You will check the single box for marital status regardless of your actual marital status and may enter one personal allowance on Step A. Enter zero on steps B, C, and E.

If you are resident of Canada, Mexico, South Korea, or India, and are allowed to claim dependents, you may enter the number of dependents on Step D.

Section 1 — Minnesota Allowances Worksheet

Complete Section 1 to find your allowances for Minnesota withholding tax. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

If you expect to owe more income tax for the year than will be withheld, you can claim fewer allowances or request additional Minnesota withholding from your wages. Enter the amount of additional Minnesota income tax you want withheld on line 2 of Section 1.

Nonwage Income

Consider making estimated payments if you have a large amount of "nonwage income." Nonwage income (other than tax-exempt income) includes interest, dividends, net rental income, unemployment compensation, gambling winnings, prizes and awards, hobby income, capital gains, royalties, and partnership income.

Two Earners or Multiple Jobs

If your spouse works or you have more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4MN. Usually, your withholding will be more accurate when all allowances are claimed on the Form W-4MN for the highest paying job and zero allowances are claimed on the others.

Head of Household Filing Status

You may claim Head of Household as your filing status if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself, your dependents, and other qualifying individuals. Enter "1" on Step E if you may claim Head of Household as your filing status on your tax return.

What if I itemize deductions on my Minnesota return or have other nonwage income?

Use the Itemized Deductions and Additional Income Worksheet to find your Minnesota withholding allowances. Complete Section 1 on page 1, then follow the steps in the worksheet on the next page to find additional allowances.

Continued

Itemized Deductions and Additional Income Worksheet

1 Enter an estimate of your 2022 Minnesota itemized deductions. For 2022, you may have to reduce your itemized deductions if your income is over $206,050 ($103,025 for Married Filing Separately). ..... _____

2 Enter one of the following based on your filing status: ..... _____
   a. $25,800 if Married Filing Jointly
   b. $19,400 if Head of Household
   c. $12,900 if Single or Married Filing Separately

3 Subtract step 2 from step 1. If zero or less, enter 0 ..... _____

4 Enter an estimate of your 2022 additional standard deduction (from page 11 of the Form M1 instructions) ..... _____

5 Add steps 3 and 4 ..... _____

6 Enter an estimate of your 2022 taxable nonwage income ..... _____

7 Subtract step 6 from step 5. If zero, enter 0. If less than zero, enter the amount in parentheses. ..... _____

8 Divide the amount on step 7 by $4,450. If a negative amount, enter in parentheses. Do not include fractions ..... _____

9 Enter the number on step F of Section 1 on page 1 ..... _____

10 Add step 8 and 9 and enter the total here. If zero or less, enter 0. Enter this amount on line 1 of page 1. ..... _____

Section 2 — Minnesota Exemption

Your employer will not withhold Minnesota taxes from your pay if you are exempt from Minnesota withholding. You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

Box A

Check box A of Section 2 to claim exempt if all of these apply:

- You meet the requirements to be exempt from federal withholding
- You had no Minnesota income tax liability in the prior year and received a full refund of Minnesota tax withheld
- You expect to have no Minnesota income tax liability for the current year

Box B

Check box B of Section 2 if you are not claiming exempt from federal withholding, but meet the second and third requirements for box A.

Box C

Check box C in Section 2 to claim exempt if all of these apply:

- You are the spouse of a military member assigned to duty in Minnesota
- You and your spouse are domiciled in another state
- You are in Minnesota solely to be with your active duty military spouse member

Boxes D-F

If you receive income from the following sources, it is exempt from Minnesota withholding. Your employer will not withhold Minnesota tax from that income when you check the appropriate box in Section 2.

- **Box D:** You receive wages as a member of an American Indian tribe living and working on the reservation of which you are an enrolled member. Enter the name of your reservation and your Certificate of Degree of Indian or Alaskan Blood (CDIB) number.
- **Box E:** You receive wages for Minnesota National Guard (MNG) pay or for active duty U.S. military pay. MNG and active duty U.S. military members can claim exempt from Minnesota withholding on these wages, even if they are taxable federally. For more information, see Income Tax Fact Sheet 5, Military Personnel.
- **Box F:** You receive a military pension or other military retirement pay calculated under U.S. Code title 10, sections 1401 through 1414, 1447 through 1455, and 12733. You may claim exempt from Minnesota withholding on this income even if it is taxable federally.

Note: You may not want to claim exempt if you (or your spouse if filing a joint return) expect to have other forms of income subject to Minnesota tax and you want to avoid owing tax at the end of the year.

If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year.

Nonresident Alien

If you are a nonresident alien for federal tax purposes, do not complete Section 2.

Line 2 — Additional Minnesota Withholding

If you would like an additional amount of tax to be deducted per payment period, enter the amount on line 2. Do not enter a percentage of the payment you want to be deducted.

Use of Information

All information on Form W-4MN is private by state law. It cannot be given to others without your consent, except to the Internal Revenue Service, to other states that guarantee the same privacy, or by court order. Your name, address, and Social Security Number are required for identification. Information about your allowances is required to determine your correct tax. We ask for your phone number so we can call if we have a question.

Questions?

- Website: www.revenue.state.mn.us
- Email: withholding.tax@state.mn.us
- Phone: 651-282-9999 or 1-800-657-3594 (toll-free)

Employer instructions are on the next page.

Form W-4MN Employer Instructions

Form W-4MN Requirement
Federal Form W-4 will not determine withholding allowances used to determine the amount of Minnesota withholding. Employees completing a 2022 Form W-4 will need to complete 2022 Form W-4MN to determine the appropriate amount of Minnesota withholding.

Lock-In Letters
Internal Revenue Service (IRS) Letter 2800C tells you when the IRS believes your employee may have filed an incorrect federal Form W-4. If you receive this letter, you must provide the Minnesota Department of Revenue with a copy of the employee's Form W-4MN. We will verify the number of allowances that the employee may claim for Minnesota purposes. Continue using the Form W-4MN you were using at the time you received Letter 2800C from the IRS, until we notify you to change the amount of allowances on the employee's Form W-4MN. If the employee has not completed a Form W-4MN, have them complete the form and use the allowances calculated on that form until notified by the department.

Use the amount on line 1 of page 1 for calculating the withholding tax for your employees.

When does an employee complete Form W-4MN?
Employees complete Form W-4MN when they begin employment or when their personal or financial situation changes.

How should I determine Minnesota withholding for an employee that does not complete Form W-4MN?
If an employee does not complete Form W-4MN and they have a federal Form W-4 (from 2019 or prior years) on file, use the allowances on their federal Form W-4. Otherwise, withhold Minnesota tax as if the employee is single with zero withholding allowances.

What if my employee claims to be exempt from Minnesota withholding?
If your employee claims exempt from Minnesota withholding, they must complete Section 2 of Form W-4MN. They must provide you with a new Form W-4MN by February 15 of each year. If you are paying an employee for wages that are exempt from withholding, such as Medicaid Waiver Payments or wages to H-2A visa workers, do not send us Form W-4MN.

When do I need to submit copies of a Form W-4MN to the department?
You must send copies of Form W-4MN to us if any of these apply:

- The employee claims more than 10 Minnesota withholding allowances
- The employee checked box A or B under Section 2, and you reasonably expect the employee's wages to exceed $200 per week
- You believe the employee is not entitled to the number of allowances claimed

You do not need to submit Form W-4MN to us if the employee is asking to have additional Minnesota withholding deducted from their pay.

We may assess a $50 penalty for each Form W-4MN you do not file with us when required.

Mail Forms W-4MN to:
Minnesota Department of Revenue
Mail Station 6501
600 N. Robert St.
St. Paul, MN 55146-6501

What if my employee is a resident of a state that has a reciprocity agreement with Minnesota?
If your employee is a resident of North Dakota or Michigan and they do not want you to withhold Minnesota tax from their wages, they must complete Form MWR, *Reciprocity Exemption/Affidavit of Residency*. They must complete a Form MWR by February 28 of each year, or within 30 days after they begin working or change their permanent residence. See Withholding Fact Sheet 20, *Reciprocity - Employee Withholding*, for more information.

What is an invalid Form W-4MN?
A Form W-4MN is considered invalid if any of these apply:

- There is any unauthorized change or addition to the form, including any change to the language certifying the form is correct
- The employee indicates in any way the form is false by the date they provide you with the form
- The form is incomplete or lacks the necessary signatures
- Both Section 1 and Section 2 were completed
- The employer information is incomplete

What if I receive an invalid form?
Do not use the invalid form to calculate Minnesota income tax withholding. Have the employee complete and submit a new Form W-4MN. If the employee does not give you a valid form, and you have an earlier Form W-4MN from them, use the earlier form to calculate their withholding.

If a valid Form W-4MN is not completed by the employee, withhold taxes as if the employee is single and claiming zero withholding allowances.

What if my employee is a nonresident alien of the United States?
If the wages to this employee are subject to income tax withholding, you will use Table 1 and the procedure under **Withholding Adjustment for Nonresident Alien Employees** in IRS Publication 15-T to determine the correct Minnesota withholding tax. Do not use this procedure for nonresident alien students from India and business apprentices from India. See IRS Notice 1392 for special instructions and withholding exceptions.

Diocese of Winona-Rochester

TERMINATING EMPLOYEE CHECKLIST*

EMPLOYEE'S NAME: _____

HIRE/TERM:

- ➢ Upload completed form to Diocese of Winona-Rochester within five days of termination
  - ☐ Notice of Employee Termination of Employment Form 001
- ➢ If there is a separation agreement, upload separation agreement to Dropbox within five days of termination in order for COBRA to be completed correctly
  - ☐ Separation agreement

IF THE EMPLOYEE HAS HAD ANY OR ALL OF THE FOLLOWING:

- Health/dental insurance
- Basic life insurance
- Flexible benefits (dependent care does not qualify for COBRA)
- Supplemental life insurance

- ➢ Give to Employee
  - ☐ Information for Terminating Employees Alerus COBRA
    - Alerus handles COBRA on behalf of the diocese

PENSION

- ➢ Give to Employee
  - ☐ 403(b) Pension Plan Information for Terminating/Retiring Participants

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***This checklist is for parish/school/cemetery/institution only and does not need to be sent to the Diocese of Winona-Rochester.**

If you receive any benefits including health, dental, life, medical flexible benefits, or supplemental life insurance from the Diocese of Winona-Rochester, you will receive information from:

ALERUS

COBRA

I'VE LOST MY BENEFIT COVERAGE. WHAT ARE MY OPTIONS FOR COVERAGE NOW?

This loss of coverage is a qualifying event that opens a special enrollment window with carriers. At this time

- A spouse/parent can add you to their policy (if applicable)
- You can look for coverage on the open market: https://www.healthcare.gov
- You can enroll in COBRA

*Please note: different options have different costs, and enrolling under one option may disqualify you from enrolling in the other option(s) for this qualifying event. Be sure to review your options carefully and select the option that works best for your situation.

WHAT IS COBRA?

COBRA is a collection of federal laws and regulations that allow you to continue coverage of certain benefits for yourself (and any covered dependents, if applicable) under your company's plan for a designated period of time after a qualifying loss of coverage. The full notice of your rights and responsibilities, eligible benefits, associated costs, and timeline to enroll will be mailed to you from our COBRA administrator (listed below). If you have any questions, you can reach Alerus toll-free at 800.761.1934 or locally at 952.253.1261, or by email at cobra@alerus.com.

Alerus Retirement and Benefits
7650 Edinborough Way, Suite 645
Edina, MN 55435

WHAT TRIGGERS COBRA?

COBRA is offered when a covered employee experiences an involuntary loss of coverage. This can happen through such events as a resignation, retirement, termination, layoff, or reduction in hours. Covered dependents may also be offered COBRA if they lose coverage under a covered employee through such events as divorce, ageing off a parent's plan, or death of the employee.

WHAT IF I WANT TO ENROLL UNDER COBRA?

You have 60 days from the latter of the last day of coverage or the date the letter was sent to make your elections. You will have 45 days from the date we receive your elections to bring your account current. **In order to reinstate coverage with the insurance carriers, we (Alerus) must receive your elections as well as your first month's premium payment.** Once we receive both pieces, we send reinstatements to the carriers. It typically takes carriers 5-7 business days to process these reinstatement requests and for coverage to be showing active again. Coverage will be reinstated back to your first day of COBRA such that there is no lapse in coverage.

WHAT IF I DON'T WANT TO ENROLL UNDER COBRA?

COBRA is opt-in only — if you don't want it, you don't need to do anything with your notice and you will not be enrolled or charged anything. Per federal regulations, Alerus is required to keep you informed of any changes that may occur (such as a plan renewal) during the election period (60 days) even if you don't want COBRA. If the election period closes and you have not elected, you will not receive any further letters.

Diocese of Winona-Rochester

403(b) Lay Employees Retirement Plan

Information for Terminating/Retiring Participants

What types of contributions are in my 403(b) account?

There are two sources of contributions that have been made to your diocesan 403(b) lay retirement plan:

1. ***Employee Contributions***: The contributions you personally made to the plan are 100% vested (owned by you).

2. ***Employer Contributions:*** The contributions made to your account by your employer are 20% vested (owned by you) per full year of covered employment. The vesting schedule of the Diocese of Winona-Rochester Plan is 20% per year, with full vesting after 5 years or upon reaching age 60, whichever occurs first.

What happens to my vested 403(b) account balance?

Terminated participants have the following options for their vested 403(b) account balance:

1. ***Distribution*** – You may request a distribution of funds from your vested account balance.
    a. ***Pre-Tax Contributions (Traditional):*** The distribution will be considered taxable income in the year of distribution and a 20% federal tax will be withheld from the distribution. Early withdrawal penalties of 10% may also apply if you are below 59 ½ years of age.
    b. ***After-Tax Contributions (Roth):*** The distribution will not be considered taxable income in the year of distribution if your account has been held for at least five years and you are at least age 59 ½. Early withdrawal penalties of 10% may also apply if you are below 59 ½ years of age.

2. ***Direct Rollover or Transfer*** – You may request a transfer of your vested balance to another qualified retirement plan or an individual IRA.

3. ***Maintain your account*** - Terminated participants with a vested balance of less than $5,000 will have their vested account balance automatically transferred to a Lincoln Small Account IRA if they do not initiate a distribution, direct rollover, or transfer. Terminated participants with a vested account balance of $5,000 or greater may choose to retain their vested balance in the plan for future distribution. Participants must begin to take a distribution from the plan at age 72, called Required Minimum Distribution (RMD).

Who do I contact and where can I obtain the necessary forms?

First determine which Lincoln retirement account(s) you have; you may have one account or two separate accounts depending on your individual situation. Although all accounts are through Lincoln, each type of account has different contact information and different forms to

complete for account distribution or transfer. Quarterly statements are provided to participants and you may also refer to those statements to determine which account(s) you have a balance in.

Please keep the following items in mind when contacting Lincoln regarding your account(s):

- Effective 3/1/2010, all employee and employer contributions to the 403(b) retirement plan have been invested in the **Lincoln Alliance Program®**
- Prior to 3/1/2010, all employee and employer contributions to the 403(b) retirement plan were invested in **Lincoln Multi-Fund® Annuity.** Participants with Multi-Fund® accounts were given the opportunity to complete contract exchange paperwork to transfer those assets to the Lincoln Alliance Program®.

Lincoln Contact Information

To obtain information on your account(s) and plan forms, please use the following:

Diocese of Winona-Rochester 403(b) Lay Retirement Plan Retirement Consultant:

Zaina Mujtaba

Email: zaina.mujtaba@lfg.com

Phone: 708-310-9756 Mobile

Lincoln Alliance Program® (Effective April 1, 2018)

CUSTOMER SERVICE
1-800-234-3500
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.LFG.com

Lincoln Multi-Fund® Annuity

CUSTOMER SERVICE
1-800-454-6265
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.LFG.com

MAILING ADDRESS
The Lincoln National Life Insurance Company
Attention - Annuities Operations
PO Box 2340
Fort Wayne, IN 46801-2340

DIOCESE OF WINONA-ROCHESTER

HEALTH INSURANCE PLANS

Participation and Form Directions

Administered by Medica and Delta Dental

Eligible participants are those employees who work at least 20 hours a week or at least one-half academic load during the school year. Employees hired on a temporary basis working 30 or more hours per week are eligible for health (medical and dental) insurance on the first of the month following 60 days of continuous employment (call HR/Benefits for further explanation). Health insurance starts on the first of the month coincident with or following the date of hire. **New employees have 30 days from their initial date of employment/eligibility to enroll. When the 30 days are over, employees can sign up at yearly renewal on January 1 or upon a qualifying event for a special enrollment.**

Please note, social security numbers are required on the enrollment forms for 1095-C purposes.

FORM REQUIRED TO ENROLL AN EMPLOYEE:

Health/Dental Enrollment/Change/Cancel/Waive form for Group Coverage Form A-1

PURPOSE: To initiate health and dental coverage by collecting required information.

a. If enrolling, employees should complete sections A, C, D (for family coverage), and G. Sections E and F needs to be completed if the employee or dependents being covered are
   1. Continuing health coverage with another company **And/OR**
   2. If the employee or dependent being covered is enrolled in Medicare.
b. Upon enrollment, the employee should register online with both Medica and Delta Dental, where they can access their summary plan descriptions and other information.

FORM REQUIRED TO WAIVE GROUP COVERAGE:

Health/Dental Enrollment/Change/Waive Form for Group Coverage Form A-2

PURPOSE: To prove the employee was offered the health/dental insurance and wishes to waive their right to this benefit. *This form is only used for new employees or during open enrollment.*

If an employee does not wish to participate in the health/dental plan, they MUST complete Section A and B, including their signature and date.

FORM REQUIRED TO BE GIVEN TO ALL BENEFIT-ELIGIBLE EMPLOYEES:

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

PURPOSE: The U.S. Government requires the diocese to give a copy of CHIP notice to EACH employee who works 20 or more hours per week – regardless of whether or not the employee is enrolled in the health care plan.

No action is required.

FORM REQUIRED FOR CHANGES TO EXISTING EMPLOYEES:

Address Change – no form needs to be completed – location to notify diocese by email.

Canceling Coverage – A-1

PURPOSE: To cancel coverage for medical and dental insurance for all health insurance coverage, all dependent coverage, or specific dependent coverage.

a. Employee should complete sections A, B (stating why canceling coverage) D, and G.
b. Notify the employee once they cancel coverage, they will not be able to enroll in health insurance until open enrollment unless they have a qualifying event. See below for special enrollment period.

Name Change - Health/Dental Enrollment/Change/Waive Form A-1

PURPOSE: To change name with no coverage changed. This form must be completed within 30 days of change. The employee's signature is required.

a. Employee should complete sections A and G.
b. Please write former name on the top of the form.

Special Enrollment Period Health/Dental Enrollment/Change/Waive Form A-1

PURPOSE: A Special Enrollment Period, which requires a qualifying event is a period during which the employee and/or employee's family has a right to enroll or make changes to existing health coverage. Special Enrollment Period qualifying or triggering events are listed below. Note: Form A-1 is used for special enrollment.

- Loss of minimum essential coverage (does not include loss due to failure to pay premiums or rescission)
    - Loss of eligibility for employer-sponsored coverage
    - Termination of employment or reduction of hours
    - Legal separation or divorce
    - Loss of dependent child status
    - Death of employee
    - Move outside HMO service area
    - Exceeding the plan's lifetime maximum
    - Employer bankruptcy
    - Employee becomes entitled to Medicare
    - Loss of minimum essential coverage
- Gaining or becoming a dependent due to marriage
- Gaining a dependent due to birth, adoption or placement for adoption,
- An individual gains or loses eligibility for Medicaid or MinnesotaCare (notice must be received within 60 days of the event).

a. Notice period is 30 days except for Medicaid/SCHIP events.
b. Employee should always complete section C, noting the "Special Enrollment." Depending on what changes the employee needs to make, sections C, D, E, and F may need completion. The employee always needs to sign section G. Documentation of the qualify event or special enrollment notice must be included with enrollment form and included in your employee file.

TERMINATING EMPLOYEES:

Notice of Employee Termination of Employment Form 001

PURPOSE: It is *very important* to complete and return this form promptly to comply with all COBRA regulations and MN Continuation laws. The Diocese of Winona-Rochester contracts with a third party administrator (Alerus) for COBRA administration on the health and life insurances. **Please complete the Notice of Employee Termination of Employment form** and return it to the Employee Benefits Coordinator in Winona **within five days of the employee's termination**. The COBRA third party administrator will contact the employee directly regarding their option to continue this health and dental coverage.

NOTE – Upload ALL FORMS to Dropbox for processing. Location to maintain original for their employee records.

GENERAL INFORMATION:

Health/Dental Group Numbers:

	Health	Dental
$2,500 Deductible	43849	00918
$5,000 Deductible	43850	00918

Renewal:
Annual renewal is January 1, with open enrollment occurring prior to the annual renewal. Employees may sign up or change deductible amounts only during open enrollment unless the employee has a qualifying event.

Single Health/Dental Coverage:
Single coverage is coverage for only the employee.

Family Health/Dental Coverage:
Family coverage is coverage for the employee and each member of the family.

- Employees may keep their adult children on the health/dental plan through age 26. A month before the adult child turns 26, the employee should notify the diocese, so COBRA may be offered to the adult child.
- Employees enrolling in family insurance will receive their health insurance identification cards from Medica; every member in the family will receive their own ID card. Delta Dental will provide cards with the employee's name only.

Insurance Address/Phone Information:

- Medica
  401 Carlson Parkway Minnetonka, MN 55305 877-347-0282

- Delta Dental of Minnesota
  PO Box 9304 Minneapolis, MN 55415 877-268-3384

Medica Health Summary

	$2500 DEDUCTIBLE IN-NETWORK BENEFIT	$5000 DEDUCTIBLE IN-NETWORK BENEFIT
Annual Deductible	$2,500 per person; $5,000 per family (Combined for in-network & out-of-network services)	$5,000 per person ; $10,000 per family (Combined for in-network & out-of-network services)
Out of Pocket Maximum	$5,000 per person; $10,000 per family (Combined for in-network & out-of-network services)	$5,000 per person; $10,000 per family (Combined for in-network & out-of-network services)
Preventive Care	100% coverage	100% coverage
Convenience Care	After deductible is met: 20% co-insurance	After deductible is met: 0% co-insurance
Office Visit and Urgent Care	After deductible is met: 20% co-insurance	After deductible is met: 0% co-insurance
Hospitalization (In and out patient)	After deductible is met: 20% co-insurance	After deductible is met: 0% co-insurance
Prescription Drugs	Generic : 25% Preferred: 25%	After deductible is met: Generic : 0% co-insurance Preferred: 0% co-insurance Non-Preferred: 0% co-insurance
Emergency Room	After deductible is met: 20% co-insurance	After deductible is met: 25% co-insurance

DELTA DENTAL

Delta Dental of Minnesota

Delta Dental PPO™ &
Delta Dental Premier®

Diocese of Winona – Rochester

Client #000917 & 000918

Plan Benefit Highlights as of January 1, 2022			
Network(s)	**Delta Dental PPO™** *New as of January 1, 2022*	**Delta Dental Premier®**	**Non-Participating***
Calendar Year Plan Maximum Per person	**$1,500**		
Lifetime Ortho Maximum *Per eligible covered Lay person's dependent child age 8 thru 18*	Lay participants only $1,000		
Deductible Per person / per family per calendar year *No deductible for diagnostic and preventive services or orthodontics*	$50 per person / $150 per family		
Eligible Dependents	Spouse and dependent children up to age 26		
Covered Services	**Dental Benefit Plan Coverage**		
Diagnostic & Preventive Services **Exams** – 2 per calendar year, as of January 1, 2022 **Cleanings** – 2 per calendar year, as of January 1, 2022 **X-rays:** • **Bitewings** - once per 12-months • **Full Mouth/Panoramic** – once per 36-month period **Fluoride treatments** – once per 12-month period for dependent children through age 18 **Sealants** – once per 2 years for permanent first and second molars for eligible dependent children through the age of 18 **Space Maintainers** – once per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth	100%	100%	100%
Basic Services Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) teeth	80%	80%	80%
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	80%	80%	80%
Periodontics Surgical/Nonsurgical periodontics	80%	80%	80%
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	80%	80%	80%
Major Restorative Crowns and Crown repair Composite resin restorations (white fillings) on posterior (back) teeth	50%	50%	50%
Prosthetic Repairs and Adjustments Denture adjustments and repairs Bridge repairs	50%	50%	50%
Prosthetics Dentures (full and partial) Bridges	50%	50%	50%
Orthodontics Treatment for the prevention/ correction of malocclusion *Available for dependent children ages 8 through age 18*	50%	50%	50%

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary.

*Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

DELTA DENTAL

Make the Most of Your Benefits

Thank you for choosing Delta Dental of Minnesota as your partner in oral health. Dental insurance is designed to pay a portion of the costs associated with your dental care. Having dental insurance is essential to keeping your mouth healthy by providing access to preventative care, such as cleanings and X-rays, and helps cover extensive dental procedures such as crowns and fillings.

Online Tools for Members:

www.DeltaDentalMN.org

Save Money, Go In Network:
Search for a participating dentist or specialist, clinic or location. By seeking care from a Delta Dental network dentist, you will save the most money because the dentist is not allowed to bill you more than our allowable charge.

Dental Insurance 101:
Robust member tools including commonly defined insurance terms, videos and frequently asked questions.

Oral Health Resources:
Access dental and health information including a section dedicated to kids' oral health.

Cost Estimator:
Use our cost estimator to find out what a dental procedure will cost, or you can always request a pre-treatment estimate from your dentist.

Prefer to Speak to Someone?

Call our national customer service

Toll Free: 1-800-448-3815
Local: 651-406-5901
Monday-Friday: 7 a.m.-7p.m. central

Tools Available in the Secure Member Portal

Coverage Summary:
Review your dental plan information including eligibility, waiting periods, plan maximums and frequency limitations.

Claims Inquiry:

View claim status, procedure details, dates of service and applied deductibles.

View your explanation of benefits (EOB) online.

Check out our new feature to opt-out of the paper delivery of your EOB.

Print ID Cards:
Print a digital or replacement ID card.

Secure Member Portal Registration

1. On DeltaDentalMN.org, go to the member page and click "Access My Secure Portal"
2. Select the Employer Plan option click "Log In Here" and follow the steps to register.
3. Remember your username and password because you will need them each time you log in.

Learn more about how your oral heath connects to your overall health at:
DeltaDentalMN.org

DELTA DENTAL

Delta Dental of Minnesota

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Diocese of Winona-Rochester		4. Employer Identification Number (EIN) 41-0694754
5. Employer address 55 W Sanborn St PO Box 588		6. Employer phone number 507-454-4643
7. City Winona	8. State MN	9. ZIP code 55987
10. Who can we contact about employee health coverage at this job? Julia Sandsness, Emp Benefits 507-858-1268 or David Fricke HR Director 507-858-1250		
11. Phone number (if different from above)	12. Email address benefits@dowr.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Employees employed by participating parishes, schools, and other diocesan institutions who work a minimum of 20 hours per week or at least one-half academic course load during the calendar year.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Spouse and/or children to the age of 26. Exceptions for disabled, Qualified Medical Child Support Order, etc.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

IOWA – Medicaid and CHIP (Hawki)	MINNESOTA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739
WISCONSIN – Medicaid and CHIP	**OTHER STATES**
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002	See publication online that lists other states under "Model Notice": https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/2010-2409

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Frequently Asked Questions
Health Insurance Enrollment/Change/Waive Form and Cancel Form

1) To enroll in medical/dental coverage:
    a. On Form A-1, complete all sections except Section B.
2) To change medical/dental coverage:
    a. On Form A-1, complete all sections except Section B.
3) To cancel the medical/dental insurance:
    a. On Form A-1, complete sections A, B (listing reason), D, and G; note effective date in section A. Note: You can cancel at any time. If you cancel 7/1/XX, your last day of coverage is 6/30/XX.
4) To waive coverage:
    a. This form is only used for new hires or during open enrollment.
    b. On Form A-1, complete sections A and B; you may also use Form A-2.
    c. You will not be able to enroll in coverage again until open enrollment unless you have a qualifying event. See 6b.
5) For new employees: Do I need to complete the form A-1 if I do not want coverage or I am under my spouse's health insurance and do not want coverage with the Diocese of Winona-Rochester?
    a. Yes, on Form A-1 complete section A and B, which requires a date and signature.
6) Can I sign up anytime for health insurance?
    a. You may sign up during open enrollment; the open enrollment process begins prior to January with our plan year January through December.
        i. If you are continuing the identical coverage you have with the DOW-R, you do not have to complete the Form A-1 (you do nothing).
        ii. If you are changing or enrolling in new coverage, complete Form A-1.
    b. Special Enrollment: You may enroll or change plans if you have a qualifying event such as a change in status - marriage, birth, job change, loss of coverage, COBRA ending, etc.
        i. There are enrollment time limits depending on the special enrollment.
        ii. To enroll for a special enrollment, complete Form A-1 all sections except for B.
            1. In section A, check special enrollment, briefly describe event, and enter date.
            2. Remit your special event documentation with the completed form.
7) Can I sign up for dental only? Can I sign up for medical only?
    a. No, the medical and dental coverage are combined and cannot be elected individually.
8) When do the deductibles start and end?
    a. Deductible and out-of-pocket maximums for all plans reset effectively on the first day of the year.
    b. If you are changing deductibles for a qualifying event
        i. You will receive credit for your deductible you have met to date.
        ii. Your out-of-pocket expenses accumulated will apply to your out-of-pocket limit.
        iii. Your prescription drug coinsurance and out-of-pocket maximums will carry forward.
9) I want to add dependents, what is the age limit?
    a. You can add any child under the age of 26 to the plan when you sign up for health/dental coverage. If you add for a newborn/adoptee, the form must be completed within 30 days of event.
    b. The month prior to your child turning 26, please complete a Form A-1 cancellation of their health and dental insurance. Because your child will qualify for COBRA insurance effective the first of the month following their 26th birthday, please include their address on a separate piece of paper.
10) How much does health insurance cost?
    a. Check with your location's benefit administrator about the cost and amount you will need to pay.

Directions for Online Access to Medica and Delta Dental

MEDICA- ONLINE

Get all of your plan information on your member website, www.medica.com

To see your information, complete a **one-time registration** step. Once your Medica account is activated, you will have online access to:

- Claims – search, sort and check status
- Coverage – review a summary of your insurance coverage
- Spending – see how close you are to reaching your deductible and maximum
- Find a network doctor, hospital or clinic – get the care you need and see quality information, too
- Health and wellness – use a range of tools and resources
- Replacement member ID card – easy to see and order
- Contact customer service – secure message center

To register online, please click the link https://www.medica.com/login and then "Sign In." You will need to create an account and will need either your social security number of Medica ID number. Please select "I get insurance through an employer" and your plan is "Medica Choice Passport." After you follow the rest of the prompts, you will actually need to sign in again to access your account.

If you encounter errors, please contact Medica Customer Service at 1-877-347-0282; Mon-Fri 7 am – 8 pm CST

DELTA DENTAL - ONLINE

Access Delta Dental online at www.DeltaDentalMN.org

To see your information complete a **one-time registration** step. If you have previously registered, you do not have to register again. Once your DeltaDentalMN.org account is activated, you will have online access to:

- Coverage Summary – review your dental plan information
- Claims Inquiry – claim status, pre-estimates, service dates, procedure date, deductibles, etc.
- Find a dentist – Search for participating dentist, clinic, location, or specialized service
- Replacement member ID card – order duplicate or replacement card online
- Oral Health Resources – videos and informational flyers to improve your health by improving your oral health
- Dental Insurance 101 – general information

What are special enrollment periods?

A special enrollment period is outside open enrollment dates. During special enrollment, you can buy or make certain changes to your plan. Special enrollment is specific to you. It's triggered by what's known as a qualifying life event.

There are five types of qualifying life events:

Losing health coverage

One qualifying life event is the involuntary loss of health insurance. This can be due to job loss or a change in eligibility. It includes people who turn 26 and lose coverage under their parents' health plan. People who lose public insurance coverage are also included.

Household Changes

These include changes caused by marriage, divorce, birth, adoption, or death.

Change in address

If you had coverage and move, you may lose it and/or gain access to other plans. You'll also need to prove you had qualifying health coverage for one or more days during the 60 days before your move.

Change in income

If your income changes, you may be eligible for different plans. You also may have new access to an individual or public insurance program like Medicaid. The amount of financial assistance you can get also can change if your income does.

Other, less common changes

Less common changes that trigger special enrollment include becoming a U.S. citizen and leaving prison. Your state's health insurance marketplace will have a complete list. If you think you qualify for a special enrollment, here's what you need to know:

- Your special enrollment period will be open for 60 days from the date of your qualifying event.
- You must buy or make changes to your plan during that 60-day time period.

You'll need to submit proof of the qualifying event, along with completing an enrollment form.

DOW-R Dental Insurance

Medica.

2022 GROUP ENROLLMENT/CHANGE/CANCELLATION/WAIVE FORM
Minnesota Healthcare Consortium and DOW-R Dental Insurance

Instructions:

IMPORTANT – PLEASE READ BEFORE COMPLETING

Please read and complete your enrollment/change/cancellation form thoroughly to ensure accurate processing.

- If **waiving Medical/Dental coverage**, complete Sections A and B.
- For new enrollees, please submit this completed enrollment/change/cancellation/waive form to your employer.
- If you are currently enrolled:
  - If **canceling Medical/Dental coverage**, please complete Sections A, D and G.
  - Only adding a dependent to your existing contract, please include your name in Section A and your dependent's information in all other sections.

Your Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption. You may have additional enrollment rights under applicable state law. For example, in Minnesota the notification period for dependent children is not limited to 30 days for newborns or children newly adopted or newly placed for adoption; however, Medica encourages you to request enrollment within 30 days.

If you or your dependents have lost coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP), you may be able to enroll yourself and/or your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends.

In addition, if you or your dependents become eligible for group health plan premium assistance provided by the Medicaid or SCHIP program, you may be able to enroll yourself and/or your dependents in this plan. You must request enrollment within 60days after the date you or your dependents are determined to be eligible for premium assistance.

To obtain more information or request special enrollment, contact Medica Customer Service at 952-945-8000 or1-800-952-3455 (TTY users, call 711).

Visit us at **Medica.com**.

DOW-R Dental Insurance

Medica.

2022 Group Enrollment/Change/Cancellation Form

DOW-R Usage Loc#_____
Effective Date_____ Invoice CR D
Date to Medica_____ Month invoice _____
Date to DD _____ #----------

Please type or print clearly.

SECTION A - EMPLOYEE INFORMATION

SECTION

Effective Date: _____ ☐ Name change only			Have you been a Medica member before? ☐ Yes ☐ No	
First Name (Legal Name)[4]	M.I.[4]	Last Name[4]	Social Security Number[1]	Marital Status ☐ Single ☐ Married
Update ☐ Enroll ☐ Cancel ☐ Change ☐ Waive	**Address (Must be a physical address, no P.O. Boxes)** [5] Street			
City	State	ZIP Code	County	
Contact Information [6] Cellular/Home Telephone	Work Telephone	Email		
Gender ☐ Male ☐Female	Birth date (mm/dd/yy)	Date of hire (mm/dd/yy)		

Important:

1 Your Social Security number (SSN) is requested to report your coverage status to the federal government. The IRS requires Medica to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS, and/or Medica asking you to verify your SSN for 1095 tax form purposes.
2 For court-ordered or adopted dependent(s), legal documentation must be attached.
3 Medica does not administer student status verification, however, your employer may request this information for their records.
4 Please provide each applicant's name as stated on their Social Security card, if they have a Social Security card.
5 Please ensure your full address is filled out, so you can receive important mailings, including your Medica ID card and welcome kit.
6 Phone numbers are important for outreach for a variety of programs that help support our members.
7 If waiving coverage, complete only Section A and B.

SECTION B – WAIVER OF MEDICAL COVERAGE

This entire section must be completed if you or your dependents DO NOT want coverage.

1. I understand that I am eligible for coverage through my employer. I DO NOT want coverage for:
☐ Me and my dependents ☐ My spouse ☐ My dependents only

2. The reason I am declining coverage at this time is because I or my dependents have coverage provided through:
☐ Spouse's group plan ☐ Individual Policy ☐ South Dakota Risk Pool (dates of coverage):
☐ Medicare ☐ Group Coverage Continuation (COBRA) ☐ CHAND (dates of coverage):
☐ MinnesotaCare ☐ Medical Assistance ☐ Other:

Employee Signature: X	Date Signed:

Only sign if you are waiving coverage

DOW-R Dental Insurance

Medica.

SECTION C – PRODUCT SELECTION and EFFECTIVE DATE (needed if not during open enrollment)

I understand that I am eligible for coverage through my employer. Check coverage below:

- ☐ Me (Single) ☐ $2,500 deductible
- ☐ Me and my dependents (Family) ☐ $5,000 deductible

2. Effective date of coverage if not during open enrollment: _____

3. Special Enrollment

- ☐ If enrolled because of special enrollment, submit documentation of qualifying event.
- ☐ List qualifying event: _____ Date of qualifying event: _____

SECTION D - MEMBER INFORMATION

	Check appropriate box	First name[4] M.I.[4] Last name[4]	Gender	Birth Date (mm/dd/ yy)	Relationship[2]	Dependent's SSN[1]
1	☐ Enroll ☐ Cancel ☐ Change		☐ M ☐ F			
2	☐ Enroll ☐ Cancel ☐ Change		☐ M ☐ F			
3	☐ Enroll ☐ Cancel ☐ Change		☐ M ☐ F			
4	☐ Enroll ☐ Cancel ☐ Change		☐ M ☐ F			
5	☐ Enroll ☐ Cancel ☐ Change		☐ M ☐ F			

(!) **List all members to be covered/canceled/changed. Write name as it is stated on their social security card.**

If more than 4 dependents, complete a second page 3 Section D for them.

SECTION E – COORDINATION OF BENEFITS

(!) **Failure to complete this section may result in a delay in the processing of your claims.**

1. While you are covered under this policy, will you or any family members covered under this plan have other health insurance or Medical coverage? ☐ Yes ☐ No **Note:** if your other policy ends at the start of this policy, do not complete.

If "Yes," you must fully complete the following section. Starting with the employee, list each family member applying for coverage and include information for all previous coverage in effect. If your coverage is still in effect, please write "current" or "present" in the end date field. Use extra paper as necessary.

Date of Coverage		Name of Insurance Company	Names of all members covered
Start:	End:		
Start:	End:		
Start:	End:		

DOW-R Dental Insurance

Medica.

SECTION F – MEDICARE INFORMATION

1. Are you, your spouse, or any of your dependents covered by Medicare? ❑ Yes ❑ No

   If "yes" please attach a copy of each Medicare ID card and complete the following:

Employee Medicare Information	**Spouse/Dependent Medicare Information**
Name:	**Name:**
Part A: ❑ Enrolled (Effective Date:____/____/____)	**Part A:** ❑ Enrolled (Effective Date:____/____/____)
Part B: ❑ Enrolled (Effective Date:____/____/____)	**Part B:** ❑ Enrolled (Effective Date:____/____/____)
Part D: ❑ Enrolled (Effective Date:____/____/____)	**Part D:** ❑ Enrolled (Effective Date:____/____/____)
Reason for Medicare eligibility: ❑ Over age 65 ❑ Kidney disease ❑ Disabled ❑ Disabled but actively at work	**Reason for Medicare eligibility:** ❑ Over age 65 ❑ Kidney disease ❑ Disabled ❑ Disabled but actively at work

SECTION

SECTION G – EMPLOYEE AUTHORIZATION & REPRESENTATION

Read this section, date and sign the form.
On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any hospital, clinic, institution, physician, insurance company, employer or other person to give Medica/Delta Dental/Delta Dental or any of its designees any and all records or information pertaining to Medica/Delta Dental history or services rendered to Us. I understand that this information will be used for underwriting, risk rating, enrollment or eligibility for benefits.I understand that in certain circumstances Medica/Delta Dental may disclose the information collected to third parties without authorization and that the individuals enrolled on or added to this form have the right to see and correct their personal information in accordance with applicable law. I understand that I have the right to review Medica/Delta Dental's Privacy Notice before signing this form and to request a copy at any time. I authorize on behalf of Us the use of a Social Security Number for the purpose of identification. The information provided on this form is accurate and complete, to the best of my knowledge and/or belief. I understand and agree that any omissions or incorrect statements knowingly made by Us on this form may invalidate my or my dependent's coverage. I understand that I may revoke this authorization by notifying Medica/Delta Dental in writing.
If I revoke the authorization, it will not affect any actions already taken by Medica/Delta Dental prior to Medica/Delta Dental's receipt of the revocation. If I refuse to sign this authorization, it will affect my dependents' and my eligibility and enrollment for benefits. I understand that I may request a copy of this completed authorization form. Information used or disclosed pursuant to this authorization will remain subject to Medica/Delta Dental's privacy standards.

For North Dakota and South Dakota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica/Delta Dental to obtain information about Us for 24 months from the date of signature.

For Minnesota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica/Delta Dental to obtain information about Us from the date of signature until termination of our coverage.

This authorization does not extend to a release concerning the performance of, or results of, a test to determine the presence of the HIV antibody or other bloodborne pathogen* performed on (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) a patient who received the services of emergency Medica/Delta Dental services personnel* at a hospital or Medica/Delta Dental care facility; or (3) emergency Medica/Delta Dental services personnel who were tested as a result of performing emergency Medica/Delta Dental services.

For Wisconsin residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica/Delta Dental to obtain information about Us for 30 months from the date of signature.

I understand that providing false information or omission of relevant information in this form may result in the denial of claims or cancellation or retroactive termination of coverage.

Employee Signature: X_____ Date Signed: _____

DOW-R Dental Insurance

Medica.

New Hires or Open Enrollment Only

2022 GROUP WAIVE FORM
Minnesota Healthcare Consortium and DOW-R Dental Insurance

Instructions:

IMPORTANT – PLEASE READ BEFORE COMPLETING

Please read and complete your waive form thoroughly to ensure accurate processing. This form is used only if you are waiving coverage.

- **If waiving Medical/Dental coverage,** complete Sections A and B.

Your Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption. You may have additional enrollment rights under applicable state law. For example, in Minnesota the notification period for dependent children is not limited to 30 days for newborns or children newly adopted or newly placed for adoption; however, Medica encourages you to request enrollment within 30 days.

If you or your dependents have lost coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP), you may be able to enroll yourself and/or your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends.

In addition, if you or your dependents become eligible for group health plan premium assistance provided by the Medicaid or SCHIP program, you may be able to enroll yourself and/or your dependents in this plan. You must request enrollment within 60days after the date you or your dependents are determined to be eligible for premium assistance.

To obtain more information or request special enrollment, contact Medica Customer Service at 952-945-8000 or1-800-952-3455 (TTY users, call 711).

Visit us at **Medica.com**.

DOW-R Dental Insurance

Medica.

2022 Health Insurance Waive Form – New Hires/Open Enrollment

DOW-R Usage Loc#_____
Effective Date_____ Invoice CR D
Date to Medica_____ Month invoice
Date to DD _____ ----------

Please type or print clearly.

SECTION

SECTION A - EMPLOYEE INFORMATION

Effective Date: _____			
First Name (Legal Name)[2] M.I.[2]		Last Name[2]	Social Security Number[1]
Update ☐ Waive	**Address (Must be a physical address, no P.O. Boxes)** [3] Street		
	City	State / ZIP Code	County
Contact Information Cellular/Home Telephone	Work Telephone	Email	
Gender ☐ Male ☐ Female	Birth date (mm/dd/yy)		

Important:

1 Your Social Security number (SSN) is requested to report your coverage status to the federal government. The IRS requires Medica to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS, and/or Medica asking you to verify your SSN for 1095 tax form purposes.
2 Please provide each applicant's name as stated on their Social Security card, if they have a Social Security card.
3 Please ensure your full address is filled out, so you can receive important mailings, including your 1095-C.

SECTION B – WAIVER OF MEDICAL COVERAGE

This entire section must be completed if you or your dependents DO NOT want coverage.

1. I understand that I am eligible for coverage through my employer. I DO NOT want coverage for:

☐ Me and my dependents ☐ My spouse ☐ My dependents only

2. The reason I am declining coverage at this time is because I or my dependents have coverage provided through:

☐ Spouse's group plan ☐ Individual Policy ☐ South Dakota Risk Pool (dates of coverage):
☐ Medicare ☐ Group Coverage Continuation (COBRA) ☐ CHAND (dates of coverage):
☐ MinnesotaCare ☐ Medical Assistance ☐ Other:

Employee Signature: X	Date Signed:

Only sign if you are waiving coverage

DIOCESE OF WINONA-ROCHESTER

TERM LIFE INSURANCE and

LONG TERM DISABILITY (LTD) INSURANCE

Participation and Form Directions

Administered by Unum Provident

Eligible employees are those who work at least 20 hours a week or at least one-half academic load during the plan year. Temporary employees are not eligible. All eligible employees **must** be enrolled in the Life and LTD insurance. The premium is paid 100% by the employer. Employees are insured on the 1st of the month coincident with or following the date of hire.

FORM REQUIRED TO ENROLL AN EMPLOYEE:

1. Group Enrollment Form B-1

PURPOSE: To provide information to participate in the life and disability plans.

Please enter the name of your parish/school/institution in "Division," the employee's wage listed in "Salary," and also fill in the date of hire. The employee should complete the remaining boxes on the top of the form, list beneficiary information, and sign/date at the bottom. The employee's life benefit will be 1.5 times their annualized wage with a maximum benefit of $50,000.

2. Summaries

Each employee should be given the "Benefits at a Glance" handouts for the Life and LTD Plans (in Life/LTD/AD&D tab). Detailed Summary Plan Booklets that outline the Life and LTD benefits are available on the diocesan website at https://www.dowr.org/offices/human-resources/index.html in the Human Resources department.

FORMS REQUIRED FOR CHANGES TO EXISTING EMPLOYEES:

1. Group Enrollment Form B-1

PURPOSE: To change designated person(s) to receive benefits upon death of policy holder or to change employee's name.

Employee should complete a new Group Enrollment Form (B-1). Forms should be returned to the Diocese of Winona-Rochester Benefits.

2. Salary Changes

Email any changes in employee annual salary to the Diocese of Winona-Rochester Benefits.

FORM REQUIRED TO FILE LIFE AND LTD CLAIMS:

Claim for Life Insurance Benefits or LTD Benefits

The employer should contact the diocese and the appropriate claim for benefits form will be provided.

TERMINATING EMPLOYEES:

PURPOSE: The Diocese of Winona-Rochester's third party vendor (Alerus) informs employees of their rights pertaining to the term life policy and to confirm their decision to elect continued coverage or terminate coverage. This only applies to the life insurance. LTD is not continued and will end when the employee's employment terminates.

DIOCESE OF WINONA-ROCHESTER

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Participation and Form Directions

Administered by Mutual of Omaha

Eligible employees are those who work at least 20 hours a week or at least one-half academic load during the plan year. Temporary employees are not eligible. All eligible employees **must** be enrolled in AD&D insurance. The premium is paid 100% by the employer. Employees are insured on the 1st of the month coincident with or following the date of hire.

FORMS REQUIRED TO ENROLL AN EMPLOYEE:

1. **Beneficiary Form B-1**

   PURPOSE: To designate person(s) to receive benefits upon death of policy holder.

2. **Summary**

   Each employee is to be given a copy of the 24-Hour Accident Insurance Summary that describes the benefits of the AD&D insurance.

FORMS REQUIRED TO MAKE CHANGES TO EXISTING EMPLOYEES:

1. **Beneficiary Form B-1**

   Employee should complete a new Beneficiary Form (B-2) for changes in beneficiaries or a name change.

2. **Salary Changes**

   Email any changes in employee annual salary to the diocese.

FORM REQUIRED TO FILE AD&D CLAIMS:

Claim for AD&D Benefit

The employer should contact the diocese and the appropriate claim for benefits form will be provided.

FORMS REQUIRED FOR TERMINATING EMPLOYEES:

No form is required. The AD&D stops when the employee's employment terminates.

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: September 1, 2003

IDENTIFICATION NUMBER: 551767 035

ELIGIBLE GROUP(S):

All full-time and part-time employees of the Diocese of Winona-Rochester who work at least 20 hours per week or are contracted for at least one half academic load and school employees contracted and non-contracted, whose employment corresponds with the academic school year and work at least 20 hours per week or are contracted for at least one half academic load in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group before November 1, 2016: None

For employees entering an eligible group on or after November 1, 2016: First of the month coincident with or next following the date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

Premium Waiver: 90 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

1.5 x annual earnings

All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$50,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: September 1, 2003

IDENTIFICATION NUMBER: 551767 034

ELIGIBLE GROUP(S):

All full-time and part-time employees of the Diocese of Winona-Rochester who work at least 20 hours per week or are contracted for at least one half academic load and school employees contracted and non-contracted, whose employment corresponds with the academic school year and work at least 20 hours per week or are contracted for at least one half academic load in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group before November 1, 2016: None

For employees entering an eligible group on or after November 1, 2016: First of the month coincident with or next following the date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

90 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

60% of monthly earnings to a maximum benefit of $5,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months

Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

OTHER FEATURES:

Minimum Benefit

Pre-Existing: 3/12

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

Benefits At A Glance - AD&D

Mutual of Omaha Insurance Company

Mutual of Omaha

DESCRIPTION OF COVERAGE FOR

Diocese of Winona-Rochester

24-HOUR ACCIDENT INSURANCE

ELIGIBILITY

All full-time and part-time employees of the Policyholder in active employment in the United States who work at least 20 hours per week or are contracted for at least one half academic load.

EFFECTIVE DATE

Each eligible person becomes an Insured on the later of: (a) the policy effective date or (b) the 1st of the month coincident with or following the date of hire.

COVERAGE

This plan offers protection on a worldwide basis, 24 hours a day, 365 days a year against any covered accident in the course of business or pleasure, including accidents on or off the job, in or away from the home, commuting, traveling by train, airplane, automobile or other private and public conveyances. It also covers accidents while riding as a passenger in any licensed civilian aircraft or in any aircraft operated by the Military Airlift Command. The benefits provided are payable in addition to any other insurance which may be in effect at the time of the accident.

BENEFIT AMOUNT

The amount of insurance you are eligible for is called the Principal Sum. Your Principal Sum amount is 1.5 times your Annual Salary, rounded to the next higher not to exceed a maximum of $50,000.00

BENEFITS

Accidental Death and Specific Loss Benefits
Benefits are payable when covered injuries result in loss within 365 days after the date of the accident. The Loss Period requirement is waived if the Insured is in a Coma or is being kept alive by artificial support system. Certain losses are payable at 100% of the Principal Sum and other losses are payable at a lesser percentage, as follows:

Loss of:	
Life	Principal Sum
Two Members	Principal Sum
One Member	½ Principal Sum
Thumb and Index Finger of the Same Hand	¼ Principal Sum

If you suffer multiple losses due to the same accident, only the largest benefit amount to which you are entitled – is payable. The benefit for loss of: (a) two limbs; (b) both eyes; (c) one limb and one eye; (d) speech and hearing; or (e) thumb and index finger of the same hand is payable only when such double loss is the result of the same accident.

Loss is defined as the severance of the hand or foot at or above the wrist or ankle joint; total and irrecoverable loss of entire sight, speech or hearing; and severance of two or more entire phalanges of both the thumb and index finger. To receive benefits, loss must be independent of sickness and all other causes.

Paralysis Benefits
When you suffer injuries that result in hemiplegia, paraplegia, quadriplegia, triplegia or uniplegia commencing within 60 days after the accident and continuing for one year, we will pay benefits as follows:

For Hemiplegia or Uniplegia	½ Principal Sum
For Paraplegia or Triplegia	¾ Principal Sum
For Quadriplegia	Principal Sum

Accident Only Comatose Benefit
If you lapse into an irreversible coma due to covered injuries received in an accident, benefits will be paid as follows. Beginning on the 32nd day of the coma, 5% of your Principal Sum will be paid per month over 20 months or until death, whichever comes first. Upon death, any remaining Principal Sum will be paid as provided in the policy. If any other benefits for this condition are payable under the policy only one of the amounts, the largest applicable, will be paid.

Seat Belt Benefit
If Injuries result in the Insured's death and at the time of the accident the Insured was: (a) the operator of or a passenger in a Private Passenger Automobile; and (b) utilizing a Seat Belt; a benefit equal to 10% of your Principal Sum will be paid. Seat Belt usage must be verified by a doctor, a coroner, a traffic officer or other person of competent authority.

Exposure and Disappearance Benefit
Benefits for exposure to the elements or the Insured's disappearance as incurred in a covered accident which results in the disappearance, sinking or damaging of a conveyance on which an Insured was riding, will be paid as follows:

1. If, (a) the Insured is unavoidably exposed to the elements; and (b) as a result of such exposure suffers Injuries for which benefits are otherwise payable, such Injuries will be covered under this policy.
2. If, (a) the Insured disappears; and (b) if the body of the Insured has not been found within 52 weeks after the date of such accident; it will be presumed, subject to no evidence to the contrary, that the Insured suffered loss of life as a result of Injuries covered by the policy.

BENEFIT REDUCTIONS

Principal Sum Benefits for covered individuals age 70 and over shall be payable according to the following schedule:

Ages	% of original Principal Sum
70 thru 74	65%
Age 75 until Retirement	50%
Retirement	Coverage Terminates

CONVERTED POLICY OPTION

A converted policy will be offered to the insured if the accidental death and dismemberment insurance under the policy terminates by ending your employment, ending your eligibility or if the policy ends for reasons other than non-payment of premium.

To obtain a converted policy, you must apply within 31 days after the policy ends and pay the first premium. If you have assigned ownership of coverage, the owner must apply for you. The converted policy will provide accidental death and dismemberment benefits. The premium will be based on the class of risk to which you belong, your age and the amount of coverage issued. The converted policy will take effect on the date you apply. The insured must be under the age of 70 to obtain a converted policy.

PAYMENT OF CLAIMS

Indemnity for loss of life will be payable in accord with the beneficiary designation made in writing by the Insured and on file with the Company. In the absence of such beneficiary designation, or in the event the designated beneficiary predeceases the Insured, indemnity for loss of life will be paid to the first of the following surviving beneficiaries: the Insured's: (a) lawful spouse; (b) child or children, jointly; (c) parents, jointly if both are living, or the surviving parent if only one survives; (d) brothers and sisters, jointly; (e) estate. Any other accrued indemnities unpaid at the Insured's death may, at Our option, be paid either to the Insured's beneficiary or to his or her estate.

DEFINITIONS

"Hospital" means any of the following places: (a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located; (b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility; (c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals; or (d) a place certified as a hospital by Medicare. Not included is a hospital or institution or a part of such hospital or institution which is licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics; or (2) as a clinic, continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

"Injuries" means accidental bodily injuries: (a) received while insured under this policy, and (b) resulting independently of sickness and all other causes.

"Irreversible Coma" means: (a) a state of unconsciousness in which there is a cessation of activity in the central nervous system as demonstrated by an electroencephalogram (using criteria established by the American Electroencephalography Society); and (b) a diagnosis of brain death by the attending physician.

Paralysis:
"Hemiplegia" means complete loss of function of one side of the body with involvement of the arm and leg.

"Paraplegia" means complete loss of function of the lower extremities of the body with involvement of both legs.

"Quadriplegia" means complete loss of function of both the upper and lower extremities of the body with involvement of both arms and legs.

"Triplegia" means complete loss of function of three limbs.

"Uniplegia" means complete loss of function of one limb.

"Seat Belt" means any factory-installed passive restraint device or child passive restraint device which meets published federal safety standards.

EXCEPTIONS

This plan does not cover: suicide, attempted suicide or intentionally self-inflicted injury while sane or insane (in Missouri, while sane only); injuries caused by an act of declared or undeclared war; injuries received while in the armed service (upon notice to us of entry into an armed service, the pro rata premium will be refunded); injuries received while acting as a pilot or crew member; injuries received while traveling as a passenger by air except as defined in the policy; or injuries resulting from the Insured's engagement in or attempt to commit a felony or being engaged in an illegal occupation.

This brochure summarizes the provisions of the policy issued to the Diocese of Winona. Should there be any discrepancy between the policy and this description, policy provisions will prevail.

Diocese of Winona-Rochester
Form B – 1 Insurance Enrollment For:

Basic Group (Term) Life (Policy #551767-18)
Long Term Disability (LTD) (Policy #551767-134)
& Accidental Death & Dismemberment (AD&D) (GMDA-BD6D)

☐ Beneficiary change only. This form cancels all prior designations. Complete your name, SS# and beneficiary information along with signature and date.
☐This includes employee name change – prior name was_____
☐ Coverage waived – sign/date bottom of page.

Employee Name (last, first, middle initial)	Policyholder Name	
	Diocese of Winona-Rochester	
Employee Address (street, city, state, zip code)	Social Security Number	Date of Birth

Beneficiary* Information – Use additional sheet if needed

Name (last name, first, middle initial)	Relation to You:	Benefit %
If the Beneficiary(ies) named above are not living, then pay:		

*Note: Benefits cannot be sent directly to a minor. Please consult your policy for additional information

Request for Coverage Signature and Certification:

I understand that my Insurance coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and understand that a copy of this form will be made available to me at my request.

Employee Signature	Date	Work Phone	Home/Cell Phone

Waive Coverage for Life/LTD/AD&D:

I understand that I am waiving employer paid coverage for the following insurance: life, long term disability (LTD), and accidental death and dismemberment (AD&D). I also understand this coverage will not be offered to me at any time during the future.

Employee Signature	Date

***Please use only to change beneficiaries or to designate multiple primary beneficiaries and/or contingent beneficiaries**

Location: _____

Diocese of Winona-Rochester

GROUP LIFE BENEFICIARY CHANGE/DESIGNATION FORM

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than five (5) primary and/or contingent beneficiaries, please attach a separate sheet of paper. Return the completed form to your employer.

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI

Social Security Number

Check the coverages listed below to which this beneficiary designation applies:

☐ Basic Life ☐ Supplemental Life ☐ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage

SECTION 3: Contingent Beneficiary (ies)

If all primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage

SECTION 4: Signature

Employee Signature

Date

Important Information About Designation of Beneficiaries

Beneficiary Information

- Primary Beneficiary(ies) means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- Contingent Beneficiary(ies) means the person(s) you choose to receive your life insurance benefits only if all primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- Minor Beneficiary(ies) — When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- Trust — You may designate a valid trust as a beneficiary.

Types of Coverage Information

- Basic Life is life insurance provided by your employer for which they pay the premiums.

- Supplemental Life is life insurance elected by you for which you pay the premiums.

- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- Updates to Your Beneficiary Designation — You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- Consult an Attorney — This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

403(b) Diocese of Winona-Rochester Lay Employees Retirement Plan Information

Type of Plan:	Tax Deferred 403(b) - *Lincoln Alliance®*
Eligibility:	Employees, age 21 or older, who are normally scheduled to work 20 or more hours per week. Participation is effective at date of hire for eligible employees. Temporary employees are not eligible.
Employer Discretionary Contribution:	3% of employee's wages.
Employee Elective Deferral:	Participant may contribute, via payroll deduction, from 1% to 100% (even numbers only) of his/her wages up to the annual IRS limits. Participant may change his/her elective deferral percentage effective the first day of any given month. Your 403(b) deduction does not reduce your wages for purposes of calculating FICA (Social Security and Medicare) taxes. "Pre-tax" only refers to income taxes, therefore, we must apply the FICA tax rate to your *gross earnings.* If you elect a contribution rate of 100%, we must first withhold FICA taxes and then you can defer 100% of your remaining compensation.
Employer Matching Contribution:	1% of employee's wages if the employee contributes 1%; 2% of employee's wages if the employee contributes 2%; 3% of the employee's wages if the employee contributes 3% or more; otherwise 0%.
Vesting - Employer Contributions:	20% vesting (ownership) per full year of eligible employment. Participant is 100% vested after 5 years.
Vesting - Employee Contributions:	Participant is always 100% vested in his/her elective deferral contributions.
Investments Options:	Participant directs all contributions to a variety of widely-recognized mutual funds. Participant also has the option to select a *LifeSpan®* asset allocation model, which provides allocation among the various investment options, based on a targeted retirement date. Participant may change investment options at any time.
Default Investment Election:	Participants who do NOT make individual investment elections for their contributions will automatically be invested in a *LifeSpan®* Target Date Model based on the participant's date of birth and the date closest to when the participant will reach the plan's normal retirement age of 65.
Loans:	Participant may borrow from his/her elective deferral account balance. Minimum loan amount is $1,000 and only one loan may be outstanding at a time. Loan must be repaid within 5 years, except loans used to purchase primary residence.

Withdrawal of Funds:	Participant may be eligible to withdraw money from the vested account balance when the following events occur: - Reach age 59½ - Upon retirement - Upon death - Upon total and permanent disability - A financial hardship, as defined by IRS guideline - No longer employed within the Diocese of Winona-Rochester *Please note that distribution restrictions may apply to certain accounts under each of the above events. Taxes will be due upon distribution and if taken before age 59½, may be subject to an additional 10% federal tax penalty.*
Fees:	The mutual funds in this program contain operating expenses just like all mutual funds.

How to Enroll

1. Complete the Salary Reduction Agreement, indicating the percentage of your wages that you choose to contribute (from 0% - 100%) to the plan each payroll.
2. Return the Salary Reduction Agreement to the person who handles payroll at your parish/school/cemetery/institution.
3. Your parish/school will provide the necessary data to the Diocese of Winona-Rochester to set up your account with *Lincoln Alliance*®.

Account Access

Lincoln Alliance® will mail you a letter containing instructions to access your account by phone and on the internet.

1. Phone – toll free @ 1-800-234-3500
   - The last four digits of your Social Security number is required to access your account.
   - You will be given prompts in the call to complete registration.
2. Internet – *www.lfg.com*
   - When in the website click on "Register Now" where you will register and establish a user name and password.

When accessing your account for the first time, either by phone or by internet, you should:

1. Make your investment choices
2. Make your beneficiary elections

Lincoln Alliance Program® Contact Information

CUSTOMER SERVICE
1-800-234-3500
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.lfg.com

RETIREMENT CONSULTANT
James Schugel
Phone: 612-257-0347
E-mail: *James.Schugel@LFG.com*

DIOCESE OF WINONA-ROCHESTER
403(b) LAY EMPLOYEES RETIREMENT PLAN

Participation and Form Directions

Eligible participants are lay employees who are age 21 and older and are scheduled to work 20 or more hours per week, or at least .5 FTE during the academic year. Temporary employees are not eligible. All benefit eligible employees receive the 3% employer discretionary contribution.

ENROLLMENT OF A PARTICIPANT:

1. Lincoln Alliance® Program Enrollment Book

Copies of the enrollment booklet may be requested from the Diocese of Winona-Rochester Employee Benefits Department or you may direct the employee to the on-line version of the document on the diocesan web site under "Lincoln 403b Information and Resources" at the following address: https://www.dowr.org/offices/human-resources/benefits.html

2. 403(b) DOW-R Lay Employees Retirement Plan Information C-1

This document provides the new participant with a brief summary of the 403(b) plan benefit, along with information regarding the process of online enrollment, investment elections and beneficiary elections.

3. Salary Reduction Agreement Form C-2

This is the only document the participant needs to return to you for enrollment in to the plan. All participants are required to complete the form.

a. In Step 2, the participant will either elect or decline to contribute through salary reduction. The participant may elect to contribute to either or to both the Traditional pre-tax and Roth plan.
b. Elective deferrals are required to be a percentage of wages (not dollars). The percentage must be a whole number, not a fraction.
c. Employee signature and date are required; please leave the plan administrator signature section blank.

The Salary Reduction Agreement needs to be uploaded to Dropbox to the Diocese of Winona-Rochester Employee Benefits Department. File copies will be returned to the location after processing.

PARTICIPANT CHANGE REQUESTS:

1. Salary Reduction Agreement Form C-2

This form is also used for current participants to change their elective deferral, as well as change their mailing address with the Lincoln Alliance® Program.

a. The effective date of a change in salary deferral must be coincide with the first payroll of any given month. Typically, forms must be to payroll 3 to 5 business days before the

first of the month. Mid-month change in salary deferral percentage is not allowed.

b. Elective deferrals are required to be a percentage of wages (not dollars). The percentage must be a whole number, not a fraction.
c. Employee signature and date are required; please leave the plan administrator signature section blank.

The Salary Reduction Agreement needs to be returned to the Diocese of Winona-Rochester Employee Benefits Department. File copies will be returned to the employer after processing is complete.

2. Other Changes

All other requests for changes (beneficiary designation, change in investment elections, transfer of investment assets, etc.) are handled by the participant directly with Lincoln. You may provide the following contact information to the participant:

Lincoln Alliance Program®

CUSTOMER SERVICE	RETIREMENT CONSULTANT
1-800-234-3500	Zaina Mujtaba
Mon - Fri 7 am - 7 pm	Phone: 708-310-9756 cell
24 Hour Voice Response	E-mail: *Zaina.Mujtaba@LFG.com*
www.lfg.com	

TERMINATING/RETIRING EMPLOYEES:

403(b) Pension Plan Information for Terminating/Retiring Participants (C-6)

This document provides the participant with all the necessary information related to vesting, distributions, rollovers, and direct transfers of their account(s). Contact information for both the Lincoln Multi-Fund® Annuity and the Lincoln Alliance Program® are provided.

Diocese of Winona-Rochester

403(b) Lay Employees Retirement Plan

Information for Terminating/Retiring Participants

What types of contributions are in my 403(b) account?

There are two sources of contributions that have been made to your diocesan 403(b) lay retirement plan:

1. ***Employee Contributions***: The contributions you personally made to the plan are 100% vested (owned by you).

2. ***Employer Contributions:*** The contributions made to your account by your employer are 20% vested (owned by you) per full year of covered employment. The vesting schedule of the Diocese of Winona-Rochester Plan is 20% per year, with full vesting after 5 years or upon reaching age 60, whichever occurs first.

What happens to my vested 403(b) account balance?

Terminated participants have the following options for their vested 403(b) account balance:

1. ***Distribution*** – You may request a distribution of funds from your vested account balance.
    a. ***Pre-Tax Contributions (Traditional):*** The distribution will be considered taxable income in the year of distribution and a 20% federal tax will be withheld from the distribution. Early withdrawal penalties of 10% may also apply if you are below 59 ½ years of age.
    b. ***After-Tax Contributions (Roth):*** The distribution will not be considered taxable income in the year of distribution if your account has been held for at least five years and you are at least age 59 ½. Early withdrawal penalties of 10% may also apply if you are below 59 ½ years of age.

2. ***Direct Rollover or Transfer*** – You may request a transfer of your vested balance to another qualified retirement plan or an individual IRA.

3. ***Maintain your account*** - Terminated participants with a vested balance of less than $5,000 will have their vested account balance automatically transferred to a Lincoln Small Account IRA if they do not initiate a distribution, direct rollover, or transfer. Terminated participants with a vested account balance of $5,000 or greater may choose to retain their vested balance in the plan for future distribution. Participants must begin to take a distribution from the plan at age 72, called Required Minimum Distribution (RMD).

Who do I contact and where can I obtain the necessary forms?

First determine which Lincoln retirement account(s) you have; you may have one account or two separate accounts depending on your individual situation. Although all accounts are through Lincoln, each type of account has different contact information and different forms to

complete for account distribution or transfer. Quarterly statements are provided to participants and you may also refer to those statements to determine which account(s) you have a balance in.

Please keep the following items in mind when contacting Lincoln regarding your account(s):

- Effective 3/1/2010, all employee and employer contributions to the 403(b) retirement plan have been invested in the **Lincoln Alliance Program®**
- Prior to 3/1/2010, all employee and employer contributions to the 403(b) retirement plan were invested in **Lincoln Multi-Fund® Annuity.** Participants with Multi-Fund® accounts were given the opportunity to complete contract exchange paperwork to transfer those assets to the Lincoln Alliance Program®.

Lincoln Contact Information

To obtain information on your account(s) and plan forms, please use the following:

Diocese of Winona-Rochester 403(b) Lay Retirement Plan Retirement Consultant:

Zaina Mujtaba

Email: zaina.mujtaba@lfg.com

Phone: 708-310-9756 Mobile

Lincoln Alliance Program® (Effective April 1, 2018)

CUSTOMER SERVICE
1-800-234-3500
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.LFG.com

Lincoln Multi-Fund® Annuity

CUSTOMER SERVICE
1-800-454-6265
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.LFG.com

MAILING ADDRESS
The Lincoln National Life Insurance Company
Attention - Annuities Operations
PO Box 2340
Fort Wayne, IN 46801-2340

Lincoln Financial Group®
The Lincoln National Life Insurance Company

For use with:
Lincoln Alliance® program

Diocese of Winona-Rochester Lay Employees Retirement Plan DOW-001

Salary reduction agreement

Location Code: _____ **Effective Date:** _____

PLEASE PRINT CLEARLY

Step A: Participant Information

Name: _____ Employee ID: _____
Last First Middle

Address: _____
Street City State ZIP

Birth Date: _____ ☐ Married ☐ Male Daytime Phone: _____

Date of hire: _____ ☐ Not married ☐ Female Evening Phone: _____

Step B: Decide how much to save

Choose one:

☐ **I elect to contribute this percentage** Pretax _____% Roth _____%

☐ **I do not want to contribute through salary deferrals.** Please complete the remainder of the form.

Step C: Read these statements carefully

- The employer will reduce your pay by the amount indicated (in **Step B** above) per pay period. The employer will send this amount to the provider as contributions.
- The first payroll deduction will take place as soon as administratively possible after we receive this form.
- While employment continues, this agreement legally binds both you and the employer for amounts deferred while it is in effect. A new agreement must be submitted to change your percentage.
- This agreement will apply only to amounts not yet currently available to you. It will not apply to any amounts earned after the agreement is terminated.
- If you do not provide investment choices, your contributions will be invested in the default fund chosen by your employer.

Step D: Signatures

By signing below, I certify that:

- I have read, understand and agree to the terms of the **Salary Reduction Agreement**. The signature of the plan administrator certifies that the plan administrator also agrees to the **Salary Reduction Agreement.**

_____ _____
Participant's Signature Date

Plan Administrator

_____ _____
Plan administrator's signature Date

Return this form to:
Your employer's Human Resources department

EM81799-AL-DOW-001 11/12
PAD1210-0797

DIOCESE OF WINONA-ROCHESTER

FLEXIBLE BENEFITS

Participation and Form Directions

Eligible employees who work at least 20 hours a week or at least one-half academic load during the plan year. Employees must be 21 years of age or older to participate. Temporary employees are not eligible. Employees may enroll in the plan at the beginning of each plan year.

New employees have 30 days from their initial date of employment to enroll. After that time, they can only enroll when the new plan year starts. There are certain qualifying events such as death, birth, adoption, change in job status, etc. that may allow an employee to join during the plan year or change their allocation. Contact the Employee Benefits Coordinator if you feel you have an employee with a qualifying event.

FORMS REQUIRED TO ENROLL OR WAIVE PARTICIPATION:

1. **Summary Plan Description, Flexible Benefits Plan - Form D-1**

   All employees have online access to the plan at https://www.dowr.org/offices/human-resources/index.html Section D. The plan should be reviewed with the employee so they are familiar with it.

2. **Enrollment Form - Form D-2** (Required completion for new employees only – whether enrolling or waiving)

   PURPOSE: To authorize the employer to withhold from wages, the amount designated by the employee, to be allocated to the flexible benefit plan.

   a) New Employees - This form is to be completed within the first 30 days of employment with the effective date as the first of the month following the date of hire.
      1. The employee shall make an annual election to either participate in each of the two individual flex plan accounts or waive (decline) participation in each flex plan account.
         - Medical Flexible Spending Account
         - Dependent Care Flexible Spending Account
      2. For employees new to the medical flexible spending account, the employee should complete the debit card signature.
      3. The signature of the employee is required at the bottom of the form.

   b) Current Employees
      1. Open enrollment – This form only needs to be completed if the employee participates in flexible spending.

2. Qualifying event – See below

All application forms are to be returned to the Diocese of Winona-Rochester. A copy will be returned to the location showing flexible spending costs by participating employee.

CLAIM FORM/Request for Reimbursement – Medical Expense and Daycare Expense

PURPOSE: Employee can use the Request for Reimbursement Form to request reimbursement from their medical care (F8503R09) and dependent care (F8420R10) spending accounts.

These forms are used for medical, dental, over-the-counter, and dependent care expenses.

- Appropriate documentation must be attached to each claim, as noted on the back of the Request for Reimbursement Form
- Reimbursement requests can either be mailed or faxed to the flexible benefits plan third party administrator, address and fax number provided at the top of the form.
- Reimbursement checks are scheduled through Further. Participants may elect to sign up to have their reimbursements directly deposited in their bank account.

Further DEBIT CARD

PURPOSE: Instead of filling out a Request for Medical Care Reimbursement F8503R09, the Further debit card can be used to pay for qualified expenses.

The debit card is automatically issued to all new employees who elect a medical flexible spending account.

FORMS REQUIRED FOR QUALIFYING EVENT OR STATUS CHANGE

Qualifying Event Notification Form (Flexible Benefits Status Change) **F39727R07**

PURPOSE: To notify the plan administrator of changes, which affect the employee's rights and obligations under the flexible benefits plan.

The employee may elect to change their Flexible Benefits election ONLY in the event of change in job status of employee or their spouse, birth or adoption, death, marriage, or divorce. The election change must be directly related to the event, which causes the status change.

Upon termination of employment, the employee may elect to revoke their election or continue participating in the flexible benefits plan for the health care spending account only. COBRA flex information will be sent to the terminating employee through our third party vendor, Alerus. If the employee chooses to continue to participate, their contributions are made onan after tax basis to Alerus. The employee can then seek reimbursement for eligible medical expenses for the rest of that plan year. If the employee chooses not to continue participation, they may seek reimbursement for eligible medical expenses incurred only through the date of termination.

FURTHER.
Formerly SelectAccount®

Diocese of Winona-Rochester Group 011486

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

January 1 – December 31, 2022 Calendar Year Plan

I waive the following:
☐ Medical Flex
☐ Dependent Care Flex

Employee Information – All enrollees must complete.

Last Name: _____ First Name: _____ MI: _____

SSN#: _____ Daytime Phone: _____ Evening Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Date of Birth: _____ / _____ / _____

Flexible Spending Account Information (Effective Date: Begins January 1 or 1st of the month following date of hire)

1. Medical Flexible Spending Account:

DOW-R minimum $150; DOW-R maximum $2,750

☐ I want to contribute a total of $ _____ during this plan year to my Medical Flexible Spending Account.

I understand this amount will be deducted from my pay throughout the plan year.

If enrolling in medical flex, you must check the Health Savings Account question below:

Are you or your spouse participating in a Health Savings Account (HSA)?

☐ No ☐ Yes: If yes, your medical FSA must be limited to dental and vision expense reimbursement until your health plan deductible has been met. Contact "Further" to remove the limit when your deductible is met.

2. Dependent Care Flexible Spending Account:

DOW-R minimum $150; IRS maximum: $5,000 ($2,500 if married but filing separate tax returns)

☐ I want to contribute a total of $ _____ during this plan year to my Dependent Care Flexible Spending Account.

I understand this amount will be deducted from my pay throughout the plan year.

Flexible Spending Account Enrollment Form Signature - All enrollees in medical and/or dependent care must sign/date

I have reviewed the above elections and understand that my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my flexible spending accounts (only medical and dependent care) at the end of the Plan year may be forfeited.

Participant Signature: **Date:**

Debit Card – For new medical flex enrollees, complete this section

Note: Employees new to medical flexible spending account: If you are requesting a debit card, please complete the section below. See "Further" website for more information www.hellofurther.com.

Debit Card Signature - I certify that such expenses will not be eligible for benefit payment by any other insurance carrier and that such expenses will not be manually submitted by me to this or any other reimbursement account when I use my debit card. I understand that any debit card transaction using funds may be subject to proof of purchase documentation upon request by Further. Failure to respond will result in cancellation of the debit card and I must reimburse the plan with after-tax dollars. I also understand that by requesting a debit card for my dependents, I am authorizing them to have access to information regarding their specific debit card transactions

Debit Card Signature: _____ **Date:** _____

Print Name: _____

Questions? Contact Benefits (Julia Sandsness) at the Diocese of Winona-Rochester at (507) 858-1268 or email benefits@dowr.org or contact "Further" at (800) 859-2144.

Location - Upload completed forms to your location's Dropbox.

Benefit Office	Location Payroll Reduction(s)				
FLEX	Effective Date: _____	Medical Mo Amt:	_____	Dependent Care Mo Amt:	_____

Location Name/#_____

DIOCESE OF WINONA-ROCHESTER

SUPPLEMENTAL LIFE INSURANCE

Participation and Form Directions

Administered by Unum Provident

Eligible employees are those who work at least 20 hours a week or at least one-half academic load during the plan year. Temporary employees are not eligible. Employees are insured on the first of the month coincident with or following the date of hire.

FORM REQUIRED TO ENROLL AN EMPLOYEE:

1. Term Life Insurance Enrollment Form E-1

PURPOSE: To provide information to participate in the supplemental life plan.

The employee should complete the form by completing their own information on the top of the first page. If the employee is enrolling the spouse, the spouse's name and date of birth is needed. Children's names and birth dates are not needed. Put in the amount elected for coverage for employee, spouse and/or child(ren). The amount of coverage will need to be the next higher multiple of $10,000 for employee, the next higher multiple of $5,000 for spouse and the next higher multiple of $2,000 for child. If taking coverage beneficiary information needs to be completed. An employee signature, date and phone number is needed at the bottom of the form.

2. Evidence of Insurability Form 1143-01MN

If the employee chooses coverage above the guaranteed amount (over $200,000 for employee and/or over $25,000 for spouse), the employee needs to complete the Evidence of Insurability Form (EOI). The employee needs to complete the questionnaire in full to prevent denial of coverage. An online questionnaire is the preferred method of submittal and a link may be obtained by contacting benefits@dowr.org. If the employee completes the paper copy, be sure to have the employee sign and date the form. The evidence of Insurability Form should be sent to the diocese or directly to UNUM at:

Mail: PO Box 9783-5083, Portland, ME 04104
Fax: 207-771-4022
E-mail: nasateamimageid@unum.com

3. Term Life Insurance Coverage Highlights E-3

Each employee should be given the Term Life Insurance Coverage Highlights. A detailed Summary Plan booklet outlining the supplemental life benefit is available on the diocesan website at www.dow.org in the Human Resources department.

FORMS REQUIRED FOR CHANGES TO EXISTING EMPLOYEES:

1. **Term Life Insurance Enrollment Form E-1**

   PURPOSE: To change beneficiary(s) to receive benefits upon death of policy holder, qualifying event, change employee's name or address.

   Employee should complete a new Term Life Insurance Enrollment Form (E-1). Forms should be returned to the Diocese of Winona-Rochester Benefits.

FORM REQUIRED TO FILE SUPPLEMENTAL LIFE CLAIMS:

Claim for Life Insurance Benefits

The employer should contact the diocese and the appropriate claim for benefits form will be provided.

TERMINATING EMPLOYEES:

Supplemental Group Life Options for Terminating/Retiring Participants

PURPOSE: The Diocese of Winona-Rochester's third party vendor, Alerus, informs employees of their rights pertaining to the term supplemental life policy and confirms their decision to elect continued coverage or terminate coverage.

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: November 1, 2014

PLAN YEAR:

September 1, 2020 to January 1, 2022 and each following January 1 to January 1

IDENTIFICATION NUMBER: 604947 001

ELIGIBLE GROUP(S):

All full-time and part-time employees of the Diocese of Winona-Rochester who work at least 20 hours per week or are contracted for at least one half academic load and school employees contracted and non-contracted, whose employment corresponds with the academic school year and work at least 20 hours per week or are contracted for at least one half academic load in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group before November 1, 2016: None

For employees entering an eligible group on or after November 1, 2016: First of the month coincident with or next following the date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

WHO PAYS FOR THE COVERAGE:

For You:

You pay the cost of your coverage.

For Your Dependents:

You pay the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 90 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

Amounts in $10,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $10,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 70; or
- 65% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

If you have reached age 75 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR INSURANCE OVER:

$200,000

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$10,000

OVERALL MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

The lesser of:
- 5 x annual earnings; or
- $500,000.

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Spouse:

Amounts in $5,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $5,000, if not already an exact multiple thereof.

THE AMOUNT OF YOUR SPOUSE'S LIFE INSURANCE WILL REDUCE BY THE SAME PERCENTAGE AND AT THE SAME TIME YOUR LIFE INSURANCE REDUCES.

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR SPOUSE'S INSURANCE OVER:

$25,000

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOUR SPOUSE:

$5,000

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR SPOUSE:

The lesser of:
- 100% of your amount of insurance (Summary of Benefits Identification #604947-001 and Summary of Benefits Identification #551767-035 combined); or
- $500,000.

Children:

Amounts in $2,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $2,000, if not already a multiple thereof.

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOUR CHILDREN:

$2,000

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR CHILDREN:

Attained age at death:

Live birth to 14 days: $1,000
14 days to 6 months: $1,000
6 months to age 26:

The lesser of:
- 100% of your amount of insurance (Summary of Benefits Identification #604947-001 and Summary of Benefits Identification #551767-035 combined); or
- $10,000.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage. Conversion is available to insured dependent child(ren), subject to all terms and conditions otherwise applicable to converted dependent coverage.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

Diocese of Winona-Rochester
Policy # 604947

Please read carefully the following description of your Unum Term Life insurance plan.

Your Plan

Eligibility

All full-time and part-time employees of the Diocese of Winona-Rochester who work at least 20 hours per week or are contracted for at least one half academic load and school employees contracted and non-contracted, whose employment corresponds with the academic school year and work at least 20 hours per week or are contracted for at least one half academic load in active employment in the United States with the Employer.

*Note: Disabled children over the maximum child age may be eligible for benefits, please see your plan administer for more details.

Coverage Amounts

Your Term Life coverage options are:

Employee: Up to 5 times salary in increments of $10,000.
Up to a maximum of the lesser of 5x salary or $500,000.

Spouse: Up to 100% of employee amount in increments of $5,000.
Not to exceed $500,000. Benefits will be paid to the employee.

Child(ren): Up to 100% of employee coverage amount in increments of $2,000.
Not to exceed $10,000 (up to age 26)
The maximum death benefit for a child between the ages of live birth and 6 months is $1,000. Benefits will be paid to the employee.

The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.

If you have coverage under policy number 551767-035 or elect coverage under 604947 – 001 for yourself, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

Coverage amount(s) will reduce according to the following schedule:

Age:	Insurance Amount Reduces to:
70	65% of original amount
75	50% of original amount

Coverage may not be increased after a reduction.

Guarantee Issue

If you and your eligible dependents enroll within 31 days of your eligibility date, you may apply for any amount of Life insurance coverage up to $200,000 for yourself and any amount of coverage up to $25,000 for your spouse. Any Life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability. If you and your eligible dependents do not enroll within 31 days of your eligibility date, you can apply for coverage only during an annual enrollment period or change in status and will be required to furnish evidence of insurability for the entire amount of coverage.

If you and your eligible dependents enroll within 31 days of your eligibility date and later wish to increase your coverage, you may do so during annual enrollment or change in status. You and your eligible dependents may purchase additional Life coverage up to the Guarantee Issue amounts without evidence of insurability. Life coverage over the Guarantee Issue amounts will require evidence of insurability and require approval by Unum's Medical Underwriters.

Please see your Plan Administrator for your eligibility date.

Term Life Coverage Rates

Rates shown are your Monthly deduction:

Age Band	Employee per $1,000	Spouse per $1,000	Child per $1,000
- 24	$.030	$.052	$.256
25-29	$.035	$.058	
30-34	$.050	$.070	NOTE: The
35-39	$.080	$.094	premium paid for
40-44	$.095	$.132	child coverage is
45-49	$.140	$.207	based on the cost of
50-54	$.215	$.326	coverage for one
55-59	$.410	$.500	child, regardless of
60-64	$.600	$.892	how many children
65-69	$.962	$1.558	you have.
70-74	$1.780	$2.784	
75+	$2.050	$5.398	

NOTE: Your rate will increase as you age and move to the next age band.

Insurance Age

Your rate is based on your insurance age. To calculate your insurance age, subtract your year of birth from the year your coverage becomes effective.

Spouse rate is based on employee's insurance age.

To calculate your cost, complete the following by selecting your coverage amount and rate (based on your insurance age).

Term Life Calculation Worksheet

Coverage Amount		Increment	Rate		Monthly Cost
Employee	$_____	÷ $1,000 x	$_____	=	$_____
Spouse	$_____	÷ $1,000 x	$_____	=	$_____
Children	$_____	÷ $1,000 x	$_____	=	$_____
		YOUR MONTHLY COST		=	$_____

_____	x 12 =	_____	÷	_____	=	_____
Your Monthly Cost		Annual Cost		# Paychecks per Year		**COST PER PAYCHECK***

Additional Benefits

Life Planning Financial & Legal Resources

This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees at no cost to you. This service is also extended to you upon the death or terminal illness of your covered spouse. The financial consultants are master level consultants. They will help develop strategies needed to protect resources, preserve current lifestyles, and build future security. At no time will the consultants offer or sell any product or service.

Portability/Conversion

If you retire, reduce your hours or leave your employer, you can take this coverage with you according to the terms outlined in the contract. However, if you have a medical condition which has a material effect on life expectancy, you will be ineligible to port your coverage. You may also have the option to convert your Term life coverage to an individual life insurance policy.

Accelerated Benefit

If you become terminally ill and are not expected to live beyond a certain time period as stated in your certificate booklet, you may request up to 75% of your life insurance amount up to $500,000 without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary(ies). This feature also applies to your covered dependents.

Waiver of Premium

If you become disabled (as defined by your plan) and are no longer able to work, your premium payments will be waived during the period of disability.

Retained Asset Account

Benefits of $10,000 or more are paid through the Unum Retained Asset Account. This interest bearing account will be established in the beneficiary's name. He or she can then write a check for the full amount or for $250 or more, as needed.

Limitations/Exclusions/ Termination of Coverage

Suicide Exclusion

Life benefits will not be paid for deaths caused by suicide in the first twenty-four months after your effective date of coverage.

No increased or additional benefits will be payable for deaths caused by suicide occurring within 24 months after the day such increased or additional insurance is effective.

Termination of Coverage

Your coverage and your dependents' coverage under the Summary of Benefits ends on the earliest of:

- The date the policy or plan is cancelled;
- The date you no longer are in an eligible group;
- The date your eligible group is no longer covered;
- The last day of the period for which you made any required contributions;
- The last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage;
- For dependent's coverage, the date of your death.

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends;
- The date your dependent ceases to be an eligible dependent;
- For a spouse, the date of divorce or annulment.

Unum will provide coverage for a payable claim which occurs while you and your dependents are covered under the policy or plan.

Next Steps

How to Apply

To apply for coverage, complete your enrollment form within 31 days of your eligibility date.

All employees: If you apply for coverage after your effective date, or if you choose coverage over the guarantee issue amount, you will need to complete a medical questionnaire which you can get from your Plan Administrator. You may also be required to take certain medical tests at Unum's expense.

Effective Date of Coverage

Please see your Plan Administrator for your effective date.

Delayed Effective Date of Coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Dependent Spouse and/or Child: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

"Totally disabled" means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:

- **is confined in a hospital or similar institution;**
- **is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;**
- **is cognitively impaired;**
- **is receiving or is entitled to receive any disability income from any source due to**
- **any sickness or injury;**
- **is receiving chemotherapy, radiation therapy or dialysis treatment;**
- **is confined at home under the care of a physician for a sickness or injury; or**
- **has a life threatening condition.**

Your dependent children:

- **are confined in a hospital or similar institution;**
- **are receiving chemotherapy, radiation therapy or dialysis treatment; or are confined at home under the care of a physician for a sickness or injury.**

Changes to Coverage

Each year at annual enrollment you and your eligible dependents will be given the opportunity to change your Life coverage. You and your eligible dependents may purchase additional Life coverage up to the Guarantee Issue amounts without evidence of insurability if you are already enrolled in the plan. Life coverage over the Guarantee Issue amounts will be medically underwritten and will require evidence of insurability and approval by Unum's Medical Underwriters. The suicide exclusion will apply to any increase in coverage.

Questions

If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator.

Diocese of Winona-Rochester

Insurance Enrollment Form For: Supplemental (Term) Life (Policy #604947-001)

Please print legibly and complete this form in its entirety.

Location_____

☐ Beneficiary change only. This form cancels all prior designations. Complete your name, SS# and beneficiary information along with signature and date.
☐This includes employee name change – prior name was_____

Application Type:
☐ **NEW HIRE ONLY: ☐ Enroll OR ☐ Waive enrollment**

☐ **QUALIFYING EVENT: Describe:** Date of Event

☐ **Annual Enrollment:** To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file with Unum. **Note: If you do not wish to make any changes, do not complete this form. Please contact your plan administrator with any questions.**

Employee Name (last, first, middle initial)	Policyholder Name	
	Diocese of Winona-Rochester	
Employee Address (street, city, state, zip code)	Social Security Number	Date of Birth

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. If you are taking coverage for your spouse, please include spouse's name and date of birth. Dependent life coverage amounts cannot exceed 100% of your life coverage amounts. Any coverage amounts left blank will result in a coverage amount of $0.

Amount of life coverage selected for:

You: $ ☐☐☐,☐☐☐,☐☐☐ Your Spouse: $ ☐☐☐,☐☐☐ Your Child: $ ☐☐,☐☐☐

Spouse First & Last Name

Spouse Date of Birth

Note: If you have chosen Life coverage over the Guarantee Issue amount of $200,000 for you or $25,000 for your spouse, you will also need to complete an Evidence of Insurability form. The amount of Life coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. **If you DO NOT APPLY FOR coverage for you or your dependent(s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage.**

Beneficiary* Information - use an additional sheet if necessary

Name *(last name, first, middle initial)*:	**Relation to You:**	**Benefit %:**
If the beneficiary(ies) named above are not living, then pay:		

*Note: Benefits cannot be sent directly to a minor. Please consult your policy for additional information

Request for Signature and Certification: *I have read and understand the included "Limitations and Exclusions*".* I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective unless I waive coverage. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ Date _____ Work Phone _____ Home/Cell Phone _____

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions*

Delayed Effective Date

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Dependent Spouse and/or Child: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

"Totally disabled" means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:

- **is confined in a hospital or similar institution;**
- **is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;**
- **is cognitively impaired;**
- **is receiving or is entitled to receive any disability income from any source due to**
- **any sickness or injury;**
- **is receiving chemotherapy, radiation therapy or dialysis treatment;**
- **is confined at home under the care of a physician for a sickness or injury; or**
- **has a life threatening condition.**

Your dependent children:

- **are confined in a hospital or similar institution;**
- **are receiving chemotherapy, radiation therapy or dialysis treatment; or**
- **are confined at home under the care of a physician for a sickness or injury.**

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER