Christina School District

BENEFITS/SERVICES PROVIDED

www.schooldistrictbenefits.com/christina

ENROLLMENT DEADLINE

The Benefit Enrollment Packet must be completed and returned as soon as possible but no later than 30 days from hire date. If enrollment forms and documents are not signed and returned within 30 days, benefits will be "waived" in accordance with 3.01 of State of Delaware regulations.

SUMMARY PLAN DESCRIPTION, BENEFITS VIDEO & PROVIDER DIRECTORIES

The Summary Plan Description, informational video, enrollment forms and participating provider directories can be found online at www.schooldistrictbenefits.com/christina.

STATE OF DELAWARE BENEFITS

Medical Insurance with Prescription Drug plan -The State of Delaware provides a state share for permanent employees' working 30 hours or more per week, after 3 months of service. The District will pay a medical stipend (flex credit) the first day of the month following the hire date based on negotiated contractual agreements. Choice of Traditional, Gold or HMO plans with Express Scripts prescription is included at no extra cost to the employee. The State wide benefits web site is http://ben.omb.delaware.gov/

Blood Bank-Blood Bank of Delmarva Members for Life Program is available to all employees for information go to www.ben.omb.delaware.gov/blood/.

Contributory Pension Plan-State Pension Plan provides Service, Disability, and Vested Pensions. Employees are vested after completing 10 years of State of Delaware service. Employees are required to contribute 5 % of earnings above $6000.00 annually. Employees may elect to withdraw their contributions upon termination of District employment. The State Pension Plan summary is available at www.delawarepensions.com.

State Disability Insurance-Short and Long-term benefits provided by the State at no cost to the employee.

State Group-Minnesota Life Insurance-Employees can purchase 1-to 6 x annual salary, after 3 months of service. Dependent insurance is also available. Enrollment information will be mailed to your home address. Rates vary based on age and coverage elections.
http://www.schooldistrictbenefits.com/christina/stategrouplife.htm

AFLAC Supplemental Insurance – AFLAC Group Accident Advantage Insurance and/or Group Critical Illness Insurance is available to employees. Information at the State wide benefits web site http://ben.omb.delaware.gov/

State Deferred Compensation (457 pretax retirement plan)-A State sponsored retirement savings plan through Fidelity Investment Services with over 250 funds to choose from. For more information contact Fidelity at 800-430-2363. Note: The Match Plan has been suspended since 2008-2009 due to budget constraints.
http://treasurer.delaware.gov/deferred_compensation/

Flexible Spending Account-Health/Dependent Care pre-tax flexible spending account. Health Care Spending Account election available for up to $2,500 annually for eligible out-of-pocket medical, dental and prescription drug expenses incurred by you or your dependents(s). Dependent Care Spending Account election available for up to $5,000 annually per household for eligible child or dependent care expenses while you are working. Eligible after 3 months of service. For more Flexible Spending Account information contact ASI at 1-800-659-3035 or visit www.asiflex.com. http://ben.omb.delaware.gov/fsa/index.shtml

Christina School District

BENEFITS/SERVICES PROVIDED

www.schooldistrictbenefits.com/christina

STATE OF DELAWARE BENEFITS CONTINUED

Employee Assistance Program (EAP)-Human Management Services, Inc. offers confidential assistance for personal and family matters to employees and their dependents enrolled in the health insurance plan. To receive an assessment and up to 5 short-term counseling sessions free of change contact HMS at 1-800 343-2186 or visit www.hmsincorp.com. Member Log in : State of Delaware

CHRISTINA SCHOOL DISTRICT LOCAL BENEFITS

A District stipend (flex credit), based on contractual agreement, is provided to purchase the following District Benefits:

District Dental Insurance-Met-Life dental coverage pays benefits for many preventive and corrective dental services for employee and eligible dependents. There are 2 option levels. The customer service number for Met-Life is 1-888-303-1113. Claim forms are available from Benefits Office or online at www.schooldistrictbenefits.com/christina.

District Group Life/Accidental Death & Dismemberment Insurance-This life insurance covers the employee for an amount 2 times annual salary (up to age 65). The customer service number for Reliance Standard is 1-800-351-7500 or online at www.rsli.com.

District Group Long Term Disability Insurance- Enhances State long-term disability plan by providing the employee 6 2/3% buy-up option, after meeting the 182 day elimination period and approval. The customer service number for The Hartford is 1-800-538-8439.

District Vision Insurance- Vision coverage for employee and eligible dependents which includes exams, lenses, frames or contacts. Participating Providers are all electronic, claim forms will only be needed for Non-Participating Providers and must be ordered prior to receiving services by contacting Vision Benefits of America (VBA) at 1-800-432-4966 or online at www.visionbenefits.com

DEPENDENT ELIGIBILITY/AGE LIMITS

Dependents are eligible for Medical/Express Scripts Prescription, Dental and Vision coverage through the end of the month age 26 is reached.

OTHER SERVICES OFFERED

Credit Union-Employees' may join the New Castle County School Employees Federal Credit Union. Checking/Savings accounts, reduced rate interest loans and Visa Credit Card Accounts, Vacation/Christmas Club Accounts. To become a member contact (302) 613-5330.

TSA- (403b retirement plan)-Voluntary pretax payroll deduction to an approved Tax Sheltered Annuity account. Vendor approved list available at http://treasurer.delaware.gov

Benefits
Cost Worksheet
2016-2017

	Annual Cost Of Plan Selected
District Dental Insurance (Metlife) Plan A / Plan B 1. Employee Only $ 738.24 / $ 577.20 2. Employee & Spouse $1,162.56 / $ 899.76 3. Employee & Children $1,444.08 / $1,116.24 4. Family $1,978.32 / $1,530.00	$_____
District Vision Care (Vision Benefits of America) 1. Employee Only $ 161.52 2. Employee & Spouse $ 302.40 3. Employee & Children $ 273.60 4. Family $ 420.48	$_____
District Life Insurance (Reliance Standard) 2.0 x annual salary x $0.139 per $1,000 (Insurance benefit rounded to next $500) ***Example:*** Annual Salary: $28,000 Amount of benefit: 2.0 x 28,000 = $56,000 Amount per pay: 56.0 x 0.139 = 7.784 Annual cost: 7.784 X 24 = $186.82	$_____
District Long-Term Disability (The Hartford) ***LTD buy up for employees covered in the State disability program*** Rate for employees to buy up from 60% to 66 2/3%, beginning on the 182nd day of disability: $0.15 (per $1,000 of covered payroll)= monthly x 12 = Annual *(The LTD benefit is capped at $8,000 per month)*	$_____
Blood Bank Free to all employees	$_____

TOTAL ANNUAL BENEFITS COST OF PLANS SELECTED ABOVE:	$_____
LESS BOARD CONTRIBUTION (Flex Credits) (Please refer to your current union contract)	$_____
YOUR ANNUAL COST OF BENEFITS (Annual cost less flex credits)	$_____
DEDUCTION PER PAY (divide total annual cost of benefits above by 24 pay)	**$**_____

www.schooldistrictbenefits.com/christina

State of Delaware
Group Health Insurance Program
New Rates Effective July 1, 2016

	Total Monthly Rate	State Pays	Employee/ Pensioner Contributions
Highmark Delaware First State Basic Plan			
Employee	$695.36	$667.52	$27.84
Employee & Spouse	$1,438.68	$1,381.16	$57.52
Employee & Child(ren)	$1,057.02	$1,014.76	$42.26
Family	$1,798.42	$1,726.50	$71.92
Aetna CDH Gold			
Employee	$719.68	$683.70	$35.98
Employee & Spouse	$1,492.22	$1,417.64	$74.58
Employee & Child(ren)	$1,099.56	$1,044.60	$54.96
Family	$1,895.74	$1,800.96	$94.78
Highmark Delaware CDH Gold			
Employee	$719.68	$683.70	$35.98
Employee & Spouse	$1,492.22	$1,417.64	$74.58
Employee & Child(ren)	$1,099.56	$1,044.60	$54.96
Family	$1,895.74	$1,800.96	$94.78
Aetna HMO			
Employee	$725.94	$678.78	$47.16
Employee & Spouse	$1,530.58	$1,431.08	$99.50
Employee & Child(ren)	$1,110.52	$1,038.34	$72.18
Family	$1,909.82	$1,785.70	$124.12
Highmark Delaware HMO/IPA			
Employee	$726.52	$679.34	$47.18
Employee & Spouse	$1,535.42	$1,435.62	$99.80
Employee & Child(ren)	$1,111.64	$1,039.38	$72.26
Family	$1,915.68	$1,791.16	$124.52
Highmark Delaware Comprehensive PPO Plan			
Employee	$793.86	$688.68	$105.18
Employee & Spouse	$1,647.34	$1,429.08	$218.26
Employee & Child(ren)	$1,223.46	$1,061.38	$162.08
Family	$2,059.40	$1,786.54	$272.86
Highmark Delaware Medicare Supplement for Pensioners Retired On or Prior to July 1, 2012			
Special Medicfill with Prescription	$426.60	$426.60	
Special Medicfill **without** Prescription*	$241.86	$241.86	
*Medicare Supplement plan WITHOUT prescription is provided for Medicare Beneficiaries enrolled in Medicare Part D			
Highmark Delaware Medicare Supplement for Pensioners Retired After July 1, 2012			
Special Medicfill with Prescription	$426.60	$405.28	$21.32
Special Medicfill **without** Prescription*	$241.86	$229.78	$12.08
*Medicare Supplement plan WITHOUT prescription is provided for Medicare Beneficiaries enrolled in Medicare Part D			
Dominion Dental HMO			
Employee	$24.52	$0.00	$24.52
Employee & Spouse	$45.62	$0.00	$45.62
Employee & Child(ren)	$49.16	$0.00	$49.16
Family	$66.76	$0.00	$66.76
Delta Dental PPO plus Premier			
Employee	$35.86	$0.00	$35.86
Employee & Spouse	$73.18	$0.00	$73.18
Employee & Child(ren)	$71.84	$0.00	$71.84
Family	$119.88	$0.00	$119.88
EyeMed Vision Plan			
Employee	$6.46	$0.00	$6.46
Employee & Spouse	$10.20	$0.00	$10.20
Employee & Child(ren)	$10.40	$0.00	$10.40
Family	$16.78	$0.00	$16.78

Christina School District

EMPLOYEE BENEFIT ENROLLMENT FORM

Date of Hire/Change_____

EMPLOYEE LAST NAME	FIRST NAME/INITIAL	BIRTHDATE	EMPL ID	SOC. SEC. NO.

LOCATION	CLASSIFICATION	SALARY	# PAYS	STIPEND

SPOUSAL COORDINATION OF BENEFITS FOR HEALTH COVERAGE

Does your spouse work for OR retired from STATE OF DELAWARE Agency?

☐ **YES** ☐ **NO** Spouse's Name: _____ Spouse's SSN: _____

If Yes: Agency Name:_____ Spouse's Birth Date:_____ Spouse's Hours Worked Per Week_____

You MUST Select or (√) No Coverage for each plan:

<STATE BENEFITS>

MEDICAL Express Scripts Prescription included with these plans	Employee	Employee & Spouse	Employee & Children	Family
Highmark Delaware – First State Basic	☐	☐	☐	☐
Highmark Delaware – Comprehensive PPO	☐	☐	☐	☐
Highmark Delaware –IPA/HMO	☐	☐	☐	☐
Highmark Delaware – CDH Gold	☐	☐	☐	☐
Aetna HMO	☐	☐	☐	☐
Aetna CDH Gold	☐	☐	☐	☐
NO Coverage ☐				

BLOOD BANK YES ☐ NO ☐

FLEXIBLE SPENDING ACCOUNT (Application Required)
Eligible after 90 day waiting period **YES** ☐ **NO** ☐

<DISTRICT BENEFITS> (Annual Plan Cost)

MET LIFE DENTAL	Employee	Employee & Spouse	Employee & Children	Family
Plan **A**	$ 738.24 ☐	$ 1,162.56 ☐	$ 1,444.08 ☐	$ 1,978.32 ☐
Plan B	$ 577.20 ☐	$ 899.76 ☐	$ 1,116.24 ☐	$ 1,530.00 ☐
NO Coverage ☐				

Vision Benefits of America	Employee	Employee & Spouse	Employee & Children	Family
	$ 161.52 ☐	$ 302.40 ☐	$ 273.60 ☐	$ 420.48 ☐
NO Coverage ☐				

Copays $10 Vision Exam $25 Lenses and/or Frames

District LIFE/AD&D INSURANCE (Reliance Standard) **2 x Annual Salary (Beneficiary Form Required)** ☐

$ _____of Coverage $ _____ Approximate Annual Cost

Calculation Example: Salary $28,000. X 2 = $56,000. Coverage
56.0 x 0.139 = 7.784 X 24 = Annual Cost of $186.82

NO Coverage ☐

HARTFORD SUPPLEMENTAL DISABILITY 6 2/3 monthly benefits after 182-day elimination period ($8,000.00 maximum) ☐

Calculation : $0.15 (per $1,000. of covered payroll)= monthly X 12 = Annual

NO Coverage ☐

REQUIRED INFORMATION: PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM. BENEFITS WILL NOT BE PROCESSED IF INFORMATION/SIGNATURE IS MISSING AND/OR THE REQUIRED FORMS ARE NOT SUBMITTED. FAILURE TO SUBMIT REQUIRED FORMS CAN ALSO RESULT IN A DELAY OF YOUR PAYCHECK.

☐ Complete benefit enrollment form (previous page) selecting your benefits.

☐ Complete dependent enrollment/application form indicating benefit selections for each covered dependent (including self and spouse) for Medical, Dental, Vision, {*Please see State Eligibility and Enrollment rules at http://ben.omb.delaware.gov/documents/eer-070113.pdf

☐ Complete Dependent Coordination of Benefits form for each dependent child regardless of age if child has other Active Health Insurance.

☐ Complete spousal coordination form online, if enrolling spouse in health coverage at http://www.employeeselfservice.omb.delaware.gov/

☐ Submit copy of Marriage/Civil Union Certificate if enrolling a spouse for the first time

☐ Submit copy of Birth Certificate if enrolling a dependent for the first time

☐ Complete beneficiary form in enrolling in the District Life Insurance Program.

CERTIFICATION (everyone must sign and date)

By my signature below, I hereby certify that the benefit elections I have made on this form are the benefit elections I have chosen, and that I have completed the required forms necessary to enroll. I understand that by completing and signing the required forms, I am making a binding election with regard to my benefits for the current plan year unless I have a permissible status change as defined by the Internal Revenue Service or I terminate my employment with the State of Delaware. I understand and agree my regular pay will be reduced by the amount of my required contribution for the benefit options I have elected. I understand if employment ends I am eligible to continue District Life Insurance by contacting the insurance carrier within 30 days of termination date for conversion to an individual coverage.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a change of employment status, 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, birth, adoption or placement for adoption.

Note: A federal law called HIPAA requires the State of Delaware Group Health Plan (the "Plan") provide a Certificate of Creditable Coverage (a "Certificate") to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. The Procedure to Request a Certificate of Creditable Coverage is available by contacting your Benefits Office.

State/District Policy: I understand after this date, I **will not** be able to make changes to any State and/or District Benefit Plans (Health, Dental, Vision, Life or Disability) for the remainder of the enrollment period unless I experience one of the following "Qualifying Events":

- Change in employment status (1/2 time to full time, full time to ½ time, teacher to administrator)
- Change in Marital Status or Dependent Status (birth/adoption)
- Spouse's loss of coverage

I understand that it is my responsibility to notify the Benefits Office within 30 days of a "qualifying event" to make changes to my Benefit Plans. Failure to notify the Benefits Office within 30 days of the "Qualifying event" will result in waiting until the next Annual Open Enrollment Period to make changes.

NAME: _____**DATE**:_____

Questions?? www.schooldistrictbenefits.com/christina

Or e-mail CSDPayrollBenefits@christina.k12.de.us

Rev.10092014

•REQUIRED BENEFIT FORMS CHECK LIST•
••NEW HIRE••

PLEASE DO NOT SEPARATE THIS BENEFIT ENROLLMENT PACKET

THIS PACKET MUST BE COMPLETED AND RETURNED TO THE BENEFITS OFFICE AS SOON AS POSSIBLE, BUT NO LATER THAN 30 DAYS FROM HIRE DATE. IF THIS ENROLLMENT PACKET AND REQUIRED DOCUMENTATION ARE NOT RETURNED WITHIN 30 DAYS OF HIRE DATE, BENEFITS WILL BE WAIVED IN ACCORDANCE WITH STATE REGULATIONS.

_____ Employee Benefit Enrollment Form **(check (√) ALL sections must be completed, signed and dated.**

_____ Dependent Enrollment/Application Form – **All sections must be completed, signed and dated.**

_____ Spousal Coordination of Benefits Policy Form (If covering a spouse) – **must be completed <u>on line</u> to insure spouse's coverage at 100%**

_____ • Copy of Marriage/Civil Union certificate is required if enrolling a spouse
_____ • Copy of Birth certificate is required for each dependent child you are enrolling for the first time.

Note: **<u>Dependent Coordination of Benefits Form</u>** - A Dependent Coordination of Benefits Form must be completed for each enrolled dependent child regardless of age **<u>if child has other Active Health Insurance</u> and for any dependent child <u>upon request by the Statewide Benefits Office or the State of Delaware GHIP health care carrier</u>**

_____ District Life/A D &D – **(Form Required)**

_____ ASI Flex **(Complete application or Refuse and sign and date)**

_____ Pension Actuarial Information Form **(Complete ALL information on both sides, sign and date)**

_____ W-4 Form- **(Complete, sign and date)**

_____ Direct Deposit Form – **(Form required-mandatory condition of employment)**

_____ Certification of Tax Dependent Status for A Civil Union Spouse/Children (Complete only if adding Civil Union Family members) if applicable

<u>Questions??</u> **<u>www.schooldistrictbenefits.com/christina</u>**

EMPLOYEE NAME _____**SOCIAL SECURITY#**_____
(Please Print)

SIGNATURE _____**SCHOOL**_____

Christina School District

DEPENDENT ENROLLMENT/APPLICATION FORM

EMPLOYEE INFORMATION Please Note: Benefits will not be processed if this form is incomplete

Name	Address	Home Telephone#	Cell #
Social Security #		Work Location	Work #

HEALTH COVERAGE PLANS (select plan choice and coverage type below) ☐ **REFUSING HEALTH COVERAGE**

Highmark DE ☐ **First State Basic** ☐ **Comprehensive PPO** ☐ **IPA/HMO** ☐ **CDH Gold** ☐ **AETNA HMO** ☐ **Aetna CDH Gold**

COVERAGE TYPE: ☐ **Employee** ☐ **Employee & Spouse** ☐ **Employee & Child(ren)** ☐ **Family**

ENROLLMENT INFORMATION List dependents (**including SELF** & spouse) and benefit plan code selections below

Dependent's/ Name	Dependent's Social Security #	Birth Date	Plan Code M=State Medical & Prescription D=Dental V=Vision M	D	V	Primary Care Name For Aetna HMO	Primary Physician's ID # for IPA/HMO	Relation Sp=Spouse D =Daughter S= Son	Adult **Dependent** Age 21-26	Disabled Child
SELF									☐	☐
									☐	☐
									☐	☐
									☐	☐
									☐	☐
									☐	☐
									☐	☐

DENTAL ENROLLMENT (select plan choice) ☐ **PLAN A** ☐ **PLAN B**

COVERAGE TYPE: ☐ **Employee** ☐ **Employee & Spouse** ☐ **Employee & Child (ren)** ☐ **Family** ☐**REFUSING DENTAL COVERAGE**

Medical Dependent Coverage ends: End of month age 26 is reached
Express Scripts State Prescription Coverage ends: End of month age 26 is reached
Dental & Vision Dependent Coverage ends: End of month age 26 is reached

_____ _____ _____

Employee Signature Date Employee ID#

Spousal Coordination of Benefits Form

If you cover your spouse in one of the State of Delaware Group Health Insurance medical plans you must complete a Spousal Coordination of Benefits form on line at:

www.ben.omb.delaware.gov/documents/cob.

HIGHMARK® Delaware

COORDINATION OF BENEFITS QUESTIONNAIRE

Your Name: _____ Social Security #: _____

A. Within the past year, have you or any member of your family been covered by another insurance company?

- ❑ **No.** Please complete question C, if applicable.
- ❑ **Yes.** Please complete the remainder of this questionnaire.

B. Check which of the following plans provide benefits for you or any member of your family:

❑ **Another Highmark Blue Cross Blue Shield Delaware contract?**
ID #: _____

❑ **Medicare?**
HIC #: _____ Part B effective date (mo., day, yr.): _____

❑ **Another health insurer?**

Name of other health insurance company: _____

Name of other employer: _____

Address where claims are submitted: _____

Name of policyholder: _____

Policyholder's date of birth (month, day, year): _____

Policyholder's ID #: _____

Effective date of policy (month, day, year): _____

Cancellation date, if applicable (month, day, year): _____

Name of persons covered:

Spouse: _____

Dependent child(ren): _____

❑ **Another dental policy?**

Name of dental carrier: _____

Effective date of dental policy (month, day, year): _____

If dental policy is canceled, date (month, date, year): _____

Who is covered under this policy? ❑ Policyholder ❑ Spouse ❑ Dependent child(ren)

continued on reverse side

COORDINATION OF BENEFITS QUESTIONNAIRE continued

C. The following information must be provided as required by our Employer's Coordination of Benefits (COB) Policy. (Check with your employer.)

My spouse is:
- ❑ Not employed
- ❑ Employed full-time
- ❑ Employed part-time
- ❑ Self-employed
- ❑ Retired

Name of spouse's employer: _____

Is medical insurance offered? ❑ Yes ❑ No

Percent of premium, if any, paid by spouse? _____

If spouse is self-employed, what percent is paid by his/her employees? _____

Renewal date of spouse's medical insurance plan: _____

Your signature: _____

Daytime telephone number: ( ) _____

Identification #: _____

Please return this survey to:
Highmark Delaware
P.O. Box 1991
Wilmington, DE 19899-1991

We thank you for the time spent completing this questionnaire.
The information provided will help us to process your claims.

State of Delaware
Office of Management and Budget, Statewide Benefits Office

Dependent Coordination of Benefits Form

Section A:
Member Name: _____
Aetna member ID Number or Social Security Number: _____
Do any of your children have other health care coverage?
_____ No…please check this line and sign this form at bottom.
_____ Yes…please complete Sections B and C below and sign this form at bottom.

Section B:
Please complete this section concerning your child/ren's other coverage. If all children have the same coverage, please list each child's name; if children have different coverage, please prepare a separate form for each child.
_____ Child/ren is covered by another Aetna plan and ID Number is _____
_____ Child/ren is covered by another health insurance plan.
Name of the other health insurance plan is _____
Name of policyholder: _____Birth date_____
Name of employer _____
Effective date of coverage: _____ Date, if cancelled: _____
Names of child/ren covered and birth date:
Child: _____
Child: _____
Child: _____
If divorced, which parent has primary, physical custody? _____ Mother _____ Father

Thank you for completing this form, your responses will enable claims to be processed properly.

Your signature: _____ Daytime Phone Number: _____

Please print this form, complete, and mail or fax to the following:

Aetna
PO Box 981106
El Paso, TX 79998-1106
Fax# 859-455-8650

STATE OF DELAWARE

Flexible Spending Account Enrollment Agreement 2015 Plan Year

As an employee eligible to participate in the State of Delaware's Flexible Spending Account program within the current Plan Year (calendar year 2015), I have reviewed the 2015 Guide to Your FSA Benefits and understand the benefits available to me as well as the other rights and obligations I have under the plan. I understand this Agreement is irrevocable during this plan year except under special circumstances as outlined in the Guide. I also understand that I will have until April 15th, 2016 to submit claims for reimbursement for services received during the plan year or coverage period. Any unused amounts remaining in my account at the end of this specified period of time will be forfeited. This Agreement is subject to the terms of the State of Delaware Flexible Spending Account Plan. I hereby request to participate in the Health Care Account and/or Dependent Care Account with the plan year election/s as indicated below and authorize my annual taxable salary to be adjusted based on my election/s for the remaining pay periods in this plan year. I understand that this request is for the current plan year and it is my responsibility to enroll to participate in future open enrollment periods for future plan years.

Employee I.D. Number _____

Name _____ _____
(Last, First MI) Agency/School District Name

Street _____ _____
Employee Daytime Phone Number

City, State, Zip _____

Plan Year Election

Health Care Flexible Spending Account $_____
(Minimum $50, Maximum $2,550)

Dependent Care Flexible Spending Account $_____
(Minimum $50, Maximum $5,000)

* Your plan year election will be divided by the number of pay dates remaining in the calendar year.

* DIRECT DEPOSIT REIMBURSEMENT enrollment information is available at www.ben.omb.delaware.gov/fsa.

➔Employee's signature: _____ Date:_____

Please contact Statewide Benefits Office, at 1-800-489-8933 with questions.

Return this form to Statewide Benefits Office by fax, (302) 739-8339

Form No. P-1 (5/15)
Email: pensionoffice@state.de.us
www.delawarepensions.com
Toll Free Number
Outside State of Delaware
1 - 800 - 722 – 7300

Office of Pensions
McArdle Building
860 Silver Lake Blvd, Suite 1
Dover, DE 19904-2402
Telephone: (302) 739 - 4208

STATE OF DELAWARE

MEMBER ACTUARIAL INFORMATION

Reset Form

PERSONAL DATA: To be completed by Member (Please Print)

1. _____ 2. Soc. Sec. No.: _____
(Last Name) (First Name) (M.I.) (Maiden Name)

3. Address: _____ 4. Telephone No.: _____
(Number) (Street) (City) (State) (Zip Code)

5. Date of Birth: _____ (Month / Day / Year) 6. Gender: ☐ Male ☐ Female (Choose One) 7. Marital Status: ☐ Married ☐ Civil Union ☐ Single (Choose One)

8. Organization: _____ Department ID: _____

9. Pension Plan: (Check One): State Employees': ☐ State Police: ☐ Judiciary: ☐ Legislative: ☐
C/M Police/Fire: ☐ C/M General: ☐ (LOSAP) Fire: ☐ Port: ☐

10. Effective Date of Hire with Present Organization: _____ 11. Current Annual Salary: _____

12. Have you previously been a member of any State of Delaware State Sponsored Pension Plan: Yes ☐ No ☐ If YES, complete list below:

PRIOR SERVICE CLAIMED (INCLUDE LEAVES OF ABSENCE AND INDICATE REASON)

NAME OF ORGANIZATION	FROM MONTH	FROM YEAR	THROUGH MONTH	THROUGH YEAR	PERIOD COVERED YEARS	PERIOD COVERED MONTHS
TOTAL PRIOR SERVICE CLAIMED				(ADD)		

13. (a) Did you serve in the Armed Forces of the United States: Yes ☐ No ☐
(b) If (a) is YES, show total Active Military Service:

FROM _____ TO _____ TOTAL CREDIT _____

(c) Did you begin a full-time vocational or professional training course within 5 years of your discharge and become a State employee within 5 years after the completion of that training: Yes ☐ No ☐
(d) If (c) is YES, show full-time vocational or professional training course dates, and date degree, diploma, or certificate granted:

FROM _____ TO _____ DATE OF DEGREE _____

14. Have you ever rendered full-time service in professional educational employment or other full-time employment for another State or the Federal Government, a county or municipality of the State of Delaware, a political subdivision of another State, or in an accredited private school or college: Yes ☐ No ☐ If YES, complete list below:

NAME OF ORGANIZATION	FROM MONTH	FROM YEAR	THROUGH MONTH	THROUGH YEAR	PERIOD COVERED YEARS	PERIOD COVERED MONTHS

15. Are you eligible for benefits as a result of any service listed in No. 14 above: Yes ☐ No ☐

DEPENDENT DATA: (This information must be filled out if you are married or in a civil union.)

16. Name of Spouse: _____ Gender: ☐ Male ☐ Female
(Last Name) (First Name) (M.I.) (Maiden Name)

_____ Telephone No.: _____
(Street Address) (City) (State) (Zip)

Date of Birth: _____ (Month/Day/Year) Soc. Sec. No.: _____ Date of Marriage/Civil Union: _____ (Month/Day/Year)

17. Dependent Child(ren) or Dependent Parents (Fill in only if parent(s) are receiving at least one-half of his or her support from you) :

(Month/Day/Year)

Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ______________

Address: ______________________________ Telephone No.: ______________

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No Dep. Child: ☐ Dep. Parent: ☐ Relationship: ______________

(Month/Day/Year)

Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ______________

Address: ______________________________ Telephone No.: ______________

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No Dep. Child: ☐ Dep. Parent: ☐ Relationship: ______________

(Month/Day/Year)

Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ______________

Address: ______________________________ Telephone No.: ______________

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No Dep. Child: ☐ Dep. Parent: ☐ Relationship: ______________

(Month/Day/Year)

Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ______________

Address: ______________________________ Telephone No.: ______________

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No Dep. Child: ☐ Dep. Parent: ☐ Relationship: ______________

DESIGNATION OF BENEFICIARY FOR PAYMENT OF PENSION CONTRIBUTIONS IF NO SURVIVOR'S PENSION IS PAYABLE

18. (If more than one name is listed, payment will be divided equally, unless otherwise specified.)

Primary/Contingent (Month/Day/Year)

☐ ☐ Name: ______________________ Date of Birth: ____________ SSN or EIN: ____________

Address: ______________________________ Telephone No.: ____________

Relationship: ____________ Gender: ☐ Male ☐ Female

Primary/Contingent (Month/Day/Year)

☐ ☐ Name: ______________________ Date of Birth: ____________ SSN or EIN: ____________

Address: ______________________________ Telephone No.: ____________

Relationship: ____________ Gender: ☐ Male ☐ Female

Primary/Contingent (Month/Day/Year)

☐ ☐ Name: ______________________ Date of Birth: ____________ SSN or EIN: ____________

Address: ______________________________ Telephone No.: ____________

Relationship: ____________ Gender: ☐ Male ☐ Female

Primary/Contingent (Month/Day/Year)

☐ ☐ Name: ______________________ Date of Birth: ____________ SSN or EIN: ____________

Address: ______________________________ Telephone No.: ____________

Relationship: ____________ Gender: ☐ Male ☐ Female

19. I hereby certify that all information given is accurate and true to the best of my knowledge and belief.

Print Form

DATE: ______________ **SIGNATURE OF MEMBER:** ______________________

PHRST PAYROLL REQUEST
Direct Deposit Authorization Form

Please return to your Human Resource or Payroll Department	Date:

Employee Name:	Empl ID:	Work Phone:

Direct Deposit Instructions:
If only one banking instruction is set up, **Section A** designates the account to receive the balance of net pay. If there are multiple banking instructions in **Section B**, then **Section A** designates the account to receive any balance funds left over after all other direct deposit instructions are processed. The priority number of 999 is established for the account in Section A. For multiple accounts, all accounts with the exception of the last account (Section A) shall be processed as **Flat Amount** and shall be designated by Priority beginning with 100, 200, etc. in Section B.

Section A: Balance Account: The following account is either the only account to be used for Direct Deposit or the account which is to receive the net amount remaining after all other deposits have been made as indicated in **Section B**, the list of Additional Accounts.

999	Balance			☐	☐
Priority	Amount	Transit #	Account #	Checking	Savings

Bank Name: _____

Bank Address: _____

Section B: Additional Accounts For Multiple Direct Deposits

				☐	☐
Priority	Flat Amount	Transit #	Account #	Checking	Savings

Bank Name: _____

Bank Address: _____

				☐	☐
Priority	Flat Amount	Transit #	Account #	Checking	Savings

Bank Name: _____

Bank Address: _____

				☐	☐
Priority	Flat Amount	Transit #	Account #	Checking	Savings

Bank Name: _____

Bank Address: _____

I hereby authorize the State of Delaware to deposit my net pay to the financial institution(s) listed above. I understand my net pay will be deposited to my designated account(s) so the funds are available to me on the day of pay. In the event funds to which I am not entitled are deposited to my account(s), I hereby authorize the State of Delaware to direct the bank to return said funds.

Direct Deposit of my net pay will remain in effect until my employment with the State of Delaware is terminated. The State may terminate this service at any time. These Direct Deposit instructions replace any previously dated instructions.

Employee Signature: _____ Date: _____

YOU ARE RESPONSIBLE for ensuring the routing and account numbers on this form are correct.

Please contact your bank to confirm routing/account numbers if you are unsure.

INCORRECT OR ILLEGIBLE ROUTING AND/OR ACCOUNT NUMBERS WILL RESULT IN YOUR PAY BEING DELAYED.

CERTIFICATION OF TAX DEPENDENT STATUS
FOR A CIVIL UNION SPOUSE/CHILDREN

State of Delaware

This form must be completed and signed by the employee when enrolling a civil union spouse and/or the civil union spouse's children in the State of Delaware Group Health Insurance Program.

Employee Name: _____

Employee ID: _____

For a civil union spouse and children of a civil union spouse to be a dependent for health plan purposes, certain requirements in Internal Revenue Code ("IRC") § 152 (as modified by IRC §105(b)) must be satisfied. The civil union spouse and children of the civil union spouse must, in general:

1. Receive at least one half of his/her support from you;
2. Live with you in the same principal place of abode as part of your household;
3. Not be claimed as a "qualifying child" dependent under IRC § 152(c) by anyone else (generally, a qualifying child is a dependent under age 19, age 24 if a full-time student, that meets certain requirements);
4. Be a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico at some time during the year in which you are claiming him/her as a dependent; and,
5. Not file a joint federal income tax return (other than only a claim of refund) with the individual's spouse (applicable to children of civil union spouse).

If you select "**Is a tax-qualified dependent,**" you are certifying the named person is a dependent described in IRC §152 (as modified by IRC §105(b)).

If you select "**Is not a tax-qualified dependent,**" you are certifying (1) the named person is **not** a dependent described in IRC §152 (as modified by IRC §105(b)) and (2) you understand federal tax law requires the fair market value of the coverage extended to the named person to be imputed to you as income on your paycheck and must be reflected on the W-2 issued to you by the State of Delaware.

Notify your Human Resources/Benefits Office in writing immediately of any changes in the named person's tax status and complete this form to provide change in status.

	Name	Date of Birth	Tax Dependent Status
Civil Union Spouse:		____/____/____	☐ Is a tax-qualified dependent ☐ Is not a tax-qualified dependent
Civil Union Spouse's Children:		____/____/____	☐ Is a tax-qualified dependent ☐ Is not a tax-qualified dependent
		____/____/____	☐ Is a tax-qualified dependent ☐ Is not a tax-qualified dependent
		____/____/____	☐ Is a tax-qualified dependent ☐ Is not a tax-qualified dependent
		____/____/____	☐ Is a tax-qualified dependent ☐ Is not a tax-qualified dependent

I understand federal income tax dependent status is separate from eligibility for health benefits. A designation as an dependent described in IRC §152 will result in the State of Delaware not reporting imputed income for the value of those benefits to the IRS for me. As a result, I understand the brief description of a federal income tax dependent above is a general summary, and I should contact my tax advisor before signing this form. I also understand falsely certifying to the tax-dependent status of any person may result in adverse tax consequences and potential charges of tax fraud.

In accordance with my completion of this form, I am requesting my Human Resources/Benefits Office use the following coverage code for enrollment of my civil union spouse and/or civil union spouse's children for health plan purposes:
_____ *(See attached Coverage Code Explanations for complete listing of coverage codes.)*

Employee's signature: _____ Date: _____

State of Delaware Group Health Insurance Program
Coverage Code Explanations
Civil Union Spouses and/or Civil Union Spouse's Children

Following the Coverage Code letter and description will be a listing of the types of dependents covered under this code:

I – Emp & IRSNQ Spouse

- Civil Union Spouse who is not qualified to be employee's tax dependent by IRS

J – Emp & IRSNQ Child

- Children of Civil Union Spouse who are not qualified to be employee's tax dependents by IRS

K – Emp & IRSNQ Spouse + NQ Child(ren)

- Civil Union Spouse who is not qualified to be employee's tax dependent by IRS
- Children of Civil Union Spouse who are not qualified to be employee's tax dependents by IRS

M – Emp & IRSQ Spouse

- Civil Union Spouse who is qualified to be employee's tax dependent by IRS

N - Emp & IRSQ Child

- Children of Civil Union Spouse who are qualified to be employee's tax dependents by IRS

O – Emp & IRSQ Spouse + QChild(ren)

- Civil Union Spouse who is qualified to be employee's tax dependent by IRS
- Children of Civil Union Spouse who are qualified to be employee's tax dependents by IRS

P – Emp+Child & IRSNQ Spouse

- Employee's son, daughter, adopted son, adopted daughter, or foster son or daughter (and/or Employee's grandchild, niece nephew, etc. who are tax dependents as defined in Group Eligibility Rule 2.01c).
- Civil Union Spouse who is not qualified to be employee's tax dependent by IRS

R – Emp+Child & IRSNQ Child(ren)

- Employee's son, daughter, adopted son, adopted daughter, or foster son or daughter (and/or Employee's grandchild, niece nephew, etc. who are tax dependents as defined in Group Eligibility Rule 2.01c).
- Children of Civil Union Spouse who are not qualified to be employee's tax dependents by IRS

S – Emp+Child & IRSNQ Spouse + NQChild(ren)

- Employee's son, daughter, adopted son, adopted daughter, or foster son or daughter (and/or Employee's grandchild, niece nephew, etc. who are tax dependents as defined in Group Eligibility Rule 2.01c).
- Civil Union Spouse who is not qualified to be employee's tax dependent by IRS
- Children of Civil Union Spouse who are not qualified to be employee's tax dependents by IRS

T - Emp+Child & IRSQ Spouse

- Employee's son, daughter, adopted son, adopted daughter, or foster son or daughter (and/or Employee's grandchild, niece nephew, etc. who are tax dependents as defined in Group Eligibility Rule 2.01c).
- Civil Union Spouse who is qualified to be employee's tax dependent by IRS

U - Emp+Child & IRSQ Child(ren)

- Employee's son, daughter, adopted son, adopted daughter, or foster son or daughter (and/or Employee's grandchild, niece nephew, etc. who are tax dependents as defined in Group Eligibility Rule 2.01c).
- Children of Civil Union Spouse who are qualified to be employee's tax dependents by IRS

V - Emp+Child & IRSQ Spouse + Q Child(ren)

- Employee's son, daughter, adopted son, adopted daughter, or foster son or daughter (and/or Employee's grandchild, niece nephew, etc. who are tax dependents as defined in Group Eligibility Rule 2.01c).
- Civil Union Spouse who is qualified to be employee's tax dependent by IRS
- Children of Civil Union Spouse who are qualified to be employee's tax dependents by IRS

W – Emp & IRSNQ Spouse + Q Child(ren)

- Civil Union Spouse who is not qualified to be employee's tax dependent by IRS
- Children of Civil Union Spouse who are qualified to be employee's tax dependents by IRS

X - Emp & IRSQ Spouse + NQ Child(ren)

- Civil Union Spouse who is qualified to be employee's tax dependent by IRS
- Children of Civil Union Spouse who are not qualified to be employee's tax dependents by IRS

Y - Emp+Child & IRSNQ Spouse + QChild(ren)

- Employee's son, daughter, adopted son, adopted daughter, or foster son or daughter (and/or Employee's grandchild, niece nephew, etc. who are tax dependents as defined in Group Eligibility Rule 2.01c).
- Civil Union Spouse who is not qualified to be employee's tax dependent by IRS
- Children of Civil Union Spouse who are qualified to be employee's tax dependents by IRS

Z - Emp+Child & IRSQ Spouse + NQChild(ren)

- Employee's son, daughter, adopted son, adopted daughter, or foster son or daughter (and/or Employee's grandchild, niece nephew, etc. who are tax dependents as defined in Group Eligibility Rule 2.01c).
- Civil Union Spouse who is qualified to be employee's tax dependent by IRS
- Children of Civil Union Spouse who are not qualified to be employee's tax dependents by IRS

T/Civil Unions for 1-1-12/CU SGM Web Pieces for 10-13/CU Doc#2.Coverage Code Explanation 9-13-13
Revised 7-1-13
Revised 9-13-13

Form W-4 (2015)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or 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-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B**
C	Enter "1" for your **spouse.** But, you may 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 number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E**
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G**
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	**H**

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2015

1	Your first name and middle initial	Last name	**2** Your social security number
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	**7**	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

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 who claims no withholding allowances; 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.