NEW HIRE PAYROLL PACKET

This packet is to be completed by **full-time, benefits-eligible** employees prior to the first day of assignment at Frazier School District. A driver's license and Social Security card will also be required. Alternate documentation is acceptable according to the List of Acceptable Documents (Form I-9) enclosed. Please bring original, valid identification to the Business Office along with this packet so copies can be made.

Updated clearances are required in the Superintendent's Office if not provided at time of application.

Please contact 724-736-9507 Ext. 110 with questions.

FRAZIER SCHOOL DISTRICT

TO: _____

FROM: Erin Clausner, Payroll Clerk

SUBJECT: Benefits Paperwork

Congratulations on your new assignment with Frazier School District! As a full-time employee of the District, you are eligible to enroll in benefits as described below. Please complete the attached and return to me as soon as possible. Your eligibility is effective the first of the month following your full-time start date unless otherwise indicated. With a start date of_____, your eligibility will begin _____.

A few things to note:

- The ACSHIC enrollment form is for medical and prescription election.
- The Enrollment/Change Form is for dental and/or vision coverages.
- You may choose dental and/or vision coverages for yourself- dental only for dependents - regardless of your medical coverage election. This premium is paid by the District.
- Please provide copies of Social Security cards and marriage certificate for spousal coverage, Social Security cards and birth certificates for coverage of any/all dependent children. Other dependency documentation may be required.
- If you have the same or similar medical insurance elsewhere, please indicate your waiver of the offer and complete all sections of the ACSHIC form. This will constitute election of the medical allowance. Verification of coverage will be required.
- If you decline coverage at this time, unless you experience a defined qualifying event, the next opportunity to enroll will be for coverage effective July 1, 2025.
- UNUM forms are for disability insurance. This is coverage for the employee only and is paid for by the District.
- The Sun Life Employee Application is for life insurance coverage. Again, coverage is for the employee, paid by the District.
- The District offers voluntary enrollment in a healthcare flex benefit plan (FSA) through American Fidelity. This account is 100% funded by the employee. (Annual open enrollment for this plan will become effective again July 1, 2025.)
- Additional voluntary insurance products are available through American Fidelity/AF.
- Our American Fidelity representative will contact you to discuss these offers and to document your decision for the District's compliance records if you decline participation.
- Also, if you have/open an account with Fayette County School Employees' Federal Credit Union, you may have an amount of your choosing deducted and forwarded from your pay.
- Frazier School District utilizes the portal through Harris School Solutions (link on the District website) for paystub distribution. Access will be available on the date of your first district pay. Username is your first initial followed by your last name, all lower case, no space-- password will be the last 4 digits of your Social Security number. You are encouraged to change your password after the initial login.

If you have any questions, please contact me at 724-736-9507 Ext. 110. Best wishes in your new position.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

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

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

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

2. Expect to work only part of the year;

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

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

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

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

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

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

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

CLGS-32-6 (05/17)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be used by employers when a new employee is hired or when a current employee notifies employer of a name or address change. Use the Address Search Application at dced.pa.gov/Act32 to determine PSD codes, EIT rates, and tax collector contact information.

EMPLOYEE INFORMATION – RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS (No PO Box, RD or RR)			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION – EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
FRAZIER SCHOOL DISTRICT			251181266
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)			
142 CONSTITUTION STREET			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	PHONE NUMBER
PERRYOPOLIS	PA	15473	724-736-9507
MUNICIPALITY (City, Borough or Township)			
PERRYOPOLIS BOROUGH			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE
FAYETTE	260405		

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES, and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

dced.pa.gov/Act32

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

Frazier School District
Payroll Schedule
2024-2025

PAY DATE*	HOURS/DAYS WORKED FROM ...	HOURS/DAYS WORKED TO ...	TIMESHEETS DUE* TO BUILDING SECRETARY OR SUPERVISOR
September 13, 2024	August 17, 2024	August 30, 2024	August 30, 2024
September 27, 2024	August 31, 2024	September 13, 2024	September 13, 2024
October 11, 2024	September 14, 2024	September 27, 2024	September 27, 2024
October 25, 2024	September 28, 2024	October 11, 2024	October 11, 2024
November 8, 2024	October 12, 2024	October 25, 2024	October 25, 2024
November 22, 2024	October 26, 2024	November 8, 2024	November 8, 2024
December 6, 2024	November 9, 2024	November 22, 2024	November 22, 2024
December 20, 2024	November 23, 2024	December 6, 2024	December 6, 2024
January 3, 2025	December 7, 2024	December 20, 2024	December 20, 2024
January 17, 2025	December 21, 2024	January 3, 2025	January 3, 2025
January 31, 2025	January 4, 2025	January 17, 2025	January 17, 2025
February 14, 2025	January 18, 2025	January 31, 2025	January 31, 2025
February 28, 2025	February 1, 2025	February 14, 2025	February 14, 2025
March 14, 2025	February 15, 2025	February 28, 2025	February 28, 2025
March 28, 2025	March 1, 2025	March 14, 2025	March 14, 2025
April 11, 2025	March 15, 2025	March 28, 2025	March 28, 2025
April 25, 2025	March 29, 2025	April 11, 2025	April 11, 2025
May 9, 2025	April 12, 2025	April 25, 2025	April 25, 2025
May 23, 2025	April 26, 2025	May 9, 2025	May 9, 2025
June 6, 2025	May 10, 2025	May 23, 2025	May 23, 2025
June 20, 2025	May 24, 2025	June 6, 2025	June 6, 2025
July 4, 2025	June 7, 2025	June 20, 2025	June 20, 2025
July 18, 2025	June 21, 2025	July 4, 2025	July 4, 2025
August 1, 2025	July 5, 2025	July 18, 2025	July 18, 2025
August 15, 2025	July 19, 2025	August 1, 2025	August 1, 2025
August 29, 2025	August 2, 2025	August 15, 2025	August 15, 2025

* Timesheet due date and/or pay date may be alterred based on bank holiday(s) and/or district closures. Revisions to these dates will be communicated through district email.

Direct Deposit Authorization Form

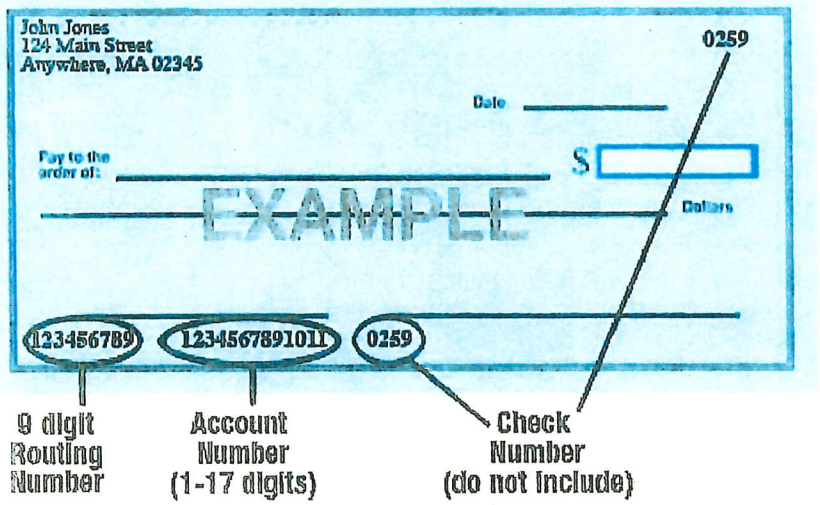
Please print and complete ALL the information below.

Employee Name: _____

Employee Social Security #: _____

Address: _____

City, State, Zip: _____



Name of Financial Institution: _____

Account #: _____

9-Digit Routing #: _____

Type of Account: Checking Savings (Circle One)

Please attach a voided check for the bank account to which funds should be deposited.

Frazier School District is hereby authorized to directly deposit my net pay in the account and financial institution indicated above. This authorization will remain in effect until I modify or cancel it in writing. Any such notification to my employer shall become effective following receipt, after a reasonable opportunity to act on it.

Employee Signature: _____

Date: _____

workpartners

Frazier School District - Perryopolis (15473)
YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS
Send Bills To: PO Box 2971, Pittsburgh, PA 15230
Fax: (412) 454-8717
To Report a Claim Call: 1-800-633-1197
WC Policy:WC300-0006189
Policy Effective Date:07/01/2024

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

Please contact your Claims Adjuster for any specialty need not listed on this panel.

Name	Address	Scheduling	Area of Specialty
St Clair Occupational Medicine (use Urgent Care after hours)	2000 Oxford Dr, Ste 100 Urgent Care: (412) 942-8800 Bethel Park, PA 15102	412-942-7115	Occupational Medicine
Excela Health WORKS - Greensburg	443 Frye Farm Rd Upper Level Greensburg, PA 15601	724-765-1230	Occupational Medicine
MedExpress Urgent Care - Belle Vernon (All Locations - MedExpress.com)	860 Rostraver Rd Belle Vernon, PA 15012	724-929-3278	Urgent Care
Mon-Vale Surgical Associates	800 Plaza Dr, Ste 140 Monongahela Valley Hospital HealthPlex Belle Vernon, PA 15012	724-929-4122	General Surgery
*UPP Dept of Neurosurgery - McKeesport	500 Hospital Way, Ste 6 John Painter Building McKeesport, PA 15132	412-647-3685	Neurosurgery
The Orthopedic Group - Belle Vernon	800 Plaza Dr, Ste 400 Belle Vernon, PA 15012	724-379-5802	Orthopedics
The Orthopedic Group at Penn Highlands - Uniontown	150 Wayland Smith Dr Uniontown, PA 15401	724-437-8200	Orthopedics
Everett & Hurite Ophthalmic Association - Rostraver	800 Plaza Dr, Ste 360 Willow Pointe Plaza Belle Vernon, PA 15012	724-929-5512	Ophthalmology
Associates in Medical Rehabilitation PLCC	1163 Country Club Rd Monongahela, PA 15063	724-258-1408	Physiatry (Musculoskeletal Injuries)
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy

*In accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.

CONTACT THE BUSINESS MANAGER (EXT. 114) TO FILE A WORKER'S COMP. CLAIM OR TO REQUEST AN UPDATED PANEL OF PROVIDERS.

Panel updated: 7/16/2024

workpartners

WORKERS' COMPENSATION INFORMATION

To All Employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information:

Department of Labor & Industry
Bureau of Workers' Compensation
651 Boas Street 8th Fl
Harrisburg, Pennsylvania 17121-0750
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____, employee of _____,
(employer)
certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file. Workpartners Claims Management Services PO Box 2971 Pittsburgh PA 15230

workpartners

EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

_____

Employee' s Signature Date

_____

Employee' s Name (Print) Employee Number

_____

Employer Department

_____

Witness' Signature Date

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.

PSERS

PUBLIC SCHOOL EMPLOYEES' RETIREMENT SYSTEM

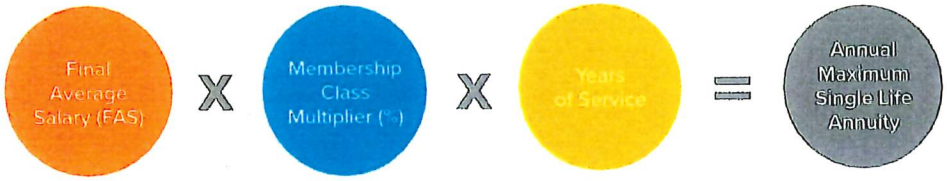
Welcome to PSERS

Understanding your membership class options

You are automatically enrolled as a Class T-G member. Class T-G provides both a Defined Benefit (DB) and a Defined Contribution (DC) component for your retirement benefit. If you wish to remain in Class T-G, ***no action is required***. You have a 90-day election period to decide if you would like to remain Class T-G or elect one of two other membership classes: Class T-H or Class DC. This guide compares the features and benefits of each membership class on the next page.

What is the difference between PSERS' Defined Benefit (DB) and Defined Contribution (DC) Plans?

The **Defined Benefit** component of your retirement guarantees you a monthly benefit based on the following calculation.



The **Defined Contribution** component of your retirement is based on the amount of contributions made by you and your employer and the investment performance on those contributions, subject to costs and expenses. Your contributions have the potential to grow based on investment earnings, but are not guaranteed against loss in declining investment markets.

How are the membership classes similar and different?

Class T-G offers the highest monthly DB benefit at retirement. You also have a DC component of your retirement, which is based on what you and your employer contribute to the DC Plan and the performance of those contributions based on the investment options you choose, subject to costs and expenses. Compared to Class T-H, Class T-G has a higher DB member contribution rate* and a higher employer DC contribution rate, but a lower participant DC contribution rate.

Class T-H offers a monthly benefit from the DB component that is lower than Class T-G. You also have a DC component of your retirement, which is based on what you and your employer contribute to the DC Plan and the performance of those contributions based on the investment options you choose, subject to costs and expenses. Compared to Class T-G, Class T-H has a lower DB member contribution rate* and a lower employer DC contribution rate, but a higher participant DC contribution rate.

Class DC offers the value of your DC account based solely on what you and your employer contribute to the DC Plan and the performance of those contributions based on the investment options you choose, subject to costs and expenses. The participant DC contribution rate is the highest and the employer DC contribution rate is the same as Class T-H, which is lower than that of Class T-G. Class DC provides no monthly DB benefit or PSERS disability retirement benefit. Class DC members cannot purchase service and cannot elect Multiple Service membership to combine PSERS credited service with service credited in the State Employees' Retirement System.

* The DB contribution rate is subject to a Shared Risk/Shared Gain contribution Rate. Please visit PSERS online for additional information and the most current contribution rates.

Membership Class Comparison

The following chart compares the unique features and benefits of Class T-G, Class T-H, and Class DC. The chart also details how much of your salary you contribute each pay period, how much you employer contributes on your behalf each pay period, when you qualify for a benefit, and how your total retirement benefit is calculated. Please review the information carefully when considering your Membership Class options.

	Your Default Option Class T-G (Hybrid of DB & DC Plans)	Elective Option Class T-H (Hybrid of DB & DC Plans)	Elective Option Class DC (DC Plan)
Total Member Contribution Rate*	8.25% (DB: 5.50% + DC: 2.75%)	7.50% (DB: 4.50% + DC: 3.00%)	7.50%
Employer Contribution Rate to Member's DC Account	2.25%	2.00%	
Vesting Period (When you qualify for a benefit)	10 years (or age 67 with 3 years of service) - DB Plan 3 eligibility points to receive the DC Employer Contributions/Earnings		No DB Plan 3 eligibility points to receive the DC Employer Contributions/ Earnings
Your Total Retirement is based on...	DB = 1.25% x FAS x Years of Service + Value in DC account	DB = 1.00% x FAS x Years of Service + Value in DC account	No DB Plan. Value in DC account only
Total Retirement Benefit	Guaranteed monthly benefit for life (DB Plan) + Contributions (DC Plan) and the investment performance, subject to costs and expenses		Contributions (DC Plan) and the investment performance, subject to costs and expenses
Purchasing Service, Disability Retirement, Electing Multiple Service	Yes		No, except for USERRA
Normal Retirement Age	For the DB Plan, earlier of: • Age 67 with 3 years of service • Combination of age and service equaling 97 with at least 35 years of service For the DC Plan, distribution after termination of service	For the DB Plan, age 67 with 3 years of service For the DC Plan, distribution after termination of service	N/A (Distribution permitted after termination of service)
Early Retirement Milestone	Age 57 with 25 years of service	Age 55 with 25 years of service	N/A

* The Member Contribution Rate is a percentage of your retirement-covered compensation that is withheld from your pay. This represents the current DB rate inclusive of the Shared Risk/Shared Gain Contribution Rate. The mandatory contributions you make to the PSERS DB and DC Plans lower your federal taxable income and increase your tax-deferred savings for retirement.

PSERS New Member Election Calculator

New members can use the PSERS New Membership Class Election Calculator to estimate what the value of their DB and DC component may be in retirement. This is particularly important for Class T-G members who are within their 90-day class election window to elect Class T-H or Class DC. You also may want to consider consulting with a certified financial planner.

PSERS Membership Class Election calculator provides estimated DB monthly annuity amounts and a potential and estimated DC vested amount. Although PSERS makes every effort to accurately represent the estimated amounts calculated using this calculator, PSERS makes no assurance, representation, or promise regarding the estimated DB benefit, future earnings or losses, or income projections.

Access the Election Calculator on the PSERS website or scan the QR code

Membership Class Example

Member assumptions: $40,000 starting salary with 3% annual increases, working for 35 years (normal retirement)

PSERS DB Plan factors: Final average salary of $103,093 and earns a guaranteed 4% on contributions and interest. Member leaves these in for maximum pension benefit. The base DB contribution rate is 5.50% for Class T-G and 4.50% for Class T-H. Shared Risk/Shared Gain rate is not applied. Visit PSERS online for the most current contribution rates.
PSERS DC Plan assumptions*: 26 pay periods per year and 6% rate of return.

	Your Default Option	Your Other Elective Options	
	Class T-G ***Highest guaranteed retirement benefit***	**Class T-H** ***Reduced guaranteed retirement benefit***	**Class DC** ***Value of account at time of distribution***
Total Retirement Benefit	$944,399	$824,388	$654,177
Retirement Benefit Breakdown	$45,103 Annual Pension for life + DC Plan Account of $344,304 at retirement	$36,083 Annual Pension for life + DC Plan Account of $344,304 at retirement	No Annual Pension + DC Plan Account of $654,177 at retirement (You assume all investment risk)
First Year Member Contributions (based on a $40,000 starting salary)	$3,300 or $126.92 from bi-weekly pay	$3,000 or $115.38 from bi-weekly pay	
Total Member Contributions	$199,525	$181,386	
Total Employer DC Contributions	$54,416	$48,370	

* These hypothetical examples assume a 6% effective annual interest rate and no withdrawals. For illustrative purposes only, to show how the contribution rate and number of years invested in the DC Plan could affect your account value. Not intended as a guarantee of past or future performance of any security. Hypothetical assumptions are not guaranteed. Your actual results may vary. Actual rate of return may be more or less than shown and will depend upon a number of different factors, including your choice of investment options.

Questions to Ask Before Making Your Irrevocable Membership Class Election

- Will you work long enough to be eligible for a DB benefit with Class T-G or Class T-H by either rendering 10 years of service, or working until age 67 with at least three years of service?
- What Membership Class will better help you attain your expected retirement income and meet your financial goals?
- Do you want the ability to make the investment decisions for all or some of your retirement plan contributions?

Watch the Series of PSERS Member Class Election Videos

Visit PSERS online and go to the Class Election page for three short videos to assist you in making this important decision.

- "Understanding Your PSERS Benefit" provides a high-level overview of the PSERS retirement benefit options for new members.
- "Understanding Membership Classes" compares the PSERS membership classes: Class T-G, Class T-H, and Class DC.
- "Selecting Your Membership Class" provides examples of what your benefit may look like in each membership class as well as instructions for remaining in your current membership class and electing a new class.

Electing Class T-H or Class DC

If you would like to elect Class T-H or Class DC, you must timely log in to your PSERS MSS account and follow the instructions on the *Class Election* tab prior to your deadline.

If you have any questions about making an election, please visit PSERS online, send a secure message from your Member Self-Service (MSS) account, or call PSERS at ***1.888.773.7748 (1.888.PSERS4U)***. The Member Service Center is staffed each business day from 8:00 a.m. to 5:00 p.m.

DC Plan Investment Options

Upon enrollment into the PSERS DC Plan, your and your employer's contributions are automatically invested in a target date investment based on your estimated normal retirement age (67) as determined by your date of birth. Target date investments are professionally managed and periodically adjusted with a specific target retirement date in mind. They are designed to adjust to changing needs *up to and throughout retirement* in a single investment option. Professional investment managers invest your money in a mix of funds across a variety of asset classes to create a diversified investment portfolio, guided by the number of years until retirement. The target date investment is automatically monitored and rebalanced to shift assets to more conservative investments as the retirement year draws near.

Your birth year:	Your default investment:
Prior to 1956	T. Rowe Price Target Date 2020
1/1/56 - 12/31/60	T. Rowe Price Target Date 2025
1/1/61 - 12/31/65	T. Rowe Price Target Date 2030
1/1/66 - 12/31/70	T. Rowe Price Target Date 2035
1/1/71 - 12/31/75	T. Rowe Price Target Date 2040
1/1/76 - 12/31/80	T. Rowe Price Target Date 2045
1/1/81 - 12/31/85	T. Rowe Price Target Date 2050
1/1/86 - 12/31/90	T. Rowe Price Target Date 2055
1/1/91 - 12/31/95	T. Rowe Price Target Date 2060
In 1996 or after	T. Rowe Price Target Date 2065

You can remain in your default target date investment or change how all or part of your account balance is invested at any time by accessing your PSERS DC account through the PSERS MSS Portal. You can select a different target date investment or choose from among the following 9 additional investment options. Visit PSERS online for more investment information and to access fund prospectuses.

Stable Value

MissionSquare PLUS Fund R10 seeks to preserve capital, limit risk of loss to your principal, and deliver stable returns.

Bonds

BlackRock High Yield K invests primarily in non-investment grade bonds with maturities of 10 years or less.

PIMCO Total Return Instl invests at least 65% of its total assets in a diversified portfolio of fixed income instruments of varying maturities.

PIMCO Real Return Instl invests at least 80% of its net assets in inflation-indexed bonds of varying maturities issued by the U.S. and non-U.S. governments.

Balanced

Calvert Balanced R6 actively manages a portfolio of stocks, bonds, and money market instruments.

Stocks

Fidelity® 500 Index invests at least 80% of assets in common stock included in the S&P 500 Index, which broadly represents the performance of common stocks publicly traded in the U.S.

Fidelity® Extended Market Index invests at least 80% of assets in common stocks included in the Dow Jones U.S. Completion Total Stock Market Index, which represents the performance of stocks of mid- to small-capitalization U.S. companies.

Fidelity® Real Estate Index corresponds to the total return of equity Real Estate Investment Trusts and other real estate-related investments.

American Funds Europacific Growth R6 invests primarily in common stock of issuers in Europe and the Pacific Basin that the investment adviser believes have the potential for growth.

PSERS
PUBLIC SCHOOL EMPLOYEES' RETIREMENT SYSTEM

With PSERS, you're on your way!

The T. Rowe Price target date trusts (the Trusts) are not mutual funds. They are common trust funds established by T. Rowe Price Trust Company under Maryland banking law, and their units are exempt from registration under the Securities Act of 1933. Investments in the Trusts are not deposits or obligations of, or guaranteed by, the U.S. government or its agencies or T. Rowe Price Trust Company and are subject to investment risks, including possible loss of principal.

Not FDIC/NCUA/NCUSIF Insured • Not a Deposit of a Bank/Credit Union • May Lose Value • Not Bank/Credit Union Guaranteed • Not Insured by Any Federal Government Agency

Plan administrative services are provided by Voya Institutional Plan Services, LLC (VIPS). VIPS is a member of the Voya® family of companies and is not affiliated with the Public School Employees' Retirement System (PSERS) or the PSERS Defined Contribution Plan.

Attached is the 2025 Plan Summary for Frazier School District from TSA Consulting Group, Inc. If you have any questions on your existing TSA plan contribution, or are interested in establishing one, please contact the appropriate vendor or representative below.

Cynthia L. Egan
Senior Financial Advisor
CEgan@lincolninvestment.com
Lincoln Investment
1606 Carmody Court, Suite 102
Blaymore One Office Building
Sewickley, PA 15143
412-231-7968 (fax)
412-883-3786 (W)
1-800-318-4828 x3340

Douglas S. Waszo
Financial Advisor
dwaszo@4kmc.com
www.4kmc.com
Kades Margolis
One Northgate Square Ste. 102
Greensburg, PA 15601
724-836-2800 (W)
724-286-7747 (C)
724-836-5800 (fax)

Kyle Bero
Financial Advisor
Kyle.bero@equitable.com
Equitable Advisors
6000 Town Center Blvd
Suite 335
Canonsburg, PA 15317
724-338-2014 (W)
724-317-6954 (C)

Rachel Acosta
Account Manager
Rachel.Acosta@americanfidelity.com

Domenic Santoleri
PA State Manager
Domenic.Santoleri@americanfidelity.com

American Fidelity Assurance Co.
877-518-2337 (W)
844-565-2235 (fax)

Invesco Oppenheimer Funds
(800)-959-4246

Daniel Hall
daniel.hall@horacemann.com
Horace Mann
412-925-6429

Bill Kuban
bill.kuban@horacemann.com
Horace Mann
412-559-6930

Security Benefits Group
(800) 888-2461

Frazier School District, PA

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION

403(b) PLAN

The 403(b) Plan is a valuable retirement savings option. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) Plan offered.

Plan administration services for the 403(b) plan are provided by U.S. OMNI & TSACG Compliance Services (OMNI/TSACG). Visit the website *at https://www.tsacg.com* for information about enrollment in the plan, investment product providers available, distributions, enrollment, exchanges or transfers, 403(b) loans, and rollovers.

ELIGIBILITY

Most employees are eligible to participate in the 403(b) plan immediately upon employment; however, private contractors, appointed/elected trustees and/or school board members are not eligible to participate in the 403(b) plan(s). Verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to the 403(b) plan and are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Traditional 403(b)

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) account up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) account are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

Roth 403(b)

Contributions made to a Roth 403(b) account are after-tax deductions from your paycheck. Income taxes are not reduced by contributions you make to your account. All qualified distributions from Roth 403(b) accounts are tax-free. Any earnings on your deposits are not taxed as long as they remain in your account for five years from the date that your first Roth contribution was made. Distributions may be taken if you are 59½ (subject to plan document provisions) or at separation from service.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. OMNI/TSACG monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2025 IS $23,500.

Additional provisions allowed:

AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 to 59 or 64 or older by 12/31/2025 qualify to make an additional contribution of up to $7,500 to the 403(b) accounts. Participants aged 60, 61, 62, or 63 on 12/31/2025, can contribute an additional amount of up to $11,250.

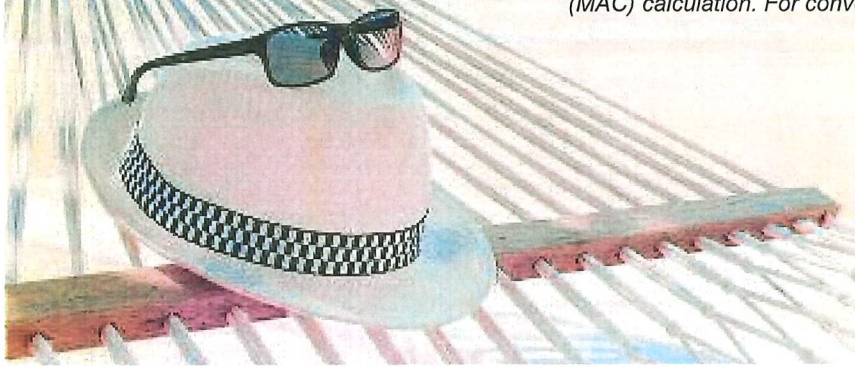
THE SERVICE-BASED CATCH UP AMOUNT

The special catch-up provision allows participants to make additional contributions of up to $3,000 if, as of the preceding calendar year, the participant has completed 15 or more full years of employment with the current employer, not averaged over $5,000 per year in annual contributions, and has not utilized catch-up contributions in excess of the aggregate of $15,000. For a detailed explanation of this provision, please visit *https://www.tsacg.com.*

ENROLLMENT

Employees who wish to enroll in the 403(b) plan must first select the provider and investment product best suited for their 403(b) account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and any disclosure forms must be completed and submitted to the employer. This form authorizes the employer to withhold 403(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. An SRA must be completed to start, stop or modify contributions to a 403(b) account. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.



2025

INVESTMENT PROVIDER INFORMATION
A current list of authorized 403(b) Investment Providers and current employer forms are available on the employer's specific Web page at *https://www.tsacg.com.*

PLAN DISTRIBUTION TRANSACTIONS
Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing. Prior to taking a loan, participants should consult a tax advisor.

PLAN-TO-PLAN TRANSFERS
A plan-to-plan transfer is defined as the movement of a 403(b) account from a previous employer's plan and retaining the same account with the authorized investment provider under the new employer's plan.

ROLLOVERS
Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS
Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations unless they have attained age 59½ or separated from service. In most cases, any withdrawals made from a 403(b) account are taxable in full as ordinary income.

EXCHANGES
Participants may exchange account accumulations from one 403(b) investment provider to another 403(b) investment provider that is authorized under the plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange.

403(b) PLAN LOANS
Participants may be eligible to borrow their 403(b) plan accumulations depending on the provisions of their 403(b) account contract and provisions of the employer's plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) account contract and provisions of the employer's plan. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider.

HARDSHIP WITHDRAWALS
Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must certify and may be asked to provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at *https://www.tsacg.com.*

EMPLOYEE INFORMATION STATEMENT
Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

PLAN ADMINISTRATOR CONTACT INFORMATION

Transactions
P.O. Box 4037 | Fort Walton Beach, FL 32549
Toll-free: 1-888-796-3786 | https://www.tsacg.com

For overnight deliveries
73 Eglin Parkway NE, Suite 202 | Fort Walton Beach, FL 32548
Toll-free: 1-888-796-3786 | https://www.tsacg.com

403(b) Plan Employee Universal Availability Notice

Frazer School District provides eligible employees the opportunity to voluntarily save for your retirement through a *403(b) plan*. The Plan allows you to make pre-tax, or if available in the plan document post-tax Roth contributions, to a 403(b) savings account to help you save for retirement. All employee contributions are made through salary reduction and employees are always 100% vested in employee contributions. Plan contributions as well as any investment earnings are tax-deferred and therefore are not taxable until distributed. Because the plan is to help you save for retirement, distributions from the plan are only permissible under certain circumstances such as retirement or termination of employment.

Eligibility

All employees who receive compensation reportable on an IRS Form W-2 are eligible to participate in the plan, with the exception of those specifically excluded below. If no exclusions are indicated, then all employees are eligible to participate.

- Employees who participate in an eligible governmental plan under Code section 457(b)
- Employees who are non-resident aliens;
- Employees who are students performing certain services
- Employees who normally work fewer than 20 hours per week

Enrollment

Whether you desire to enroll in the plan, or you are already enrolled but wish to make a change to the amount you currently defer, you may accomplish this by establishing an account with one of our approved providers and completing a Salary Reduction Agreement for the plan. You may obtain a list of participating providers from Payroll at the District Office or under Employee Resources/Documents of Interest/Payroll Form on the Frazier website.

Contribution Limitations

- You may contribute up to $23,500 for 2025 based on contribution limits set by federal tax law. If you attain age 50 during the calendar year of the deferral or are over age 50 you may make an additional $7,500 contribution in 2025. These amounts are subject to change annually.

If you are age 50 or over with 15 or more years of service, additional catch-up contributions may be available.

Your participation in this plan is voluntary. Participation in and contributions to the plan may change or cease at any time, subject to the rules of the plan.

I, _____ the undersigned employee hereby attest that I have been made aware of my employers 403(b) Plan and the eligibility requirements thereof.

_____ _____

Employee Signature Date

FRAZIER SCHOOL DISTRICT
142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390 FAX: (724) 736-0688

Mr. Michael V. Turek
Superintendent of Schools
mturek@fraziersd.org
724-736-9507 x116

Confidentiality Agreement

It is the policy of Frazier School District to provide our employees or students with a level of privacy and confidentiality with any information concerning any of our employees or students.

In the course of your work, you may have access to confidential information (oral, written or computer generated not otherwise available to the public at large) about employees or students, their families and/or personal business. School business information includes computer programs, software and supporting documentation, technology improvement plans, strategy plans, financial information and employee information (including but not limited to co-workers and their families).

THEREFORE, I AGREE that:

My right to enter or make use of confidential information is restricted to my need to know the data or information to perform my job responsibilities. I will keep my computer access password(s) confidential. If another method of accessing a computer system is used, I will restrict its use to myself. I will not discuss any confidential information in any public areas, hallways, gathering spaces, etc.

I will hold all confidential information of which I have knowledge in the truest confidence, as required by law. I agree to utilize confidential information obtained by me for the benefit of the employee or student or in performance of my job responsibilities.

Unauthorized disclosure, copying and/or misuse of confidential information is a serious breach of duty and will result in disciplinary action up to and including termination of employment or contract with Frazier School District. Further, this agreement mandates compliance extending beyond employment, contract, or association with Frazier School District as required by law.

I HAVE READ THIS CONFIDENTIALITY AGREEMENT AND AGREE TO ITS TERMS.

_____

Employee Name (PRINT)

_____

Employee Signature Date

Please note…

- Required notices and additional information about Frazier School District's current medical plans can be found on the Allegheny County Schools Health Insurance Consortium (ACSHIC) website, acshic.com/your-benefits/plans-grids-summaries/#. Look for Member Benefit Grids and Summaries under the 'Your Benefits' dropdown.
- Visit the Optum Rx website at http://welcome.optumrx.com/acshic/ to learn more about your prescription benefit and finding a network pharmacy.
- Frazier School District does not utilize ACSHIC's network for Dental and Vision plan coverages.
- Create an Account at unitedconcordia.com to access your dental summary of benefits or contact the Business Office for a paper copy of the Benefit Summary for your applicable group.
- Register at davisvision.com to access more information on your vision plan coverage or access their automated system at 1-800-999-5431. Your Social Security number is the Member ID.

Notice of Special Enrollment Rights

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), group health plans such as ACSHIC are required to provide active employees, their dependents and COBRA qualified beneficiaries with special enrollment opportunities for certain situations.

You may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for coverage under another plan, such as a spouse's plan. The following are some events that may trigger a Special Enrollment Event:

Loss of eligibility for other coverage

- Due to divorce or legal separation;
- Dependent loss of eligibility due to age under a parent's plan;
- Death of an employee's spouse which leaves the spouse with no coverage;
- Spouse's loss of employment that terminates insurance coverage; and
- Spouse no longer eligible for insurance coverage for other reasons.

You must request enrollment within 30 days after your or your dependents' other coverage ends.

In addition, if you have a new dependent as 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.**

If you or a dependent have exhausted entitlement to benefits under COBRA under a different group health plan (usually after 18 or 36 months) you may be able to enroll yourself and/or your dependents under the ACSHIC Plan. **However, you must request enrollment within 30 days after the COBRA coverage ends.**

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

You must notify ***YOUR HR DEPARTMENT*** within the required period after a Special Enrollment Event takes place. Coverage will not be provided if the request is not made in a timely manner.

If you are enrolling in the Plan for the first time, you must complete an enrollment form and provide the supporting documentation for your Special Enrollment Event. If you are currently enrolled and adding a dependent, then a written request is required along with the supporting documentation.

Please contact ***YOUR HR DEPARTMENT*** if you have any questions regarding the submittal of a Special Enrollment Request.

ACSHIC Enrollment Form - Frazier School District

Effective Date: _____

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER □ MALE □ FEMALE	MARITAL STATUS □ SINGLE □ MARRIED

ADDRESS	CITY	STATE	ZIP CODE

Coverage Type	Election	Coverage Level
Medical/RX	□ **EPO** □ **PPO**	□ Individual □ Parent/Child □ Parent/Children □ Employee/Spouse □ Family

Dependent Election

	NAME	SSN	D.O.B.	GENDER	RELATIONSHIP
1					
2					
3					
4					
5					
6					

Open Enrollment is the time that you can make changes to your benefits outside of a qualifying life event. For information on changes outside of open enrollment please see the HIPAA Notice of Special Enrollment Rights.

Waiving Coverage (continued on reverse, completion required to waive)

☐ I **decline** to enroll in medical coverage for myself and any/all dependents. By checking this box, I understand that I/we will not be enrolled in any of the above coverages. I understand that this waiver of coverage may affect my ability and that of any/all dependents to obtain coverage at a later date, specifically, except during applicable "Special Enrollment Periods". As a benefits-eligible employee waiving medical coverage through Frazier School District, completion of the reverse side of this form (and providing the necessary documentation) indicates my election of the applicable medical allowance in lieu of medical enrollment.

Enrollment Attestation

To the best of my knowledge, the information provided on these forms is true and correct. I understand that this form enrolls those eligible persons listed above in the selected plans and I authorize any payroll deductions required for the coverage I have selected. I also understand that I must select coverage for my dependents, or they will not be enrolled. By signing below, I also acknowledge contents of the HIPAA Notice of Special Enrollment Rights.

Employee Signature (Acceptance and Waiver) _____ **Date** _____ **Authorized Employer Signature** _____ **Date** _____

Waiving Coverage (continued from front)

The parties hereto agree that if the Frazier employee entitled to the health insurance benefits set forth on the reverse side of this form is insured by the same or a similar plan elsewhere, that employee shall so notify the District of that fact and make an election as to the insurance plan with which he/she will choose to be insured.

Employees covered by a spouse's insurance or other similar insurance coverage may choose not to be in the insurance program offered by the District. Employees making such a choice shall receive five hundred dollars ($500) per month through payroll in lieu of the District plan enrollment-- unless specified elsewhere-- by providing the following.

If enrolled in spouse's coverage, please complete the following and provide documentation from the plan coordinator/employer verifying enrollment for yourself and any/all dependents. If enrolled in other similar coverage, complete the name of plan, account number of plan, and provide documentation.

Name of Employee _____

Name of Employer _____

Address of Employer _____

_____

_____

Employer Telephone Number _____

Name of Plan _____

Account Number of Plan _____

I hereby verify the statements set forth in this form are true and correct to the best of my knowledge, information and belief.

_____ _____

Employee Signature (Waiving Coverage) **Date**

Enrollment/Change Form

United Concordia Dental / Davis Vision

School District _____

SECTION I - TO BE COMPLETED BY EMPLOYEE/RETIREE

Use this form to select/change a medical, dental and/or vision plan and coverage level. **Return this completed form within 31 days of your full-time date of hire or qualifying event, along with any required documentation i.e. marriage certificate, birth certificate, etc.**

Reason For Completing this Form: ☐ New Hire ☐ Current Employee Enrolling ☐ Change ☐ Termination

Type of change: ☐ Address ☐ Name ☐ Add or Remove Spouse/Dependent ☐ Waive Coverage

Hire Date: | Benefit Type (check all that apply): ☐ Dental ☐ Vision

Name	Social Security Number	Date of Birth	Male/Female	Add or Remove
Employee/Retiree			☐ M ☐ F	
Spouse			☐ M ☐ F	
Dep			☐ M ☐ F	
Dep			☐ M ☐ F	
Dep			☐ M ☐ F	
Street Address				
City	State		Zip Code	

Required Documentation Provide the required document along with this form. Refer to the Instructions for Benefit Elections/Changes to determine what documents you need to provide. Your benefits will not be updated until all documentation is received.

I certify that the above information is true and correct. For New Hire: By not enrolling in certain benefits at this time (within 31 days of full-time date of hire or within 31 days of a qualifying change in family status), I understand that I will be unable to enroll or make changes again until the next annual Open Enrollment period.

Signature of Employee/Retiree: Date:

SECTION II - TO BE COMPLETED BY SCHOOL DISTRICT

District: | Representative:

Effective Date of Change: | Date Section I Received:

Group #(s)	Current (if applicable)	New	Coverage Level/Tier
Dental			☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM
Vision			☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM

Type of Activity (check all that apply):

☐ New Hire
☐ Current Employee Enrolling
☐ Termination
☐ Add Spouse/Dependent
☐ Remove Spouse/Dependent
☐ Change of Address
☐ Name Change
☐ Act 110 / Act 43 Eligible
☐ Waive Coverage
☐ COBRA (check all that apply and indicate Qualifying Event below)
Dental Vision Other

Qualifying Event or Change of Family Status:

☐ Newborn
☐ Adoption
☐ Retirement
☐ Marriage
☐ Divorce
☐ Death
☐ Voluntary Resignation
☐ Involuntary Resignation
☐ Legal Guardianship
☐ Court Ordered
☐ Over Age Dependent
☐ Medicare Entitlement
☐ Other _____

Required documentation must be collected, reviewed and approved by district prior to enrollment. DO NOT send documentation to ReSo; keep at district for auditing purposes.

Signature of District Rep: Date:

-required for processing -

GROUP INSURANCE ENROLLMENT FORM
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Policyholder Name: FRAZIER SCHOOL DISTRIC
Policy No.: 214945
Division No.: 001

Employee Social Security Number ___ - ___ - ____
Gender M ☐ F ☐
Date of Birth (mm/dd/yyyy) __/__/____
Hours Worked Per Week ____

Employee First Name _____ **M.I.** **Last Name** _____

Employee Street Address _____ **City** _____ **State** ____ **Zip Code** _____

Original Date of Hire __/__/____
Annual Salary $ ___,___,___
Occupation _____

☐ Exempt ☐ Non-Exempt

☐ **Date entered into an eligible class** ***(ex: part time to full time)*** **or**
☐ **Rehire Date or**
☐ **Date of promotion to an eligible class** __/__/____

Spouse First Name (If coverage is selected) _____
Spouse Date of Birth (mm/dd/yyyy) __/__/____

COVERAGE ELECTIONS: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life/AD&D ☐ Yes ☑ No **Dependent Life** ☐ Yes ☑ No **LTD** ☑ Yes ☐ No **STD** ☑ Yes ☐ No

AMOUNT OF COVERAGE SELECTED FOR:

LIFE/AD&D You: $ X,XXX,XXX **Spouse:** $ X,XXX,XXX **Child:** $ XX,XXX

Note: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Evidence of Insurability form. 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. You may complete and electronically submit an Evidence of Insurability form—please see your Plan Administrator.

Beneficiary Information:

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

Request for Signature and Certification: I understand that my 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 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. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ *Date* _____ *Work Phone* _____ *Home Phone* _____

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Employee Application - LIFE INSURANCE

Please print clearly in blue or black ink.

ISSUE
Check one – Employer Use

☒ New Employee ☐ Change ☐ COBRA

Employee Information – *Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.*

Employee name (*last, first, initial*)	Employer	Employment location
	FRAZIER SCHOOL DISTRICT	

Group policy/participant #	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate

Sex	Job title or position	Employee hire date	# hours per week	Earnings $ _____	Married	Children
☐ M ☐ F				☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No

Address	City	State	Zip

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

Dependent Information – ***Required if Dependent coverage applies***

Name (Last name, First Name)	Date of Birth	Gender	Relationship
N/A			

NOTE – *Coverage not elected will be assumed refused even if not specifically refused*

Benefits
You may select the benefits below.

☒ Employee Life ☐ Voluntary Life Amount Electing _____
Have you used tobacco in any form in the last 12 months? ☐ Yes ☐ No

☒ Employee AD&D ☐ Voluntary AD&D Amount Electing _____

☐ Dependent Life ☐ Voluntary Spouse Amount Electing _____
Name of Spouse _____
Date of birth _____
Has your spouse used tobacco in any form in the last 12 months? ☐ Yes ☐ No

☐ Voluntary Child ☐ $1,000 ☐ $5,000 ☐ $10,000

☐ Short Term Disability ☐ Voluntary STD Amount Electing _____

☐ Long Term Disability ☐ Voluntary LTD Amount Electing _____

☐ Dental – Employee

☐ Dental – Employee + Spouse
☐ Dental – Employee + Child(ren)
☐ Dental – Employee + Family
Were you covered under another dental plan within the last 31 days? ☐ Yes ☐ No
If "Yes," termination date _____ Reason for termination of coverage _____
☐ Vision – Employee
☐ Vision – Employee + Spouse
☐ Vision – Employee + Child(ren)
☐ Vision – Employee + Family
☐ Critical Illness: ☐ Level 1 ☐ Level 2 (includes cancer option)
☐ Employee Critical Illness Amount Electing _____
Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No
☐ Spouse Critical Illness Amount Electing _____
Has your spouse used tobacco in any form in the past 12 months? ☐ Yes ☐ No
☐ Child(ren) Critical Illness Amount Electing _____
☐ Cancer: ☐ Level 1 ☐ Level 2
☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family
Have you used tobacco, in any form in the past 12 months? ☐ Yes ☐ No
☐ Accident ☐ Employee
☐ Spouse - Include Spouse Off the Job Disability Benefit? ☐ Yes ☐ No
☐ Child(ren)

Beneficiaries - *Applies to all coverages for which a beneficiary designation is required*

Last Name	First	MI	Relationship	
* COMPLETE ATTACHED BENEFICIARY DESIGNATION FORM IN LIEU OF THIS SECTION.				☐ Primary ☐ Secondary
				☐ Primary ☐ Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.
1) Give FULL names and relationships of each beneficiary.
2) Beneficiaries elected will apply to all coverage elected on this form for which a beneficiary designation is required.
3) If primary/secondary election is not noted, the beneficiary will be considered primary.
4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries.
5) If your designation does not fit in the above arrangement, or you want to specify a beneficiary by coverage, please contact Union Security Insurance Company for the appropriate forms.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:
(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company.
(2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant Limitation period specified in the policy.
(3) Authorize any required deductions from my earnings.
(4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death.
(5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief.
(6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.
(7) Understand that I have the right to select any dental care provider of my choice.

(8) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.
(9) Understand that coverages include waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

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

Employee's signature _____ Date _____

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____

Beneficiary Tips

Sun Life Financial®

I want the money to pay my final expenses and to support my spouse and children. The easiest way is to name your spouse (by name) as the primary beneficiary ("Jane Doe, spouse," for example). You can also name a secondary beneficiary in case your spouse dies before you.

Be careful about naming your children as either primary or secondary beneficiaries if they are not yet 18. Minor beneficiaries pose special problems because a legal guardian of their estate must be appointed by a court – even if one of their parents is still living. Often, the money must be held until the child reaches 18.

Can I name more than one person as beneficiary? You can name as many beneficiaries as you want. Proceeds will be paid in equal shares unless you indicate percentages (not dollar amounts).

Proceeds will be paid first to the named primary beneficiaries who survive you. If no primary beneficiaries survive you, then proceeds will be paid to the named secondary beneficiaries.

What if I get divorced? If you named your prior spouse as the beneficiary and never changed the beneficiary designation, it depends on the terms of the divorce decree and applicable law whether your prior spouse will be the beneficiary. It is wise to check with your attorney.

The best way to avoid problems is to review your beneficiary designations whenever a life event (like marriage, divorce, birth of a child, etc.) occurs.

What if I don't have a spouse or children? You aren't required to name your spouse and children as beneficiaries. You can name any individual you like, including relatives, friends and/or most non-profit organizations. **Please note: You may not designate your employer as your beneficiary even in the event they are a non-profit organization.**

What if I don't designate a beneficiary? Our life insurance policy has a provision that details how the proceeds will be paid; we will use the provision to pay your surviving family. The order is 1 – current surviving spouse, 2 – your living children; including children by legal adoption (even if they are minors), 3 – parents and 4 – the estate of the insured.

Can I designate my estate as the beneficiary? In order for us to pay your estate, the estate must go through a probate court (unless waiver of administration laws apply) and someone must be appointed by the court as the legal representative.

What if we don't want to go through probate? In some states, we can pay under "waiver of administration" laws. These laws allow us to make the payment to the person who is handling the estate, if the amount is within the limits set by the state and with documentation required by the state.

What about payment to a trust? We can make payment to the trustee of a trust. Trusts can be complicated; therefore, you are strongly advised to seek an attorney's assistance to set one up correctly.

Can we pay according to directions left in a will? No. However, we can pay to your estate which is distributed in accordance with the instructions of a will. We can also pay to a trust created by a probated will, if we receive documentation within one year of your death that the trustee is legally authorized to receive payment. If this information is not received within one year of your death, we will pay the executors or administrators of your estate.

What about the other Sun Life coverages? If you have dependent life insurance, you are the beneficiary. The same is true if you qualify for the dismemberment provision under the Accidental Death & Dismemberment policy.

Sun Life Administrative Office P.O. Box 981624 El Paso, Texas 79998-1624
T 800.733.7879 F 888.208.2823

Sun Life Assurance Company of Canada

CM REGENT SOLUTIONS

CM Regent Solutions
Beneficiary Designation

You may use this form to designate who will receive the Group Life Insurance proceeds in the event of your death. The designations you make on this form replace any prior beneficiary designations.

When applicable, designations apply to any Basic, Optional, Voluntary, Accidental Death and Dismemberment ("AD&D"), or other Group Life Insurance you have under the Group Policy shown in Section 1.

See Page 3 of this form for sample beneficiary designations and more information.

1 Employee and employer information

Name of employee (first, middle initial, last)		Social Security number
Name of employer Frazier School District	Group policy number 932135	Billing group number

2 Beneficiary designation

For primary beneficiaries, indicate who should receive the group life or AD&D insurance proceeds in the event of your death.

For secondary, (also known as contingent) beneficiaries, indicate who should receive the group life insurance proceeds in the event that ALL of your primary beneficiaries are not living at the time of your death.
Please make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%. If you do not specify percentages, surviving beneficiaries within the class will share proceeds equally.

Primary Beneficiary(ies)

			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
3 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
4 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

2 Beneficiary designation, continued

Secondary Beneficiary(ies)

			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
3 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
4 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

* The total within each class (Primary and Secondary) must equal 100%.

3 Signature

You must sign and date this form for your designation to become effective. Make a copy for your records and **return the signed original to your employer.**

Name of employee (first, middle initial, last)	Date

4 Beneficiary wording alternatives

Proposed Beneficiary(ies)	Suggested Wording
1. Estate	Estate
2. One beneficiary	Martha Doe, wife
3. More than one beneficiary in equal shares	Jane Doe, Mary Doe and Richard Doe, children, or survivor(s) of them, in equal shares.
4. Two beneficiaries, in succession	Primary: Martha Doe, wife; Secondary: Richard Doe, son. *(Richard will only receive proceeds if Martha Doe is not living at the time of the employee's death.)*
5. One beneficiary followed by two beneficiaries in equal shares	Primary: Martha Doe, wife; Secondary: Jane Doe and Mary Doe, children in equal shares, or the survivor of them. *(Jane and Mary will only receive proceeds if Martha Doe is not living at the time of the employee's death.)*
6. More than one Beneficiary in equal shares per descendent order	Jane Doe, Mary Doe and Richard Doe, or the survivor(s) of them, in equal shares. However, if any of my children predecease me and leave issue who survive me, the issue of the deceased child will receive their parents' share in equal shares.
7. One or more minor children	John Smith, as custodian for Jane Doe, a minor, under the Uniform Transfers to Minors Act (UTMA) so that proceeds can be paid before the child reaches the age of maturity.
8. To a church or non-profit organization	Name and address of the beneficiary organization.
9. Beneficiaries shown in percentages	John Smith, brother - 40%, or in the event of his death, to my estate; Alan Smith, brother 60%, or in the event of his death, to my estate.
10. Trust under Last Will and Testament	Proceeds to be paid to the Trustee under my Last Will and Testament.
11. Existing Trust	Jane Doe, Trustee of the Doe Family Trust, dated 1/1/2001.

Please Note: You cannot name your Employer as a beneficiary for Group Life Insurance proceeds under the Group Policy. Unless you specifically instruct otherwise, your beneficiary designation will be revocable.

Dependent Life Insurance benefits are payable to the Employee. If the Employee does not survive the Dependent, Dependent Life Insurance benefits will be paid to the Employee's estate.

Sun Life Assurance Company of Canada is not a tax or legal advisor and the above information is provided as general information only. Before making beneficiary designations, you may want to consult with your tax or legal advisor.

Contact us

By mail
CM Regent Solutions
300 Sterling Parkway, Suite 100
Mechanicsburg, PA 17050

By fax
866.691.6291

By e-mail
EBSS@cmregent.com

H511.340 (Rev. 5/2019)

SCHOOL PERSONNEL HEALTH RECORD
(FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)

I. INFORMATION

School Position Offered _____

Last Name | First | MI | Sex | Date of Birth

Home Phone | Cell Phone | Work Phone

Mailing Address: Street | City | State | Zip

Emergency Contact

Name: Relationship:

Address:

Telephone number:
(Home) (Work) (Cell)

II. IMMUNIZATION HISTORY (Recommended, but not mandated by law)

VACCINE Check appropriate box	Enter Month, Day, and Year Each Immunization DOSE Was Given				
Diphtheria, Tetanus with Pertussis ☐Td ☐TdaP	1	2	3	4	5
Hepatitis B	1	2	3		
Measles-Mumps-Rubella (MMR)	1	2	Rubella Serology/Date/Titer Mumps disease diagnosed by a physician: Date Measles Serology/Date/Titer		
Varicella☐ Vaccine☐ Disease ☐ Serology Date: Neg/Pos	1	2			
Influenza	1	2	3		

III. TUBERCULOSIS SKIN TEST RESULTS (Testing required per Regulations of the Department of Health)

DATE GIVEN	SITE: LA / RA	GIVEN BY:	ANTIGEN NAME	MANUFACTURER / LOT # / EXP DATE	SIGNATURE
DATE READ	RESULTS in MM		READ BY SIGNATURE		

OR

IGRA TEST RESULTS

DATE COLLECTED	TEST NAME (QFT-GIT, T-SPOT, etc)	POSITIVE	NEGATIVE	INDETERMINATE	QUANTITATIVE RESULT

DATE TEST COMPLETED _____ **SIGNATURE** _____

Previously known/new positive reactors: _____

Chest X-ray: Date: Results:
(Attach a copy of the report.)

Other: Date: Results:
(Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PRIMARY CARE PROVIDER REPORT MUST STATE THAT THE APPLICANT IS CURRENTLY FREE FROM TUBERCULOSIS DISEASE.

IV. MEDICAL CONDITIONS (✓)

	Yes	No	If Yes, Explain:
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

V. PHYSICAL EXAMINATION (✓)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: RL				
Eyes – Color Vision				
Ears – Hearing (dB) RL				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc…				
Lungs – Adventious Findings				

Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify

Are there any special equipment or accommodations needed to enable this person to perform their duties? If so, specify

Physician Name (Print) Signature of Examiner Date

Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

Signature of Employee Date