AVOYELLES PARISH SCHOOL BOARD
Payroll Enrollment Form

SCHOOL ______
POSITION ______

The information contained within this form is needed by the payroll department to issue a paycheck to all new employees. It is the responsibility of the payroll clerk to have this form completed by all new employees, to enter this information into the computer, and to place this form in the employee's payroll file.

SECTION I - TO BE COMPLETED BY THE EMPLOYEE
Please print in ink or type all entries except the signature line.

Social Security Number

Last Name ***as printed on Social Security Card***

First Name Middle Initial

Mailing Address: Street / Post Office Box

City, State, & Zip Code

☐ MALE ☐ FEMALE

☐ BLACK ☐ HISPANIC
☐ WHITE ☐ OTHER ______

Date of Birth ☐☐ Month ☐☐ Day ☐☐ Year

Phone Number

Email Address

Did you retire from a Louisiana Public Retirement System?
☐ - YES ☐ - NO

If Yes, name the retirement system below.

By my signature below, I certify that the information contained on this form is accurate. I also acknowledge and agree that upon severance, whether voluntary or involuntary, I will return all property owned by the Avoyelles Parish School to the work site to which I am assigned. To insure compliance with this obligation, I hereby authorize the Board to hold my final paycheck pending my return of such property.

Signature Date

SECTION II - TO BE COMPLETED BY THE EMPLOYER
This information agrees with the data to be entered in the computer system.

School or Department ______
Rate Information
- Pay Frequency **M M**
- Hourly/Salary **H S**
- Full Time/Part Time **F P**
- Hours per week **21 37.5 40**
- Pay Cycle **1**

Salary
- PIP **Y/06 N**

Taxes
- FICA **Y N**

Deductions
- Retirement **1 2 3 4 5 26**

Sick days
- New Days ______
- Transfer Days ______

Extended Medical
- Start to End Dates ______
- Days Remaining ______

Personal
- Degree **B M M+30 SpE EdD PhD NA**
- Certificate Number ______ **NA**

First Check **731 831 930**
- Years Experience ______ **Parish** ______ **Other**
- Days Per Year ______ **Worked** ______ **Contracted**
- Retiree Rehired Code **1 2 9 NA**

Revised 6/20/14

R-1300 (6/00)

State of Louisiana
Department of Revenue

Employee Withholding Exemption Certificate
(L-4)

Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Basic Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet below. Do not claim more than your correct withholding personal exemptions and the correct number of withholding dependency credits. Do not claim additional withholding exemptions if you qualify as head-of-household. In such cases, only the withholding personal exemption applicable to single individuals is allowable. You must file a new certificate within 10 days if the number of your exemptions decreases, except where the change occurs as the result of death of a spouse or a dependent. You may file a new certificate at any time the number of your exemptions increases. Penalties are imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption. This form must be filed with your employer. Otherwise, he must withhold Louisiana income tax from your wages without exemption.

Note to Employer: Keep this certificate with your records. If the employee is believed to have claimed too many exemptions or dependency credits, the Secretary of Revenue should be so advised by forwarding a copy of the employee's signed L-4 form to the Department.

Personal Allowances Worksheet

A. In Block A, enter "0" if you claim neither yourself nor your spouse, or

In Block A, enter "1" if you claim yourself, provided you do not claim this exemption in connection with other employment or your spouse has not claimed your exemption, or

In Block A, enter "2" if you claim yourself and your spouse. You may choose to enter "0" if you are married, and have either a working spouse, or more than one job. (This may help you avoid having too little tax withheld.)

A.

B. In Block B, enter the number of dependents (other than your spouse or yourself) whom you will claim on your tax return. If no credits are claimed, enter "0".

B.

— — **Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.** — —

Form **L-4**

Louisiana Department of Revenue

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial — Last name

2. Social Security Number

3. ☐ No exemptions or dependents claimed ☐ Single ☐ Married

4. Home address (number and street or rural route)

5. City, State, ZIP

6. Total number of exemptions you are claiming (from Block A above) — **6.**

7. Total number of dependents you are claiming (from Block B above) — **7.**

8. Additional amount, if any, you want withheld each pay period — **8.**

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature — Date

The following is to be completed by employer.

9. Employer's name and address
Avoyelles Parish School Board, 221 Tunica Dr W. Mks.

10. Employer's state withholding account number

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

2021

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

▶ **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.*

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

Multiply the number of other dependents by $500 . . . . ▶ $ ______

Add the amounts above and enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
AVOYELLES PARISH SCHOOL BOARD 221 TUNICA DRIVE WEST MARKSVILLE, LA 71351		72-6000115

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2021)

E-MAIL ADDRESS: ______________ **CURRENT PHONE** ______________

Social Security Administration

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name ____________________ **Employee ID#** SOC SEC

Employer Name AVOYELLES PARISH SCHOOL **Employer ID#** 72-6000115

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee ______________________ **Date** __________

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

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

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

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

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

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

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

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

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

☒ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Avoyelles Parish School Board

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code
221 Tunica Drive West	Marksville	LA	71351

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

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

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

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

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

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

Workers
Implementing
Safety
Education

Injury Management Policy for Avoyelles Parish School System

It is the policy of the Avoyelles Parish School Board, as a condition of employment, that you report any and all workplace injuries, no matter how minor, immediately to your immediate supervisor (Principal) or designee. Once the incident is reported, we (APSB) will:

→ For non-emergencies, provide same-day medical care by the APSB designated medical clinic Avoyelles Hospital Rural Health Clinic, 597 Tunica Drive West (318-253-0679). For emergencies, provide medical care at a hospital emergency room. You must give approval to the APSB (Carolyn Decuir) to release all medical records related to the work-related injury.

→ collect a same-day post accident drug screen

→ assist in all manner to return you to work quickly

→ perform an accident investigation to determine the facts of the incident

→ report the incident to the Workman's Compensation Administration after you have completed a First Injury Report with the school's designee

You are hereby notified that all injuries, no matter how slight, must be reported immediately to your immediate supervisor (Principal) or designee!!!! This is required under OSHA laws CFR 1910.35 and by the state workers' compensation statues.

We will not tolerate any form of insurance fraud. We will work with claims adjusters to prosecute workers who allege workplace injuries but the facts do not support an injury in the course and scope of employment.

We invite any questions you may have on this matter.

I hereby sign that I have received and understand the above Injury Management Protocol.

Employee Name (Print):______________________________________

Employee Signature:_____________________________ Date:____________

STATEMENT

PRIOR WORKERS' COMPENSATION CLAIM

SECTION ONE:

____I HAVE A PRIOR WORKERS' COMPENSATION CLAIM FOR A FORMER EMPLOYER.
(IF CHECKED, PLEASE DESCRIBE IN SECTION TWO THE NATURE OF THE INJURY AND PROVIDE A PHYSCIAN STATEMENT.)

__________ I HAVE, ___________ I HAVE NOT BEEN RELEASED.

____I HAD A PRIOR WORKERS' COMPENSATION CLAIM FOR A FORMER EMPLOYER.
(IF CHECKED, PLEASE DESCRIBE IN SECTION TWO THE NATURE OF THE INJURY AND PROVIDE A PHSYSICAN STATEMENT)

__________ I HAVE, ___________ I HAVE NOT BEEN RELEASED.

____I NEVER HAD A PRIOR WORKER'S COMPENSATION CLAIM FOR A FORMER EMPLOYER.
(IF CHECKED, PLEASE SIGN AND DATE)

SECTION TWO:

MY INJURY(S) CONSIST OF THE FOLLOWING:

____
____
____
____
____
____
____

______________________________ ______________________________
SIGNATURE **DATE**

SIGNED TO AND SUBSCRIBED TO ON __________ DAY OF _________________, 20___________

____
NOTARY PUBLIC, NOTARY #_____________
AVOYELLES PARISH, LOUISIANA
MY COMMISSION EXPIRES: ______________

LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.[1] This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

Employee Signature:______________________ Date: __________

Employer Representative Signature: [signature] Date: __________

Employer Name: Avoyelles Parish School Board

Employee Name:______________________

Date of Birth (mm/dd/yyyy): __________ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only):__________

Home Address: ______________________

Telephone Number: (____) ______________

[1] Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystropy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertension	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

☐ ☐ Spinal Disc Surgery — Year (approximate if unsure)__________

☐ ☐ Spinal Fusion Surgery — Year (approximate if unsure)__________

☐ ☐ Amputated Foot — Left ☐ Right ☐ Year (approx. if unsure) __________

☐ ☐ Amputated Leg — Left ☐ Right ☐ Year (approx. if unsure) __________

☐ ☐ Amputated Arm — Left ☐ Right ☐ Year (approx. if unsure) __________

☐ ☐ Amputated Hand — Left ☐ Right ☐ Year (approx. if unsure) __________

☐ ☐ Knee Replacement — Left ☐ Right ☐ Year (approx. if unsure) __________

☐ ☐ Hip Replacement — Left ☐ Right ☐ Year (approx. if unsure) __________

☐ ☐ Other Joint Replacement — Joint __________________ Year ______________

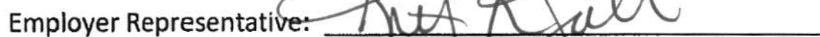
☐ ☐ Other Surgical Procedure — Procedure ________________ Year ______________

☐ ☐ Other Surgical Procedure — Procedure ________________ Year ______________

☐ ☐ Other Surgical Procedure — Procedure ________________ Year ______________

☐ ☐ Other Surgical Procedure — Procedure ________________ Year ______________

Employee Signature: ______________________________ Date: ____________________



Employer Representative: __________________________ Date: ____________________

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) **or** any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: ______________________ Year Diagnosed (approx): __________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________

CONDITION: ______________________ Year Diagnosed (approx): __________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________

CONDITION: ______________________ Year Diagnosed (approx): __________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________

CONDITION: ______________________ Year Diagnosed (approx): __________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________

Employee Signature: ______________________ Date: __________

Employer Representative: ______________________ Date: __________

SIB FORM D (10/17)

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐
   If "Yes," please list the restrictions: ______
   Were the restrictions: Permanent ____ Temporary ____
   Are your activities currently restricted? Yes ☐ No ☐
   What is the medical condition for which you have restrictions? ______

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

   Please list the medical condition being treated: ______

   Doctor's Name: ______ Specialty: ______

   Doctor's Address: ______

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

   Medication: ______ Prescribing Doctor: ______

   Medication: ______ Prescribing Doctor: ______

4. Have you ever had an on the job accident? Yes ☐ No ☐
   If you answered "YES," please provide the date for each injury and the nature of the injury:

   ______

   How long were you on compensation? ______

   Name of Employer: ______

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐
   If you answered YES, please provide:

   Recommended surgery: ______

   Approximate date of recommendation: ______

   Doctor's Name: ______ Specialty: ______

   Doctor's Address: ______

Employee Signature: ______ Date: ______

Employer Representative: ______ Date: ______

SIB FORM D (10/17)

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature:____________________________________ Date: ____________

Employee Printed Name: ____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;

2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;

3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;

4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and

5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;

6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature: ____________ Date: ____________

Employer Representative Printed Name: Kristy K Gremillion

Title: Payroll Acct

SIB FORM D (10/17)

Teachers' Retirement System of Louisiana
8401 United Plaza Blvd, Ste 300 • Baton Rouge, LA 70809-7017
PO Box 94123 • Baton Rouge, LA 70804-9123
Telephone: (225) 925-6446 • Fax: (225) 925-4779
www.trsl.org • web.master@trsl.org

Form 2 (02/15)

00-2

Enrollment Application/Employment Notification

Print in ink or type all entries except signatures. This form is designed for multipurpose use and for automated data entry by the Teachers' Retirement System of Louisiana (TRSL).

Section 1 — To be completed by applicant

Name: Last, first, MI, suffix (Jr., III, etc.)

Social Security number ☐☐☐-☐☐-☐☐☐☐

Attach copy of card

Street / P.O. Box

City, state, zip

Daytime telephone ( )

Evening telephone ( )

Email address

Date of birth ___ / ___ / _____ mm-dd-yyyy

Sex: ☐ Male ☐ Female

Are you a U.S. citizen? ☐ Yes ☐ No If not, what type of visa do you possess? __________

Previous employment and membership information

1. Have you ever contributed to a Louisiana public retirement system? ☐ Yes ☐ No Name of system __________
2. Did you withdraw your contributions when you left previous employment? ☐ Yes ☐ No
3. Please indicate the position(s) you previously held:

Position	Years employed		Employer
____ Teacher, professor, instructor	From______	To______	______
____ Custodian, school bus driver	From______	To______	______
____ School food service worker	From______	To______	______

4. If you withdrew retirement contributions before 1978, provide TRSL membership number if known. __________
5. If you contributed to another Louisiana public retirement system, do you wish to apply for reciprocal recognition of retirement credit between systems or actuarial transfer of funds and retirement credit to TRSL? ☐ Yes ☐ No

Applicant's signature (Do not print or type) ▶

Date signed (mm-dd-yyyy)

Section 2 — To be completed by employer

Name of employer
AVOYELLES PARISH SCHOOL BOARD

Agency number 0 0 0 5

Name of school

Title of position

Employment Status

☒ Full-time ☐ Part-time ☐ Unclassified (if applicable) Full-time equals ______ hours per day.

Annual full-time earnings $__________ This employee will work ______ hours per week.

Date of employment ___ / ___ / 201__ mm-dd-yyyy

Applicant is being enrolled in: ☒ Regular Plan ☐ Plan B

Basis of employment ☒ 9 months ☐ 10 months ☐ 11 months ☐ 12 months

For what percent of the first year will the applicant be employed? ______%

Check the appropriate box for each category below:

☐ YES ☐ NO* His/her first employment making him eligible for membership in a Louisiana public retirement system began on or after January 1, 2013.

☐ YES ☐ NO* He/she was employed in a position eligible for membership in a Louisiana public retirement system prior to January 1, 2013, but he/she terminated service prior to January 1, 2013. Through re-employment on or after January 1, 2013, he/she is again eligible for membership in a Louisiana public retirement system.

☐ YES ☐ NO* He/she assumes an elective office on or after January 1, 2013, and by virtue of that service or previous public service, he/she is eligible for membership in a Louisiana public retirement system.

*** If the answer to all three questions above is *NO*, you do not have to complete the "Forfeiture of Benefits" section below.**

Forfeiture of Benefits - Employee Attestation *(Check the appropriate box below whether or not the employee has signed Form 2FRB.)*

☐ **YES** I hereby certify that this employee has received and executed TRSL's *Forfeiture of Retirement Benefits - Attestation of Understanding* (Form 2FRB), and that this form will be permanently maintained in the personnel records of this employer.

☐ **NO** State law, La. R.S. 11:293, requires that this employee receive and execute TRSL's *Forfeiture of Retirement Benefits - Attestation of Understanding* (Form 2FRB). The enrollment of this employee cannot be completed until Form 2FRB is properly executed in compliance with state law.

Signature of employer's authorized representative ▶

Title

Date signed (mm-dd-yyyy)

TRSL
Teachers' Retirement System of Louisiana
8401 United Plaza Blvd, Ste 300 • Baton Rouge, LA 70809-7017
P.O. Box 94123 • Baton Rouge, LA 70804-9123
Telephone: (225) 925-6446 • Fax: (225) 925-4779
www.trsl.org

Form 2FRB (12/12)
00-2FRB

Forfeiture of Retirement Benefits – Attestation of Understanding

All individuals employed on or after January 1, 2013 are required to read and sign this attestation form.

La. R.S. 11:293 provides for the forfeiture of retirement benefits by a public employee or elected official (hired or beginning service on or after January 1, 2013) convicted of a "public corruption crime." This law defines "public corruption crime" as a state or federal felony committed on or after January 1, 2013, in which the sentencing judge finds that the public servant acted willfully and in the course and scope of his official capacity and that any of the following apply:

1. The public servant realized or attempted to realize a financial gain for himself or for a third party.
2. The public servant committed any criminal sexual act with or upon the person of a minor, and there was a direct association between the public servant and the minor related to the public servant's employment.

The statutory text of La. R.S. 11:293, setting forth the provisions of law governing forfeiture of benefits, is below.

Section 1 — Member Information

Name: Last, first, MI, suffix (Jr., III, etc.)	Social Security number

Section 2 — La. R.S. 11:293. Forfeiture of retirement benefits; public corruption crimes

A. As used in this Section, the following words or phrases shall have the following meanings:

(1) "Conviction" or "convicted" means a criminal conviction, guilty plea, or plea of nolo contendere that is final, and all appellate review of the original trial court proceedings is exhausted.

(2) "Public corruption crime" means a state or federal felony committed on or after January 1, 2013, in which the sentencing judge finds the public servant acted willfully and in the course and scope of his official capacity and the evidence establishes either of the following:

(a) The public servant realized or attempted to realize a financial profit or a financial gain for himself or for a third party.

(b) The public servant committed any criminal sexual act with or upon the person of a minor, and there was a direct association between the public servant and the minor related to the public servant's employment.

(3) "Public retirement system" means any state, statewide, or any local public retirement system, plan, or fund.

(4) "Public servant" means a public employee or an elected official as defined in R.S. 42:1102 who is a member, former member, deferred retirement option plan participant, or retiree under the provisions of any public retirement system and who meets any of the following criteria:

(a) His first employment making him eligible for membership in a public retirement system began on or after January 1, 2013.

(b) He was employed in a position making him eligible for membership in a public retirement system prior to January 1, 2013, but he terminated his service prior to that date and is reemployed in such a position on or after that date.

(c) He assumes an elective office on or after January 1, 2013, and by virtue of that service or previous public service he is eligible for membership in a public retirement system.

B.(1) Following the conviction of a public corruption crime, the sentencing court shall determine if the conviction warrants forfeiture as provided in this Subsection or garnishment as provided in R.S. 11:292. In order to determine the appropriate remedy the sentencing court shall review the following factors:

(a) The nature of the offense.

(b) The prior service of the public servant and the appropriateness of any mitigating factors.

(2)(a) If the court determines that forfeiture is appropriate, the court may order the forfeiture of the public servant's right to receive any benefit or payment of any kind under this Title except a return of the amount contributed by the public servant to the retirement system without interest, subject to Subparagraph (b) of this Paragraph.

(b) If the court orders the public servant to make restitution to the state or any political subdivision of the state for monetary loss incurred as a result of the public corruption crime for which he is convicted, the court may order restitution to be paid from the amount contributed by the public servant to the retirement system.

(c) Subject to the requirements of Paragraph (3) of this Subsection, the court may award to the member's spouse, dependent, or former spouse, as an alternate payee, some or all of the amount that, but for the order of forfeiture under Subparagraph (a) of this Paragraph, may otherwise be payable. Upon order of the court, the retirement system shall provide information concerning the member's membership that the court considers relevant to the determination of the amount of an award under this Subparagraph. The system shall also calculate the spousal share of the public servant's benefit for the sentencing court in accordance with existing community property law. Any dependent's share shall be calculated in the same manner as a spousal share. In determining the award, the court shall consider the totality of the circumstances, including but not limited to:

(i) The role, if any, of the member's spouse, dependent, or former spouse in connection with the crime.

(ii) The degree of knowledge, if any, possessed by the member's spouse, dependent, or former spouse in connection with the crime.

(3) An award ordered under Subparagraph (2)(c) of this Subsection may not require the retirement system to:

(a) Provide a type or form of benefit or an option not otherwise provided by the retirement system.

(b) Provide increased benefits determined on the basis of actuarial value.

(c) Take an action contrary to the system's governing laws or plan provisions other than the direct payment of the benefit awarded to the spouse, dependent, or former spouse.

(4) All of the convicted public servant's service credit attributable to employer contributions and interest on those contributions that are not otherwise assigned pursuant to Subparagraph (2)(c) of this Subsection shall be forfeited, and any dollar amount of such employer contributions and interest, together with any funds in the individual's deferred retirement option plan account, shall be applied to reducing the balance of the unfunded accrued liability of the system in a manner determined by the system's board of trustees. If the system has no unfunded accrued liability, the employer contributions and interest shall revert to the system's trust.

C. Notwithstanding the provisions of Subsection B of this Section, survivor benefits being received by the surviving unmarried spouse, the surviving minor child, or the surviving physically or mentally handicapped child who is entitled to a survivor benefit of a deceased public servant convicted of a public corruption crime shall be based solely on the amount of the public servant's benefit forfeited to the retirement system and shall not be based on any amount remitted to the public servant.

D. No provision of this Section shall impinge on any judicially recognized community property interest of a current or former spouse.

E. Each public retirement system shall create an attestation form explaining the provisions of this Section and shall provide such attestation form to each employing agency. Each employing agency shall provide every public servant with such attestation form and such public servant shall be required to sign the form indicating that he has read it and understands the contents thereof.

F.(1) A parish prosecutor shall inform the secretary of the Department of Public Safety and Corrections in writing when a conviction for a state public corruption crime is entered against a person who the prosecutor knows, or has reason to believe, is a member of a public retirement system and who is subject to the provisions of this Section. The secretary shall compile such information and transmit it to the appropriate public retirement system.

(2) The secretary of state, upon being notified by a United States attorney of a felony conviction for a federal public corruption crime, whether or not such conviction qualifies as a conviction as defined by this Section, shall promptly transmit to each public retirement system information pertaining to such conviction.

G. The provisions of this Section shall apply only to benefits earned on or after January 1, 2013.

Section 3 — Attestation

I, ______________________________ (print name), have read this form, *Forfeiture of Retirement Benefits – Attestation of Understanding*, and understand its contents.

Signature	Date (mm/dd/yyyy)
▶	

Teachers' Retirement System of Louisiana
8401 United Plaza Blvd, Ste 300 • Baton Rouge, LA 70809-7017
PO Box 94123 • Baton Rouge, LA 70804-9123
Telephone: (225) 925-6446
Toll free (outside Baton Rouge area): 1-877-ASK-TRSL (877-275-8775)
www.TRSL.org • *web.master@trsl.org*

Form 3 (04/18)

01-3

Submit original form ONLY. No copies, faxes, or scans are accepted.

☐ Check here if multiple beneficiary forms submitted

Beneficiary Designation for Non-Retired Members

Print in ink or type all entries except signatures. Incomplete or altered forms will be returned. The following beneficiary designation(s) will **replace all** previous choices. Designations of beneficiaries become effective when received in the office of the Teachers' Retirement System of Louisiana (TRSL). Forms received by TRSL after the date of the member's death shall be null and void. ***This form is not to be used for retired members or members who have participated in DROP. Retirees who have returned to work should complete Form 3C (Beneficiary Designation for Retiree Return-to-Work Employee Contributions).***

Section 1 — Member information

Name: Last, first, MI, suffix (Jr., III, etc.)	Phone ( )	Social Security number
Street / P.O. Box	City, state, zip	Email address

Section 2 — Beneficiary designation

This designation supersedes all prior designations. You must include **ALL** beneficiaries that you wish to designate. If percentages are not provided, any amounts payable will be divided equally among all beneficiaries. Primary and contingent beneficiaries must separately total 100%. The number of primary or contingent beneficiaries that you may name is not limited (attach an additional sheet if necessary). "Contingent" beneficiaries are eligible for payment only if all primary beneficiaries die before the member does. A trust is not an acceptable designation; only human beings or succession may be named.

PRIMARY beneficiary's name *Last, First, M*	**Social Security number**	**Gender**	**Birth date** *mm/dd/yyyy*	**Relation**	**Percentage** *must equal 100%*
		☐M ☐F	___/___/_____		_____ %
		☐M ☐F	___/___/_____		_____ %
		☐M ☐F	___/___/_____		_____ %
		☐M ☐F	___/___/_____		_____ %

CONTINGENT beneficiary's name *Last, First, M*	**Social Security number**	**Gender**	**Birth date** *mm/dd/yyyy*	**Relation**	**Percentage** *must equal 100%*
		☐M ☐F	___/___/_____		_____ %
		☐M ☐F	___/___/_____		_____ %
		☐M ☐F	___/___/_____		_____ %

Section 3 — Member signature

I hereby request that my beneficiary(ies) be designated as above. I understand that the beneficiary(ies) designated on this form will receive my contributions to the retirement system, unless I have qualifying survivors (spouse, children) entitled to a monthly survivor's benefit.

I hereby authorize TRSL to make payment to the beneficiary(ies) whom I have designated and agree, on behalf of myself and heirs and assigns, that payment and acceptance of any such refund to my designated beneficiary(ies), if any, or my estate shall discharge all obligations of TRSL on account of any creditable service rendered prior to payment of the refund and shall constitute a release of all accrued rights of every kind and nature against TRSL. I hereby direct that, should I survive the aforementioned beneficiary(ies), the amount that would otherwise have been payable to the beneficiary(ies) shall be paid to my estate or to such other beneficiary(ies) as I shall designate with TRSL in accordance with the rules and regulations prescribed by the Board of Trustees.

Before these undersigned witnesses, I have signed my name this ________ day of ______________________________, 20__________.

Member's signature (do not print or type) ▶	Maiden name or other names used for employment

Section 4 — Witness signatures (*Must be witnessed by persons other than beneficiaries.*)

Signature of witness (do not print or type) ▶	Please print name of witness
Signature of witness (do not print or type) ▶	Please print name of witness

Teachers' Retirement System of Louisiana
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www.TRSL.org • *web.master@trsl.org*

Form 2SS (10/14)
00-2SS
(Form SSA-1945)

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name	Employee SS#
Employer Name AVOYELLES PARISH SCHOOL BOARD	Employer ID# 0005

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision (WEP)

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to the Social Security publication, "Windfall Elimination Provision."

Government Pension Offset (GPO)

Under the Government Pension Offset, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a federal, state, or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security, $500 – $400 = $100. Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to the Social Security publication, "Government Pension Offset."

For more information

Social Security publications and additional information, including information about exceptions to each provision, are available at *www.socialsecurity.gov*. You may also call toll free 1-800-772-1213, or, for the deaf or hard of hearing, call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received TRSL Form 2SS (Form SSA-1945) that contains information about the possible effects of the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO) on my potential future Social Security benefits.

Signature of Employee ▶	Date (mm-dd-yyyy)

Form SSA-1945 (11-2004)

Employee SS# [ ][ ][ ][■][ ][ ][■][ ][ ][ ][ ]

Form 2SS (10/14)

00-2SS

(Form SSA-1945)

Information about TRSL Form 2SS (Form SSA-1945), Statement Concerning Your Employment in a Job Not Covered by Social Security

New federal legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires state and local government employers to provide a statement to employees hired January 1, 2005, or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

TRSL Form 2SS (Form SSA-1945), **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers with TRSL-covered employees should use to meet the requirements of the law. The form explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision (WEP) can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset (GPO) can affect any possible Social Security benefit entitlement as a spouse or an ex-spouse.

Employers must:

- Give the statement to the employee before the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to TRSL.

Copies of TRSL Form 2SS (Form SSA-1945), *Statement Concerning Your Employment in a Job Not Covered by Social Security*, are available online at www.trsl.org → general info → publications → forms.

A similar form is also available from the Social Security Administration (Form SSA-1945). Copies of the SSA-1945 are available online at the Social Security website at www.socialsecurity.gov/form1945/SSA-1945.pdf and information about the form is available at www.socialsecurity.gov/form1945.

Please use TRSL Form 2SS for all TRSL-covered employees.

NOTE: YOU CAN MAKE DEPOSITS IN UP TO THREE ACCOUNTS (CHECKING AND/OR SAVINGS)

DIRECT DEPOSIT ENROLLMENT

Employee's Authorization – Please fill out and return to the Payroll Department of the Avoyelles Parish School Board

I AUTHORIZE MY EMPLOYER, THE AVOYELLES PARISH SCHOOL BOARD, AND THE FINANCIAL INSTITUTION LISTED BELOW (YOUR BANK) TO INITIATE ELECTRONIC CREDIT ENTRIES, AND IF NECESSARY, DEBIT ENTRIES AND ADJUSTMENTS FOR ANY CREDIT ENTRIES IN ERROR TO MY:

☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT

EACH PAY PERIOD. THIS AUTHORITY WILL REMAIN IN EFFECT UNTIL I HAVE CANCELLED IT IN WRITING BY THE 15TH DAY OF THE MONTH FOR THE FOLLOWING MONTH TO ALLOW MY EMPLOYER, THE AVOYELLES PARISH SCHOOL BOARD, TO ACT ON IT.

NAME: ______________________ DATE: ______________________

ADDRESS: ______________________

____

SOCIAL SECURITY #______________________ ______________________

SIGNATURE

PLEASE PLACE A VOIDED CHECK or DOCUMENT FROM THE BANK REFLECTING THE ROUTING AND ACCOUNT NUMBER HERE

AND RETURN TO THE PAYROLL OFFICE

Avoyelles Parish School Board

221 Tunica Drive West
Marksville, LA 71351

Blain Dauzat, Superintendent
Thelma J. Prater, Assistant Superintendent

Demetria Alexander
Director of Federal Programs/Curriculum

Mary L. Bonnette, CPA
Director of Finance

BOARD MEMBERS:

Robin Moreau
President
District 4

Rickey Adams
Vice-President
District 7

Latisha S. Small
District 1

Lynn Deloach
District 2

Chris Lacour
District 3

Stanley Celestine, Jr.
District 5

Chris Robinson
District 6

Van Kojis
District 8

Aimee B. Dupuy
District 9

PHONE:

Bunkie (318) 346-2994
Cottonport (318) 876-3391
Marksville (318) 253-5982
FAX#: (318) 253-9680
FAX#: (318) 253-5178

An Equal Opportunity Employer

MEMO TO: Employees Interested in Direct Deposit

MEMO FROM: Finance Department

Please complete the attached Direct Deposit Authorization Form, sign below and return to Payroll Department after reviewing the following conditions:

It is understood that the funds will be available for direct deposit distribution through the CAPITAL ONE BANK by the DUE DATE OF EACH PAYROLL.

The Avoyelles Parish School Board will not be responsible for any NSF charges or fees resulting from direct deposit errors.

Once errors become apparent, it is understood that corrections will be made within a reasonable length of time.

All payroll checks will be deposited directly into your account unless there are issues and a paper check will then be produced.

Any changes made (ie. Account closure, name change, etc) must be requested in writing 10 days before each payroll is generated for the month the change will go into effect.

Please note that the bank is authorized to initiate debit or credit entries (adjustments) to your account to correct errors.

It is recommended that you notify your bank of your intent to participate in this program.

____
EMPLOYEE

____
DATE

Electronic Notification by Employer

I hereby certify that I agree to receive any employment related forms, not limited to W-2 forms, checkstubs and any other forms that are related to my earnings and benefits in an electronic format.

______________________ **Signature**	______________ **SSN**
______________________ **Name**	______________ **email address**
______________________ **Date**	

PLEASE WRITE EMAIL ADDRESS NEATLY
SO THAT IT CAN BE TRANSCRIBED CORRECTLY!
THANK YOU.

ITEMS NEEDED FOR YOUR FILE BY THE AVOYELLES PARISH SCHOOL BOARD

____________ Copy of Birth Certificate

____________ Copy of your Driver's License

____________ Copy of your Social Security Card

VERY IMPORTANT
RETIREE RETURN TO WORK

IF YOU HAVE BEEN HIRED BY THE AVOYELLES PARISH SCHOOL BOARD AS A RETIREE RETURN TO WORK AND PRESENTLY HAVE HEALTH INSURANCE, ***IT IS IMPERATIVE*** YOU REPORT TO THE FINANCE DEPARTMENT AND SPEAK WITH MRS. JUDY GUILLOTE CONCERNING YOUR HEALTH INSURANCE. IF YOU ARE RETIRED WITH ANOTHER STATE AGENCY, ***IT IS OF THE UTMOST IMPORTANCE*** YOU INFORM THE HEALTH INSURANCE DEPARTMENT OF THE AVOYELLES SCHOOL BOARD OF YOUR RETIREMENT AND ALSO INFORM YOUR RETIREMENT AGENCY OF YOUR EMPLOYMENT WITH THE AVOYELLES PARISH SCHOOL BOARD.

I ACKNOWLEDGE I HAVE READ AND BEEN INFORMED OF MY OBLIGATIONS CONCERNING MY HEALTH INSURANCE AS A RETIREE RETURN TO WORK.

________________________ ______________________________

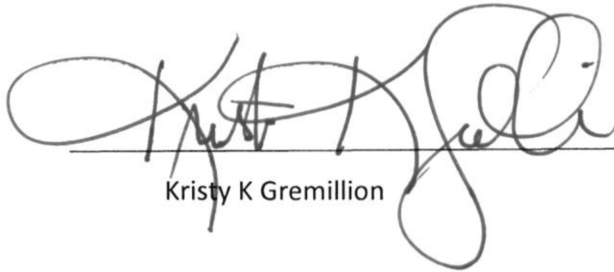
DATE SIGNATURE

OFFICE OF GROUP BENEFITS NOTIFICATION

I, ____ have been notified by the Payroll Department that I must speak to the Insurance clerk regarding medical insurance. I understand that even though I do not wish to sign up for the medical insurance offered thru the Avoyelles Parish School Board, that I must still see the Insurance clerk.

____ ____________________

Signature Date



____ ____________________

Kristy K Gremillion Date

7.7. 866-541-5096

Supplemental Benefits

As an employee of the Avoyelles Parish School Board, you are given the opportunity to apply for any supplemental policies available through First Financial Group of America.

Please review the list below and complete the bottom portion of this letter. Check off the benefits you are interested in or have questions about and fax it to 985-893-7663. A representative from First Financial will contact you. If you do not hear from a representative in a reasonable time or if you have any questions, you can **email James.Odom@ffga.com or Mike.Greene@ffga.com**

____ **Life Insurance – personally owned, permanent life policy to age 121 that can never be canceled or reduced as long as you pay the necessary premiums, even if your health changes**

____ **Disability Income Protection – provides a monthly cash benefit when you suffer a sickness or off-the-job injury that leaves you totally or partially disabled.**
No Health Questions for New Employees – Maternity Covered

____ **Cancer Insurance – supplemental insurance protection in the event you or a covered family member is diagnosed with cancer. It is portable.**

____ **Critical Illness Insurance – provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness.**

____ **Heart & Stroke – supplemental coverage works in addition to medical insurance. Benefits are paid as you go and cover the costs of specific treatments and expenses (up to the maximum allowable) as they happen.**

____ **Accident Only Insurance – can offer a solution to those rising medical costs if you have to receive medical treatment for an Accidental injury.**

____ **Dental & Vision Coverage**

____ **457 Deferred Compensation Savings Programs – an additional before-tax supplementary retirement plan**

____ **DECLINE ALL AT THIS TIME**

By signing this form, I understand the following:

- *Signing this form does not activate coverage, applications must be completed through First Financial*
- *All applications must be completed in the first 30 days of hire*
- *If I choose to apply for this coverage at future open enrollments, I may be required to furnish evidence of insurability to the insurance company before I can be considered for coverage*
- *The insurance company has the right to reject such future applications*

Signature: ______________________________

Printed Name: ______________________________ Daytime Phone #_(______)______________

School: ____________________ Best Time to Call: __________ Email Address:____________________
(During the day)

403(b) Newsletter:

It's Time to Save for your Future!

Planning Ahead

403(b) retirement plans are a great investment and great way to get a head start on saving for your retirement. A 403(b) is a supplemental retirement plan option that allows investment earnings to grow tax-deferred until withdrawal.

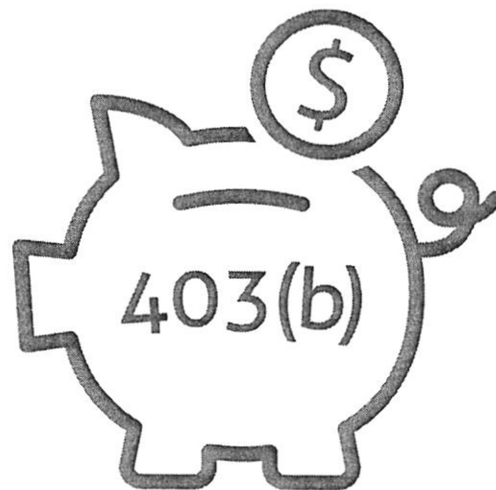
Also, 403(b) allow you to take advantage of a savings tax credit, take a loan or financial hardship (if allowed under your employer plan). In order to transfer/rollover you must have a qualifying event (IRS guidelines) to withdraw or move funds. Qualifying events are: Severance from employment, age 59 1/2 or older, disability, death, or financial hardship.

A 403(b) will allow transfers in and out of your plan allowing you to move previous 403(b) funds into the new employer's 403(b) plan. If the funds come from a 401(k) or IRA then those funds can move into your employer's plan as well. Not happy with your current investment provider? You can do an exchange with an approved investment provider in the plan. *(Please visit www.ffga.com and click on, "View employer retirement plans" to review available options for your employer.)*

Current Contributions limits allow you to max out at $18,000.00 if you are 49 and under; $24,000.00 if you are age 50 and older per calendar year. With enrollment open all year round the time to save is now.

Time to Enroll

Please visit *www.ffga.com* for a list of available investment providers in your employer's plan. Once you have picked an approved provider, then you or your financial advisor must complete enrollment forms directly with the investment company. If you do not have an financial advisor please utilize our 403(b) agent search located on www.ffga.com.



Once your account is established please complete the First Financial Administrators, Inc. Salary Reduction Agreement and fax completed forms to 1-866-265-4594. This form allows your employer to withhold 403(b) contributions from your paycheck, which will be forwarded to the investment company of your choice.

Visit www.ffga.com for forms and employer plan information!

Universal Availability Notice

First Financial Group of America

Act Now to Maximize Your 403(b) and 457(b) Contributions

In compliance with the requirements of IRC §403(b)(12(A)(ii) this Notice will advise you of the voluntary 403(b) Program established and maintained for the benefit of all employees.

Now is the time to act if you wish to maximize your pre-tax contributions to the 403(b) and 457(b) Plans or make changes for this calendar (taxable) year.

Go to www.ffga.com to view your employers' retirement plan options and availability. You can also verify if the plan offers both 403(b) and 457(b) Plans before you decide how to proceed.

Eligibility - All employees who are employed by the Employer, including full and part-time employees.

Contributions - When you enroll in the program, the amounts you designate as salary deferrals are withheld from your wages and forwarded to an investment provider of your choice. Several types of contributions may be available in your plan:

Pre-Tax Salary Deferrals: These are amounts contributed into a 403(b) Plan that are deferred from your paycheck before federal income taxes are applied.

Roth Salary Deferrals: (If your plan allows) These amounts are also deferred from your paycheck, but are subject to federal income taxes. When you withdraw monies from a Roth plan the funds may be excluded from taxation. Special rules apply to Roth contributions and you should contact your tax advisor before electing this option.

For **2016**, you may defer from your wages, a maximum of $18,000 to all 403(b) and 457(b) plans unless you will reach 50 years of age during the year. In that case, you would be eligible to contribute an additional $6,000. Deferrals may not exceed 100% of your wages.

Rollovers: (If your plan allows) You may also rollover funds from another employer's plan if you receive an eligible rollover distribution.

Plan Investment Options - Your contributions to the 403(b) Plan must be made to an investment provider approved by your Employer. Before enrolling in the plan, you must first establish an account with one of the Providers listed. Once you have executed an investment contract and established an account, you can begin making contributions.

Assistance - You may enroll in the plan or receive assistance with these provisions by contacting the plan's Third Party Administrator, First Financial Administrator, Inc. or a representative for one of the plan's Investment Companies listed on www.ffga.com.

Additional information about the provisions and options in your plan are available by contacting First Financial Administrators at (800) 523-8422 or from the plan's web site, www.ffga.com.