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 _____ Contract
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		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 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

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** _____

Form **SSA-1945** (01-2013)
Destroy Prior Editions

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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: _____ 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: __________

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: _____

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:_____

Title: _____

LSERS
LOUISIANA SCHOOL EMPLOYEES' RETIREMENT SYSTEM
8660 United Plaza Blvd. (70809), P.O. Box 44516, Baton Rouge, Louisiana 70804-4516
Phone: 225.925.6484, Toll-free: 1.800.256.3718, Fax: 225.922.1001, www.lsers.net

Enrollment Application/Employee Notification

Please type or print in ink all entries except signatures.

This form is being submitted for one of the following (mark one):

☒ New Hire ☐ Current Employee, Change in Employment ☐ Continued Employment after DROP ☐ Act 213 of 2007 Retiree Return to Work

Section 1 - To be completed by applicant

Name: Last, First, MI, Suffix (Jr., III, etc.)

Social Security Number - attach copy of card

Address (Street/P. O. Box)

Your date of birth - attach proof of birth date -Enter as **MM/DD/YYYY**

/ /

City, State, and Zip Code

A copy of birth certificate is attached or has been submitted ☐ Yes ☐ No

Daytime Telephone Number(with area code) ( )

Evening Telephone Number(with area code) ( )

Sex ☐ Female ☐ Male

Marital Status - Check one:

☐ Never Married ☐ Legally Married Date of Marriage (Enter as **MM/DD/YYYY**) / / ☐ Divorced ☐ Widowed

Nearest relative not living with you (name and relationship)

Nearest relative's telephone number (with area code) ( )

Previous employment and membership information

1. Please mark with an "X" if you were previously a member of one of the following:
   - ☐ Louisiana School Employees' Retirement System
   - ☐ Teachers' Retirement System of Louisiana (includes food service employees)
   - ☐ Louisiana State Employees' Retirement System
   - ☐ Other Louisiana public retirement system
2. Please list the dates of your membership in the system marked above: from ___/___/_____ (Enter as **MM/DD/YYYY**) to ___/___/_____ (Enter as **MM/DD/YYYY**).
3. Did you withdraw your contributions when you left your previous employment? ☐ Yes ☐ No

Applicant's Signature (Do not print or type)

Date Signed (MM/DD/YYYY)

Section 2 - Certification to be completed by current employer

Name of Employer
AVOYELLES PARISH SCHOOL BOARD

Agency Number
0005

Name of School

Title of Position

Employment status

☐ Full-time Full-time equals 4 hours per day. Annual full-time earnings_____

☐ Part-time This employee will work _____ hours per week.

Date of Employment **(MM/DD/YYYY)**
___ / ___ / 201

Basis of employment

☒ 9 months ☐ 10 months ☐ 11 months ☐ 12 months

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

The applicant was provided and has signed the Forfeiture of Benefits Attestation, Form 2F, attesting to the provisions of La. R.S. 11:293. The Form 2F will be maintained in the personnel file with the employer. ☒ Yes ☐ No

Signature of Certifying Official (Do not print or type)(No facsimile accepted) Title

Denise Laborde PAYROLL SPECIALIST

Date Signed (MM/DD/YYYY)

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LOUISIANA SCHOOL EMPLOYEES' RETIREMENT SYSTEM

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Phone: 225.925.6484 • Toll-free: 1.800.256.3718 • Fax: 225.922.1001 • www.lsers.net

04-2F
Form 2F
05/16

Forfeiture of Benefits Attestation

(For Employer Use Only - Do Not Return to LSERS)

Section 1 - Employee Information

Last Name	First Name	MI	Suffix	Social Security Number

Position Title	Date of Employment
	/ /

Section 2 - Provisions of Forfeiture Law

In accordance with La R.S. 11:293E, all individuals employed on or after January 1, 2013 are required to read and sign this attestation form.

By accepting this position, I understand that I will be enrolled in the Louisiana School Employees' Retirement System.

I further understand that my retirement benefits and the benefits payable to my spouse or children may be forfeited if I am convicted of a public corruption crime of either of the following types:

1. Public corruption crime resulting in financial gain or attempted financial gain for myself or a third party.

2. Public corruption crime that involves sexual contact with a minor and there was a direct association by virtue of my public employment.

The statute contains many terms and conditions and can be read in its entirety on the Louisiana Legislature website at http://www.legis.state.la.us/lss/lss.asp?doc=814585.

Section 3 - Attestation

I certify I have read the provisions of the forfeiture law as outlined in Section 2 of this form.

Signature of Employee (Do not print or type)	Date Signed (MM/DD/YYYY)

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Named Beneficiary

Print Reset

Please type or print in ink all entries except signatures when adding, changing or deleting a beneficiary.

Incomplete or altered forms will be returned. Designations of beneficiaries become effective when received in the office of the Louisiana School Employees' Retirement System (LSERS). Forms received by LSERS after the date of the member's death shall be null and void. Please complete additional forms if more than three designations are to be made. All forms must be submitted at the same time. **Only human beings or a member's estate may be named.** The following beneficiary designation will replace all previous choices.

Check at least one:

- ☐ Active Member (Do not check this box if you are retired or have entered DROP)
- ☐ Retired Return to Work Member (Only applies to contributions made after retirement)
- ☐ Retired Maximum or Option One
- ☐ DROP or IBRP Account (Only applies to balances in this account). Complete and attach Form 11 if married and not providing at least 50% of account balance to spouse.

☐ Check here if more than one form is submitted

Section 1 - Member Information

Last Name	First Name	Middle Initial	Suffix (Jr., III,etc.)	Social Security Number

Address (Street/P. O. Box)	Primary Telephone Number
City, State, and Zip Code	Secondary Telephone Number

Section 2 - Primary Beneficiary(ies)

If more than one beneficiary is named in this section, the interest of all beneficiaries shall be equal, unless specified otherwise. Upon the death of any designated beneficiary, his or her portion shall pass to the remaining primary beneficiary(ies). If there is no primary beneficiary, balance will be paid to the named contingent beneficiary(ies). If no beneficiary(ies) are on file, the balance will be paid to the member's estate.

Name: Last, First, MI, Suffix (Jr., III, etc.)

1

Address (Street/P. O. Box)	Primary Telephone Number
City, State, and Zip Code	Secondary Telephone Number

Social Security Number	Date of Birth mm/dd/yyyy	Sex	Relationship	Percentages
	/ /	☐ Male ☐ Female		%

Name: Last, First, MI, Suffix (Jr., III, etc.)

2

Address (Street/P. O. Box)	Primary Telephone Number
City, State, and Zip Code	Secondary Telephone Number

Social Security Number	Date of Birth mm/dd/yyyy	Sex	Relationship	Percentages
	/ /	☐ Male ☐ Female		%

Name: Last, First, MI, Suffix (Jr., III, etc.)

3

Address (Street/P. O. Box)	Primary Telephone Number
City, State, and Zip Code	Secondary Telephone Number

Social Security Number	Date of Birth mm/dd/yyyy	Sex	Relationship	Percentages
	/ /	☐ Male ☐ Female		%

Member and witnesses signatures must be completed on the reverse

Change of Beneficiary - Continued

Member Name _____ Social Security Number _____

Section 3 - Contingent Beneficiary(ies)

The contingent beneficiary(ies) **do not** share in the amount due if any of the primary beneficiary(ies) are living on member's date of death. If more than one beneficiary is named in this section, the interests of all contingent beneficiaries shall be equal, unless otherwise specified. **Only human beings or a member's estate may be named.**

Name: Last, First, MI, Suffix (Jr., III, etc.)

1

Address (Street/P. O. Box)	Primary Telephone Number
City, State, and Zip Code	Secondary Telephone Number

Social Security Number	Date of Birth mm/dd/yyyy	Sex	Relationship	Percentages
	/ /	☐ Male ☐ Female		%

Name: Last, First, MI, Suffix (Jr., III, etc.)

2

Address (Street/P. O. Box)	Primary Telephone Number
City, State, and Zip Code	Secondary Telephone Number

Social Security Number	Date of Birth mm/dd/yyyy	Sex	Relationship	Percentages
	/ /	☐ Male ☐ Female		%

Name: Last, First, MI, Suffix (Jr., III, etc.)

3

Address (Street/P. O. Box)	Primary Telephone Number
City, State, and Zip Code	Secondary Telephone Number

Social Security Number	Date of Birth mm/dd/yyyy	Sex	Relationship	Percentages
	/ /	☐ Male ☐ Female		%

Section 4 - Member and Witnesses' Signatures

I hereby request that my beneficiary(ies) be designated as listed in Sections 2 and 3. I understand that the beneficiary(ies) 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.

Signature of Member (Do not print or type)	Date Signed (MM/DD/YYYY)

Must be witnessed by persons other than beneficiary(ies)

Signature of Witness (Do not print or type)	Signature of Witness (Do not print or type)
Address (Street/P. O. Box)	Address (Street/P. O. Box)
City, State, and Zip Code	City, State, and Zip Code

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Form 2SS
6/09

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

Please type or print in ink all entries except signatures.

Employee and Employer Information

Employee Name: Last, First, MI, Suffix (Jr., III, etc.)	Social Security Number - attach a copy of card
Employer Name	**Employer Agency (ID) Number**
AVOYELLES PARISH SCHOOL BOARD	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. 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 Social Security office.

I certify that I have received LSERS Form 2-SS (Form SSA-1495) 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 Signed (MM/DD/YYYY)

Return this completed page to the address at the top of this page

Fact Sheet - Your Employment is Not Covered by Social Security

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

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.

LSERS Form 2-SS, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers with LSERS-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 LSERS.

Copies of LSERS Form 2-SS, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** are available online at ***www.lsers.state.la.us.*** Click on Employer Services; then on 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/SSAA-1945.pdf* and information about the form is available at *www.socialsecurity.gov/form1945*.)

Please use LSERS Form 2-SS for all LSERS-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

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

PHONE:

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

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

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

F.F. 866-541-5046

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.

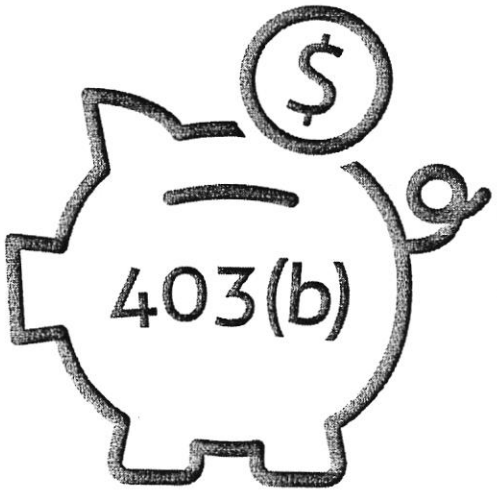
A 403(b) will allow transfers in and out of your plan allowing you to move previous 403(b) funds into the new employer's 403(b) plan. If the funds come from a 401(k) or IRA then those funds can move into your employer's plan as well. Not happy with your current investment provider? You can do an exchange 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.



First Financial Administrators, Inc.
First in Service and Expertise

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

Toll Free: 1-800-523-8422 | Fax: 1-866-265-4594 | Email: retirement@ffga.com | Mail: P.O. Box 670329 Houston, TX 77267-0329

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.

Universal Availability Notice

First Financial Group of America

The following are some guidelines to assist you with your decisions. Note that any changes you make now will continue in 2016 forward, so don't forget to readjust your contributions once 2017 begins, if that is what you wish to do.

403(b) Retirement Plan

The tax structure of a 403(b) is similar to 401k. As you make contributions through your salary, on a pre-tax basis, they attract interest. It is when you start receiving monthly payments from the plan on maturity that you are required to pay taxes, just like any other ordinary income. This is why 403(b) is also known as Tax Sheltered Annuity (TSA). This plan is popular among non-profit organizations, and employers opt for it, as it is exempt from Employer Retirement Income Security Act which allows the employer to offer this plan to all employees.

457(b) Retirement Plan

A 457(b) is a retirement benefit plan that is open for mostly government sector employees. The employer may offer this plan which is also similar to a 401k. The contributions made by an employee are exempt from tax until the employee receives a benefit from the plan, this is also known as a tax deferred plan. But unlike 401k or 403b, there is no penalty for withdrawal before the age of 59 ½ (subject to a qualifying event under 457(b) provisions). However, the amount withdrawn is subject to ordinary taxation. This plan allows employees to save a part of their income without paying tax on contributions, or the earnings that accrue in the form of interest, until funds are distributed from the plan based on a qualifying event.

Difference between 403(b) and 457(b)

Both are tax deferred plans.

In 457(b), there is no minimum retirement age which means there is not a 10% penalty upon withdrawal of money based on a qualifying event. An early withdrawal penalty does apply to both 403(b) and 401k plans.

What is notable is that if an employer offers both 457(b) and 403(b), an employee can choose to contribute to both from his salary.

While under 403(b), an employee can withdraw money for hardship circumstances such as buying a home or for the education of himself or a qualified dependent. Such withdrawals are not allowed under the unforeseen emergency provisions of a 457(b) plan.

Questions? Contact First Financial at (800) 523-8422 or visit us at www.ffga.com.

First Financial Administrators, Inc.
First in Service and Expertise