Ralph C. Mahar Regional School
Orange Elementary
Petersham Center School

Consolidated Central Offices
507 South Main Street
P.O. Box 680
Orange, MA 01364

Dr. Elizabeth Zielinski, Superintendent of Schools
Email: ezielinski@rcmahar.org Phone: 978-544-2920

Educational Support

This is your Full-Time employee packet from the Consolidated Central Office. Inside are the following forms and documents that need to be completed:
To be completed:

Employee	For Internal	
_____	_____	Federal & MA Tax Withholding Forms
_____	_____	CORI Form & Fingerprinting Information
_____	_____	Emergency Contact Form
_____	_____	Conflict of Interest Packet
_____	_____	Acknowledgement of Personnel Policy Handbook
_____	_____	Ethnicity Code Form
_____	_____	I-9 Form- Please include 2 forms of ID or Passport
_____	_____	FRR Paperwork (includes NMA, Beneficiary Form, Not covered by SSA)
_____	_____	Direct Deposit Form- Mandatory
_____	_____	21 or 26 pay form
_____	_____	Hampshire County Insurance Affidavit Form (If enrolling in health insurance- need marriage license and birth certificates)
_____	_____	Refusal of insurance form (if you choose not to enroll in insurance)
_____	_____	HMO & PPO Summary of Benefits & Health Insurance Enrollment Form
_____	_____	Dental Insurance Summary of Benefits & Dental Insurance Enrollment Form
_____	_____	Life Insurance Enrollment Form
_____	_____	Refusal of insurance form (if you choose not to enroll in insurance)

Informational:

_____	_____	List of payroll dates
Employee	For Internal	
_____	_____	Insurance Rate Informational Page
Employee	For Internal	
_____	_____	Online paystub access information
Employee	For Internal	

All forms need to be returned to the Central Office before _____ to ensure your deductions are correct and you are properly enrolled in all applicable benefit plans.. If you have any questions, please contact me at the Central Office- 978-544-2920 or via email amagoffin@rcmahar.org

Thank you,

Alyssa Magoffin
HR/Payroll Coordinator

Disclaimer: The accurate and timely completion of the above documents is the sole responsibility of the prospective employee. Failure to complete the above documents within the prescribed time may disqualify you from obtaining the benefits for which you may be eligible. I accept the responsibility to complete the new employee paperwork in a timely manner. I agree to hold the School District (Department) harmless if benefits are withheld as a result of inaccurate or late submission of required documents.

_____ _____

Employee Signature Date

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

2020

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 online estimator, 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 2020 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 income will be $200,000 or less ($400,000 or less if married filing jointly):

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

▶ _____ ▶ _____

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

Employers Only

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

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

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

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

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

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

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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

FORM M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 1/12

Print full name ..... Social Security no. .....

Print home address ..... City..... State ..... Zip .....

Employee:
File this form or Form W-4 with your employer. Otherwise, Massachusetts income Taxes will be withheld from your wages without exemptions.

Employer:
Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" .....
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C. .....
3. Write the number of your qualified dependents. See Instruction D. .....
4. Add the number of exemptions which you have claimed above and write the total. .....
5. Additional withholding per pay period under agreement with employer $ _____

A. ☐ Check if you will file as head of household on your tax return.

B. ☐ Check if you are blind. C. ☐ Check if spouse is blind and not subject to withholding.

D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed $8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date..... Signed .....

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. If you claim more than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you **decreases.** For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a wife or husband, write "4" in line 2. Using "4" is the withholding system adjustment for the $4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

IF THE ALLOWABLE MASSACHUSETTS WITHHOLDING EXEMPTIONS ARE THE SAME AS YOU ARE CLAIMING FOR U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.

Ralph C. Mahar Regional School
Orange Elementary
Petersham Center School

Consolidated Central Offices
507 South Main Street
P.O. Box 680
Orange, MA 01364

Dr. Elizabeth Zielinski, Superintendent of Schools
Email: ezielinski@rcmahar.org Phone: 978-544-2920

CORI (CRIMINAL OFFENDER RECORD INFORMATION) REQUEST FORM

The RALPH C. MAHAR REGIONAL and ORANGE ELEMENTARY SCHOOL DISTRICTS have been certified by the Department of Criminal Justice Information Services for access to all criminal case data including conviction, non-conviction, and pending criminal case data.

As an applicant/employee/ for the position of _____,
I understand that a criminal record check will be conducted for conviction, non-conviction and pending criminal case information only and that it will not necessarily disqualify me. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the R.C. Mahar Regional School District/Orange Elementary School District with written notice of my intent to withdraw consent to a CORI check. If the R.C. Mahar Regional School District/Orange Elementary School District conducts a subsequent CORI check within one year, I must be provided with written notice of this check. By signing below, I provide my consent to a CORI check and acknowledge that the information provided is correct to the best of my knowledge.

_____
Applicant/Employee Signature

_____ _____ _____
Last Name First Name Middle Name

_____ _____ _____
Maiden Name or Alias (If Applicable) Place of Birth Date of Birth

_____ _____
Social Security # (Last 6 digits) Mother's Maiden Name

CURRENT & FORMER ADDRESS: _____

_____

_____
STATE DRIVER'S LICENSE NUMBER (Include State of Issue)

PLEASE DO NOT WRITE BELOW THIS LINE

The above information was verified by reviewing the following form of government issued photographic identification:

_____

REQUESTED BY: _____
Signature of CORI Authorized Employee

_____

Ralph C. Mahar Regional School
Orange Elementary
Petersham Center School

Consolidated Central Offices
507 South Main Street
P.O. Box 680
Orange, MA 01364

Dr. Elizabeth Zielinski, Superintendent of Schools
Email: ezielinski@rcmahar.org Phone: 978-544-2920

Memorandum

To: Employee(s), Student Teachers(s), and Substitutes(s)
From: Orange Elementary Superintendent's Office
Re: Implementation of Chapter 77 of the Acts of 2013

In September 2013, Governor Patrick signed into law Chapter 77 of the Acts of 2013, "An Act Relative to Background Checks." This new law expands on what we as public schools already do with Criminal Offender Record Information (CORI) checks. Specifically, it requires a fingerprint-based state and national criminal record check for all school employees. The State Applicant Fingerprint Identification System (SAFIS) and the MorphoTrust-IdentoGo website and fingerprinting locations have been created for this purpose. Currently there are 8 of these locations open in MA with one in Leominster and in Springfield. There will be an additional 25 locations opening across the state in the next few months.

- To register online at http://www.identogo.com/FP/Massachusetts.aspx, select Online Scheduling or by phone at (866) 349-8130.
- You will be required to provide **Orange Elementary Schools ESE Organization Code: 02230000** (Substitutes and Student Teachers may provide up to 10 districts organization codes to eliminate the need to pay the fee multiple times).
- Unlike the state CORI checks that do not have an associated fee, **individuals** will pay a fee to comply with this requirement. The fee is **$35.00** for non-licensed employees and **$55.00** for DESE Licensed Professionals (including those with pending applications/licenses). *Please note, no cash payments are permitted. A debit or credit card may only be used during the online/phone registration process. You can pay the day of fingerprinting with a check or money order.*

- Substitutes are school employees under the new law and, therefore, must submit their fingerprints for the state and national checks. If substitute teachers hold educator licenses issued under G.L. c.71, § 38G, they will pay the $55.00 fee; otherwise, they will pay the $35.00 fee.

- You will be provided with a fingerprint receipt. A copy of this receipt must be returned to Megan Young in the Superintendent's Office and will be confirmation that the fingerprints were captured.

For more information please visit:

http://www.mass.gov/edu/2013newsupdates/frequently-asked-questions-regarding-background-checks.html. You can also visit our website, www.orange-elem.org, to view the SAFIS Registration Guide.

Thank you in advance for your cooperation.

Town of Orange

Employee Data:

Employee Name: _____ Birthdate: _____

Address: _____

Phone: _____ Email: _____

Marital Status: single married Social Security Number: _____

Emergency Contact:

Name: _____ Phone: _____

Cellphone: _____

Relationship to Employee: _____

Address: _____

Additional Contact Names and Phone Numbers:

1. _____
2. _____
3. _____

Summary of the Conflict of Interest Law for Municipal Employees

This summary of the conflict of interest law, General Laws chapter 268A, is intended to help municipal employees understand how that law applies to them. This summary is not a substitute for legal advice, nor does it mention every aspect of the law that may apply in a particular situation. Municipal employees can obtain free confidential advice about the conflict of interest law from the Commission's Legal Division at our website, phone number, and address above. Municipal counsel may also provide advice.

The conflict of interest law seeks to prevent conflicts between private interests and public duties, foster integrity in public service, and promote the public's trust and confidence in that service by placing restrictions on what municipal employees may do on the job, after hours, and after leaving public service, as described below. The sections referenced below are sections of G.L. c. 268A.

When the Commission determines that the conflict of interest law has been violated, it can impose a civil penalty of up to $10,000 ($25,000 for bribery cases) for each violation. In addition, the Commission can order the violator to repay any economic advantage he gained by the violation, and to make restitution to injured third parties. Violations of the conflict of interest law can also be prosecuted criminally.

I. Are you a municipal employee for conflict of interest law purposes?

You do not have to be a full-time, paid municipal employee to be considered a municipal employee for conflict of interest purposes. Anyone performing services for a city or town or holding a municipal position, whether paid or unpaid, including full- and part-time municipal employees, elected officials, volunteers, and consultants, is a municipal employee under the conflict of interest law. An employee of a private firm can also be a municipal employee, if the private firm has a contract with the city or town and the employee is a "key employee" under the contract, meaning the town has specifically contracted for her services. The law also covers private parties who engage in impermissible dealings with municipal employees, such as offering bribes or illegal gifts.

II. On-the-job restrictions.

(a) Bribes. Asking for and taking bribes is prohibited. (See Section 2)

A bribe is anything of value corruptly received by a municipal employee in exchange for the employee being influenced in his official actions. Giving, offering, receiving, or asking for a bribe is illegal.

Bribes are more serious than illegal gifts because they involve corrupt intent. In other words, the municipal employee intends to sell his office by agreeing to do or not do some official act, and the giver intends to influence him to do so. Bribes of any value are illegal.

(b) Gifts and gratuities. Asking for or accepting a gift because of your official position, or because of something you can do or have done in your official position, is prohibited. (See Sections 3, 23(b)(2), and 26)

Municipal employees may not accept gifts and gratuities valued at $50 or more given to influence their official actions or because of their official position. Accepting a gift intended to reward past official action or to bring about future official action is illegal, as is giving such gifts. Accepting a gift given to you because of the municipal position you hold is also illegal. Meals, entertainment event tickets, golf, gift baskets, and payment of travel expenses can all be illegal gifts if given in connection with official action or position, as can anything worth $50 or more. A number of smaller gifts together worth $50 or more may also violate these sections.

Example of violation: A town administrator accepts reduced rental payments from developers.

Example of violation: A developer offers a ski trip to a school district employee who oversees the developer's work for the school district.

Regulatory exemptions. There are situations in which a municipal employee's receipt of a gift does not present a genuine risk of a conflict of interest, and may in fact advance the public interest. The Commission has created exemptions, and is considering creating additional exemptions, permitting giving and receiving gifts in these situations. One commonly used exemption permits municipal employees to accept payment of travel-related expenses when doing so advances a public purpose. Other exemptions are listed on the Commission's website.

Example where there is no violation: A fire truck manufacturer offers to pay the travel expenses of a fire chief to a trade show where the chief can examine various kinds of fire-fighting equipment that the town may purchase. The chief fills out a disclosure form and obtains prior approval from his appointing authority.

(c) Misuse of position. Using your official position to get something you are not entitled to, or to get someone else something they are not entitled to, is prohibited. Causing someone else to do these things is also prohibited. (See Sections 23(b)(2) and 26)

A municipal employee may not use her official position to get something worth $50 or more that would not be properly available to other similarly situated individuals. Similarly, a municipal employee may not use her official position to get something worth $50 or more for someone else that would not be properly available to other similarly situated individuals. Causing someone else to do these things is also prohibited.

Example of violation: A full-time town employee writes a novel on work time, using her office computer, and directing her secretary to proofread the draft.

Example of violation: A city councilor directs subordinates to drive the councilor's wife to and from the grocery store.

Example of violation: A mayor avoids a speeding ticket by asking the police officer who stops him, "Do you know who I am?" and showing his municipal I.D.

(d) Self-dealing and nepotism. Participating as a municipal employee in a matter in which you, your immediate family, your business organization, or your future employer has a financial interest is prohibited. (See Section 19)

A municipal employee may not participate in any particular matter in which he or a member of his immediate family (parents, children, siblings, spouse, and spouse's parents, children, and siblings) has a financial interest. He also may not participate in any particular matter in which a prospective employer, or a business organization of which he is a director, officer, trustee, or employee has a financial interest. Participation includes discussing as well as voting on a matter, and delegating a matter to someone else.

A financial interest may create a conflict of interest whether it is large or small, and positive or negative. In other words, it does not matter if a lot of money is involved or only a little. It also does not matter if you are putting money into your pocket or taking it out. If you, your immediate family, your business, or your employer have or has a financial interest in a matter, you may not participate. The financial interest must be direct and immediate or reasonably foreseeable to create a conflict. Financial interests which are remote, speculative or not sufficiently identifiable do not create conflicts.

Example of violation: A school committee member's wife is a teacher in the town's public schools. The school committee member votes on the budget line item for teachers' salaries.

Example of violation: A member of a town affordable housing committee is also the director of a non-profit housing development corporation. The non-profit makes an application to the committee, and the member/director participates in the discussion.

Example: A planning board member lives next door to property where a developer plans to construct a new building. Because the planning board member owns abutting property, he is presumed to have a financial interest in the matter. He cannot participate unless he provides the State Ethics Commission with an opinion from a qualified independent appraiser that the new construction will not affect his financial interest.

In many cases, where not otherwise required to participate, a municipal employee may comply with the law by simply not participating in the particular matter in which she has a financial interest. She need not give a reason for not participating.

There are several exemptions to this section of the law. An appointed municipal employee may file a written disclosure about the financial interest with his appointing authority, and seek permission to participate notwithstanding the conflict. The appointing authority may grant written permission if she determines that the financial interest in question is not so substantial that it is likely to affect the integrity of his services to the municipality. Participating without disclosing the financial interest is a violation. Elected employees cannot use the disclosure procedure because they have no appointing authority.

Example where there is no violation: An appointed member of the town zoning advisory committee, which will review and recommend changes to the town's by-laws with regard to a commercial district, is a partner at a company that owns commercial property in the district. Prior to participating in any committee discussions, the member files a disclosure with the zoning board of appeals that appointed him to his position, and that board gives him a written determination authorizing his participation, despite his company's financial interest. There is no violation.

There is also an exemption for both appointed and elected employees where the employee's task is to address a matter of general policy and the employee's financial interest is shared with a substantial portion (generally 10% or more) of the town's population, such as, for instance, a financial interest in real estate tax rates or municipal utility rates.

(e) <u>False claims</u>. Presenting a false claim to your employer for a payment or benefit is prohibited, and causing someone else to do so is also prohibited. (See Sections 23(b)(4) and 26)

A municipal employee may not present a false or fraudulent claim to his employer for any payment or benefit worth $50 or more, or cause another person to do so.

Example of violation: A public works director directs his secretary to fill out time sheets to show him as present at work on days when he was skiing.

(f) <u>Appearance of conflict</u>. Acting in a manner that would make a reasonable person think you can be improperly influenced is prohibited. (See Section 23(b)(3))

A municipal employee may not act in a manner that would cause a reasonable person to think that she would show favor toward someone or that she can be improperly influenced. Section 23(b)(3) requires a municipal employee to consider whether her relationships and affiliations could prevent her from acting fairly and objectively when she performs her duties for a city or town. If she cannot be fair and objective because of a relationship or affiliation, she should not perform her duties. However, a municipal employee, whether elected or appointed, can avoid violating this provision by making a public disclosure of the facts. An appointed employee must make the disclosure in writing to his appointing official.

Example where there is no violation: A developer who is the cousin of the chair of the conservation commission has filed an application with the commission. A reasonable person could conclude that the chair might favor her cousin. The chair files a written disclosure with her appointing authority explaining her relationship with her cousin prior to the meeting at which the application will be considered. There is no violation of Sec. 23(b)(3).

(g) <u>Confidential information</u>. Improperly disclosing or personally using confidential information obtained through your job is prohibited. (See Section 23(c))

Municipal employees may not improperly disclose confidential information, or make personal use of non-public information they acquired in the course of their official duties to further their personal interests.

III. After-hours restrictions.

(a) Taking a second paid job that conflicts with the duties of your municipal job is prohibited. (See Section 23(b)(1))

A municipal employee may not accept other paid employment if the responsibilities of the second job are incompatible with his or her municipal job.

Example: A police officer may not work as a paid private security guard in the town where he serves because the demands of his private employment would conflict with his duties as a police officer.

(b) Divided loyalties. Receiving pay from anyone other than the city or town to work on a matter involving the city or town is prohibited. Acting as agent or attorney for anyone other than the city or town in a matter involving the city or town is also prohibited whether or not you are paid. (See Sec. 17)

Because cities and towns are entitled to the undivided loyalty of their employees, a municipal employee may not be paid by other people and organizations in relation to a matter if the city or town has an interest in the matter. In addition, a municipal employee may not act on behalf of other people and organizations or act as an attorney for other people and organizations in which the town has an interest. Acting as agent includes contacting the municipality in person, by phone, or in writing; acting as a liaison; providing documents to the city or town; and serving as spokesman.

A municipal employee may always represent his own personal interests, even before his own municipal agency or board, on the same terms and conditions that other similarly situated members of the public would be allowed to do so. A municipal employee may also apply for building and related permits on behalf of someone else and be paid for doing so, unless he works for the permitting agency, or an agency which regulates the permitting agency.

Example of violation: A full-time health agent submits a septic system plan that she has prepared for a private client to the town's board of health.

Example of violation: A planning board member represents a private client before the board of selectmen on a request that town meeting consider rezoning the client's property.

While many municipal employees earn their livelihood in municipal jobs, some municipal employees volunteer their time to provide services to the town or receive small stipends. Others, such as a private attorney who provides legal services to a town as needed, may serve in a position in which they may have other personal or private employment during normal working hours. In recognition of the need not to unduly restrict the ability of town volunteers and part-time employees to earn a living, the law is less restrictive for "special" municipal employees than for other municipal employees.

The status of "special" municipal employee has to be assigned to a municipal position by vote of the board of selectmen, city council, or similar body. A position is eligible to be designated as "special" if it is unpaid, or if it is part-time and the employee is allowed to have another job during normal working hours, or if the employee was not paid for working more than 800 hours during the preceding 365 days. It is the position that is designated as "special" and not the person or persons holding the position. Selectmen in towns of 10,000 or fewer are automatically "special"; selectman in larger towns cannot be "specials."

If a municipal position has been designated as "special," an employee holding that position may be paid by others, act on behalf of others, and act as attorney for others with respect to matters before municipal boards other than his own, provided that he has not officially participated in the matter, and the matter is not now, and has not within the past year been, under his official responsibility.

Example: A school committee member who has been designated as a special municipal employee appears before the board of health on behalf of a client of his private law practice, on a matter that he has not participated in or had responsibility for as a school committee member. There is no conflict. However, he may not appear before the school committee, or the school department, on behalf of a client because he has official responsibility for any matter that comes before the school committee. This is still the case even if he has recused himself from participating in the matter in his official capacity.

Example: A member who sits as an alternate on the conservation commission is a special municipal employee. Under town by-laws, he only has official responsibility for matters assigned to him. He may represent a resident who wants to file an application with the conservation commission as long as the matter is not assigned to him and he will not participate in it.

(c) Inside track. Being paid by your city or town, directly or indirectly, under some

second arrangement in addition to your job is prohibited, unless an exemption applies. (See Section 20)

A municipal employee generally may not have a financial interest in a municipal contract, including a second municipal job. A municipal employee is also generally prohibited from having an indirect financial interest in a contract that the city or town has with someone else. This provision is intended to prevent municipal employees from having an "inside track" to further financial opportunities.

Example of violation: Legal counsel to the town housing authority becomes the acting executive director of the authority, and is paid in both positions.

Example of violation: A selectman buys a surplus truck from the town DPW.

Example of violation: A full-time secretary for the board of health wants to have a second job working part-time for the town library. She will violate Section 20 unless she can meet the requirements of an exemption.

Example of violation: A city councilor wants to work for a non-profit that receives funding under a contract with her city. Unless she can satisfy the requirements of an exemption under Section 20, she cannot take the job.

There are numerous exemptions. A municipal employee may hold multiple unpaid or elected positions. Some exemptions apply only to special municipal employees. Specific exemptions may cover housing-related benefits, public safety positions, certain elected positions, small towns, and other specific situations. Please call the Ethics Commission's Legal Division for advice about a specific situation.

IV. After you leave municipal employment. (See Section 18)

(a) Forever ban. After you leave your municipal job, you may never work for anyone other than the municipality on a matter that you worked on as a municipal employee.

If you participated in a matter as a municipal employee, you cannot ever be paid to work on that same matter for anyone other than the municipality, nor may you act for someone else, whether paid or not. The purpose of this restriction is to bar former employees from selling to private interests their familiarity with the facts of particular matters that are of continuing concern to their former municipal employer. The restriction does not prohibit former municipal employees from using the expertise acquired in government service in their subsequent private activities.

Example of violation: A former school department employee works for a contractor under a contract that she helped to draft and oversee for the school department.

(b) One year cooling-off period. For one year after you leave your municipal job you may not participate in any matter over which you had official responsibility during your last two years of public service.

Former municipal employees are barred for one year after they leave municipal employment from personally appearing before any agency of the municipality in connection with matters that were under their authority in their prior municipal positions during the two years before they left.

Example: An assistant town manager negotiates a three-year contract with a company. The town manager who supervised the assistant, and had official responsibility for the contract but did not participate in negotiating it, leaves her job to work for the company to which the contract was awarded. The former manager may not call or write the town in connection with the company's work on the contract for one year after leaving the town.

(c) Partners. Your partners will be subject to restrictions while you serve as a municipal employee and after your municipal service ends.

Partners of municipal employees and former municipal employees are also subject to restrictions under the conflict of interest law. If a municipal employee participated in a matter, or if he has official responsibility for a matter, then his partner may not act on behalf of anyone other than the municipality or provide services as an attorney to anyone but the city or town in relation to the matter.

Example: While serving on a city's historic district commission, an architect reviewed an application to get landmark status for a building. His partners at his architecture firm may not prepare and sign plans for the owner of the building or otherwise act on the owner's behalf in relation to the application for landmark status. In addition, because the architect has official responsibility as a commissioner for every matter that comes before the commission, his partners may not communicate with the commission or otherwise act on behalf of any client on any matter that comes before the commission during the time that the architect serves on the commission.

Example: A former town counsel joins a law firm as a partner. Because she litigated a lawsuit for the town, her new partners cannot represent any private clients in the lawsuit for one year after her job with the town ended.

* * * * *

This summary is not intended to be legal advice and, because it is a summary, it does not mention every provision of the conflict law that may apply in a particular situation. Our website, www.mass.gov/ethics, contains further information about how the law applies in many situations. You can also contact the Commission's Legal Division via our website, by telephone, or by letter. Our contact information is at the top of this document.

Town of Orange

Conflict of Interest Law

All new town employees must complete the "Conflict of Interest Law" online training and pass the test. This can be done at your convenience online on any computer within your first week of employment. If you don't have a computer at home, please see your Supervisor to make arrangements to use one of the Town computers. The link to bring you to the training is:

www.mass.gov/ethics

Once you complete the test, you will need to print out the completion certificate and drop it off to HR.

Attached is a summary of the law for your reference.

Ralph C. Mahar Regional School
Orange Elementary
Petersham Center School

Consolidated Central Offices
507 South Main Street
P.O. Box 680
Orange, MA 01364

Dr. Elizabeth Zielinski, Superintendent of Schools
Email: ezielinski@rcmahar.org Phone: 978-544-2920

ACKNOWLEDGEMENT RECEIPT OF PERSONNEL POLICY HANDBOOK

I hereby acknowledge that I have reviewed a copy of the Orange Elementary Schools Personnel Policy Handbook. This document is available to be viewed on the Orange Elementary Schools website at www.orange-elem.org. I understand that it is my obligation to immediately read the enclosed policies and abide by them at all times while employed with the Orange Elementary Schools.

Employee's Signature: _____

Employee's Name: _____

Date: _____

U.S. Office of Personnel Management Guide to Personnel Data Standards	**ETHNICITY AND RACE IDENTIFICATION** (Please read the Privacy Act Statement and Instructions before completing form.)	
Name (Last, First, Middle Initial)	Social Security Number	Birthdate (Month and Year)
Agency Use Only		

Privacy Act Statement

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

☐ Yes ☐ No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
☐ American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
☐ Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐ Black or African American	A person having origins in any of the black racial groups of Africa.
☐ Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Standard Form 181
Revised August 2005
Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **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 *(Employee 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 preparer(s) and/or translator(s) 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 *Employee 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 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

A. New Name *(if applicable)*

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

New Member Enrollment Application (NMA)

(Use this form for initial or new membership positions. Call FRRS if clarification needed.)

Retirement Board

Franklin Regional Retirement System
278 Main Street, Suite 311
Greenfield, MA 01301
413-774-4837

Section A: Employee Information

First (Print) | MI | Last | S.S.Number | Gender

Birth Name or Former Name (if different) | Date of Birth

Please send us a copy of your birth certificate.

First Phone # | First Email Address

Second Phone # | Second Email Address

Address | City | State | Zip

|__|M |__|S |__|W |__|D | Number of Children

Marital Status

Spouse's Name | Date of Birth

Military Service Information

Are you a Veteran? |__|Y |__|N Dates of Active Duty Service |_____ to _____|

Please send us a copy of your discharge papers (DD214).

Employment

This position only (please use APIF form for additional positions)

Name of Employer | Title/Position | First date of work

Are you retired from any retirement system in Massachusetts? |__|Y |__|N

Name of retirement system | Date of retirement

Name |_____| SSN Last 4: XXX-XX-_____|

Other current or previous governmental employment

Other Retirement Systems

Please list government employment when you were a member of another retirement system in Massachusetts, i.e, Mass Teachers', State Retirement, outside of Franklin County, Greenfield, Montague, F.C. Technical School, etc.

Town, school, district, agency	Retirement System	Dates	Funds still there?
		to	Yes ☐ No ☐
		to	Yes ☐ No ☐
		to	Yes ☐ No ☐
		to	Yes ☐ No ☐

Other "non-membership" employment

If you worked in a position that might not have been eligible for membership with one of the retirement systems in Massachusetts, you may be able to "purchase" that service credit and add it to your retirement.

Please list any government employment that you think might have been "non-membership" service . We will contact you when we have completed the necessary research.

Town, school, district, agency	Position	Dates
		to
		to
		to
		to
		to
		to

Beneficiary Selection section (If Member Dies Before Retirement)

CHOICE OF BENEFICIARY TO RECEIVE ACCUMULATED TOTAL DEDUCTIONS AT MEMBER'S DEATH (Lump-sum payout)

I hereby request the Board of Retirement to pay any sum referred to in G.L. c. 32, § 11(2)* due at my death to the following beneficiary or beneficiaries in the proportions designated. My selection may be superseded by an Option D (see Option D page) selection under G.L. c. 32 § 12(2)(d) or if I die leaving an eligible spouse who elects to receive a monthly benefit. I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement, this form becomes void.

Name |_____| SSN Last 4: XXX-XX-_____|

*The types of payments covered under G.L. c. 32 § 11(2) include:

- The payment of the accumulated deductions credited to a member's account in the annuity savings fund at the date of death when the member's death occurs prior to his/her retirement.
- The amount of any uncashed checks payable to a member at his or her death.

Any person or entity may be a beneficiary under G.L. c. 32 § 11(2). Give complete name and address of each beneficiary below (use reverse side if needed):

Primary Beneficiaries

Proportion to be paid

Name |_____|TIN/SSN |_____| |_____%

Address |_____|

(In the event that this person/entity becomes deceased/disbanded, please use the additional section (below) for further instructions)

Name |_____|TIN/SSN |_____| |_____%

Address |_____|

(In the event that this person/entity becomes deceased/disbanded, please use the additional section (below) for further instructions)

Name |_____|TIN/SSN |_____| |_____%

Address |_____|

(In the event that this person/entity becomes deceased/disbanded, please use the additional section (below) for further instructions)

Additional/Alternate/Secondary Beneficiaries

Name |_____ _____|TIN/SSN |_____|

Address |_____|

Notes |_____| **Proportion** |_____%

Name |_____ _____|TIN/SSN |_____|

Address |_____|

Notes |_____| **Proportion** |_____%

Name |_____ _____|TIN/SSN |_____|

Address |_____|

Notes |_____| **Proportion** |_____%

Name |_____ _____|TIN/SSN |_____|

Address |_____|

Notes |_____| **Proportion** |_____%

Name |_____| SSN Last 4: XXX-XX-_____|

Attention: This is a separate option that you may wish to choose.
CHOICE OF OPTION (D) BENEFICIARY (Monthly benefit)

I hereby nominate the beneficiary* listed below, under the provisions of G.L. c. 32, § 12(2)(d) to receive from the retirement system a benefit equal to the Option (C) retirement allowance which would otherwise have been payable to me in the event that I die before being retired. I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement this form becomes void. I understand that this choice of Option D Beneficiary can be superseded if, at my death, I leave a spouse to whom I have been married for over one year and with whom I am living on the date of my death or if living apart, for justifiable cause as determined by the Retirement Board.

* An eligible beneficiary is defined under G.L. c. 32, § 12(2)(d) as the spouse, former spouse who has not remarried, child, father, mother, sister or brother of the member.

BENEFICIARY

|_____| ❑ Spouse ❑ Former Spouse who has not remarried
Name of Eligible Beneficiary ❑ Child ❑ Father ❑ Mother ❑ Sister ❑ Brother

|_____| |_____|
Beneficiary's Date of Birth (Attach birth record) Beneficiary's Social Security #

Name |_____| SSN Last 4: XXX-XX-_____|

Social Security Administration – Form SSA-1945 (01-2013)

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

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.

Name |_____| SSN Last 4: XXX-XX-_____|

Signature

I hereby authorize the Treasurer to withhold the proper percent of my regular compensation due on each pay period and to deposit such deductions to my credit in the annuity savings fund of the retirement system. I understand the full amount of such deductions, with regular interest as provided by law, will be returned to me upon my written request if I terminate service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth. In the event that I die before retiring, my beneficiary or beneficiaries may receive survivor benefits or a refund of my accumulated total deductions as allowed by law.

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.

I sign this form under the pains and penalties of perjury. I affirm that the information presented in this form is correct, complete, and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

Employee's Signature (required): _____ **Date** _____

Signature of Witness (required): _____
Witness of Employee's Signature

Name of Witness (Print): _____

Name |_____| SSN Last 4: XXX-XX-_____|

Section B: To Be Completed by the Treasurer, or payroll personnel, of Town, School District, or Agency (aka: units)

(Please use APIF form for additional positions.)

Employment Dates

Do you agree with the "First date of work" stated by the employee on page 1 of this form? (Y/N) |___|___|

If you do not agree, what do you say the Start Date is for this particular position? |_____|

What's the date of the first day of work included in the first deductions you are sending FRRS? |_____|

Please explain any No answers: _____

_____

Deduction Rate (check the appropriate box)

9% |___| **New Members** Longstanding members: 5% |___| 7% |___| 8% |___|

9% for new members starting after July 1, 1996 -- (5, 7, and 8% are for people that started as members years ago)

(If you have questions, i.e., because the employee said or indicated they have prior governmental employment in Massachusetts, please contact the retirement system (413.774.4837 x1, or admin@frrsma.com) and ask which rate to deduct.)

Employment Status (check all that apply)

Permanent |___| Temporary |___| Interim |___| Elected |___|

Full-time |___| Part-time |___|

Salary Information

When do you pay them?: weekly |___| biweekly |___| monthly |___| other |_____|

If it's a School Year schedule, how many school days are they scheduled to work: |_____|, and how many pays: (21, 22, or 24 pays) |_____|

How many HOURS are they expected to work each WEEK: |_____|

What is the corresponding HOURLY rate: |_____| How much is that ANNUALLY: |_____|

If you are NOT paying them hourly, how are you paying them? (daily, or are you dividing their annual salary and paying them equal amounts each time?

Circle one or please describe: |_____|

And now, tell us "the numbers" for this NON-Hourly pay pattern:

Number of periods: |_____| Rate of pay per period: |_____| Annual pay: |_____|

Authorized Signature : _____ **Date:** _____

Print Name: |_____|

Name |_____| SSN Last 4: XXX-XX-_____|

Section C: To Be Completed by the Retirement Board

I have reviewed the above information from the applicant and the treasurer, and unless noted differently, I confirm below the start date, the annual salary, employment status, and deduction rate, and I have determined the following service credit percentage:

Group Classification: |____|

Start Date |_____/_____/_____|

Annual Salary |_____|

Employment Status:

Permanent |____| Temporary |____| Interim |____|

Full-time |____| Part-time |____|

Deduction Rate

5% |____| 7% |____| 8% |____| 9% |____| additional 2% |____|

Service: This and all other membership positions held by this person together are now categorized at the following (circled) percentage.

20-22.99=50%; 23-25.99=60%; 26-28.99=70%; 29-31.99=80%; 32-34.99=90%; 35-40=100%

Signature _____ Retirement staff

Print Name |_____|

At its meeting on the date: _____, the Retirement Board

approved |___|, denied |___| this application.

Reason for being denied:

Social Security Administration

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

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

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.

Town of Orange

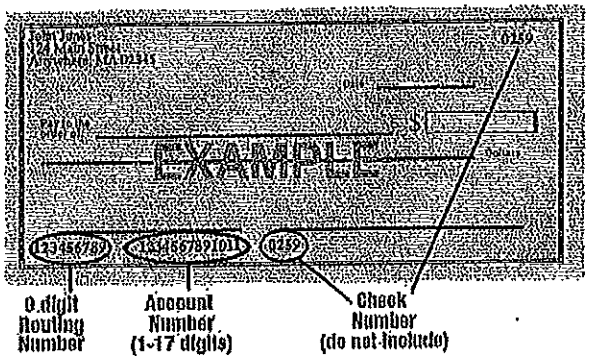
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: ☐Checking ☐Savings

The Town of Orange is hereby authorized to directly deposit my pay to the account listed above. I authorize the Town of Orange to initiate credit entries and debit entries if necessary to correct any credit errors made to the account or depository bank listed above. I understand that my account will be credited on the Thursday of the payroll processing week. In the event of a transmittal problem with either the Town of Orange or the Depository Bank, it is my responsibility to confirm that funds are available before accessing them.

This authorization will remain in effect until I modify or cancel it in writing to the Town of Orange. The depository bank may terminate this authorization by written notice to the employee for just cause.

Employee Signature: _____ Date: _____

ORANGE ELEMENTARY SCHOOLS
507 South Main St.
PO Box 680
Orange, Massachusetts 01364

The contract negotiated between the Orange Elementary School Committee and the Orange Non-Teaching Personnel Employees Group dated July 1, 2019 - June 30, 2020 included language which allows all school year employees to receive equalized pay over twenty-six (26) pay periods (pg. 27. in the contract; located underneath all of the payroll schedules).

We would like to allow employees to have a choice between the current twenty-one (21) pay period schedule and the newly negotiated twenty-six (26) pay period schedule. We are seeking your pay period authorization via this form. Please indicate your selection below and return the authorization to Alyssa Magoffin by Friday, August 28th.

_____ I elect to receive my compensation in (21) twenty-one payments subject to the provisions of the ESP Contract for the fiscal 2021 school year.

_____ I elect to receive my compensation in (26) twenty-six payments subject to the provisions of the ESP Contract for the fiscal 2021 school year.

_____
Signed

_____
Date

HAMPSHIRE COUNCIL
OF GOVERNMENTS

HAMPSHIRE COUNTY
GROUP INSURANCE TRUST

REQUIRED DOCUMENTS AND INFORMATION TO ENROLL IN HEALTH INSURANCE COVERAGE

RELATIONSHIP	REQUIRED DOCUMENTATION/INFORMATION
Spouse	Signed marital status affidavit and a photocopy of city/town issued marriage certificate.
Divorced or Separated Spouses	Signed marital status affidavit and photocopy of health insurance provision language from divorce/separation agreement and first page listing names of both parties and signature page showing date of order.
Child Up to Age 26	Photocopy of city/town issued birth certificate (long form listing parents' names), or court order documenting guardianship or adoption papers.
All Enrollees	The social security number must be provided on the enrollment form for all members enrolling in the health insurance coverage.

CHURCH OR JUSTICE OF THE PEACE CERTIFICATES AND HOSPITAL RECORDS ARE NOT ACCEPTABLE. SEND PHOTOCOPIES ONLY – NO ORIGINALS PLEASE

99 MAIN STREET
NORTHAMPTON, MA 01060

413-584-1300
HAMPSHIREGOG.ORG

HAMPSHIRE COUNTY GROUP INSURANCE TRUST

Subscriber Affidavit of Marital Status

Please print

Subscriber Name: _____

Address: _____

Town/City: _____ State: _____ Zip Code: _____

Best Contact Number: _____

Email Address: _____

Dependent Spouse or Former Spouse:

Name: _____ Date of Birth: _____

Address (if different than above): _____

Are you currently legally married to this dependent? YES / NO

If YES, attach a photocopy of the City/Town Clerk's marriage certificate.

If NO, attach a copy of signature page of divorce and page relating to health insurance provision.

Are you remarried? NO / YES

If Yes, Date of remarriage: _____

Is your former spouse remarried? YES / NO / Unknown

If YES, Date of marriage: _____

Please initial each after reading:

_____ I hereby certify that the information provided above is true and accurate.

_____ I understand that I am obligated to inform my employer immediately if there are any changes in my status or that of my spouse/ex-spouse.

_____ I understand that should I or my ex-spouse remarry, my ex-spouse may not continue on my coverage beyond the date of marriage except by court order and must be enrolled in individual coverage for which I will be responsible for 100% of the cost.

_____ I understand that any misrepresentation in the information given may result in termination of benefit eligibility for myself and/or my spouse/ex-spouse.

_____ _____

Subscriber Signature Date

Navigating the Hampshire Council of Governments website: www.hampshirecog.org

1. Go to www.hampshirecog.org (you must put in the www. to connect to the site).
2. Click on the Programs & Services tab.
3. On the left side bar click on Hampshire County Group Insurance Trust.
4. Then on the left side bar, click on Health Insurance for easy access to forms, summaries of benefits and general information. This is what you'll see:

GENERAL INFORMATION
- New Subscriber's Eligibility/Enrollment Requirements
- BCBS Find A Doctor (This only needs to be used if selecting the Network Blue New England plan.)
- Current Rate Sheet
- Rate History

FORMS
- BCBS Member Enrollment Form
- Marital Status Affidavit
- Subscriber Claim Reimbursement Form
- Request for Retaining Disabled Dependent Coverage
- Fitness Benefit Form
- Weight Loss Benefit Form

SUMMARIES OF BENEFITS
- Network Blue New England (HMO)
- Blue Care Elect Preferred (PPO)
- Guardian $500 Plan (This plan is available for ONLY those employees who are covered under Blue Care Elect Preferred.)
- Guardian $500 Plan Enrollment Form
- Guardian Voluntary Dental
- CareRX – HCGIT Meds

SENIOR PLANS: Summary, Forms, and Information
- 2016 MEDEX 2 (PPO) Summary
- Blue Medicare RX (PDP) Summary
- Blue Medicare RX Enrollment Form
- CVS Caremark Mail Order Form
- 2016 Drug Formulary Book
- Creditable Coverage Certification

5. Also on the left side bar, you can click on Wellness Initiative for the latest information on the Wellness Initiative program.

TOWN OF ORANGE

Gabriele Voelker, Treasurer/Finance Director
6 Prospect Street
Orange, MA 01364
Phone 978-544-1100 ~ ext. 103
Fax 978-544-1120
Email: treasurer@townoforange.org

PCP NUMBERS

The easiest way to get your PCP numbers is to call your Doctor's Office and explain that you need the PCP numbers for your New HMO Blue New England insurance.

If they do not wish to disclose it to you, here is the alternative To locating it.
GO TO:
www.bluecrossma.com

1. Purple box, click find Doctor & Estimate Costs
2. Middle blue box-right corner there is a yellow box that says Go find doctor without logging in, click on that.
3. It will then bring you to a select network box. Click over the select network box and it will give you a drop down list and there is a bar that will scroll down to HMO Blue New England, click on that.
4. Then you hit the blue button (GO)
5. It should come up with a screen that says Search Doctor/current location/HMO blue. If it doesn't say current location it will not find your doctor, or you need to use the drop down to find the city or try typing the city in.

***This is where we are having the most trouble.

6. The doctor's name should pop up with the PCP number under his/her
7. Name. usually begins with 700J+++++

If still no success please see your payroll specialist.

The Town of Orange is an equal opportunity provider.

Please Read the Instructions Before Filling Out This Form.

Please PRINT CLEARLY using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Enrollment and Change Form.

Please mail to: P.O. Box 986001 Boston, MA 02298 or fax to 1-617-246-7581.

Company Name		Current Medical Group #:		Medical Group #, Transferring To
Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group #, Transferring To

Type of Transaction
- ☐ ADD
- ☐ CHANGE
- ☐ TRANSFER
- ☐ CANCEL

(If cancelling, please see instructions for three digit termination code.) ☐ ☐ ☐

Remarks (i.e., qualifying event for a new add, change to family or other information)

- ☐ Open Enrollment
- ☐ New Hire
- ☐ COBRA
- Change to Family: ☐ Add Spouse ☐ Add Dependent
- ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
- ☐ Other

What products are you selecting?	☐ HMO Blue ☐ Network Blue ☐ Blue Choice ☐ Saver Blue	☐ Dental Blue ☐ Access Blue ☐ PPO	☐ HMO Blue New England ☐ Blue Choice New England ☐ Group Medex or Managed Blue for Seniors ☐ Blue Medicare Rx (PartD)	Kind of Membership (Medical) ☐ Individual ☐ Family	Kind of Membership (Dental) ☐ Individual ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
Street Address / P.O. Box #	Apt. #	City / Town	State	Zip Code
Social Security # (REQUIRED)*	Telephone # (area code) ( )	Other Insurance? Y ☐ / N ☐	Other Insurance Company Name	City / State
POP ID # (see instructions)	Name of POP	City / State	Is this your current POP? Mark X, if yes.	
Are you covered by Medicare? Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # ☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐ If Retired, Date:

Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered)

Member 2's First Name	M.I.	Last Name	Sex	Date of Birth
Street Address / P.O. Box #	Apt. #	City / Town	State	Zip Code
Social Security # (REQUIRED)*	Telephone # (area code) ( )	Other Insurance? Y ☐ / N ☐	Other Insurance Company Name	City / State
POP ID # (see instructions)	Name of POP	City / State	Is this your current POP? Mark X, if yes.	
Is Member 2 covered by Medicare? Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # ☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐ If Retired, Date:

1. If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

3.) Dependent's First Name	M.I.	Last Name	Sex	Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐
Social Security # (REQUIRED)*	Date of Birth	POP ID #: (see instructions)	Name of POP	Is this your current POP? Mark X, if yes.
4.) Dependent's First Name	M.I.	Last Name	Sex	Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐
Social Security # (REQUIRED)*	Date of Birth	POP ID #: (see instructions)	Name of POP	Is this your current POP? Mark X, if yes.
5.) Dependent's First Name	M.I.	Last Name	Sex	Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐
Social Security # (REQUIRED)*	Date of Birth	POP ID #: (see instructions)	Name of POP	Is this your current POP? Mark X, if yes.

Please check if you are using separate forms for additional dependent children ☐ Total # of Dependents: ____

☐ FSA: Health Savings Account	Start Date:	End Date:	FSA GOAL AMOUNTS: (Please see instructions for limits)
☐ FSA – Health: Health Flexible Spending Account	Start Date:	End Date:	Health $:
☐ FSA – Dep: Dependent Care Reimbursement Account	Start Date:	End Date:	Dependent Care $:

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

(REQUIRED)* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

BlueCross® BlueShield®

SUMMARY OF BENEFITS

Network Blue® New England

Hampshire County Group Insurance Trust

Download the MyBlue Member App. Get instant and secure access to your personal health care information any time you need it. A simple tap connects you to your claims history, your ID card, financial accounts, even your doctor. Download the app from the App Store℠ or Google Play™.

✔ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

An Association of Independent Blue Cross and Blue Shield Plans

Your Care

Your Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at blueorossma.com; consult the Provider Directory; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for retail prescription drugs under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your retail prescription drug deductible is $100 per member (or $200 per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is $5,000 per member (or $10,000 per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). You pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost
Preventive Care Well-child care visits	Nothing
Preventive dental care for children under age 12 (one visit each six months)	Nothing
Routine adult physical exams, including related tests	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing
Routine hearing exams, including routine tests	Nothing
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing
Family planning services–office visits	Nothing
Outpatient Care Emergency room visits	$100 per visit (waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, OB/GYN physician, nurse practitioner, nurse midwife, physician assistant, or limited services clinic • Other covered providers	$20 per visit $35 per visit
Chiropractors' office visits	$35 per visit
Mental health or substance abuse treatment	$20 per visit
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*)	$20 per visit
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit
Diagnostic X-rays and lab tests	Nothing
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date
Home health care and hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Durable medical equipment–such as wheelchairs, crutches, hospital beds	20% coinsurance**
Prosthetic devices	20% coinsurance
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, OB/GYN physician, nurse practitioner, nurse midwife, or physician assistant • Other covered providers	$20 per visit† $35 per visit†
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	$250 per admission
Mental hospital or substance abuse facility care (as many days as medically necessary)	$250 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	$250 per admission
Skilled nursing facility care (up to 100 days per calendar year)	$250 per admission

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
† Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Prescription Drug Benefits	Your Cost*
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	After deductible $10 for Tier 1 $30 for Tier 2 $65 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $25 for Tier 1*** $75 for Tier 2 $165 for Tier 3

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.
** Cost share may be waived for certain covered drugs and supplies.
*** Certain generic medications are available through the mail service pharmacy at $0. For more information, go to bluecrossma.com/mail-service-pharmacy.

Get the Most from Your Plan

Visit us at bluecrossma.com or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program **Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs** This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs. (See your benefit description for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.)	$150 per calendar year per policy
24/7 Nurse Care Line—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.com.
Interested in receiving information from us via e-mail? Go to bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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BlueCross® BlueShield®

BlueCross® BlueShield®

SUMMARY OF BENEFITS

Blue Care® Elect Preferred

Hampshire County Group Insurance Trust

Download the MyBlue Member App. Get instant and secure access to your personal health care information any time you need it. A simple tap connects you to your claims history, your ID card, financial accounts, even your doctor. Download the app from the App Store℠ or Google Play™.

✔ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

An Association of Independent Blue Cross and Blue Shield Plans

Your Choice

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible for medical benefits is $250 per member (or $500 per family) for out-of-network services. Your deductible for retail prescription drug benefits is $100 per member (or $200 per family).

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your "in-network" benefits. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits. See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is $5,000 per member (or $10,000 per family) for in-network and out-of-network services combined.

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). You pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Utilization Review Requirements

Certain services require pre-approval/prior authorization through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your cost in Network	Your cost out of Network
Preventive Care Well-child care exams, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing	20% coinsurance after deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care Emergency room visits	$100 per visit (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, physician assistant, nurse practitioner, limited services clinic, or multi-specialty provider group	$20 per visit	20% coinsurance after deductible
• Other covered providers	$35 per visit	20% coinsurance after deductible
Chiropractors' office visits	$35 per visit	20% coinsurance after deductible
Mental health or substance abuse treatment	$20 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$20 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$20 per visit	20% coinsurance after deductible
Diagnostic X-rays and lab tests	Nothing	20% coinsurance after deductible
MRIs, CT scans, PET scans, and nuclear cardiac imaging tests	$100 per category per service date	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance after deductible**
Prosthetic devices	20% coinsurance	40% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, physician assistant, nurse practitioner, or multi-specialty provider group	$20 per visit***	20% coinsurance after deductible
• Other covered providers	$35 per visit***	20% coinsurance after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost In Network	Your Cost Out of Network
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	$250 per admission	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$250 per admission	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	$250 per admission	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	$250 per admission	20% coinsurance after deductible
Prescription Drug Benefits* At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	After deductible $10 for Tier 1 $30 for Tier 2 $65 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible $25 for Tier 1*** $75 for Tier 2 $165 for Tier 3	Not covered

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.
** Cost share may be waived for certain covered drugs and supplies.
*** Certain generic medications are available through the mail service pharmacy at $9. For more information, go to bluecrossma.com/mail-service-pharmacy.

Get the Most from Your Plan

Visit us at bluecrossma.com or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program **Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs** This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs. (See your benefit description for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.)	$150 per calendar year per policy
24/7 Nurse Care Line—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.com.

Interested in receiving information from us via e-mail? Go to bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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BlueCross® BlueShield®

Please Read the Instructions Before Filling Out This Form.

Please PRINT CLEARLY using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Enrollment and Change Form.

Please mail to: P.O. Box 986001 Boston, MA 02298 or fax to 1-617-246-7581

Company Name	Current Medical Group #		Medical Group #, Transferring To
Current BCBS ID #, if any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #	Dental Group #, Transferring To

Type of Transaction
☐ ADD
☐ CHANGE
☐ TRANSFER
☐ CANCEL

(If cancelling, please see instructions for three digit termination code.) ☐ ☐ ☐

Remarks (i.e., qualifying event for a new add, change to family or other instruction)

☐ Open Enrollment
☐ New Hire
☐ COBRA

Change to Family
☐ Add Spouse
☐ Add Dependent

☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
☐ Other

What products are you selecting?				Kind of Membership (Medical)	Kind of Membership (Dental)
	☐ HMO Blue ☐ Network Blue ☐ Blue Choice ☐ Saver Blue	☐ Dental Blue ☐ Access Blue ☐ PPO	☐ HMO Blue New England ☐ Blue Choice New England ☐ Group Medex or Managed Blue for Seniors ☐ Blue Medicare Rx (Part D)	☐ Individual ☐ Family	☐ Individual ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
Street Address / P.O. Box #	Apt. #	City / Town	State	Zip Code

Social Security # (REQUIRED)*	Telephone # (area code) ( )	Other Insurance? Y ☐ / N ☐	Other Insurance Company Name	City / State
POP ID # (see instructions)	Name of POP	City / State	Is this your current POP? Mark X, if yes.	

Are you covered by Medicare? Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	Actively Working? Y ☐ / N ☐ If Retired, Date:
				☐ 65+ ☐ Disabled ☐ ESRD	

Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered)

Member 2's First Name	M.I.	Last Name	Sex	Date of Birth
Street Address / P.O. Box #	Apt. #	City / Town	State	Zip Code

Social Security # (REQUIRED)*	Telephone # (area code) ( )	Other Insurance? Y ☐ / N ☐	Other Insurance Company Name	City / State
POP ID # (see instructions)	Name of POP	City / State	Is this your current POP? Mark X, if yes.	

Is Member 2 covered by Medicare?* Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	Actively Working? Y ☐ / N ☐ If Retired, Date:
				☐ 65+ ☐ Disabled ☐ ESRD	

1. *If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

Dependent's First Name 3.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐
Social Security # (REQUIRED)*	Date of Birth	POP ID # (see Instructions)	Name of POP	Is this your current POP? Mark X, if yes.
Dependent's First Name 4.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐
Social Security # (REQUIRED)*	Date of Birth	POP ID # (see Instructions)	Name of POP	Is this your current POP? Mark X, if yes.
Dependent's First Name 5.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐
Social Security # (REQUIRED)*	Date of Birth	POP ID # (see Instructions)	Name of POP	Is this your current POP? Mark X, if yes.

Please check if you are using separate forms for additional dependent children ☐ Total # of Dependents: _____

	Start Date:	End Date:	FSA GOAL AMOUNTS: (Please see instructions for limits.)
☐ FSA: Health Savings Account			
☐ FSA – Health: Health Flexible Spending Account	Start Date:	End Date:	Health $:
☐ FSA – Dep.: Dependent Care Reimbursement Account	Start Date:	End Date:	Dependent Care $:

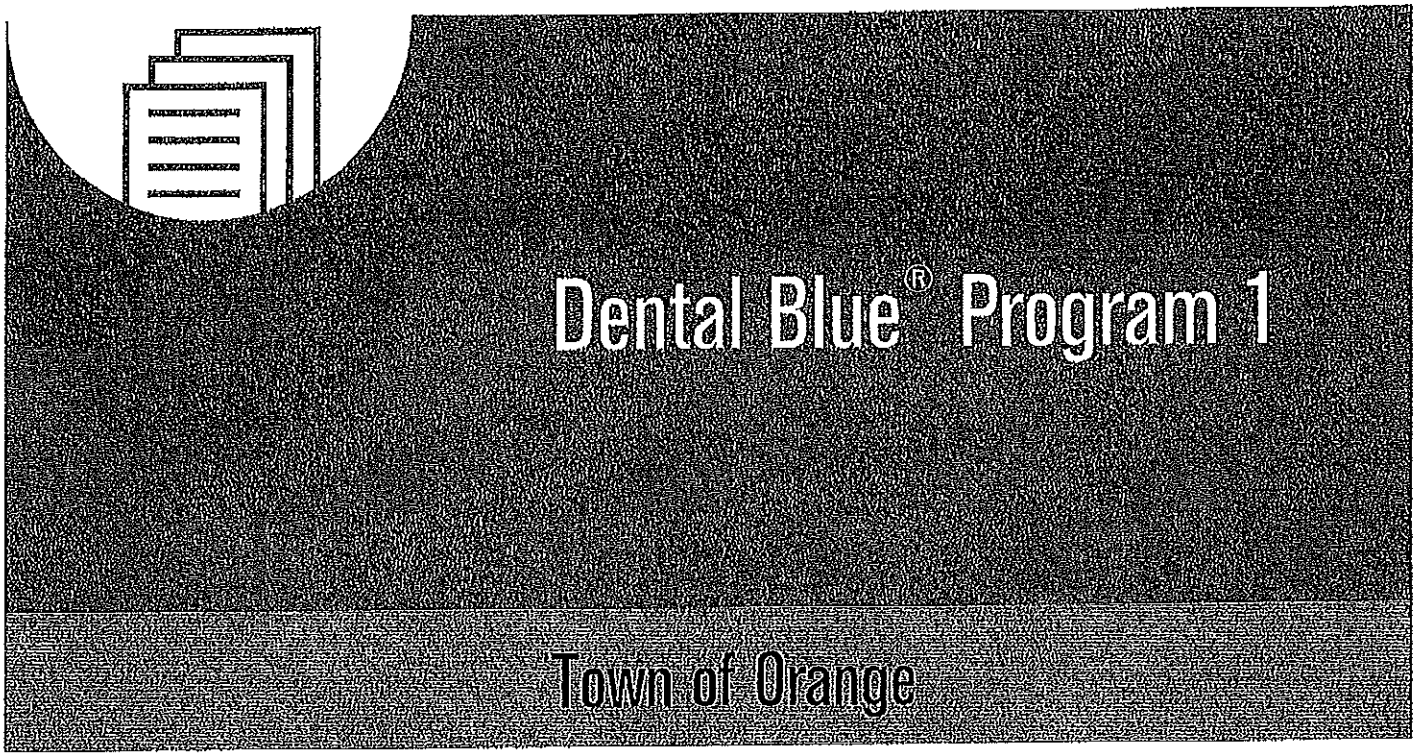
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

(REQUIRED)* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

MASSACHUSETTS

SUMMARY OF BENEFITS



Dental Blue® Program 1

Town of Orange

Dental Blue®

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Dental Blue Program 1

Preventive Benefit Group	Basic Benefit Group
No Deductible	**$25 Per Member/$75 Per Family Calendar-Year Deductible**
Full Coverage	**80% Coverage**
$750 Calendar-Year Benefit Maximum	

Diagnostic
- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- Bitewing X-rays once each six months
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams once each six months
- Emergency exams

Preventive
- Routine cleaning, scaling, and polishing of the teeth once each six months
- Fluoride treatment once each six months (members under age 19)
- Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per bicuspid or molar surface each 48 months.
- Space maintainers needed due to premature tooth loss (members under age 19)

Restorative
- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period)
- Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery
- Tooth extraction
- Root removal
- Biopsies

Periodontics (gum and bone)
- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)
- Root canal therapy (permanent teeth, once in a lifetime per tooth)
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- Other endodontic surgery to treat or remove the dental root

Prosthetic Maintenance
- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- Adding teeth to an existing complete or partial denture
- Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Services
- Occlusal adjustments once each 24 months
- Services to treat root sensitivity
- Emergency dental care to treat acute pain or to prevent permanent harm to a member
- General anesthesia when administered in conjunction with covered surgical services

Welcome to Dental Blue, a comprehensive dental plan providing broad network access to meet your dental care needs.

Your Dentist

Dental Blue offers an extensive network of dentists. Over 90 percent of dentists in Massachusetts and Rhode Island participate with Blue Cross Blue Shield of Massachusetts. Dental Blue members also have access to participating dentists nationwide.

If you would like help choosing a dentist, or already have a dentist and want to know if she or he participates with your plan, you can call the dentist, look at the current dental provider directory, or call Member Service at the toll-free phone number shown on your Dental Blue ID card. You can also access the online dental provider directory at bluecrossma.com.

Your Benefits

The dental benefits your plan covers are subject to the deductible and coinsurance (if applicable), and benefit maximum amounts shown in the chart. The chart also shows the percentage of costs your plan will pay for covered dental services. Many of the covered services have specific time or age limits.

Pre-Treatment Estimates

If your dentist expects that your dental treatment will involve covered services that will cost more than $250, Blue Cross Blue Shield recommends that your dentist send a copy of the "treatment plan" to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service. Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year benefit maximum or eligibility status has changed.)

Multi-Stage Procedures

Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure. You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Dentists Are Paid

Participating Dentists

Dentists that participate with Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Rhode Island, or participating out-of-area dentists accept the lesser of either the dentist's actual charge or the allowed charge as payment in full for covered services. You pay only your deductible and coinsurance (if applicable), and charges beyond your calendar-year benefit maximum.

In Massachusetts, benefits are usually only provided when covered services are furnished by a participating dentist. The exceptions are described in your plan description.

Non-participating Dentists Outside of Massachusetts

Benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on the dentist's actual charge or the allowed charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year benefit maximum.

When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your plan description (and riders, if any) for exact coverage details.

Enhanced Dental Benefits

Enhanced Dental Benefits for certain dental care services are available for members who have been diagnosed with qualifying conditions. To learn more about specific conditions included in this benefit, review your plan description (and riders, if any) on MyBlue at bluecrossma.com/myblue.

If You Have to File a Claim

Participating dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist as long as the claims are received within one year of the completed service.

If you receive care from a non-participating dentist, you will typically need to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service.

After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

If you have a grievance, see your plan description for instructions on how to file a grievance.

Other Information

Coordination of benefits applies to plan members who are covered by another plan for health care expenses. Coordination of benefits ensures that payments from other insurance or health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause, which means that Blue Cross Blue Shield can recover payments if a member has already been paid for the same claim by a third party.

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.com.

Interested in receiving information from us via e-mail? Go to bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders. Note: Blue Cross and Blue Shield of Massachusetts, Inc., is the administrator of the benefits described in this summary. Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payments only and does not assume financial risk for claims.

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April 2019

MASSACHUSETTS

MASSACHUSETTS

Nondiscrimination Notice

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com.**

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD).**

Complaint forms are available at **hhs.gov.**

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164264M
55-1487 (9/16)

MASSACHUSETTS

Translation Resources

Proficiency of Language Assistance Services

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat idantifikasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/عربي:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توجه: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígííjí' béésh bee hodíílnih (TTY: **711**).

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55-1493 (8/16)
104711MB

BOSTON MUTUAL LIFE INSURANCE COMPANY 1-800-669-2668 x700

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP LIFE INSURANCE ENROLLMENT FORM

18469 TOWN OF ORANGE

Group Number/Division Number Employer/Policyholder Dept. ID

Employee Name (Last, First, Middle) Social Security Number

Home Address (Street, City, State, Zip) ( ) Telephone #

Gender (M/F) Occupation or Job Title Date of Birth Age PAYROLL: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annual Earnings $

Average Hours Worked Date of Hire or Date of Full Time Employment if different Effective Date State Class Rate Book

Spouse (Last, First, Middle) Gender (M/F) Date of Birth Age No. of Dependents

ONLY THESE BOSTON MUTUAL COVERAGES MAY BE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

EMPLOYER PAID COVERAGE	YES	NO	Insurance Amount
LIFE	☐	☐	$ 5,000
AD&D	☐	☐	$ 5,000
DEPENDENT LIFE			
SPOUSE	☐	☐	$
CHILD(REN)	☐	☐	$
SHORT TERM DISABILITY	☐	☐	$
LONG TERM DISABILITY	☐	☐	$
☐ OTHER (Please specify coverage & amt.)			

VOLUNTARY COVERAGE	YES	NO	Insurance Amount
LIFE	☐	☐	$
AD&D	☐	☐	$
DEPENDENT LIFE			
SPOUSE LIFE AND AD&D	☐	☐	$
CHILD(REN)	☐	☐	$
SHORT TERM DISABILITY	☐	☐	$
LONG TERM DISABILITY	☐	☐	$
☐ OTHER (Please specify coverage & amt.)			

DESIGNATION OF BENEFICIARY

Primary Beneficiary(ies) Residential Address Date of Birth Social Security # Tax # Relationship % of Benefit

Contingent Beneficiary(ies):

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

Please complete as much beneficiary information as you can provide.

EMPLOYEE STATEMENT OF INSURABILITY

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer (or the Association with whom I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

☐ All Coverages ☐ Life & AD&D ☐ Dependent Coverage ☐ Short Term Disability ☐ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee Date

Signature of Witness Date

EMPLOYEE SIGNATURE REQUIRED

I apply for the insurance for which I am now eligible (or for which I may become eligible) under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work. I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee Date

WHITE - EMPLOYER COPY YELLOW - BOSTON MUTUAL COPY PINK - EMPLOYEE COPY

Town of Orange

Insurance Election Form

Please indicate your selection below. You will need to complete additional forms for any plans you want to enroll in. Your effective date for benefits is your date of hire. Any delay in submitting your forms to HR could result in loss of coverage until the next Open Enrollment.

1.	**Health Insurance**	Elect	Decline
2.	**Dental Insurance**	Elect	Decline
3.	**Basic Life Insurance**	Elect	Decline

_____ _____

Employee Signature Date

PAYROLL DATES 2020/2021

July 9, 2020
July 23, 2020
August 6, 2020
August 20, 2020
September 3, 2020 (1st new payroll for FY21)
September 17, 2020
October 1, 2020
October 15, 2020
October 29, 2020
November 12, 2020
November 26, 2020
December 10, 2020
December 24, 2020
January 7, 2021
January 21, 2021
February 4, 2021
February 18, 2021
March 4, 2021
March 18, 2021
April 1, 2021
April 15, 2021
April 29, 2021
May 13, 2021
May 27, 2021
June 10, 2021 (21st pay)
June 24, 2021

Summer pays:
July 8, 2021
July 22, 2021
August 5, 2021
August 19, 2021

TOWN OF ORANGE

GROUP NUMBERS AND RATES

THE FOLLOWING RATES ARE EFFECTIVE JULY 1, 2020 TO JUNE 30, 2021:

NETWORK BLUE NEW ENGLAND
GROUP#004047785

	Full Cost	Employee- 26 pays	Employee- 21 pays
INDIVIDUAL	$633.26	$87.68	$108.56
EMP+1	$1,474.70	$204.19	$252.81
FAMILY	$1,817.88	$251.71	$311.64

BLUE CARE ELECT PREFERRED
GROUP#002321976

	Full Cost	Employee-26 pays	Employee- 21 pays
INDIVIDUAL	$729.84	$101.05	$125.12
FAMILY	$1,993.26	$275.99	$341.70

BLUE CARE ELECT PREFERRED- TEFRA
GROUP#002321982

	Full Cost	Employee-26 pays	Employee- 21 pays
INDIVIDUAL	$729.84	$101.05	$125.12
FAMILY	$1,993.26	$275.99	$341.70

THE FOLLOWING RATES ARE EFFECTIVE JANUARY 1, 2017 TO DECEMBER 31,2018:

MEDEX
GROUP#502289192

	Full Costs	Retiree Costs
INDIVIDUAL	$355	$106.50- Retiree Share $248.50- Town Share

Town of Orange

6 Prospect Street
Orange, MA 01364
www.townoforange.org

To All Town of Orange Employees,

The Town of Orange uses a self-service model for paystubs. In this model, you will log on to an online portal (EmployeeForward) to access your bi-weekly paystubs and ultimately your annual W-2 forms.

Your pay will be direct deposited into the account you designate. You will need to log onto the portal if you wish to view or print your paystub. When you view your stub, there is a button at the bottom to print a PDF copy, which has your year-to-date information.

The portal is available 24/7 and can be accessed from a computer or smart phone. There are computers available in the town hall if you don't have one at home to use.

Please be on the lookout for an email from no-reply@employeeforward.com to your personal or work email account, with instructions on how to access the EmployeeForward portal. You will be provided with a link and required to establish a username and password, which you will use going forward to access your paystub information. In addition, you can use this portal for the following:

- Enter address changes
- Print your W-2
- Access policies and documents

You will also be able to view your benefit deductions and tax withholding information via this portal.

Please contact me at tbarnes@townoforang.org or (978) 544-1100 X-107 if you have any questions with accessing EmployeeForward.

Best Regards,

Trish Barnes
HR Administrator

Employee Self Service Account Set Up and Login Instructions

1

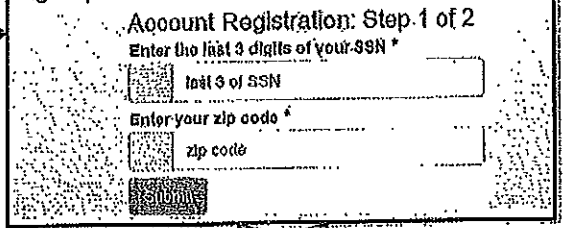
Email Notification

Open up your email and check for an email from **noreply@employeeforward.com** with a subject of **"Create your ESS account"**. Per the email instructions, click on the link in the email – i.e, **http://....**, and a browser window will be opened for you. If the link does not work, cut and paste the link into your browser window address line. Check your Junk / Spam email folder if you do not see the initial email.

2

Account Registration: Step 1 of 2

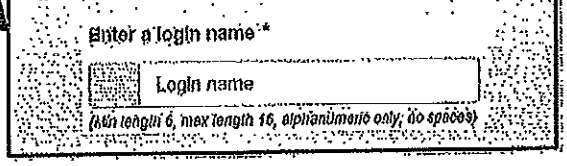
Enter the last three digits of your SSN and your 5 digit zip code:



3

Account Registration: Step 2 of 2

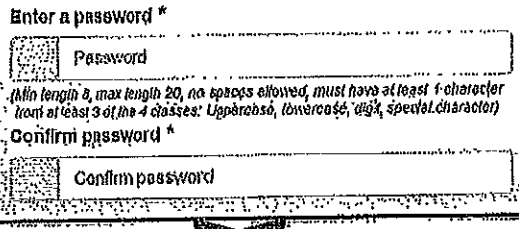
Your browser window will be refreshed and you will now be prompted to enter a login name that you will use, a password and a security question. First enter a login name:



4

Account Registration: Step 2 of 2 cont.

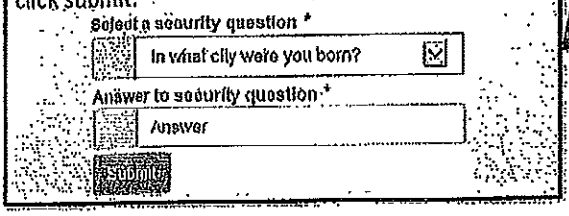
After entering your login name, enter a password and confirm the password:



5

Account Registration: Step 2 of 2 cont.

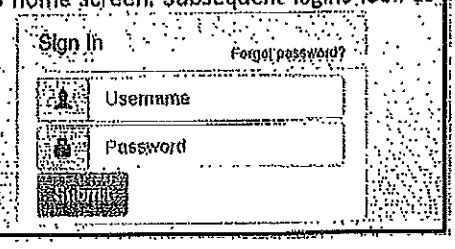
After setting up your password, select a security question from the dropdown, supply an answer and click submit:



6

Success – you are now logged in to ESS !

After clicking submit, you will be brought to your main ESS home screen. Subsequent logins look as follows:



Special Notes: It is extremely important that you take note of your user / login name, your password and also your security question and the answer to your security question. If at any time you forget your password, you can click on the **"Forgot Password"** prompt in **Step 6** – but you will be required to know your user / login name, email address, the last 3 digits of your SSN, your zip code and your security question and answer for the password reset process. It is possible that any emails sent to you may end up in your Junk / Spam email folder so check in those folders if you are expecting emails from **noreply@employeeforward.com**. You can flag those emails as not being junk / spam if needed. If you forget your user / login name, you will need to contact your company's HR / Payroll department.