

GRAVETTE SCHOOL DISTRICT
609 BIRMINGHAM ST SE
GRAVETTE, AR 72736

PAYROLL OFFICE RECORD

COMPLETE ALL BLANKS

Name: _____ DOB: _____

Street Address: _____

City/State: _____ Zip: _____

Social Security Number: _____

Name as it Appears on Your Social Security Card: _____

Home Phone Number: _____ Alternate Number: _____

Emergency Contact: _____ Phone Number: _____

NEW HIRE CHECKLIST

**ALL DOCUMENTS MUST BE COMPLETED AND TURNED IN PRIOR TO
RECEIVING YOUR CONTRACT AND BEGINNING WORK.
YOU MUST ALSO COMPLETE A BACKGROUND CHECK AND FINGERPRINTS.
THIS WILL BE DONE AT THE ADMINISTRATION OFFICE**

Name: _____ Start Date: _____

FORMS & DOCUMENTS TO BE COMPLETED TURNED INTO THE PAYROLL OFFICE

- _____ Teaching License (Certified Staff Only)
- _____ Official Transcript (Certified Staff Only)
- _____ Copy of Social Security Card
- _____ Copy of Driver's License
- _____ Office Record Form
- _____ Federal Tax W-4
- _____ State Tax AR4EC
- _____ Employment Eligibility Verification
- _____ Direct Deposit Form
- _____ Teacher Retirement Enrollment
- _____ Verification of Prior Employment
(It is your responsibility to complete and send to previous employers)
- _____ Background Check Authorization and Payment Receipt
(Call to schedule a time to get fingerprints done at the Admin office)
- _____ Child Maltreatment Form **(Complete process online including payment)**
- _____ AR Benefits Enrollment Form **(Complete even if Decline Coverage)**
(Dependents will need a copy of Birth Certificate or Social Security Card,
Spouse will need a marriage certificate)
- _____ Colonial Life Insurance **(Complete even if Decline Coverage)**

OPTIONAL

- _____ Delta Dental/Vision Enrollment
- _____ HSA Application (only if enrolled in AR Benefits)

Employee's Withholding Certificate

OMB No. 1545-0074

Department of the Treasury
Internal Revenue Service

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.

2024

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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, and when to use the estimator at www.irs.gov/W4App.

Step 2: Multiple Jobs or Spouse Works	Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following.
	(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; or
	(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or
	(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate <input type="checkbox"/>

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 and you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 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 15, 2025.

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

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

1. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. 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.

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



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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4** Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter:

{	• \$29,200 if you're married filing jointly or a qualifying surviving spouse	}	2	\$ _____
	• \$21,900 if you're head of household				
	• \$14,600 if you're single or married filing separately				

- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5** Add lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$780	\$850	\$940	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,370
\$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
\$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
\$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
\$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
\$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
\$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
\$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
\$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
\$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
\$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
\$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
\$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
\$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
\$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
\$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	\$240	\$870	\$1,020	\$1,020	\$1,020	\$1,540	\$1,870	\$1,870	\$1,870	\$1,870	\$1,910	\$2,040
\$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
\$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
\$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
\$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
\$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
\$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
\$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
\$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
\$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
\$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
\$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
\$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	\$510	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,220	\$1,870	\$1,870	\$1,870	\$1,960
\$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
\$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
\$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
\$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
\$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
\$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
\$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
\$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
\$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
\$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
\$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
\$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
\$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

STATE OF ARKANSAS
Employee's Withholding Exemption Certificate



Print Full Name _____ Social Security Number _____
 Print Home Address _____ City _____ State _____ Zip _____

How to Claim Your Withholding

See instructions below

Employee:

File this form with your employer. Otherwise, your employer must withhold state income tax from your wages without exemptions or dependents.

Employer:

Keep this certificate with your records.

1. CHECK ONE OF THE FOLLOWING FOR EXEMPTIONS CLAIMED

- a. ☐ You claim yourself. (Enter one exemption) 1a
 b. ☐ You claim yourself and your spouse. (Enter two exemptions) 1b
 c. ☐ Head of Household, and you claim yourself. (Enter two exemptions) 1c

2. NUMBER OF CHILDREN or DEPENDENTS. (Enter one exemption per dependent) 2

3. TOTAL EXEMPTIONS. (Add Lines 1a, b, c, and 2)
 If no exemptions or dependents are claimed, enter zero..... 3

4. Additional amount, if any, you want deducted from each paycheck. (Enter dollar amount) 4

5. I qualify for the low-income tax rates. (See below for details)..... 5
 Please check filing status: ☐ Single ☐ Married Filing Jointly ☐ Head of Household

Number of Exemptions Claimed

☐ Yes ☐ No

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

Signature: _____ Date: _____

Instructions

TYPES OF INCOME - This form can be used for withholding on all types of income, including pensions and annuities.

NUMBER OF EXEMPTIONS - (Husband and/or Wife) Do not claim more than the correct number of exemptions. However, if you expect to owe more income tax for the year, you may increase your withholding by claiming a smaller number of exemptions and/or dependents, or you may enter into an agreement with your employer to have additional amounts withheld. This is especially important if you have more than one employer, or if both husband and wife are employed.

DEPENDENTS - To qualify as your dependent (line 2 of form), a person must (a) receive more than 1/2 of their support from you for the year, (b) not be claimed as a dependent by such person's spouse, (c) be a citizen or resident of the United States, and (d) have your home as their principal residence and be a member of your household for the entire year or be related to you as follows: son, daughter, grandchild, stepson, stepdaughter, son-in-law or daughter-in-law; your father, mother, grandparent, stepfather, stepmother, father-in-law or mother-in-law; your brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law or sister-in-law; your uncle, aunt, nephew or niece (but only if related by blood).

CHANGES IN EXEMPTIONS OR DEPENDENTS - You may file a new certificate at any time if the number of exemptions or dependents INCREASES. You must file a new certificate within 10 days if the number of exemptions or dependents previously claimed by you DECREASES for any of the following reasons:

(a) Your spouse for whom you have been claiming an exemption is divorced or legally separated from you, or claims his or her own exemption on a separate certificate, or

(b) The support you provide to a dependent for whom you claimed an exemption is expected to be less than half of the total support for the year. OTHER DECREASES in exemptions or dependents, such as the death of a spouse or a dependent, does not affect your withholding until next year, but requires the filing of a new certificate by December 1 of the year in which they occur.

You may claim additional amounts of withholding tax if desired. This will apply most often when you have income other than wages.

You qualify for the low income tax rates if your **total** income from all sources is:

(a) Single	\$12,493	to	\$14,900
(b) Married Filing Jointly (1 or less dependents)	\$21,068	to	\$24,800
(c) Married Filing Jointly (2 or more dependents)	\$25,356	to	\$30,800
(d) Head of Household/Qualifying Widow(er) (1 or less dependents)	\$17,762	to	\$21,600
(e) Head of Household/Qualifying Widow(er) (2 or more dependents)	\$21,173	to	\$24,800

For additional information consult your employer or write to:

Arkansas Withholding Tax Section
 P. O. Box 8055
 Little Rock, Arkansas 72203-8055



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.	
1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____	
QR Code - Section 1 Do Not Write In This Space	

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title	Document Title	Document Title		
Issuing Authority	Issuing Authority	Issuing Authority		
Document Number	Document Number	Document Number		
Expiration Date (if any) (mm/dd/yyyy)	Expiration Date (if any) (mm/dd/yyyy)	Expiration Date (if any) (mm/dd/yyyy)		
Document Title	Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space	
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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

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

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative		
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name		
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)			B. Date of Rehire (if applicable)
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)

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

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

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

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

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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 		<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 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 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

DIRECT DEPOSIT

*****ATTACH A VOIDED CHECK FOR THE ACCOUNT TO WHICH YOUR DEPOSIT SHOULD BE MADE.**

NAME: _____

MAILING ADDRESS: _____

BANK NAME: _____

TYPE OF ACCOUNT: _____ **CHECKING** _____ **SAVINGS**

ROUTING NUMBER: _____

ACCOUNT NUMBER: _____

I hereby authorize the Gravette School District to have my salary deposited directly to the financial institute named above. I authorize and request my financial institution to credit the same to my account. I also authorize Gravette School District to initiate debit entries to my account in the event that a credit entry is found to be incorrect.

EMPLOYEE SIGNATURE: _____

DATE: _____

Irrevocable Contributory Election Form

PLEASE READ THOROUGHLY. This election form to participate in the Arkansas Teacher Retirement System (ATRS) contributory plan is to be completed by both the member and employer. Once received by ATRS this becomes a binding and irrevocable election to participate in the contributory plan. Under the contributory plan deductions are withheld from the member's salary for retirement purposes.

This election form is to be utilized by the following (please check one):

_____ Non-contributory member who is electing to become a contributory member, must make an election by June 30 to become effective July 1. Status may be also changed to contributory if the election is made prior to their first salary payment of the fiscal year. Elections made after the first salary payment of the fiscal year shall become effective the July 1 next following receipt of this form in the ATRS office. The official receipt date may be determined by the postmark date.

_____ New member under contract for 184 days or less who is electing to become contributory.

_____ New member not under contract who is electing to become contributory.

Once signed by both the member and employer and received by ATRS, this election to be contributory is IRREVOCABLE. This means the undersigned member's election cannot be changed under any circumstances and will remain in effect throughout the member's entire career with ATRS.

I have read and understand the above material and I elect **TO MAKE CONTRIBUTIONS TO THE RETIREMENT SYSTEM** for the remainder of my career.

THIS FORM IS NOT OFFICIAL UNLESS SIGNED BY BOTH THE MEMBER AND EMPLOYER AND RECEIVED BY ATRS.

I. To be completed by Member: Social Security Number _____
Print Member's Name _____
Signed by (Member's Name) _____
Address _____
City, State, Zip _____
Date _____

II. To be completed by Employer: Signed by (Employer Representative) _____
Employer _____
First Salary Payment this fiscal year (date) _____
Fiscal Year Effective (xxxx-yyyy) _____

Return original completed form to ATRS; the employer and member should each keep a copy.

Gravette School District

Gravette School District 609 Birmingham St. SE Gravette, AR 72736

Phone 479-787-4100 Fax 479-974-1066

VERIFICATION OF PRIOR EMPLOYMENT

To Whom it May Concern:

I have been hired by the Gravette School District. Since my salary will be determined by my years of verified teaching experience, I would appreciate you completing Part II below and forwarding it within five (5) days to the Payroll Department, **Attn: Kim Skaggs Gravette School District, 609 Birmingham St. SE, Gravette, AR 72736 or fax to the number above.**

Employee Signature

Part I- Personal Data (to be completed by employee)

Name _____ SSN # _____
Last First MI Maiden

If more than one (1) prior school district, please duplicate this form for each district

Prior School District	Mailing Address/Fax#	Position Held	Dates of Employment
_____	_____	_____	_____

Part II- Employment Record/Teaching Experience (to be completed by the appropriate school official)

****Sick days to be transferred from Arkansas schools only****

<u>Employment Dates</u> <u>Beginning/Ending</u>	<u>Sick Leave</u> <u>Balance</u>	<u>FT or PT/Days Worked/</u> <u>Contracted Days</u>	<u>Position/Subject/Grade</u>
____/____/____	_____	____/____/____	_____
____/____/____	_____	____/____/____	_____
____/____/____	_____	____/____/____	_____
____/____/____	_____	____/____/____	_____

Signed _____ Title _____
(School Official)

School System/Employer _____ Date _____

Address _____ Phone/Fax # _____



PUBLIC SCHOOL ACTIVE EMPLOYEE MONTHLY PREMIUMS

RATES EFFECTIVE JANUARY 1, 2024 – DECEMBER 2024

PLAN	BASE MONTHLY PREMIUM	STATE, DISTRICT, & PLAN CONTRIBUTION	TOTALLY MONTHLY COST
PREMIUM			
EMPLOYEE ONLY	\$489.36	\$287.40	\$201.96
EMPLOYEE & SPOUSE	\$1,150.00	\$443.08	\$706.92
EMPLOYEE & CHILD(REN)	\$954.25	\$496.97	\$457.28
EMPLOYEE & FAMILY	\$1,614.89	\$835.21	\$779.68
CLASSIC			
EMPLOYEE ONLY	\$425.44	\$337.06	\$88.38
EMPLOYEE & SPOUSE	\$999.78	\$652.02	\$347.76
EMPLOYEE & CHILD(REN)	\$829.61	\$620.31	\$209.30
EMPLOYEE & FAMILY	\$1,403.95	\$1,012.07	\$391.88
BASIC			
EMPLOYEE ONLY	\$375.49	\$332.25	\$43.24
EMPLOYEE & SPOUSE	\$882.41	\$640.83	\$241.58
EMPLOYEE & CHILD(REN)	\$732.21	\$592.19	\$140.02
EMPLOYEE & FAMILY	\$1,239.13	\$977.01	\$262.12
The Basic Plan meets the minimum essential coverage required under A.C.A.			

State Contribution is funded by legislation.

Plan Contribution is funded by PSE Trust Fund as Claims Reserve Allocation.



BENEFITS

Below is a snapshot of benefits covered by the ARBenefits plan for each of our 2024 Arkansas Public School Employee plan levels. A full schedule of benefits for each plan level is available here. If you have any questions, please contact EBD at 1-877-815-1017 or email Ask.EBD@arkansas.gov.

	PREMIUM		CLASSIC		BASIC	
	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK
INDIVIDUAL DEDUCTIBLE	\$750	\$2,000	\$1,750	\$3,000	\$4,000	
FAMILY DEDUCTIBLE	\$1,500	\$4,000	\$3,200/\$3,300	\$6,000	\$8,000	
INDIVIDUAL OUT-OF-POCKET MAX (MEDICAL)	\$3,250	N/A	\$6,450	N/A	\$6,450	
FAMILY OUT-OF-POCKET MAX (MEDICAL)	\$6,500	N/A	\$9,675	N/A	\$12,900	
YOU PAY						
COVERED SERVICES	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK
PHYSICIAN'S OFFICE VISIT	\$25 COPAY	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
SPECIALIST'S OFFICE VISIT	\$50 COPAY	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
OTHER PHYSICIAN SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
ADVANCED IMAGING (RADIOLOGY)	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
ER VISIT AND OBSERVATION	\$250 COPAY	0%	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
IN-PATIENT HOSPITAL SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
OUTPATIENT HOSPITAL SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
DIAGNOSTIC SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
URGENT CARE CENTER	\$100 COPAY	0%	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
PHYSICAL EXAMS/PREVENTATIVE CARE	0%	40% AFTER DEDUCTIBLE	0%	40% AFTER DEDUCTIBLE	0%	0%
IMMUNIZATIONS	0%	0%	0%	0%	0%	0%
WELL BABY/CHILD CARE VISITS	0%	40% AFTER DEDUCTIBLE	0%	40% AFTER DEDUCTIBLE	0%	0%
VISION SCREENING	\$50 COPAY	\$50 COPAY	\$50 COPAY	\$50 COPAY	\$50 COPAY	\$50 COPAY
HEARING SCREENING	\$50 COPAY	\$50 COPAY	\$50 COPAY	\$50 COPAY	\$50 COPAY	\$50 COPAY
INSULIN PUMP	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
GLUCOMETERS	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE

- Members must meet their plan's deductible amount before coinsurance begins for covered services.
- The family deductible is the deductible amount for any tier above Employee Only coverage (Employee + Spouse, Employee + Children, Family).
- Copays do not count towards the satisfaction of your deductible amount.
- The out-of-pocket maximum includes the deductible, copays, and coinsurance amounts you have paid toward covered in-network services.
- Employees on the Premium plan can have the \$250 ER copay waived if they are referred to the ER by the 24/7 Nurse Hotline (1-866-458-0408). The 24/7 Nurse Hotline is not intended for use during a medical emergency.
- The plan will pay 100 percent for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
- No out-of-network coverage for Basic Coverage.

PRESCRIPTION DRUGS		PREMIUM		CLASSIC		BASIC	
TIER 1 - GENERIC		\$15 COPAY		20% AFTER DEDUCTIBLE		20% AFTER DEDUCTIBLE	
TIER 2 - PREFERRED		\$40 COPAY		20% AFTER DEDUCTIBLE		20% AFTER DEDUCTIBLE	
TIER 3 - NON-PREFERRED		\$80 COPAY		20% AFTER DEDUCTIBLE		20% AFTER DEDUCTIBLE	
TIER 4 - SPECIALTY		\$100 COPAY		20% AFTER DEDUCTIBLE		20% AFTER DEDUCTIBLE	
REFERENCED PRICE DRUGS		PLAN PAYS CERTAIN AMOUNTS PER UNIT; MEMBER RESPONSIBLE FOR REMAINING COST		NOT COVERED		NOT COVERED	
INDIVIDUAL RX OUT-OF-POCKET MAX		\$3,100		N/A		N/A	
FAMILY RX OUT-OF-POCKET MAX		\$6,200		N/A		N/A	

Employees on the Classic or Basic plans must meet their plan medical deductible amounts prior to starting 20% coinsurance for covered drugs.

2024 Rates

Premium

\$

Employee Only: \$201.96
Employee and Spouse: \$706.92
Employee and Children: \$457.28
Employee and Family: \$779.68

Classic

\$

Employee Only: \$88.38
Employee and Spouse: \$347.76
Employee and Children: \$209.30
Employee and Family: \$391.88

Basic

\$

Employee Only: \$43.24
Employee and Spouse: \$241.58
Employee and Children: \$140.02
Employee and Family: \$262.12

2025 Open Enrollment



Open enrollment for the 2025 plan year is October 1-31, 2024. You can enroll online through the ARBenefits Member Portal at my.ARBenefits.org. Changes elected during Open Enrollment are effective 1/1/2025. If you do not want to make any changes to your ARBenefits health plan, you do not need to re-enroll with the exception of an FSA. If you have an FSA, you must re-enroll each year. Your current coverage will stay as is for 2025. Visit our website at www.transform.ar.gov for more information.

Changes that can be made during Open Enrollment include:

- Enroll in the plan
- Change plan level (Basic, Classic, Premium)
- Cancel Coverage
- Add/drop a spouse and/or dependents from your plan



State & Public-School Employee Election Form

This form is to be used for Open Enrollment and New Enrollees ONLY. Please use the Change Form for other Qualifying Events.

Employee Information

First Name	MI	Last Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Agency or District		Group Number	Home/Cell Number		Work Number
Mailing Address			City	State	Zip Code
Physical Address				<input type="checkbox"/> ONLY check this box if you wish to have your premiums withheld on a post-tax basis	

Coverage

Reason for Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire Period <input type="checkbox"/> Loss of Group Coverage <input type="checkbox"/> Loss of Medicaid <input type="checkbox"/> Newborn	Type of Action <input type="checkbox"/> Enroll in the Plan <input type="checkbox"/> Add/Drop Dependant(s) <input type="checkbox"/> Decline Coverage	Pick a Benefit Option <input type="checkbox"/> Premium <input type="checkbox"/> Classic <input type="checkbox"/> Basic Pick Coverage Level <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Family
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Add/Drop Dependents

Please check the correct column to ADD a dependent to the plan or DROP a dependent currently covered. Proof of a dependent's eligibility must be submitted with this application for all dependents. To complete the RELATIONSHIP column, use the number that describes the dependent(s). Spouse - 1, Child - 2, Permanent Legal Guardianship - 3

ADD	DROP	NAME (FIRST, MI, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE	FEMALE	RELATIONSHIP
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	

Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 60 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or claim. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

Employee Signature	Date	Email Address
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FOR PSE HIR USE ONLY: Board Approval Date: _____ Contract Start Date: _____

SUBMISSION TO EMPLOYEE BENEFITS DIVISION IS FINAL

Department of Transformation and Shared Services • Employee Benefits Division

P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-683-0983

Coverage is effective 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.

Instructions

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

Social Security Numbers are required for enrollment. Exception: A newborn's Social Security Number will be accepted after enrollment but must be sent in once it is received.

You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received by any dependent(s) while your dependent(s) was incorrectly listed as eligible.

If you experience a qualifying event that allows you to cancel your health insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event. Qualifying status change events include marriage, birth, and loss of group coverage.

You should receive ID cards in a timely manner from the Employee Benefits Division (EBD). If you do not, call EBD at 1-877-815-1017 (when you hear the recording, press 1).

Your effective date of coverage will be the first of the month following date of EBD receiving application and **ALL** corresponding documentation. Note: The qualifying date is NOT the date of eligibility.

Pre-tax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. You will automatically be in a pre-tax status unless you select the post-tax option on this form and/or notify your payroll clerk.

Active members who turn age 65 or become eligible for Medicare must send in a copy of their Medicare card to EBD.

Supporting documentation is required for proof of dependent eligibility. For changes being made due to a qualifying event, documented proof a qualifying event has occurred is also required such as a Certificate of Credible Coverage (COCC). More information is available in the ARBenefits Summary Plan Description.

If adding a dependent as a Permanent Legal Guardian your account will be subject to an annual review.

If a Member is currently not enrolled on the plan and has a newborn, only **ONE** parent is permitted to enroll with the newborn.

Completed election forms can be submitted to EBD by fax, mail, or online through the ARBenefits Member Portal at www.myarbenefits.org.

For assistance, contact EBD at 1-877-815-1017 Monday - Friday, from 8:00AM - 4:30PM CST or email Ask.EBD@arkansas.gov. To learn more about plans, costs, and network providers visit www.transform.ar.gov/employee-benefits.

SUBMISSION TO EMPLOYEE BENEFITS DIVISION IS FINAL.

Coverage is effective 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.



BENEFITS Affidavit of Spousal Healthcare Coverage

Employee Name		Employee SSN	
Spouse Name		Spouse SSN	

To be completed by employee electing to enroll a spouse or when dropping a spouse due to gaining employer group coverage.

Pursuant to Arkansas Code Ann. §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the ARBenefits Plan.

1. Is your spouse currently employed?
☐ Yes (If yes, please proceed to question #2)
☐ No (If no, sign and return this form along with your election form and a copy of your marriage license)
2. Is your spouse currently employed by an Arkansas state agency or public school district?
☐ Yes (If yes, sign and return this form along with your election form and a copy of your marriage license).
☐ No (If no, proceed to question #3)
3. Is your spouse eligible for his/her employer-sponsored group health plan?
☐ Yes
☐ No (If no, please submit information from your spouse's employer as to why your spouse is not covered)

For any questions or concerns, contact EBD at 1-877-815-1017 or email Ask.EBD@arkansas.gov

By signing this affidavit I certify that the information provided above is accurate. I understand that any misrepresentations in the information I provided above will permit the ARBenefits Plan to terminate my coverage. If applicable, I authorize the release of the information noted above and agree to its use in the application process for ARBenefits Plan coverage.

Employee signature: _____

Date: _____

Spouse signature: _____

Date: _____

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
E-mail: eligibility@deltadentalar.com
Fax (501) 992-1890

☐ New Enrollment ☐ Status Change ☐ Address Change ☐ Termination
☐ Dental Only ☐ Vision Only ☐ Dental/Vision ☐ Cobra

Effective Date			Group Number: <u>GA 918903</u>		Social Security Number	
Month	Day	Year	Group Name: <u>Gravette Schools</u>		Subscriber's Identifier (if applicable)	

LAST NAME: _____ FIRST: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

Date of Birth Marital Status Sex Date of Hire
 / / / /
 MM DD YY ☐ Single ☐ Male
 ☐ Married ☐ Female MM DD YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code.")
 Enter P for pregnant, D for diabetes, and H for Heart Disease)
☐ Pregnancy - Expected due date _____
☐ Diabetes - Date of onset _____
☐ Heart Disease - Date of onset _____

1. COVERAGE CHANGES * Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)		Reason(s) for Change:	
Dental	Vision	<input type="checkbox"/> Add Dependent(s) listed below	<input type="checkbox"/> Change Coverage
<input type="checkbox"/> Employee	<input type="checkbox"/> Employee	<input type="checkbox"/> Remove Dependent(s) listed below	<input type="checkbox"/> Address Change only
<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Name Change	<input type="checkbox"/> Qualifying event
<input type="checkbox"/> Employee/Child	<input type="checkbox"/> Employee/Child	<input type="checkbox"/> Late Entrance (employee)	<input type="checkbox"/> Late Entrance (dependent)
<input type="checkbox"/> Employee/Children	<input type="checkbox"/> Employee/Children	<input type="checkbox"/> Marriage	Date of event _____
<input type="checkbox"/> Employee/Family	<input type="checkbox"/> Employee/Family	<input type="checkbox"/> Divorce	<input type="checkbox"/> Loss of spouse's coverage
		<input type="checkbox"/> Birth or adoption of child	<input type="checkbox"/> No longer dependent child
		<input type="checkbox"/> Full Time Student	<input type="checkbox"/> Death of dependent
		<input type="checkbox"/> Handicapped	<input type="checkbox"/> No longer Full Time Student
		<input type="checkbox"/> Other _____	
		<input type="checkbox"/> COBRA effective date _____	

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	Vision	Add	Remove	EBD Code	Onset Date	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ☐ I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, I waive coverage at this time.
☐ I authorize payroll deductions.

Signature: _____ Date: _____

HSA Application and Salary Reduction Agreement

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account. Do not send contributions with this form. By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined in the adoption agreement and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Please fill out the form below and return to your payroll office.

Do you currently have an HSA with DataPath Administrative Services?

- ☐ **Yes** Provide the name of the prior employer you had an HSA with and complete all sections. Prior Employer Name _____
- ☐ **No** Complete ALL information and sign the form.

Section 1: Account Holder Information (Please Print)

Name (First, MI, Last) _____

Preferred Mailing Address ☐ Home Address ☐ Mailing Address (if different)

Home Address _____ Mailing Address _____

City _____ City _____

State _____ Zip _____ State _____ Zip _____

Email Address _____

Preferred Phone Number ☐ Home ☐ Work Best Time to Call _____ ☐ AM ☐ PM

Home Phone(____) _____ Work Phone(____) _____

Date of Birth _____ Social Security Number _____

Driver's License Number _____ Mother's Maiden Name (Security) _____

Employer School/Agency _____

Section 2: Primary Beneficiary

Name (First, MI, Last) _____ Percentage _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Relationship _____

If all individuals listed as Primary Beneficiaries precede you in death or cannot be located after a reasonable search by the custodian, all non-allocated funds (if any) in your account will be distributed to your Contingent Beneficiary (to add/edit/change Contingent Beneficiary(ies), log in to your account). In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

Section 3: HSA Contribution Election

HDHP Effective Coverage Date _____ Check one: ☐ Single Coverage ☐ Family Coverage

I elect a payroll contribution of \$ _____ (amount) to my HSA effective _____ (date).

Section 4: Debit Card

☐ I hereby request a debit card as an alternate distribution method from my HSA account. (See Article IV of the Custodial Account Agreement for terms of usage.)

Print exactly as you would like it to appear on your card: 21 characters maximum including spaces. If more than two cards are needed, attach a separate sheet.

Name on 1st Card

Name on 2nd Card

Section 5: Adoption Agreement/Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that DataPath Administrative Services, Inc. is facilitating but not initiating the contribution. If the account is closed at any time, there will be a \$25 closing fee.

This application is for the establishment of my individually owned Health Savings Account at the custodian displayed below. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement, and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the bottom of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I am currently, or will be upon the date of my first contribution, an Eligible Individual as described in the Custodial Account Agreement. I understand that maintaining my eligibility is my responsibility and that the custodian will assume that all contributions are made while I am eligible to do so. I am currently, or will be upon the date of my contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

Signature of Account Holder _____ Date _____

Employer Signature: The employee's election of the Health Savings Account contribution is accepted as of the date below.

Employer Signature _____ Date _____

Custodian
National Advisors Trust of South Dakota, Inc.
800 East 101st Terrace, Suite 300
Kansas City, MO 64131

Plan Service Provider
DataPath Administrative Services, Inc.
1601 Westpark Drive, Suite 9, Little Rock, AR 72204
501-687-6954 • Toll-Free 877-685-0655 • Fax 501-687-3282
www.datapathadmin.com • hsaenefits@datapathadmin.com

Serial No. 666576474227



Group Term Life Insurance with Accidental Death & Dismemberment (AD&D) Insurance for Active Employees



How secure is your family's financial future without you?

If something happened to you, would your family be able to maintain their way of life? How would they cover ongoing living expenses? Colonial Life's group term life insurance can help provide financial security for your family.

There are two convenient options to enroll:

1. Enroll with a telephonic Colonial Life benefits counselor.

Ask benefits questions and complete your enrollment by calling:

833-703-1967 Employer Code: 8038317 | Monday-Friday | 7 a.m. to 7 p.m. CT

Benefit confirmation forms can be emailed to you at the conclusion of the enrollment.

2. Self-enroll online.

Access the enrollment site URL: Harmony.Benselect.com/SoA

Use the following login information:

■ **Log In: MEMBER ID** (This is also your Health ID number.)

■ **Personal Identification Number:** The last four digits of your Social Security number and the last two digits of your birth year (six digits total)

During your online enrollment, you will be prompted to accept or decline each coverage type, premiums will be displayed for your selections and the appropriate health questions will be displayed, when applicable. Benefit confirmation forms can be printed or saved at the conclusion of the enrollment.

Enrollment opportunities:

1. During annual enrollment
2. 60-day new hire eligibility period
3. Within 60 days of a qualifying event, such as marriage, birth or adoption

Employees who are eligible for ARBenefits health insurance are also eligible for Group Term Life with AD&D insurance. Employees should allow a minimum of 7 business days from their new hire date before accessing the enrollment site or the telephonic enrollment. This will allow time for employees' eligibility data to be uploaded into the enrollment platform.

Your basic and optional coverages

Coverage options	Who pays	Benefit amount(s)	
Basic group term life with AD&D insurance	Employer or Employee*	\$10,000	You will be automatically enrolled if your district is participating in the Colonial Life group term life with AD&D insurance offering. A newly eligible employee may opt-out during the 60-day new hire eligibility period. Health questions are not asked during the 2024 plan year open enrollment and new hire enrollment.
Expanded basic group term life with AD&D insurance	Employee	\$1,000 increments up to \$40,000	Health questions are not asked during the 2024 plan year open enrollment and new hire enrollment.
Supplemental employee group term life with AD&D insurance	Employee	\$1,000 increments up to \$250,000	Health questions are not asked during the 2024 plan year open enrollment and new hire enrollment, for benefit amounts up to \$100,000. Any benefit amount over \$100,000 is subject to evidence of insurability.
**Supplemental spouse group term life with AD&D insurance	Employee	\$1,000 increments up to \$50,000	Health questions are not asked during the 2024 plan year open enrollment and new hire enrollment, for spouse benefit amounts up to \$10,000. Any benefit amount over \$10,000 is subject to evidence of insurability.
**Supplemental dependent child group term life with AD&D insurance	Employee	\$1,000 increments up to \$50,000	Health questions are not asked during the 2024 plan year open enrollment and new hire enrollment, for spouse and coverage up to \$10,000. Any benefit amount over \$10,000 is subject to evidence of insurability.

* Some districts are not participating in the employer-paid basic group term life with AD&D insurance.
** Employee must elect supplemental group term life with AD&D insurance on themselves in order to elect supplemental group term life with AD&D insurance for the spouse or dependent child(ren). Effective 1/1/2020, the spouse and/or child supplemental group term life with AD&D benefit amount must be either equal to or lower than the employee's supplemental group term life with AD&D benefit amount.

2024 Rates (per \$1,000) Monthly cost of coverage	
Basic group term life with AD&D insurance	
\$0.23 per \$1,000	
Expanded basic group term life with AD&D insurance	
\$0.22 per \$1,000	
Supplemental group term life with AD&D insurance	
Age	Employee
Under 25	\$0.12
25-29	\$0.12
30-34	\$0.15
35-39	\$0.16
40-44	\$0.25
45-49	\$0.41
50-54	\$0.66
55-59	\$0.95
60-64	\$1.43
65-69	\$2.78
70-74	\$ 4.53
75+	\$ 9.03
Supplemental spouse group term life with AD&D insurance	
All eligible ages	\$0.86
Supplemental dependent child group term life with AD&D insurance	
All eligible ages	\$0.12

EXCLUSIONS AND LIMITATIONS

Losses Not Covered Under Your Life Insurance Benefit:

Your life insurance benefit does not cover any losses where death is caused by, contributed to by, or results from suicide occurring within 24 months after a covered person's initial effective date of insurance or after the date any increases or additional insurance becomes effective, whether sane or insane.

This applies to any amounts of insurance for which you pay all or part of the premium.

This applies to any amount subject to evidence of insurability requirements and we approve the evidence of insurability form and the amount you applied for at that time.

You will be given credit for any period of time applied toward the satisfaction of the suicide provision, if any, under your Employer's prior group life insurance plan.

Losses Not Covered Under the AD&D Insurance Benefit:

Your AD&D benefit does not cover any losses that are caused by, contributed to by, or resulting from:

- an attempt to commit or commission of suicide or intentional self-inflicted injury while sane or insane;
- active participation in a riot;
- an attempt to commit or commission of a felony or engaging in an illegal occupation;
- voluntary use of any drugs, poisonous substance, intoxicant or narcotic, except any drugs taken as prescribed by a physician and taken as prescribed. Accidental exposure to any poisonous substance will not be excluded;
- the presence of that percentage of alcohol in the covered person's blood which raises a presumption that the covered person was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the accident occurred;
- disease of the body, mental infirmity or diagnostic, medical or surgical treatment;
- being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release; or
- investigational or experimental procedures, surgery, or drugs, including complications arising from having experimental or investigative procedures, surgeries, or drugs.

Termination

Coverage terminates:

- if the group policy ends;
- the date you no longer meet eligibility requirements;
- the end of the grace period if we do not receive the required premium for your insurance; or
- the date the next premium is due after you ask us to end your coverage.

If you are no longer eligible for coverage as an active employee, you may be eligible to port your group term life and AD&D coverage, or you may convert your group term life and AD&D coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

Evidence of Insurability means a statement of medical history which we will use to determine if an applicant is approved for coverage. Blood profiles and medical examinations, if applicable, will be provided at our expense. Evidence of Insurability is required for any amount of life insurance over the maximum guaranteed issue amount.

Premium will vary based on plan options and face amount selected.

The effective date of your coverage will be delayed if you are not a member of an eligible class on the coverage effective date. The coverage will be effective on the date that you return to status as a member of an eligible class. If the certificate covers your spouse and/or dependent children, their coverage will be effective on the date that you return to status as a member of an eligible class.

Applicable to policy number GTL1.0-P-AR-SOA and certificate number GTL1.0-C-AR-SOA. This is not an insurance contract and only the actual policy provisions will control.

A person may only be insured once under this plan. Married employees eligible for ARBenefits life insurance may not be insured both as an employee and spouse, and a child may only be

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365, COLUMBIA, SC 29202
STATE OF ARKANSAS PUBLIC SCHOOL EMPLOYEES - GROUP TERM WITH AD&D INSURANCE ENROLLMENT FORM

District Name: <u>Gravette</u>				District Code: <u>E5380522</u>	
SECTION 1: EMPLOYEE INFORMATION – Always complete					
Proposed Insured Name (First, MI, Last)			Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street		City	State	Zip Code	Member ID No.
Email Address				Primary Phone No. Secondary Phone No.	
Date Employed		Actively Employed by: AR Public School			Annual Salary
SECTION 2: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage					
Spouse Name (First, MI, Last)		Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
Are there any eligible dependent children applying for coverage?					<input type="checkbox"/> Yes <input type="checkbox"/> No
SECTION 3: GUARANTEED ISSUE COVERAGE INFORMATION – Always complete (For any amount over the maximum benefit shown below, you must complete Evidence of Insurability form.) *Administrative use only					
Coverage Type	Tax Status	Coverage Amount	*Plan Code	*Monthly Premium	
<input type="checkbox"/> Basic Group Term Life with AD&D (\$10,000)		\$10,000	8F1B	\$	
<input type="checkbox"/> Expanded Basic Group Term Life with AD&D (\$1,000 increments, up to \$40,000)	Pre-Tax <input type="checkbox"/> Post Tax <input type="checkbox"/>	\$	8F1E	\$	
<input type="checkbox"/> Supplemental Group Life with AD&D (\$1,000 increments, up to \$100,000)	Post Tax	\$	8F1S	\$	
<input type="checkbox"/> Spouse Supplemental Group Term Life with AD&D (\$1,000 increments, up to \$10,000)	Post Tax	\$	8SP1	\$	
<input type="checkbox"/> Dependent Child(ren) Supplemental Group Term Life with AD&D (\$1,000 increments, up to \$10,000)	Post Tax	\$	4CH1	\$	
<input type="checkbox"/> I do not wish to participate/continue the State of Arkansas Public School Employee (PSE) Group Term Life with AD&D Plan. I understand that if I enroll later, I must provide evidence of insurability.				Total Premium \$	
SECTION 4: BENEFICIARY INFORMATION – for the employee benefit only					
Beneficiary's Name (First, MI, Last)	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
AGREEMENT SECTION					
<p>THE PROPOSED INSURED AGREES AS FOLLOWS:</p> <p>Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. I have read this form and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this form will not be binding upon Colonial Life & Accident Insurance Company (Colonial Life) until both: 1) the certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this form are the basis for any certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the form.</p> <p>I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.</p> <p>If I have elected to pay my premiums for Colonial Life & Accident Insurance Company's Group Term Life insurance with pre-tax dollars, I am aware of the tax savings I receive through a flexible benefits plan. While the Internal Revenue Service (IRS) allows me to receive tax savings on my premiums, the IRS also may require me to pay taxes on insurance benefits I receive from coverage purchased through a flexible benefits plan.</p> <p>If applicable, I have received and read a copy of the Notice of Insurance Information Practices.</p> <p>Signed at: City _____ State _____ Date _____ mm/dd/yyyy</p> <p>(x) _____</p>					