

GEORGE COUNTY SCHOOL DISTRICT EMPLOYEE CONTACT FORM

NEW HIRE REGULAR FULL TIME EMPLOYEE

EMPLOYEE INFORMATION- Please complete the following:

- Full Name: _____
- Social Security Number (Last 4 Digits): _____
- School/Department: _____
- Home Address: _____
- City: _____ State: _____
- Zip Code: _____ Phone Number: _____
- Personal Email Address: _____

EMERGENCY CONTACT #1

- Full Name: _____
- Home Address: _____
- City: _____ State: _____
- Zip Code: _____ Phone Number: _____
- Personal Email Address: _____
- Employer: _____
- Relationship: _____

EMERGENCY CONTACT #2

- Full Name: _____
- Home Address: _____
- City: _____ State: _____
- Zip Code: _____ Phone Number: _____
- Personal Email Address: _____
- Employer: _____

Relationship: _____

EMERGENCY CONTACT #3

- Full Name: _____
- Home Address: _____
- City: _____ State: _____
- Zip Code: _____ Phone Number: _____
- Personal Email Address: _____
- Employer: _____

Relationship: _____

AUTHORIZATION

I have voluntarily provided the above contact information and authorize George County Schools and its representatives to contact any of the above on my behalf in the event of an emergency.

Employee Signature: _____

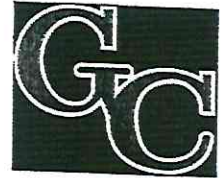
Date: _____

GEORGE COUNTY SCHOOL DISTRICT

494 COWART STREET

LUCEDALE, MS 39452

TELEPHONE: 601-947-6993



BACKGROUND CHECK ACKNOWLEDGEMENT FORM

All employment with the George County School District is contingent upon a satisfactory background check that includes fingerprinting and a current child abuse registry check.

If such fingerprinting or criminal history records check discloses a felony conviction, guilty plea or a plea of nolo contendere to a felony of possession or a sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, sex offense listed in the MS Code Section 45-33-23(g), child abuse, arson, grand larceny burglary, gratification of lust or aggravated assault which has not been reversed on appeal or for which a pardon has not been granted, the applicant shall not be eligible for employment.

Any school and/or department under the purview of the Mississippi Department of Education may employ and individual prior to receiving criminal records background checks information; however, IF George County School District does receive any disqualifying information from the background check, it may be grounds for immediate dismissal.

I have read and understand the provisions of employment stated above, and I accept that a job offer is "conditional" until I receive a satisfactory background check.

Applicant Printed Name: _____

Applicant's Signature: _____

Date: _____

If you have any questions, please contact Phyllis McDonald, Human Resources Director, at 601-947-6993 Ext.2025 or by email at phyllis.mcdonald@gcsd.us.

New Employee Information

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____ SOCIAL SECURITY NUMBER _____

PREFIX _____ PREVIOUS NAME (IF ANY) _____ DATE OF BIRTH _____

STREET ADDRESS _____ MARRITAL STATUS _____

CITY _____ STATE _____ ZIPCODE _____ PHONE NUMBER _____

GENDER _____ RACE _____ YES - NO
HISPANIC CULTURE/ORIGIN _____ PERSONAL EMAIL _____

PREVIOUS EMPLOYEE MS PERS RETIREE TRANSFER FROM ANOTHER DISTRICT IN MISSISSIPPI

LICENSED EMPLOYEE FULL-TIME EMPLOYEE PART-TIME EMPLOYEE

ADDITIONAL INFORMATION:

The George County School District does not discriminate in employment on the basis of race, color, religion, sex (including pregnancy and gender identity), national origin, political affiliation, sexual orientation, marital status, disability, and genetic information, and age, membership in an employee organization, retaliation, parental status, military service, or other non-ment factor.

To Be Completed by Payroll Department

EMPLOYEE ID _____ JOB TITLE _____ LOCATION _____

DATE OF HIRE _____ BENEFIT DATE START _____ ANNUAL SALARY _____



George County School District
494 Cowart Street
Lucedale, Mississippi 39452
Telephone: 601-947-6993

VERIFICATION OF EXPERIENCE ACKNOWLEDGEMENT

George County School District

Dear _____ (Employee's Name),

Welcome to the George County School District! We are excited to have you join our team and look forward to working with you.

Certified Applicants (those who hold an educator license):

All previous certified employment verifications must be received before we can complete your new hire file and submit your name to the school board for approval.

Classified Applicants:

You may choose to have your new hire file processed prior to submitting all employment verifications. However, if you later decide to submit verifications for prior experience, they must be received within 60 days of your hire date. After this 60-day period, verifications will not be considered.

Please note that if you are seeking credit for previous work experience, that experience must be verified by your former employer. Official verification of employment is required and must be submitted within 60 days of your hire date. Unfortunately, employment verifications received after this 60-day period cannot be processed.

If you have any questions or need assistance, please contact Phyllis McDonald at 601-947-6993, extension 2025, or via email at phyllis.mcdonald@gcsd.us

We look forward to working with you and wish you success in your new role.

Sincerely,

GCSD Human Resources Department

Applicant Printed Name: _____

Applicant's Signature: _____

Date: _____

Direct Deposit Agreement Form

Revised June 2019

Authorization Agreement

- I hereby authorize George County School to initiate automatic deposit to my account at the financial institution(s) named below. I also authorize George County Schools to make withdrawals from this account in the event that a credit entry is made in error.
- Further, I agree not to hold George County Schools Responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.
- This agreement will remain in effect until George County Schools receives a written notice of cancellation from me or until I submit a new direct deposit form to the Payroll Department.

Account Information

Type of Account	Bank	Routing Number	Account Number	Distribution	
				Percent / Amount / Residual	Amount

Due to banking regulations, you will need to provide the following documents:

- For checking account – a check (marked cancel) preprinted/typed by financial institution with your name, account number, and routing number
 - For savings account – a deposit slip (preprinted/typed by financial institution with your name, account number, and routing number)
- If you are unable to provide this information, your banking institution can provide the information on their letterhead.

All forms must be returned by the 5th of the month in order to take effect that month.

Printed Name _____

Location _____

Signature _____

Date _____

GEORGE COUNTY SCHOOL
DISTRICT

Important!!

A voided check or a letter of authorization for automatic deposit from your bank or credit union must be attached to this page.

Employee's Withholding Certificate

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.

2026

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.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do only one of the following.

- (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; or
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	(a) Multiply the number of qualifying children under age 17 by \$2,200	3(a) \$	
	(b) Multiply the number of other dependents by \$500	3(b) \$	
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here		3 \$

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here	4(b) \$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c) \$

Exempt from withholding I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027

**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.

Employers Only	Employee's signature (This form is not valid unless you sign it.)	Date	
	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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, 2027.

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

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

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

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

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

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) 4 \$ _____

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



See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1		Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.	
a	Qualified tips.	If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000	1a \$ _____
b	Qualified overtime compensation.	If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	1b \$ _____
c	Qualified passenger vehicle loan interest.	If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000	1c \$ _____
2	Add lines 1a, 1b, and 1c. Enter the result here		2 \$ _____
3		Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):	
a	Enter \$6,000 if you are age 65 or older before the end of the year		3a \$ _____
b	Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment		3b \$ _____
4	Add lines 3a and 3b. Enter the result here		4 \$ _____
5	Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information		5 \$ _____
6		Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:	
a	Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income		6a \$ _____
b	State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)		6b \$ _____
c	Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)		6c \$ _____
d	Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income		6d \$ _____
e	Other itemized deductions. Enter the amount for other itemized deductions		6e \$ _____
7	Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here		7 \$ _____
8		Limitation on itemized deductions.	
a	Enter your total income		8a \$ _____
b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9		8b \$ _____
9	Enter:	<ul style="list-style-type: none"> • \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,600 if you're single or head of household • \$384,350 if you're married filing separately 	9 \$ _____
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here		10 \$ _____
11		Standard deduction.	
Enter:	<ul style="list-style-type: none"> • \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately 		11 \$ _____
12	Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)		12 \$ _____
13	Add lines 11 and 12. Enter the result here		13 \$ _____
14	If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12		14 \$ _____
15	Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4		15 \$ _____

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	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,980

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	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047

Expires 05/31/2027

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
<p>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. An alien authorized to work until (exp. date, if any) _____						
If you check Item Number 4. , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

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

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

Document Title 1	List A	OR	List B	AND	List C
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code		

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: <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 individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 	OR	<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, sex, 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, sex, 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 <li style="text-align: center;">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 	AND	<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 <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List B document. 	AND	<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name (<i>Family Name</i>) from Section 1.	First Name (<i>Given Name</i>) from Section 1.	Middle initial (if any) from Section 1.
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

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

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

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

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

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

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

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



Supplement B, Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name (<i>Family Name</i>) from Section 1.	First Name (<i>Given Name</i>) from Section 1.	Middle initial (if any) from Section 1.
--	--	---

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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



MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Mississippi Department of Revenue
P.O. Box 960
Jackson, MS 39205

Employee's Name _____ SSN _____

Employee's Residence Address _____
Number and Street _____ City or Town _____ State _____ Zip Code _____

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION

EMPLOYEE:	Marital Status	Personal Exemption Allowed	Amount Claimed
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	1. Single	<input type="checkbox"/> Enter \$6,000 as exemption ▶ <input type="checkbox"/>	\$
	2. Marital Status (Check One)	(a) <input type="checkbox"/> Spouse NOT employed: Enter \$12,000 <input type="checkbox"/>	\$
		(b) <input type="checkbox"/> Spouse IS employed: Enter that part of \$12,000 claimed by you in multiples of \$500. See instructions 2(b) below. ▶ <input type="checkbox"/>	\$
3. Head of Family	<input type="checkbox"/> Enter \$9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d) below ▶ <input type="checkbox"/>	\$	
EMPLOYER: Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	4. Dependents <input type="text" value="Number Claimed"/>	You may claim \$1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim \$1,500 for each dependent excluding the one which qualifies you as head of family. Multiply number of dependents	\$
	5. Age and Blindness	• Age 65 or older <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Single • Blind <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Single Multiply the number of blocks checked by \$1,500. Enter the amount claimed. ▶ * Note: No exemption allowed for age or blindness for dependents.	\$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5 ▶		\$
7. Additional dollar amount of withholding per pay period if agreed to by your employer ▶		\$	
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write "Exempt" on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form		

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ Date: _____

INSTRUCTIONS

- The personal exemptions allowed:**

(a) Single Individuals	\$6,000	(d) Dependents	\$1,500
(b) Married Individuals (Jointly)	\$12,000	(e) Age 65 and Over	\$1,500
(c) Head of family	\$9,500	(f) Blindness	\$1,500
- Claiming personal exemptions:**
 - Single Individuals enter \$6,000 on Line 1.
 - Married individuals are allowed a joint exemption of \$12,000.
If the spouse is not employed, enter \$12,000 on Line 2(a). If the spouse is employed, the exemption of \$12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of \$500. For example, the taxpayer may claim \$6,500 and the spouse claims \$5,500; or the taxpayer may claim \$8,000 and the spouse claims \$4,000. The total claimed by the taxpayer and spouse may not exceed \$12,000. Enter amount claimed by you on Line 2(b).
 - Head of Family
A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter \$9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).
 - An additional exemption of \$1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent **excluding** the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.
 - An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the age of 65 before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.
 - An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by \$1,500 and enter amount of exemption claimed.
- Total Exemption Claimed:**
Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.
- A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN**
- PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION**
- IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL**
- To comply with the Military Spouse Residency Relief Act (PL111-97) signed into law

Mississippi New Hire Reporting Form



Mail completed form to: Mississippi State Directory of New Hires
PO Box 437
Norwell, MA 02061

Or fax completed form to: 1-800-937-8668

Effective October 1, 1997, all Mississippi employers (or independent contractors) are required to report certain information about personnel who have been newly hired, rehired, or have returned to work. **Reports must be made within 15 calendar days from date of hire.** Employers must either (1) complete this form, or (2) submit a copy of the worker's IRS W-4 form with the "other information section" completed on this form, or (3) submit the information by magnetic tape or floppy diskette. *To submit new hire reports electronically, call 1-800-241-1330 to obtain information.*

Below, please complete all employer information

EMPLOYER INFORMATION

*Federal Employer Identification Number (FEIN): -
(Please the same FEIN for which listed employee(s) quarterly wages will be reported under)

State Employer Identification Number (SEIN): -

*Employer Name: GEORGE COUNTY SCHOOL DISTRICT DBA: _____

*Address: 494 COWART ST

(Please indicate the address where the Income Withholding Order will be sent)

*City: LUCEDALE *State: MS *Zip Code: 39452 +4: _____

Contact Name: KIMBERLY COLLINS Phone: 601-947-6993 EXT 2042

Email: KIMBERLY.COLLINS@GCSD.US

Below, please complete one entry for each new employee

EMPLOYEE INFORMATION

*Social Security Number: - - Gender (circle one): Male Female

*First Name: _____ Middle: _____

*Last Name: _____

*Employee Address: _____

*City: _____ *State: _____ *Zip Code: _____ +4: _____

Date of Birth: ____/____/____ *Date of Hire: ____/____/____ State of Hire _____

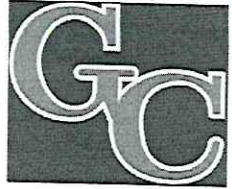
Employee Salary: _____ Payment Frequency (circle one): Weekly Bi-weekly Monthly Annually

Is this employee eligible for medical insurance (circle one)? Yes No

For information please visit our website at www.ms-newhire.com or call us toll-free at 1-800-241-1330

NEW HIRE INFORMATION FORM

To be completed by all new employees and returned to the Human Resources Office.



Employee's Legal Name: _____

Position/Title: _____

Work Location/Department: _____

Start Date: _____

Phone Number: _____

Personal Email Address: _____

1. Are you currently retired from any U.S. state including Mississippi?

Yes No

If yes, please provide the following:

• State you are retired from: _____

• Name of the company or agency you retired from: _____

We ask this question to ensure your new employment does not affect any retirement benefits you may currently be receiving. Some state retirement systems have rules about post-retirement employment, and we want to help you remain compliant and fully informed.

2. Do you have any other current jobs (with this district or another employer)?

Yes No

If yes, please provide details: _____

This helps us determine if your hours or earnings will impact eligibility for benefits or compliance with labor laws.

3. Have you ever worked for this district before?

Yes No

If yes, when and in what role? _____

What name(s) did you use the last time you worked for this district? _____

4. What is your highest level of education completed?

High School Some College Associate's Bachelor's Graduate or Higher

5. Do you require any workplace accommodations under the ADA (Americans with Disabilities Act)?

Yes No

If yes, please describe or speak with HR directly.



Membership Application

Form 1 – Revised 02/11/2026

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Member Information – Attach a copy of the member's Social Security card.

First Name: _____ MI: _____ Last Name: _____ Gender: M F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date mm/dd/ccyy: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: _____ Other Phone: _____

Have you previously served on active duty in the U.S. Armed Forces? If yes, attach a legible Form(s) DD214 Yes No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? Yes No

2 Retirement Plan – Plans are governmental plans qualified under Section 401(a) of the Internal Revenue Code. Select applicable plan.

Public Employees' Retirement System of Mississippi (PERS) Mississippi Highway Safety Patrol Retirement System (MHSPRS)

3 Family Information – Use additional Membership Applications if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B, Beneficiary Designation, to officially designate any and all beneficiaries.

Marital Status – Select one. Add date for last three. Single Married Divorced Widowed Effective Date mm/dd/ccyy: _____

Spouse's Full Name	Social Security No.	Birth Date mm/dd/ccyy	Wedding Date mm/dd/ccyy	Gender
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

Dependent Child's Full Name – Up to age 19, or 23 if unmarried and a full-time student	Social Security No.	Birth Date mm/dd/ccyy	Relationship	Gender
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

4 Member Certification – I certify that the above information is true and correct. Furthermore, I understand that if I became a member of PERS on or after March 1, 2026, I have been automatically enrolled in a hybrid retirement plan, which consists of a defined benefit and defined contribution components administered by PERS and a contracted third-party administrator.

Member's Signature: _____ Date mm/dd/ccyy: _____

5 Employer Certification – This section must be completed by an authorized employer representative, not the member.

Member's Position Held/Job Title: _____ Member's Hire Date for Position mm/dd/ccyy: _____

Member's Status: Elected Official: Yes No Fee Paid Official: Yes No Public Safety Employee: Yes No

Employer Name: GEORGE COIUNTY SCHOOL DISTRICT PERS Employer No.: _____ 0315

Employer Representative's Name: KIMBERLY COLLINS Employer Representative's Title: PAYROLL SPECIALIST

Employer Representative's Phone: (601) 947-6993 Fax: (601) 530-0968 E-Mail: KIMBERLY.COLLINS@GCSD.US

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, Eligibility of Part-time Employees for State Retirement Annuity Service Credit, and PERS Board of Trustees Regulation 36, Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS). I understand that, if the employee named in Section 1 became a member of PERS on or after March 1, 2026, I am required to report employee information, as well as contributions as defined in state statute to both PERS and the contracted third-party administrator. Mandatory employer contributions must be reported to PERS.

Employer Representative's Signature: _____ Date mm/dd/ccyy: _____



Beneficiary Designation

Form 1B – Revised 08/30/2022

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ Member Retiree
Social Security No.: _____ Birth Date mm/dd/ccyy: _____ Gender: M F

2 Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. Select applicable plan.

- Public Employees' Retirement System of Mississippi (PERS) Mississippi Highway Safety Patrol Retirement System (MHSPRS)
- Supplemental Legislative Retirement Plan (SLRP)

3 Beneficiary Information – Use additional Form 1B, Beneficiary Designation, to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary beneficiaries must equal 100 percent, and total secondary beneficiaries must equal 100 percent. Secondary beneficiaries will only receive payment if all listed primary beneficiaries are deceased.

Beneficiary Name	Social Security No.	Birth Date mm/dd/ccyy	Relationship	Beneficiary Percentage P=Primary, S=Secondary Use whole numbers	Gender
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F

4 Member/Retiree Certification – Check applicable acknowledgement then sign. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

- Member** – I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).
- Retiree** – I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date mm/dd/ccyy: _____

5 Employer Certification – This section must be completed by an authorized employer representative, not the member. Only complete for active members.

Employer Name: _____ Employer No.: _____ - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

Employer Representative's Signature: _____ Date mm/dd/ccyy: _____

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
EFFECTIVE JANUARY 1, 2026

Legacy - Initially hired before 1/1/2006
Horizon - Initially hired on or after 1/1/2006

ACTIVE EMPLOYEE	LEGACY EMPLOYEES			
	BASE		SELECT	
	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	\$513	\$0	\$533	\$20
Employee + Spouse	\$1,074	\$561	\$1,173	\$660
Employee + Spouse & Child(ren)	\$1,367	\$854	\$1,467	\$954
Employee + Child	\$659	\$146	\$759	\$246
Employee + Children	\$886	\$373	\$983	\$470

ACTIVE EMPLOYEE	HORIZON EMPLOYEES			
	BASE		SELECT	
	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	\$513	\$0	\$566	\$53
Employee + Spouse	\$1,074	\$561	\$1,205	\$692
Employee + Spouse & Child(ren)	\$1,367	\$854	\$1,499	\$986
Employee + Child	\$659	\$146	\$790	\$277
Employee + Children	\$886	\$373	\$1,015	\$502

*The State pays 100% of the employee's premium for Base Coverage. Active employees enrolling in Select Coverage must pay a portion of the employee premium.

RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	LEGACY RETIREES	
	BASE	SELECT
Retiree	\$590	\$614
Retiree + Spouse (Non-Medicare)	\$1,235	\$1,349
Retiree + Spouse & Child(ren) (Non-Medicare)	\$1,571	\$1,686
Retiree + Child	\$758	\$839
Retiree + Children	\$1,017	\$1,063
Retiree + Spouse (Medicare)	N/A	\$854
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$1,069

RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	HORIZON RETIREES	
	BASE	SELECT
Retiree	\$941	\$975
Retiree + Spouse (Non-Medicare)	\$1,887	\$2,010
Retiree + Spouse & Child(ren) (Non-Medicare)	\$2,109	\$2,234
Retiree + Child	\$1,109	\$1,200
Retiree + Children	\$1,368	\$1,425
Retiree + Spouse (Medicare)	N/A	\$1,225
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$1,450

RETIRED EMPLOYEE - MEDICARE ELIGIBLE	LEGACY RETIREES	
	BASE	SELECT
Retiree	N/A	\$250
Retiree + Spouse (Non-Medicare)	N/A	\$965
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	\$1322
Retiree + Child	N/A	\$474
Retiree + Children	N/A	\$699
Retiree + Spouse (Medicare)	N/A	\$500
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$725

RETIRED EMPLOYEE - MEDICARE ELIGIBLE	HORIZON RETIREES	
	BASE	SELECT
Retiree	N/A	\$250
Retiree + Spouse (Non-Medicare)	N/A	\$1285
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	\$1509
Retiree + Child	N/A	\$474
Retiree + Children	N/A	\$699
Retiree + Spouse (Medicare)	N/A	\$500
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$725

COBRA	LEGACY	
	BASE	SELECT
Participant	\$522	\$545
Participant + Spouse	\$1,095	\$1,197
Participant + Spouse & Child(ren)	\$1,394	\$1,496
Participant + Child	\$672	\$774
Participant + Children	\$903	\$1,003
COBRA DISABILITY EXTENSION	BASE	SELECT
Participant	\$769	\$801
Participant + Spouse	\$1,611	\$1,760
Participant + Spouse & Child(ren)	\$2,051	\$2,201
Participant + Child	\$988	\$1,138
Participant + Children	\$1,329	\$1,476

COBRA	HORIZON	
	BASE	SELECT
Participant	\$522	\$577
Participant + Spouse	\$1,095	\$1,229
Participant + Spouse & Child(ren)	\$1,394	\$1,529
Participant + Child	\$672	\$806
Participant + Children	\$903	\$1,036
COBRA DISABILITY EXTENSION	BASE	SELECT
Participant	\$769	\$849
Participant + Spouse	\$1,611	\$1,806
Participant + Spouse & Child(ren)	\$2,051	\$2,249
Participant + Child	\$988	\$1,186
Participant + Children	\$1,329	\$1,524

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://www.dfa.ms.gov/insurance> or call 1-800-709-7881. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can also view the Glossary at www.ccifio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network and Out-of-network: \$1,800/individual; \$3,400/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Preventive prescription drugs: \$75/individual . There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network providers: \$6,500/individual; \$13,000/family. Out-of-network providers: no out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges this health care plan doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Go here for a list of network providers or call 1-800-294-6307.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Telehealth provider visit: \$10 <u>Copayment</u> (Subject to <u>deductible</u>)
	Specialist visit	No charge. <u>Deductible</u> does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive, then check what your <u>plan</u> will pay for.
If you have a test	Preventive care/screening/immunization	No charge. <u>Deductible</u> does not apply.	Not covered.	
	Diagnostic test (X-ray, blood work). Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition, or information about <u>prescription drug coverage</u> . Additional information is available at www.caremark.com	Preferred Generic drugs	Retail: \$12 <u>copay</u> Mail order: \$24 <u>copay</u>		\$75 individual preventive <u>prescription drug deductible</u> (for certain preventive medications) if the Base Coverage <u>deductible</u> has not been met. Mail Order (2X Copay) quantity 60-90 day supply. No charge for FDA-approved generic contraceptives or brand name contraceptives if a generic is medically inappropriate or unavailable. If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the brand <u>copayment</u> . Certain prescriptions require prior approval.
	Non-Preferred Generic drugs	Retail: \$30 <u>copay</u> Mail order: \$60 <u>copay</u>	You pay 100% then request reimbursement of the in-network amount, less the applicable <u>deductible</u> or <u>copay</u> .	
	Preferred brand drugs	Retail: \$45 <u>copay</u> Mail order: \$90 <u>copay</u>		
	Non-preferred brand drugs	Retail: \$100 <u>copay</u> Mail order: \$200 <u>copay</u>		
	Specialty drugs	Retail: \$100 <u>copay</u>	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Provider/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Emergency room care	\$50 <u>copay</u> /1 st visit; \$200 <u>copay</u> /each additional visit plus 20% <u>coinsurance</u> .	\$50 <u>copay</u> /1 st visit; \$200 <u>copay</u> /each additional visit plus 20% <u>coinsurance</u> .	<u>Copayment</u> waived if admitted.
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Urgent care	20% coinsurance	40% coinsurance	
	Facility fee (e.g., hospital room) Provider/surgeon fees	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
	Outpatient services	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health or substance abuse services	Inpatient services	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Certification required.
	Habilitation services	20% coinsurance	40% coinsurance	Maintenance or exercise therapy is excluded.
	Skilled nursing care	20% coinsurance	40% coinsurance	Certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	Hospice services	20% coinsurance	40% coinsurance	Certification Required. Benefits available for up to six months.
	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in network.
If your child needs dental or eye care	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in network.
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)• Dental care (Adult) | <ul style="list-style-type: none">• Dental care (Children)• Hearing aids• Infertility treatment• Routine eye care (Adult) | <ul style="list-style-type: none">• Routine eye care (Children)• Routine foot care• Weight loss programs (except as required by ACA) |
|--|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | |
|--|---|
| <ul style="list-style-type: none">• Bariatric surgery (prior approval required)• Chiropractic services (limited to 30 visits/individual/year) | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing (prior approval required) |
|--|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Marketplace, visit <https://www.healthcare.gov/> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact [Health Help Mississippi](#) at 1-877-314-3843 or healthhelpms@mhap.org.

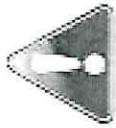
Does this plan provide Minimum Essential Coverage? Yes

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a plan through the [Marketplace](#).

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

- The plan's overall deductible \$1,800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (ultrasounds and blood work)
 Specialist visit (anesthesia)

Total Example Cost \$12,800

In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$1,800
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,000

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care provider office visits (including chronic condition education)
 Diagnostic test (blood work)
 Prescription drugs
 Durable medical equipment (glucose meter)

Total Example Cost \$7,400

In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$1,800
Copayments	\$144
Coinsurance	\$1091.20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,035.20

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

- The plan's overall deductible \$1,800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
 Diagnostic test (X-ray)
 Durable medical equipment (crutches)
 Rehabilitation services (physical therapy)

Total Example Cost \$1,900

In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$1,800
Copayments	\$50
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,860

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$1,800 /individual; \$3,600 /family. Out-of-network: \$2,300 /individual; \$4,600 /family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, payments made on individual deductible will combine towards the family deductible until the \$3,600 is met.
Are there services covered before you meet your deductible?	Yes. In-network preventive care and primary care network provider office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Prescription drugs: \$75 /individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network providers: \$6,500 /individual; \$13,000 /family. Out-of-network providers: no out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing, charges this health care plan doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Go here for a list of network providers or call 1-800-294-6307.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Telehealth provider visit: \$10 <u>copayment</u>
	Specialist visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Preventive care/screening/immunization	No charge. <u>Deductible</u> does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition, or information about <u>prescription drug coverage</u> . Additional information is available at www.caremark.com	Preferred Generic drugs	Retail: \$12 <u>copay</u> Mail order: \$24 <u>copay</u>		\$75 individual <u>prescription drug deductible</u> Mail Order (2X copay) Quantity: 60-90-day supply.
	Non-Preferred Generic drugs	Retail: \$30 <u>copay</u> Mail order: \$60 <u>copay</u>	You pay 100% then request reimbursement of the in-network amount, less the applicable <u>deductible</u> or <u>copay</u> .	No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate or unavailable). If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the brand <u>copayment</u> .
	Preferred brand drugs	Retail: \$45 <u>copay</u> Mail order: \$90 <u>copay</u>		Certain prescriptions require prior approval
	Non-preferred brand drugs	Retail: \$100 <u>copay</u> Mail order: \$200 <u>copay</u>		**PrudentRx coupon program will allow enrolled participants to pay \$0.
	Specialty drugs **	30% <u>coinsurance</u>	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Provider/surgeon fees			
If you need immediate medical attention	Emergency room care	\$50 copay/1 st visit; \$200 copay/each additional visit plus 20% <u>coinsurance</u>	\$50 copay/1 st visit; \$200 copay/each additional visit plus 20% <u>coinsurance</u>	<u>Copayment</u> waived if admitted.
	Emergency medical transportation	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Facility fee (e.g., hospital room) Provider/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250. <u>Cost sharing does not apply for preventive services.</u> Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery professional services Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification required.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maintenance or exercise therapy is excluded.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
If your child needs dental or eye care	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification Required. Benefits available for up to six months.
	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in-network.

Excluded Services and Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs (except as required by ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (prior approval required)
- Chiropractic services (limited to 30 visits/individual/year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (prior approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccifio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit <https://www.healthcare.gov/> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact [Health Help Mississippi](#) at 1-877-314-3843 or healthhelpms@mhap.org.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a plan through the **Marketplace**.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section. _____



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

- The plan's overall deductible \$1,800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u> (Medical and Rx)	\$1,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,180
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,980

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
 Primary care provider office visits (*including chronic condition education*)
 Diagnostic test (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u> (Medical and Rx)	\$75
<u>Copayments</u>	\$194
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$469

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

- The plan's overall deductible \$1,800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Diagnostic test (*X-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,800
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,040

MISSISSIPPI'S STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN APPLICATION FOR COVERAGE

PLEASE PRINT

Section A: Enrollee Information (all fields are required)		Employer Name	
Social Security Number	First Name	MI	Last Name
Home Address		City	State
Primary Telephone Number	Secondary Telephone Number	Personal Email Address	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement

Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? No (Horizon) Yes (Legacy)

If **yes**, please list your most recent (pre-1/1/06) employer and dates of employment: _____

If married, is your spouse a Plan participant? Yes No If yes, Spouse Name and SSN: _____

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

I hereby apply to **ADD, CONTINUE AND/OR CHANGE COVERAGE** for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the Plan Document. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

I hereby **WAIVE COVERAGE** in the State and School Employees' Health Insurance Plan. I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. **If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.**

Enrollee Signature: _____ Date: _____

Section C: Coverage

Enrollee Type: <input type="checkbox"/> Employee - Legacy <input type="checkbox"/> Employee - Horizon <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse	Coverage Type: <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee + Spouse <input type="checkbox"/> Enrollee + Child <input type="checkbox"/> Enrollee + Children <input type="checkbox"/> Enrollee + Spouse & Child(ren)	Coverage Option: (Choose Only One) <input type="checkbox"/> Base <input type="checkbox"/> Select	Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Number: _____ <input type="checkbox"/> "A" Effective Date: _____ <input type="checkbox"/> "B" Effective Date: _____ Reason for Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability
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Are you a tobacco user? Yes No If yes, are you interested in participating in the Plan's free cessation program? Yes No

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? Yes No If yes, please provide the following:

Name of Individual Covered:	1. _____	2. _____	3. _____	4. _____
Policyholder's Name:	_____	_____	_____	_____
Policyholder's Date of Birth:	_____	_____	_____	_____
Policyholder's Insurance Effective Date:	_____	_____	_____	_____
Policy Number:	_____	_____	_____	_____
Policyholder's Employment Status:	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Insurance Company Name address & phone #:	_____	_____	_____	_____
Coverage Type:	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:
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Section E: Dependents

Dependents to be Covered <small>(Last Name, First Name, MI)</small>	Relation to Enrollee	Social Security Number	Date of Birth <small>(mm/dd/yyyy)</small>	Address <small>(if different from Enrollee)</small>	Current Status
1.	Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female				Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled
3.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled
4.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? Yes No
 If yes, please provide the following:

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Section F: Change Information

Add Enrollee: Open Enrollment Marriage Birth Adoption Loss of Coverage due to Divorce
 Other: _____ Requested Effective Date: _____

Add Dependent(s): Open Enrollment Marriage Birth Adoption Other: _____
 (List all dependents in Section E.) Qualifying Event/ Effective Date: _____

Change Coverage: Base Coverage Select Coverage

Drop Dependent(s): Divorce Deceased Other: _____

Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date
_____	_____	_____

Other Changes (Explain):

<p>FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER: _____</p> <p>New Legacy Employee, Requested Effective Date: _____</p> <p>New Horizon Employee, Requested Effective Date: _____</p> <p>Retiree, Requested Effective Date: _____</p> <p>COBRA, Requested Effective Date: _____</p> <p>Surviving Spouse, Requested Effective Date: _____</p> <p>Change(s), Requested Effective Date: _____</p>	<p>ENTERED BY: _____</p> <p>DATE: _____</p> <p>VERIFIED BY: _____</p> <p>DATE: _____</p>
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STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN ENROLLMENT/CHANGE REQUEST FORM

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.
Policy 33683-G

SECTION A: Employee/Employer Information

Employee/Retiree Last Name:	First Name:	MI:	Social Security Number:	Birthdate: (MM/DD/YYYY):
Employee/Retiree Home Address:			Email Address:	Home Phone:
				Alternate Phone:
Employer Name:				Employer Phone:
Employer Address:				

SECTION B: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)

ACTIVE FULL-TIME EMPLOYEE: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of \$30,000 and a maximum of \$100,000. The employee and employer each pay 50 percent of the monthly premium.

- New Employee** – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.
- Late Enrollee Applicant** – Applications made after initial 31 days of employment will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life. (Employee must also complete the Minnesota Life GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form.)

Date of Employment: _____

- RETIRED EMPLOYEE:** Life benefit amounts are limited to \$5,000, \$10,000 or \$20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

Date of Retirement: _____ COVERAGE AMOUNT REQUESTED: \$5,000 \$10,000 \$20,000

- DISABLED EMPLOYEE:** Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months. (Employee must also complete the Minnesota Life NOTICE OF DISABILITY and ATTENDING PHYSICIAN'S STATEMENT forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

NOTE: You cannot designate your life insurance beneficiary on this form. To designate your life insurance beneficiary, please follow the instructions below:

1. Log in to your *myBlue* site, <https://myblue.bcbsms.com>, and click on the My Benefits tab.
2. Scroll down to the Life Benefits section below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on the site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through the *myBlue* portal.

If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the policy.

If you do not have Internet access, contact Minnesota Life toll free at **877-348-9217** to request a paper beneficiary designation form.

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone
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SECTION D: Authorization and Certification

I am applying for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Insurance Company, Group Policy #33683-G, and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

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

Employee/Retiree Signature (Required)

Date

SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)

Waiver of Coverage – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

Cancellation of Coverage – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.

Employee/Retiree Signature

Date

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT <http://KnowYourBenefits.dfa.ms.gov/> OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	GROUP NUMBER:	INFORMATION VERIFIED: (INITIAL AND DATE)