P.O. Box 178 • 114 Woodhull Street • Laingsburg, Michigan 48848-0178
Phone (517) 651-5374 • Fax (517) 651-5604 • www.laingsburg.us

Discover ☆ Enjoy ☆ Celebrate!

New Hire Packet (Part-Time)

1. Emergency Information
2. I-9
3. Michigan W-4
4. Federal W-4 (Update Annually)
5. Direct Deposit Form
6. Michigan New Hire Form
7. Handbook with receipt of acknowledgment
8. Seasonal Acknowledgment Form
9. Sexual Harassment Policy with receipt of acknowledgment
10. MERS- Voluntary Deduction- 401k or Roth Enrollment
11. AFLAC
12. Social Security Disclosure
13. Health Insurance Market Information
14. Standard Life Insurance (Police Only)
15. All-State Enrollment/Waiver

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Employee Emergency Information

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

SSN or Gov't ID: _____

Birth Date: _____ Date of Hire: _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

This information will be kept confidential and will only be used in an emergency situation. Please feel free to discuss any concerns with the Clerk.

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization

List A

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

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

List B

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

List C

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. ***Read instructions on page 2 before completing this form.***

Issued under P.A. 281 of 1967.

▸ 1. Full Social Security Number	▸ 2. Date of Birth

▸ 3. Name (First, Middle Initial, Last)	4. Driver's License Number or State ID

Home Address (No., Street, P.O. Box or Rural Route)			▸ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire..... (mm/dd/yyyy) ☐ No
City or Town	State	ZIP Code	

6. Enter the number of personal and dependent exemptions (see instructions) ..... ▸ 6.	
7. Additional amount you want deducted from each pay (if employer agrees) .....7.	$ .00

8. I claim exemption from withholding because (see instructions):

a. ☐ A Michigan income tax liability is not expected this year.

b. ☐ Wages are exempt from withholding. Explain: _____

c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	▸ Date

EMPLOYER: Complete the below section.

10. Employer's Name	▸ 11. Federal Employer Identification Number		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
Name of Contact Person	Contact Phone Number		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See **www.mi-newhire.com** for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

INSTRUCTIONS TO *EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE* (Form MI-W4)

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal or dependency exemptions or claimed that you are exempt from withholding.

You MUST provide a new MI-W4 to your employer within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent no longer qualifies under the Internal Revenue Code.

Line 5: If you check "Yes," enter your date of hire.

Line 6: Personal and dependency exemptions. The number of exemptions claimed here may not exceed the number of exemptions you are entitled to claim on a *Michigan Individual Income Tax Return* (Form MI-1040). Dependents include qualifying children and qualifying relatives under the Internal Revenue Code, even if your AGI exceeds the limits to claim federal tax credits for them.

Do not claim the same exemptions more than once or tax will be under-withheld. Specifically, **do not claim:**

- Your personal exemption if someone else will claim you as their dependent.
- Your personal exemption with more than one employer at a time.
- Your spouse's personal exemption if they claim it with their employer.
- Your dependency exemptions if someone else (for example, your spouse) is claiming them with their employer.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8a: You may claim exemption from Michigan income tax withholding if all of the following conditions are met:

i) Your employment is intermittent, temporary, or less than full time;

ii) Your personal and dependency exemptions exceed your annual taxable compensation;

iii) You claimed exemption from federal withholding; and

iv) You did not incur a Michigan income tax liability for the previous year.

Line 8b: Reasons wages might be exempt from withholding include:

- You are a nonresident spouse of military personnel stationed in Michigan.
- You are a resident of one of the following reciprocal states while working in Michigan: Illinois, Indiana, Kentucky, Minnesota, Ohio, or Wisconsin.
- You are a member of a Native American tribe that has a tax agreement with the State of Michigan and whose principal place of residence is within the designated agreement area.
- You are an enrolled member of a federally-recognized tribe that does not have a tax agreement with the State of Michigan, you reside within that tribe's Indian Country (as defined in 18 USC 1151), and compensation from this job will be earned within that Indian Country.

Line 8c: For questions about Renaissance Zones, contact your local assessor's office.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

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

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . 2 $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

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AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

COMPANY NAME: City of Laingsburg

I (we) hereby authorize the City of Laingsburg to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my/our account indicated below, and for the depository bank named below to credit and/or debit the same to such account.

DEPOSITORY (Bank) NAME_____

CITY _____ STATE_____ ZIP_____

TRANSIT/ABA NO. _____ _____ _____ _____-_____ _____ _____-_____ _____

ACCOUNT NO. _____

[ ] Checking
[ ] Savings
Select One

This authority is to remain in full force and effect until the City of Laingsburg has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the City of Laingsburg a reasonable opportunity to act on it.

NAME(S) _____

PLEASE NOTE: It is <u>YOUR</u> responsibility to inform the City of Laingsburg of any changes to your deposit account information. If a change occurs that hinders the transaction and results in a fee charged to the City, <u>such fee will be deducted from your next deposit amount</u>.

SIGNED _____ DATE _____

Michigan Department of Treasury
3281(Rev. 9-12)

State of Michigan New Hire Reporting Form

Federal law requires public (State and local) and private employers to report all newly hired or rehired employees who are working in Michigan to the State of Michigan.[1] This form is recommended for use by all employers who do not report electronically.

Michigan New Hire Operations Center
P.O. Box 85010
Lansing, MI 48908-5010
Phone: (800) 524-9846
Fax: (877) 318-1659

- A newly hired employee is an individual not previously employed by you, and a rehired employee is an individual who was previously employed by you but separated from employment for at least 60 consecutive days.
- Reports must be submitted within 20 days of hire date (i.e., the date services are first performed for pay).
- This form may be photocopied as necessary. Many employers preprint employer information on the form and have the employee complete the necessary information during the hiring process.
- When reporting new hires with special exemptions, please use the MI-W4 form.
- Online and other electronic reporting options are available at: www.mi-newhire.com.
- Employers who report electronically and have employees working in two or more states may register as a multi-state employer and designate a single state to which new hire reports will be transmitted. Information regarding multi-state registration is available online at: http://www.acf.hhs.gov/programs/cse/newhire/employer/private/newhire.htm#multi or call (410) 277-9470.
- Reports will not be processed if mandatory information is missing. Such reports will be rejected and you must correct and resubmit them.
- For optimum accuracy, please print neatly in all capital letters and avoid contact with the edge of the box. See sample below.

A B C 1 2 3

EMPLOYEE Information *(Mandatory)*

Social Security Number:

First Name:

Middle Initial:

Last Name:

Address:

City:

State:

Zip Code:

Hire Date:

Date of Birth:

Driver's License No:

EMPLOYER Information *(Mandatory)*

Federal Employer Identification Number (FEIN): 38 6021103

Employer Name: CITY OF LAINGSBURG

Address: PO BOX 178

City: LAINGSBURG

State: MI

Zip Code: 48848

Contact Name: PAULA WILLOUGHBY

Contact Phone: 517 651 5374

Contact Fax:

Contact Email: CLERK@LAINGSBURG.US

[1] Ref: Social Security Act section 453A and the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. 104-193), effective October 1, 1997.

CITY OF LAINGSBURG

PERSONNEL POLICIES

PREAMBLE

These Personnel Policies are approved by the City Department Supervisors and the Laingsburg City Council.

The purpose of these policies is to provide a set of principles for establishing and maintaining harmonious and productive City employee relationships in the conduct of City business.

The fundamental objectives of good personnel administration as supported by these policies include:

1. To promote and increase effectiveness, efficiency, and high quality performance in the service of the City through systematic performance planning and review.

2. To provide for fair and equal treatment of applicants and employees in accordance with appropriate legislation and judicial mandates.

3. To provide a program of recruitment, selection, and advancement that is based on qualifications and demonstrated performance in order to make the service of the City attractive as a career and encourage each employee to render his/her best services to the City.

4. To establish and maintain an equitable and uniform plan of position classification and compensation based upon the relative duties and responsibilities of positions in the service of the City.

5. To motivate employees to work toward the goals of the City administration by providing optimum working environments and relationships, and opportunities for achievement, recognition, and growth.

6. To safeguard the employee's right to be treated with respect, dignity, equity, and fairness.

CITY OF LAINGSBURG
Personnel Handbook
Table of Contents

Dear Employee:

As Mayor of the City of Laingsburg, and on behalf of the City Council, I would like to take this opportunity to welcome you as a newly hired employee for the City of Laingsburg. I hope this Personnel Handbook might have concerning your job. Each department, also, has its own written Rules and Regulations governing their own department.

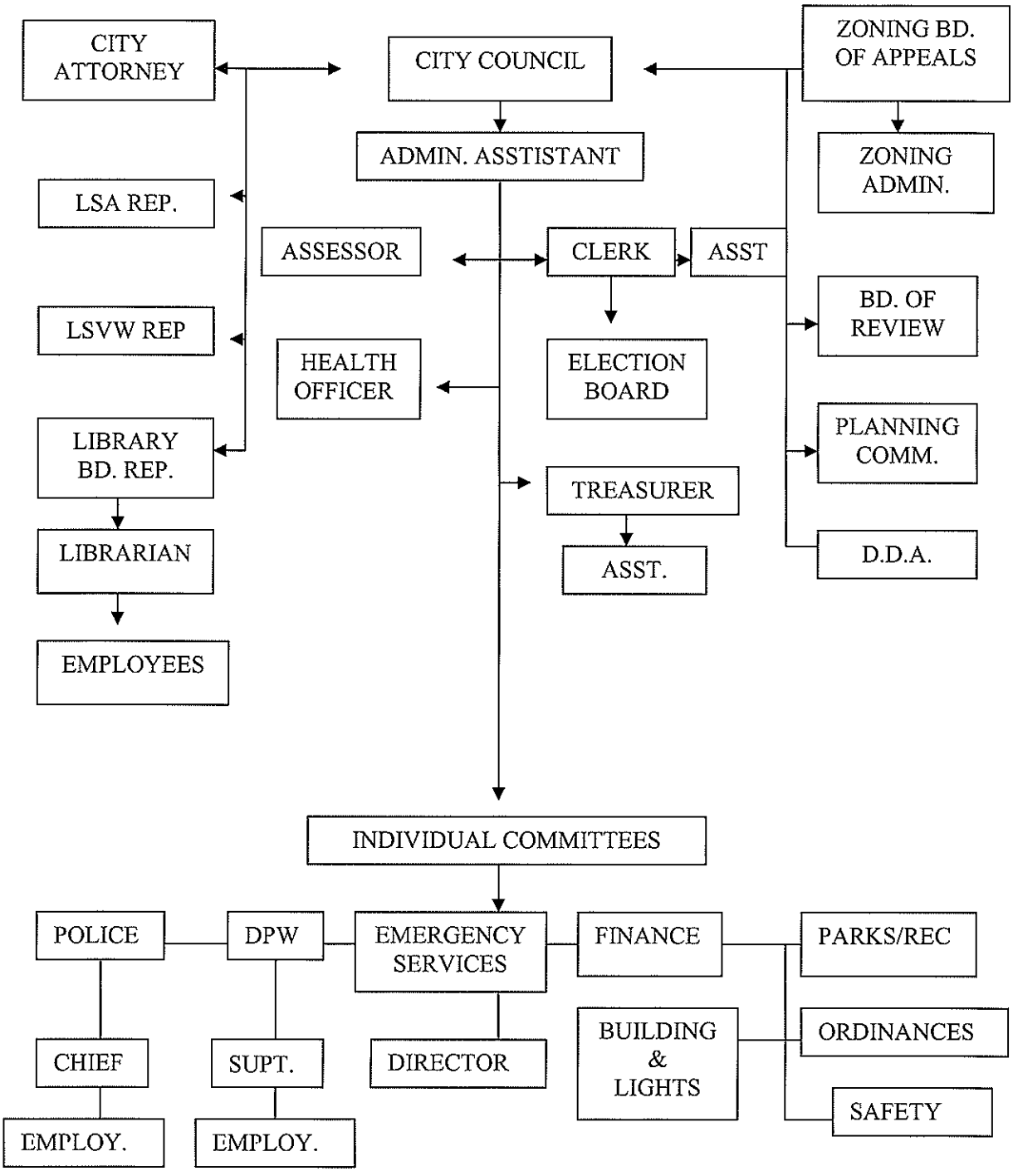
By all of us working together, I feel that we can make Laingsburg a better Community in which to work and live. Any suggestions for operational improvements can be forwarded to the Committee Chairperson or to the Mayor.

If at anytime I can be of any help to you, it would be my pleasure to do so.

Sincerely,

Jeff Geasler
Mayor
City of Laingsburg

ORGANIZATIONAL CHART



POLICIES

A. Appearance - Every employee is to give a neat clean appearance for his/her position. Different departments have regulations regarding wearing of uniforms.

B. Attendance – Each department has different work hours. In case of absence or tardiness the department supervisor or committee member should be notified at the earliest opportunity.

C. Change of Personnel Records – Employees are to report personal changes, such as address changes, number of dependants, or marital status to the Treasurer.

D. Civil Rights Policy – (Council 2-1-93)

1. General Public Policy – It is hereby declared to be contrary to the public policy of the City of Laingsburg for any persons to be discriminated against in employment, housing or participation in publicly funded programs because of race, religion, national origin, color, sex, marital status, age or handicap.

2. Employment – The opportunity to obtain employment without discrimination because of race, religion, national origin, color, sex marital status, age or handicap is hereby recognized and declared to be a civil right. Further, it shall be contrary to the public policy of the City of Laingsburg for any employer to discriminate in hire, promotion, tenure, terms or conditions of employment because of race, religion, national origin, color, sex, martial status, age or handicap.

3. Housing – The opportunity to purchase, lease, sell, hold, use and convey housing without discrimination because of race, religion, national origin, color, sex, marital status, age or handicap is hereby recognized and declared to be a civil right.

4. Publicly Funded Programs – The opportunity to participate in federal, state and locally funded programs without discrimination because of race, religion, national origin, color, sex, marital status, age or handicap is hereby recognized and declared to be a civil right.

E. Conduct – Employees are to be polite at all times and to conduct themselves in a respectable manner.

F. Confidential Relations – Having access to knowledge of personal matters of both individuals and businesses, employees should never use or release confidential information except for lawful purposes.

G. Cost Control – Employees are to keep cost to a minimum and be looking for ways to eliminate unnecessary spending.

H. Council – Employee – Any person who serves on the City Council cannot simultaneously be a city employee (Council minutes 2-2-81).

I. Definition of Employee – Full time employment for the City of Laingsburg is 30 hours per week scheduled on a year around basis. Part-time employees may work any specified period of time but not be scheduled on a year around basis.

J. Department Policies- Each department has additional policies written into its Rules and Regulations. They are considered to be part of the Employee Handbook.

K. Discipline and Dismissal – An employee is subject to reprimand, suspension without pay or discharge because of conduct unbecoming his position; conviction of a misdemeanor or felony; or violation of department rules and regulations. The City Charter states an employee can request a hearing before the Council regarding any action against him.

L. Employee Performance Appraisal – All full-time and part-time employees, shall receive an annual evaluation between November 1 and December 1. The evaluation becomes a permanent item within an employee's personnel file.

M. Jury Duty – When full-time employees serve on jury duty the check from the jury duty be reimbursed to the City for service on jury duty during normal working hours; the employee to be paid straight time from the city while serving on jury (Council minutes 8-3-81).

N. Laws and Licenses – Employees must meet and maintain any and all state and federal laws, regulations, certifications and licenses that are required as part of their employment.

O. Lunch and Rest Periods – Schedules for lunch and rest periods are set by individual departments.

P. Outside Employment – A full-time employee working for anyone other than the City must have the outside employment approved by his department chairperson.

Q. Overtime – Overtime is paid at time and one-half cash remuneration. Hourly Police Officers receive overtime after working 86 or more hours in a bi-weekly pay period. (Council Minutes 3/1/2004) All other departments, overtime is computed for hours over forty hours per week. Payment of hours worked on a holiday defined under benefits shall be at double time. (Council minutes 2-3-86).

R. Pay Checks/Periods – Full-time and part-time employee paychecks are issued Friday following the previous Bi-weekly pay period. A pay stub will be issued to the employee and their paycheck will be directly deposited into their checking or savings account. A week is Sunday through Saturday.

S. Probationary Periods – A full-time employee's performance is reviewed by his supervisor after six months from the date of employment During the Probationary period an employee may be discharged with no written notice.

T. Sexual Harassment Policy – The City of Laingsburg prohibits sexual harassment of employees or members of the public by any employee. Supervisors must refrain from sexual harassment, and must also be alert to stop any such conduct occurring in our work place. Sexual harassment is a serious violation of the City's rules, and will subject the violator to discipline, including the possibility of immediate discharge.

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communication of a sexual nature when:

1. Submission to such conduct or communication is made a term or condition either explicitly or implicitly to obtain employment;

2. Submission to or rejection of such conduct or communication by an individual is used as a factor in decisions affecting such individual's employment.

3. Such conduct or communication has the purpose or effect of reasonably interfering with an individual's employment or creating an intimidating, hostile or offensive employment environment.

An employee who believes he or she has been sexually harassed should immediately report such harassment. This also includes anyone who is an unwilling participant in a romantic relationship with another employee or member of management. Such a report should be made either to the head of the department, chair of the committee or the City Council. If the department head receives a report of sexual harassment, he/she will report it to the Chair of the Committee or a member of the City Council.

The City of Laingsburg will make every effort to promptly investigate any report of sexual harassment in as confidential manner as possible and take appropriate corrective action if warranted. Any employee who is determined, after an investigation, to have engaged in sexual harassment, he/she will report it to the Chair of the Committee or a member of the City Council.

The City of Laingsburg will make every effort to promptly investigate any report of sexual harassment in a confidential manner as possible and take appropriate corrective action if warranted. Any employee who is determined, after an investigation, to have engaged in sexual harassment in violation of this policy will be subject to appropriate disciplinary action, up to and including discharge.

U. Sexual Harassment Policy – Police Department – The City of Laingsburg Police prohibits sexual harassment of employees or members of the public by any employee. Supervisors must refrain from any sexual harassment and must also be alert to stop any such conduct occurring in our work place. Sexual harassment is a serious violation of the Department's rules, and will subject the violator to discipline, including the possibility of immediate discharge.

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communication of a sexual nature when:

1. Submission to such conduct or communication is made a term or condition either explicitly or implicitly to obtain employment.

2. Submission to or rejection of such conduct or communication by an individual is used as a factor in decisions affecting such individual's employment.

3. Such conduct or communication has the purpose or effect of reasonably interfering with an individual's employment or creating an intimidating, hostile or offensive employment environment.

An employee who believes he or she has been sexually harassed should immediately report such harassment. This also includes anyone who is an unwilling participant in a romantic relationship with another employee or member of management. Such a report should be made either to the Chief of Police or to the Chair of the Police Committee. If the Chief of Police receives a report of sexual harassment, he/she will report it to the Chair of the Police Committee.

The City of Laingsburg will make every effort to promptly investigate any report of sexual harassment in as confidential manner as possible and take appropriate corrective action if warranted. Any employee who is determined, after an investigation, to have engaged in sexual harassment in violation of this policy will be subject to appropriate disciplinary action, up to and including discharge.

V. Sick Leave – An employee must obtain approval of the city physician prior to:

1. Returning to city employment after being on sick leave.
2. City employment while on sick leave from other employer.

W. Solicitation on City Property – Because the City does not endorse or give preference to anyone or group, no one is allowed to solicit on City property.

X. Suggestions – Operational improvements many times originate at the employee level. Suggestions should be forwarded to the committee chairperson.

FULL-TIME EMPLOYEES' BENEFITS

a. Eligibility: All new full-time employees will be eligible for employee benefits once they have successfully completed sixty-days of their probationary period. (Affordable Care Act 1/1/2014)

   Part-time employees of the City of Laingsburg that are promoted to full time status and have worked for the City of Laingsburg on a continuous basis for at least six months will become immediately eligible for full time employee benefits, otherwise the employee must meet the 60-day waiting period from original date of hire. Health insurance, life insurance and short-term disability eligibility would be at the beginning of the month following the effective date of the promotion to full time status. (Affordable Care Act 1/1/2014)

b. Bereavement Leave – Be granted up to five days for employee's spouse, employee's and employee's spouses children, parents; three days for employees and employees spouses brother, sister, grand parents. All days are considered as working days.

c. Health Insurance – The City offers health insurance coverage for full-time employees and their family members. Employees that are eligible for health insurance coverage are offered Health Insurance as described in the Group Benefits package. Benefits are subject to change based on contract pricing and council approval. A Flexible Reimbursement Account is available, with the City allotting a given amount per policy to the employee using the health insurance, this amount will vary based on insurance contracts and deductibles. The employees will be allowed to add pretax dollars for an account total of $2,500. A third party administrator will administer the Flex Account reimbursements. City will pay full insurance premium. (Council Minutes 5-12-03) Full-time employees who "opt out" of taking the Health Insurance will receive $1,000 in a Flexible Spending Account, and $1,200 with the option to be paid out to the employee or added their Flexible Spending Account. (Council Minutes 6-2-03)

d. Holiday Schedule – The City of Laingsburg recognizes the following holidays off with pay (pay = eight hours regardless of shift – Minutes 3/1/2004): New Year's Day and Day Before, Martin Luther King, JR. Day, Lincoln's Birthday, Washington's Birthday, Good Friday Afternoon, Memorial Day, 4th of July, Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day and Day After, Christmas Day and Day Before. Full time employees that work City recognized holidays are paid double-time. If a City recognized holiday falls on Saturday the full time employee has Friday off. If the Holiday falls on Sunday the full-time employees shall

have Monday off. Employees who work Easter Sunday will be paid double time.

e. Involuntary Lay-Off – If a full-time employee is laid off from his/her position, it should be acted on by the Council. The following benefits will be continued for the employee while on Lay Off: seniority accumulation; status as an active employee for vacation time qualification; health insurance; unemployment insurance benefits. The following benefits will be continued for the employee for vacation time qualification; health insurance up to the 89th day of Lay-Off; life insurance; unemployment insurance benefits. The following benefits will not be continued during a Lay-Off: usage of sick leave, personal days, bereavement leave; wage continuation insurance; worker's compensation; social security; holiday benefits; pension contribution from the City. Any involuntary lay offs be based on seniority be department and job classification. Employees will be notified five working days previous to a lay off.

f. Life Insurance – Each full-time employee is covered by $20,000 life insurance policy. (council meeting 6-2-97)

g. Other Benefits – The City pays for Social Security, Medicare, Worker's compensation and unemployment insurance, to the extent required by law.

h. Personal Days – Employees are able to have time off with payment for 32 hours per year for personal leave. Personal time is non-accumulate. Payment shall be given for 100 percent of the unused hours payable at the employee's anniversary date.

i. Retirement –The City of Laingsburg joined MERS on 10-1-02. (City Council Minutes 8-5-02) The MERS benefits are as follows: B-2 a 2% multiplier on the final five-year average compensation with ten-year vesting. Full-time employees are required to pay 3% of their income toward their retirement program. See MERS handbook.

j. Sick Days – After the first anniversary employees are able to have time off with payment for 64 hours per year for sick time. Time may be accumulated up to 96 hours. Payment shall be given for 100 percent of the unused sick time accumulated over 96 hours, payable at the employee's anniversary date. During an employee's first year of employment they shall be granted 4 hours per month of sick time. A doctor's statement may be required after an employee has been off work three consecutive working days.

k. Vacations – Employees must take vacations by the following schedule. Request for vacation time should be submitted two weeks in advance to the supervisor. Pay will not be given for unused vacation time.
    i. 1 year 1 week
    ii. 2-4 years 2 weeks

iii. 5-9 years 3 weeks
iv. 10-24 years 4 weeks
v. 25 yrs & over 5 weeks

l. Voluntary Lay-Off and/or Sick Leave of Absence Policy – no benefits to be carried on the employee except Health/Dental Insurance for 89 days, seniority and the drawing of unemployment insurance.

m. Wage Continuation Insurance – To provide income protection 24 hours a day, the City provides insurance which covers 66.67 percent of an employee's gross monthly wage, with a first day accident and eight day illness waiting period, for six months.

REFERENCE TO CITY ORDINANCES AND CITY CHARTER

The City Ordinances and City Charter are mandatory reading material for all full-time employees. The City Ordinances and City Charter are available through the Clerk's office.

HANDBOOK ACKNOWLEDGEMENT

I understand that I am responsible for reading this handbook, familiarizing myself with its contents, and adhering to all of the policies and procedures of the City of Laingsburg, whether set forth in this handbook or elsewhere.

The policies, procedures and benefits described in this handbook are not conditions of employment and this handbook does not create an implied contract between the City of Laingsburg and its employees.

I understand that the City of Laingsburg reserves the right to modify this handbook, amend or terminate any policies, procedures or employee benefit whether or not described in this handbook at any time, with or without notice.

Policies, procedures or employee benefits contained herein were adopted by the City of Laingsburg on or before July, 2019 and supersede previous policy.

I acknowledge that I have read the information within this handbook.

_____ _____

Employee Name Printed Employee Signature/Date

_____

Supervisor Signature/ Date

This signed acknowledgement needs to be submitted to the Treasurer/Clerk office to be placed in the employee's personnel file.

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CITY OF LAINGSBURG

Sexual Harassment Policy

The City of Laingsburg prohibits sexual harassment of employees or members of the public by any employee. Supervisors must refrain form any sexual harassment, and must also be alert to stop any such conduct occurring in our workplace. Sexual harassment is a serious violation of the Cities' rules, and will subject the violator to discipline, including the possibility of immediate discharge.

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communication of a sexual nature when:

1. Submission to such conduct or communication is made a term or condition either explicitly or implicitly to obtain employment;

2. Submission to or rejection of such conduct or communication by an individual is used as a factor in decisions affecting such individuals employment;

3. Such conduct or communication has the purpose or effect of reasonably interfering with an individual's employment or creating an intimidating, hostile or offensive employment environment.

An employee who believes he or she has been sexually harassed should immediately report such harassment. This also includes anyone who is an unwilling participant in a romantic relationship with another employee or member of management. Such a report should be made either to the head of the department, chair of the committee or the City Council. If the department head receives a report or sexual harassment, he/she will report it to the Chair of the Committee or a member of the City Council.

The City of Laingsburg will make every effort to promptly investigate any report of sexual harassment in a confidential manner as possible and take appropriate corrective action if warranted. Any employee who is determined, after an investigation, to have engaged in sexual harassment in violation of this policy will be subject to appropriate disciplinary action, up to and including discharge.

CERTIFICATION AND ACKNOWLEDGMENT
Sexual Harassment Policy

I have been given coy of the /City of Laingsburg Sexual Harassment Policy. I have thoroughly read and reviewed its contents and understand that I am responsible for knowing and complying with its provisions throughout my employment with the City.

I understand that the policy may be amended, deleted, modified or added to from time to time by the City in its sole discretion.

_____ _____

Signature of Employee Date

ENROLL TODAY

MERS 457 Supplemental Savings Program

MERS Municipal Employees' Retirement System

About the Program

The MERS 457 Supplemental Retirement Program offers you a flexible retirement account you manage. You decide how much to contribute, how to invest the assets, and how to plan for the future. One of the benefits of the program is that you have access to your account when you leave employment, even if that's before age 60.

Contributions

The MERS 457 Program is flexible because you determine how much you want to contribute, either a flat dollar amount or a percentage of pay, and you can start, stop, increase or decrease your contributions, without fees or penalties. Your contributions can be made pre-tax or Roth (if your employer has adopted this option). *So how do you decide? Let's start with the basics.*

With a **pre-tax** election you make contributions with pre-tax dollars, so you get a tax break up front, helping to lower your current income tax bill. Your money—both contributions and earnings—grow tax-deferred until you withdraw them. At that time, withdrawals are considered to be ordinary income and taxed at your current tax rate.

With a **Roth** contribution, it's basically the reverse. You make your contributions with after-tax dollars, meaning there's no upfront tax deduction. However, withdrawals of both contributions and earnings are tax-free at age 59½, as long as you've held the account for five years.

So it all comes down to deciding when it's better for you to pay the taxes—now or later. You can access online calculators on the MERS website to help you determine the best option for your goals.

Why Should You Enroll?

Help meet your retirement goals
Experts suggest that you should plan on needing at least 80% of your current income in retirement, so chances are you're going to need to rely on personal savings, over and above your Social Security and other retirement benefits.

Low cost
As a nonprofit organization, the MERS program is the most cost-effective way of saving – putting more of your money to work for you.

It's easy!
You contribute through the convenience of automatic payroll deduction.

One-stop planning
Experienced retirement educators are available to help with any questions you may have.

Our convenient online calculators enable you to estimate what your financial future may look like and help you decide what makes the most sense to reach your goals. Find the *457 Savings Calculator* under Resources at *www.mersofmich.com*.

Who is MERS?

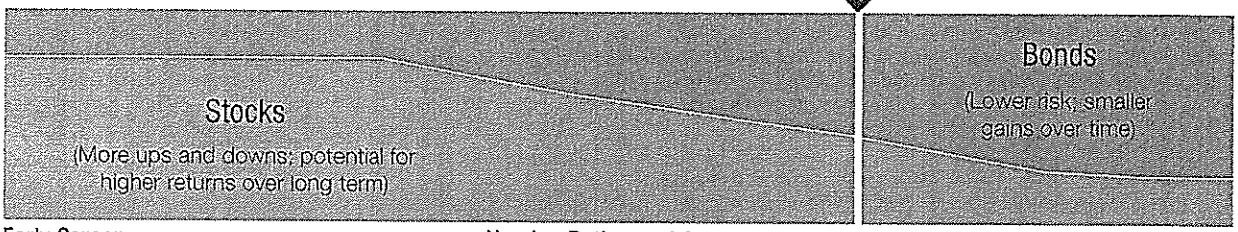
MERS is an independent, professional retirement services company that serves local units of government across the state of Michigan. MERS listens and works in partnership with our members to deliver a superior value that meets our members' needs.

Invest Your Money

While you can't control the markets, you can control where your money is invested. Initially, your money will be invested in an age-appropriate **Retirement Strategy** fund to help you work toward your retirement goals.

How the Retirement Strategy Fund Works

First, you select the year you expect to retire.



Early Career	Nearing Retirement Age	During Retirement
The fund starts out in mostly stocks where higher gains are expected and the risk of losses can be absorbed over time.	The fund automatically shifts to more bonds. They earn less, but the risk of sudden losses is reduced.	Your money stays invested where stable earnings can help offset your withdrawals over time.

You can change your investment allocation online after you sign-up for your myMERS account. For more information on your investment options, please visit our website.

Name Your Beneficiaries

Once your enrollment has been processed, you will be able to designate beneficiaries by logging into your *myMERS* account. This is an important step to ensure your funds are handled appropriately should something happen to you. You may name a spouse, non-spouse, child(ren), a trust and/or charity as a beneficiary.

MERS Helps You Become Retirement Ready

myMERS Online Account offers you a secure login that connects you to your account information, calculators, webinars, and other resources to help you stay on the right retirement track. Visit our website today at ***www.mersofmich.com.***

MERS Service Center is available to assist you with your questions at **800.767.MERS (6377)** or send us a private message through Facebook.

Free, Local Seminars, called *Pizza & Planning*, are held throughout the state during the year. These, along with webinars and Facebook Live events, can provide important information on your MERS plans.

Sign up by visiting the MERS website.

This publication contains a summary description of MERS benefits, policies or procedures. MERS has made every effort to ensure that the information provided is accurate and up to date (as of the date of publication 09/19/2019). If this publication conflicts with the relevant provisions of the Plan Document, the Plan Document controls. MERS, as a governmental plan, is exempted by state and federal law from registration with the SEC. However, it employs registered investment advisors to manage the trust fund in compliance with Michigan Public Employee Retirement System Investment Act. Past performance is not a guarantee of future returns. Please make independent investment decisions carefully and seek the assistance of independent experts when appropriate.

MERS
Municipal Employees' Retirement System

457 Supplemental Savings Program
Quick Enrollment Form

For Employer Use Only

Name of Employer	Division number (6 digits)*	Date of hire/participation (mm/dd/yyyy)*
	4 _ _ _ _ _	☐ Rehire?

Personal Information

Last name*	First name*	MI	Full SSN*

Mailing address*	Gender*	Date of birth (mm/dd/yyyy)*
	☐ Male ☐ Female	

City*	State*	Zip code*	Daytime phone number (with area code)*

Email address	Marital status*
	☐ Single ☐ Married

! Your email address ensures you get important information about your plan(s). Please provide a personal email so we can reach you if you change employment or retire. MERS will never share your personal data for use beyond administration of your benefits.

Contribution Information

All contribution changes will be effective as of the first pay period of the month following the date you submit this form to your employer, or as soon as administratively possible thereafter.

Pre-tax: Amount to be deducted from each pay period	**Roth/after-tax:** Amount to be deducted from each pay period (only available if your employer's program has this option)
_____% **OR** $ _____.00	_____% **OR** $ _____.00

Signature

My signature acknowledges that I have received, read, understand, and agree to this *457 Quick Enrollment Form* and affirms that all information I have provided is true and correct. I have also received all informational material detailing the general program features, the investment options offered, and any and all administrative charges and fees which may be deducted from the account(s) maintained on my behalf. I understand that my rights under the program shall be governed by the terms and conditions of the MERS Plan Document pursuant to all applicable state and federal laws, rules and regulations.

I understand that my contributions will be placed in an age-appropriate Retirement Strategies fund. Once enrolled, I can make changes online or by phone.

Signature*	Last four digits of SSN*	Date (mm/dd/yyyy)*

Please submit your completed form to your Human Resources representative.

To review other investment options, designate beneficiaries, or roll qualified funds into your Defined Contribution account, please visit *www.mersofmich.com*.

* Required field

What's Next?

1 Complete the Enrollment Application
After completing the above information, submit it to your employer.

2 Receive Welcome Email
Once your employer enters your information, MERS will send you a welcome email with more information about your plan.

3 Set up your myMERS account
After receiving your welcome email, visit **www.mersofmich.com** to log in to your myMERS account.

Enter **beneficiary information** and verify contact details *(including email)* are accurate and up to date.

City of Laingsburg Employees:

If you are interested in signing up for **AFLAC** a Folder is available in the Clerks Office for your viewing.

If you are not interested in signing up for **AFLAC**, please sign the attached WAIVER FORM and hand it into the Clerk's Office.

Thank You

Aflac PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name _____

SSN/Emp. ID _____

I hereby authorize my employer:

_____

employer payroll account No. _____ to deduct from my earnings such amounts as may now or hereafter be payable by me under the insurance plan purchased through Aflac. In the event of a rate change, I authorize a corresponding change in the amount deducted from my earnings.

In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.

Signature of Applicant X _____ Date _____

WAIVER OF PARTICIPATION

I certify that the features and benefits of Aflac's supplemental health coverages have been explained to me completely.

I understand that these programs are offered through my employer by payroll deduction.

☐ I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time.

☐ I am currently an Aflac policyholder and have decided not to upgrade to any newer coverages at this time.

EMPLOYEE SIGNATURE _____ DATE _____

Dept No. _____

Location _____

Date of first deduction _____

Deduction Mode: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

PAYROLL ACCOUNT

Mode _____	OLD AFTER-TAX	OLD PRE-TAX	NEW AFTER-TAX	NEW PRE-TAX
☐ Other _____	$		$	
☐ Specified Disease (Cancer) _____	$		$	
☐ Return of Premium Rider _____	$		$	
☐ Dental _____	$		$	
☐ Vision _____	$		$	
☐ LTC _____	$		$	
☐ Hospital Incentive Care _____	$		$	
☐ Specified Health Event _____	$		$	
☐ Hospital Confinement Indemnity _____	$		$	
☐ Accident _____	$		$	
☐ Disability Rider _____	$		$	
☐ Short-Term Disability _____	$		$	
☐ Life _____				
Employee	$		$	
Dependent	$		$	
TOTAL	$		$	

The amount of deduction and frequency thereof shall be determined by my employer and based on a plan that will comply with the payment checked above.

Insurance Producer/Agent	Date	Insurance Producer/Agent's Writing No.	Insurance Producer/Agent's Phone No.

Social Security Number
Disclosure Listing

As an employer, The City of Laingsburg is required by federal and state law to use Social Security numbers (SSNs) to report and withhold payroll taxes.

The City will use employee SSNs (including elected and appointed officials, employees, and volunteers to whom compensation is paid) for payroll functions, expense reimbursement, MERS Insurance, Midwest Insurance, Basic Flex and federal and state income tax reporting purposes.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Paula Willoughby.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
CITY OF LAINGSBURG	38-6021103
5. Employer address	6. Employer phone number
114 N. WOODHULL STREET	517-651-6101

7. City	8. State	9. ZIP code
LAINGSBURG	MI	48848

10. Who can we contact about employee health coverage at this job?
PAULA WILLOUGHBY

11. Phone number (if different from above)	12. Email address
	TREASURER@LAINGSBURG.US

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:
    EMPLOYEES CONSIDERED FULL TIME
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    SPOUSES AND CHILDREN
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Police Officer Only

Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.* ☐ Name Change
☐ Add or ☐ Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female

Your Address	City	State	ZIP

Former Name (Last, First, Middle) *Complete only if name change*	Phone Number

Employer Name	Job Title/Occupation

Hours Worked Per Week _____ Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year

Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.*

1. Life and Accidental Death and Dismemberment (AD&D) Insurance

☐ Life (Employer Paid) ☐ Voluntary Life Your requested amount $ _____
☐ Life with AD&D (Employer Paid) ☐ Voluntary Life with AD&D Your requested amount $ _____
☐ Additional/Optional Life ☐ Additional/Optional Life with AD&D Your requested amount $ _____

2. Dependents Life and AD&D Insurance

☐ Spouse Life Requested amount $_____ ☐ Spouse Life with AD&D Requested amount $_____
Spouse Name _____ Date of Birth _____
☐ Child(ren) Life Requested amount $_____ ☐ Child(ren) Life with AD&D Requested amount $_____

3. Voluntary Accidental Death and Dismemberment (AD&D) Insurance

☐ You only $_____ ☐ Your Spouse $_____ or _____ % ☐ Your Child(ren) $_____ or _____ %

4. Supplemental Life Insurance ☐ Your requested amount $_____ ☐ Spouse requested amount $_____

5. Short Term Disability ☐ Employer Paid ☐ Voluntary STD ☐ Buy-up

6. Long Term Disability ☐ Employer Paid ☐ Voluntary LTD ☐ Buy-up

7. Dental (see below) ☐ Employer Paid ☐ Voluntary Dental ☐ Low Dental Plan ☐ High Dental Plan

8. Vision (see below) ☐ Employer Paid Voluntary Balanced Care Vision ☐ Plan 1 ☐ Plan 2 ☐ Plan 3

Dental and Vision *If you are enrolling in Dental and/or Vision, please provide the following information.*

Coverage requested for Dental ☐ You, your Spouse and Children ☐ You and your Spouse ☐ You only ☐ You and your Children (no Spouse)
Coverage requested for Vision ☐ You, your Spouse and Children ☐ You and your Spouse ☐ You only ☐ You and your Children (no Spouse)
Are you covered for dental insurance under another plan? ☐ Yes ☐ No Are one or more Dependents? ☐ Yes ☐ No

List Dependents to enroll or delete. (Last name if different, First, Middle Initial)	Sex M	Sex F	Date of Birth	*List Dependents to enroll or delete.* (Attach sheet for additional Dependents if needed.)	Sex M	Sex F	Date of Birth
Spouse				Child 2			
Child 1				Child 3			

Dental and Vision Insurance Waiver: Contributory Dental and/or Vision Insurance

The Insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the Insurance coverage may be subject to a Late Enrollment Penalty.

I decline ☐ Dental and/or ☐ Vision Insurance for myself. I decline ☐ Dental and/or ☐ Vision Insurance for one or more Dependents.

Beneficiary *This designation applies to coverage available through your Employer, if any, under Coverage Section 1 or 3 above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to coverage available through your Employer, if any, under Coverage Section 4 above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.*

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr)_____

Return completed form to your Human Resources Department.

Allstate.

Workplace Division

GROUP INSURANCE ENROLLMENT FORM TO:
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

For Home Office use only

Group No.	Account
Dep Code	Location Code
EFFECTIVE DATE	

Please print with black ink.

EMPLOYEE'S NAME Last (Sr, Jr, etc) First M. I.	SEX	SOCIAL SECURITY NUMBER – –	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)		CITY / STATE / ZIP	
BIRTHDAY (MM/DD/YR)	PHONE NUMBER	EMPLOYER	DATE OF HIRE (MM/DD/YR)
JOB TITLE	PLANT OR DIVISION	CURRENT EARNINGS $_____ ☐ Hourly ☐ Bi-weekly (26) ☐ Monthly ☐ Semi-monthly (24) ☐ Weekly ☐ Annually	
BENEFICIARY'S NAME (Last, First, M.I.)	RELATIONSHIP		

AHL minimedical® ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 2 ☐ Plan 3	☐ Employee Only ☐ Employee + 1 ☐ Family	Section 125 ☐ Yes ☐ No	**Home Office Use Only** SET ID:_____

If you do not elect MEDICAL coverage, is this because of other health coverage? ☐ Yes ☐ No

Notice of Preexisting Conditions Exclusion: The group health coverage you are applying for may not provide benefits for Preexisting Conditions for a period of 12 months for persons who are enrolled when first eligible or who enroll during a Special Enrollment Period, or for a period of 18 months for persons who are Late Enrollees. This period may be reduced if you had previous Creditable Coverage and furnish American Heritage Life Insurance Company with a Certificate of Creditable Coverage from your prior carrier. Until this certification is received and a determination is made as to whether or not the person is entitled to a reduced period of preexisting conditions exclusions, any claim submitted for a preexisting condition, incurred during the respective 12 or 18 month periods, will be denied. If a Certificate, or other evidence of Creditable Coverage is subsequently received, the claim will be reconsidered.

Short-Term Disability ☐ Yes ☐ No	Benefit Amount per month	Monthly Premium	**Home Office Use Only** STD STD2 STD0 STD3 STDB STD1 STD4

Long-Term Disability ☐ Yes ☐ No	Benefit Amount per month	Monthly Premium	**Home Office Use Only** LTD LTD2 LTD0 LTD3 LTDB LTD1 LTD4

Life / Accidental Death & Dismemberment ☐ Yes ☐ No	Benefit Amount	Monthly Premium	**Home Office Use Only** LIFE AD&D GI _____

Dependent Coverage (If Applicable)					
Spouse	☐ Yes ☐ No	Benefit Amount (Cannot exceed 50% of Employee Amount)	Monthly Premium	**Home Office Use Only** Life AD&D GI_____
Child(ren)	☐ Yes ☐ No	Benefit Amount (Cannot exceed 50% of Employee Amount)	Monthly Premium	**Home Office Use Only** OPT A OPT C OPT B OPT D

Have you used tobacco in any form in the last 12 months? **EMPLOYEE:** ☐ Yes ☐ No **SPOUSE:** ☐ Yes ☐ No

If "Yes," indicate the type and date last used (Employee):_____

If "Yes," indicate the type and date last used (Spouse):_____

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____
Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No If "Yes," please enter the date coverage effective:_____				**Home Office Use Only** P1NG1 P1NG2 P1NG3

Cancer / Specified Disease ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Benefits	Hospital	Radiation/ Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option ☐	Intensive Care Option ☐	Cancer Screening Option ☐
Units				1			

To your knowledge, is this a change to your existing AHL Cancer/Specified Disease coverage? ☐ Yes ☐ No
If "Yes," please enter certificate number and date of the qualifying event.
Certificate No._____ Date of Qualifying Event _____

Accident Insurance ☐ Yes ☐ No	Base Units _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Optional Disability Riders for Employee and Spouse

☐ Off the Job Accident
☐ On and Off the Job Accident
☐ Off the Job Accident and Sickness
☐ On and Off the Job Accident and Sickness
☐ On and Off the Job Accident for Insured Spouse*
☐ On and Off the Job Accident and Sickness for Insured Spouse*

***Available only when family coverage is selected and the Insured Spouse has worked 25 hours per week for 3 consecutive months.**

Disability Rider Units
Employee _____
Spouse_____

Premium/Billing Mode	Case Number	Agent Number	Percentage Credit
☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly			%
☐ Weekly ☐ Other_____	Employee Number		%
Requested Issue Date_____			%
Date of First Deduction_____	Situs State		%
Cash With Application_____			%

DEPENDENT COVERAGE SECTION *(Please complete if dependent coverage elected)*

Choose Plans: Medical	Life	Dental	Cancer	Accident	Dependents Name (Last, First, M. I.)	SEX	Date of Birth (MM/DD/YR)	Social Security Number
					Spouse			– –
					Child			– –
					Child			– –
					Child			– –
					Child			– –

A SPECIAL DEPENDENT STATEMENT (G-4014-05/96) must be completed for any dependent children listed above who have a **different last name** from you and/or do not **live with you** and/or if they are **over 18** years of age.

ACCEPTANCE: I hereby request all coverage checked "yes" above for which I am or may become eligible under the group coverages issued by the American Heritage Life Insurance Company. I authorize my employer to deduct from my earnings any contributions required of me for the payment of premiums for such coverage. I UNDERSTAND that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment form is signed.

WAIVER/DECLINATION: I understand that if I refuse any coverage for which I am eligible (by checking NO above), satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

Date Signed_____ Employee's Signature_____