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 (Full-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. Sexual Harassment Policy with receipt of acknowledgment
9. MERS- Voluntary Deduction- 401K or Roth Enrollment
10. AFLAC
11. Social Security Disclosure
12. Health Insurance Coverage
13. All-State Enrollment/Waiver

AFTER 6 Months

1. MERS Retirement Beneficiary Form
2. Health Insurance Enrollment/Waiver
3. Basic Flex
4. The Standard

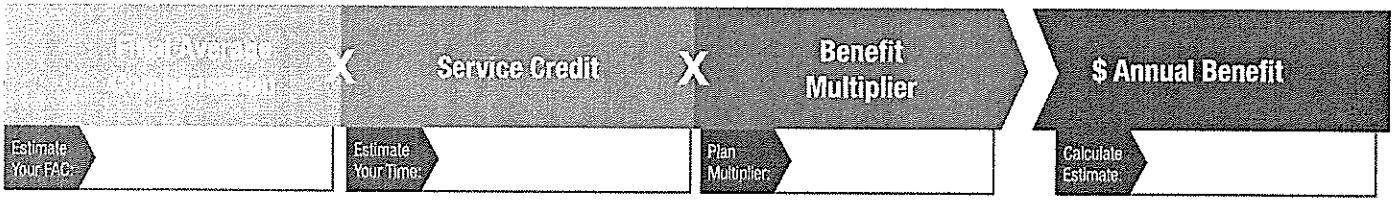
ENROLL TODAY

MERS Defined Benefit Plan

MERS® Municipal Employees' Retirement System

How the Retirement Plan Works

The MERS Defined Benefit Plan is a retirement plan offered to you through your employer. This benefit provides you with a **lifetime pension** payment in retirement once you become vested (see the Vesting section below for more details). Your benefit amount will not fluctuate with investment gains or losses; instead, it is calculated based on the formula below. Check with your employer or log on to your myMERS account for the provisions and details that apply to you.



Final Average Compensation (FAC) is the average of the highest consecutive wages over a period of time as determined by your employer.

Service Credit is the total amount of all your qualifying months of work (this can include purchases of service credit). You earn service credit for each month of work that meets your employer's requirement.

The Benefit Multiplier is a percentage chosen by your employer and typically ranges from 1.0% to 2.5%.

Estimating your benefit is easy using the online calculator through your myMERS account.

Contributions

You may be required to contribute to the MERS Defined Benefit Plan.

Your employer sets the required contribution rate. Your contributions don't change your benefit formula, but they do help meet funding needs.

Contribution Requirement:

Vesting

Vesting refers to your eligibility to receive a pension benefit when you meet retirement age. It is based on a required amount of time you must work (or other service credit) to qualify.

There are two other types of service you may have earned from a participating municipality that could help you meet your vesting and early retirement eligibility requirements: **MERS-to-MERS** and the Reciprocal Retirement Act (also known as **Act 88**).

Vesting Requirement:

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.

Name Your Beneficiaries

One of the most important things you can do for yourself and your family is to name beneficiaries and keep your information updated.

You can update beneficiary and contact information any time by logging into your myMERS account through the MERS website.

A **Monthly Pension Beneficiary** is one person who would receive a lifetime benefit if you are *vested* and die before you begin collecting your retirement benefits (or if you die as a result of work duties). If married, your spouse must be named your *Monthly Pension Beneficiary* unless they waive this right in writing.

A **Refund Beneficiary** is a person(s), trust, estate or charity that receives a refund of your employee contributions (plus interest) if you die *before* you are vested. If married, your spouse must be named your *Primary Refund Beneficiary* unless they waive this right in writing.

You'll also be asked to provide a *Contingent Refund Beneficiary* in case your *Primary Refund Beneficiary* is deceased.

Retirement Eligibility

You are eligible for retirement benefits once you meet the age and service requirements of your employer's plan provisions:

- If you are vested, the standard retirement age is 60.

Other early retirement options are available if adopted by your employer:

- At age 50 with either 25 or 30 years of service
- At age 55 with either 15, 20, 25, or 30 years of service
- At any age with a minimum of 20-30 years of service, in whole numbers

Reduced retirement benefits:

- Must meet the requirements of age 55 with 15 years of service or age 50 with 25 years of service to qualify
- Benefit is permanently reduced by 0.5% per month the participant is under age 60

Retirement Eligibility Requirement:

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.

MERS
Municipal Employees' Retirement System

Defined Benefit Retirement Plan Enrollment Form

Personal Information

Last name*	First name*	MI	Full SSN*

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

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

Email address	Marital status* ☐ Single ☐ Married

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

* 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.

MERS®
Municipal Employees' Retirement System

Municipal Employees' Retirement System of Michigan
1134 Municipal Way • Lansing, MI 48917
800.767.MERS (6377) • Fax: 517.703.9706
www.mersofmich.com

Defined Contribution Beneficiary Designation Form

Please print clearly • See attached guide for details • Retain a copy for your records

For employer use only – Return completed copy of form to MERS

Name of employer*	Municipality number (4 digits)*	Division number (6 digits)*
City of Laingsburg	7608	760801

1. Information about you

Last name*	First name*	MI	Last four digits of SSN*

Email address

Marital status* ☐ Single ☐ Married

Are you changing beneficiaries as a result of divorce or death?	If "Yes," include with this form a complete copy of the judgment of divorce and any Eligible Domestic Relations Order (EDRO) entered by the court, or death certificate.
☐ Yes ☐ No	Former beneficiary's (or spouse's) full name

2. Primary beneficiary

If you are married, **your spouse is automatically your primary beneficiary (100%)** and can be entered below. If you want to name someone other than your spouse, include their information in the space provided, and your spouse must sign the spousal consent section below.

I hereby designate the following as primary beneficiary(ies) of my account under the plan if I should die prior to the payout of my account.

Name of primary beneficiary* (Spouse, if applicable)	Relationship*	SSN*	Date of birth (mm/dd/yyyy)*	Percentage*

If you want to add more beneficiaries, please attach a separate list that you have signed and dated. Must equal 100%

Spousal consent of forfeiture *(if applicable):*
By my signature, I voluntarily and knowingly forfeit ("give up") my automatic right to be my spouse's primary beneficiary.

Signature of spouse	Spouse full name (please print clearly)	Date (mm/dd/yyyy)

Witness signature *(required if someone* ***other than spouse*** *is named as survivor beneficiary):*
A witness must be present to verify spouse signing, be at least 18, and not have a financial interest in the form (such as a beneficiary.)

Witness signature	Witness name (please print clearly)	Date (mm/dd/yyyy)

* Required field

Defined Contribution Beneficiary Designation Form

3. Contingent beneficiary

In the event there is no living primary beneficiary(ies) at my death, I hereby designate the following person(s) as contingent beneficiary(ies) of my account under the plan.

Name of contingent beneficiary*	Relationship*	SSN*	Date of birth (mm/dd/yyyy)*	Percentage*

If you want to add more beneficiaries, please attach a separate list that you have signed and dated.

Must equal 100%

4. Required signature

I have completed, understand, and agree to all pages of this *Defined Contribution Beneficiary Designation Form*. I hereby revoke all prior beneficiary designations (if any).

Participant signature*	Date (mm/dd/yyyy)*

Participant name (please print clearly)*	Last four digits of SSN*

* Required field

Step-by-Step Guide to Completing the Defined Contribution Beneficiary Designation Form

This form is available for download at *www.mersofmich.com*.

Please print clearly. Fields with an asterisk (*) are required fields and must be completed to submit the form accurately.

The Employer Verification* section should be filled out by your employer, so proceed directly to Step 1. Information about you.

1. Information about you*

This section gathers basic information about you – your legal name and Social Security number, and current marital status. If you are changing your beneficiary due to divorce or death, check the "Yes" or "No" box. If you check the "Yes" box, due to a divorce, include all pages of the final copy from the judgment of divorce and any eligible domestic relations order (EDRO/QDRO) ordered by the court. Be sure to enter your spouse's full legal name. If you are completing this form for the first time or have made recent changes to your personal information, please be sure to complete the *Personal Information Form (MD-001)*. You can download the form at *www.mersofmich.com* or call 800.767.2308 to have a form mailed to you.

2. Primary beneficiary

If you are married, your spouse is always your primary beneficiary. Enter their name and information in the table and the percent of benefit to be paid.

If you wish to name someone other than your spouse (or in addition), your spouse must sign in the "*Spousal consent of forfeiture*" box to waive his or her rights. Additionally, you will need to have a third-party witness present when they sign the form who can verify that the signature on the form is your spouse's. A witness must be over the age of 18 and not have an interest in the form (i.e., not be your spouse or listed as a beneficiary on the form).

If listing more than one person, the percentage total must equal 100%.

If you want to add more beneficiaries, please attach a separate list that you have signed and dated.

3. Contingent beneficiary

In the event there is no primary beneficiary(ies) upon your death, please designate your contingent beneficiary(ies). Please list their name, relationship to you, Social Security number, date of birth, and the percentage they are to receive. If listing more than one person, the percentage total must equal 100%.

If you want to add more beneficiaries, please attach a separate list that you have signed and dated.

4. Required signature*

Your signature acknowledges that you have read and agree to the terms of this agreement. Your signature voids all prior designations of beneficiaries.

MERS will only use the information listed on this form for identification and documentation only. Your Social Security numbers are classified information and will not be shared without your written consent.

Submitting this form:

- If you are an active member:

  Please give it to your current employer

- If you are no longer with the employer, please mail or fax it to MERS at:

  Municipal Employees' Retirement System of Michigan
  1134 Municipal Way
  Lansing, MI 48917

  Fax: 517.703.9706

Questions? Please contact us at 800.767.MERS (6377).

If you have speech or hearing difficulties and need assistance completing this form, contact the Michigan Relay Center at 800.649.3777. If you have other disabilities, contact MERS at 800.767.MERS (6377) to request special accommodations.

ENROLLMENT FORM

Company Name: _____

Participant Name: _____ Social Security Number: ___-___-___
(Please Print All Information)

Address: _____ Date of Birth: _____

City, State, Zip: _____ Phone Number: _____

Pay Period: ❑ Weekly ❑ Semi-Monthly

E-Mail Address: _____ ❑ Bi-Weekly ❑ Monthly

❑ New Hire ❑ Key Employee (Officer or Owner) ❑ Open Enrollment

❑ Change in Status Explanation: _____

---

1 PREMIUM CONTRIBUTIONS

I elect to participate. ❑ Yes ❑ No

The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer. This amount will be changed as necessary, if premium charged by the insurance company changes.

Check all that apply:

❑ Health Insurance ❑ Group Life Insurance ❑ Disability Insurance ❑ Dental Insurance
❑ Other(s) _____

---

2 MEDICAL REIMBURSEMENT ACCOUNT

I elect to participate. ❑ Yes ❑ No

(not to exceed Employer Limit_____)

$ _____ per pay x _____ (# of pays) = $ _____ Annually (do not round)

EMPLOYER MUST COMPLETE FOR MID YEAR ENROLLMENTS

Date of First Deduction: _____

Eligibility Date: _____

---

3 DEPENDENT CARE ACCOUNT

I elect to participate. ❑ Yes ❑ No

(not to exceed $5000, or $2500 if married filing separately)

$ _____ per pay x _____ (# of pays) = $ _____ Annually (do not round)

EMPLOYER MUST COMPLETE FOR MID YEAR ENROLLMENTS

Date of First Deduction: _____

Eligibility Date: _____

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

Complete and return to your benefits coordinator.

Plan Year Start _____
End _____

Admin Use Only
Ent _____
File _____

B•A•S•I•C
Human Resource Connection
Benefit Administrative Services International Corporation
9246 Portage Industrial Drive
Portage, Michigan 49024
1-800-444-1922 • 269-327-1922 • FAX 269-327-0716
Email: basic@basicflex.nu • Website: http://www.basicflex.com

REV 9-02

TEAR ALONG THIS LINE

DIRECT DEPOSIT AUTHORIZATION

Employer Name: _____

Employee Social Security Number: _____

Employee Name: _____

Internet E-Mail Address*: _____

*Internet e-mail required for direct deposit notification. If no e-mail address is provided you will not be notified of your claim payment.

To check claim and/or payment status, you can view your account at www.basicHR.nu on the Internet or use OmniLine at (800) 444-1922 ext. 487

Please direct deposit my Medical and/or Dependent Care Reimbursement into the following account (choose one):

Checking Account ❑ Savings Account ❑

Financial Institution _____

<u>You MUST attach a copy of a VOIDED CHECK for a checking account deposit</u>. If you want to deposit into a savings account, please check with your financial institution for the proper routing number of the account the deposit is to be made to and attach a copy of the deposit slip.

Direct deposits will begin approximately 2 weeks after we receive this information from you. Funds are available within two business days of the date BASIC processed the claim.

I understand that **ALL** reimbursements will be direct deposited into my account.

Employee Signature _____ Date_____

TAPE VOIDED CHECK HERE
<u>(DO NOT STAPLE)</u>

B•A•S•I•C
Human Resource Connection

9246 Portage Industrial Drive
Portage, Michigan 49024
269.327.1922 • 800.444.1922 extension 1

TEAR ALONG THIS LINE

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

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:

  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.