PALESTINE - WHEATLEY SCHOOL DISTRICT

OFFICE OF THE SUPERINTENDENT
P. O. Box 790
Palestine, Arkansas 72372
Phone Number: 870-581-2646 Fax Number: 870-581-4420

New Employee Checklist

Employee Information Form	
Copy of Transcript	
Arkansas Educator License	
Verification of Employment Form from Previous Employer	
Copy of Social Security Card	
Copy of Driver's License	
Copy of Birth Certificate	
AR4EC – State of Arkansas Tax Form	
W-4 Form	
I-9 Form	
Direct Deposit Form	
EBD Health Insurance Enrollment Form	
Eb*i* New Hire Information Form (Dental/Vision/FSA Enrollment)	
Colonial Life Insurance Form	
Arkansas Teacher Retirement Membership Data Form	
Arkansas Teacher Retirement Lump Sum Death Benefit Form	
Arkansas Teacher Retirement Deposition of Residue Form	
Arkansas New Hire Reporting Form	
Arkansas Department of Education Background Check Receipt Copy	
Department of Human Services Child Maltreatment Receipt Copy	

All items must be completed and returned to Tammy Roberts, Assistant Bookkeeper within 5 days. A check <u>will not</u> be issued until all items/forms are completed and returned.

<u>Every</u> employee must complete the Arkansas Department of Education Background Check and Department of Human Services Child Maltreatment – NO EXCEPTIONS! Copies of receipts should be turned in to Tammy Roberts, Assistant Bookkeeper.

Palestine – Wheatley School District

Employee Information Form

Personal Information:

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Home Phone Number: _____ **Alternate Phone Number:** _____

Date of Birth: _____ **Social Security Number:** _____

Email: _____

Emergency Contact Information:

Full Name: _____
Last First

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Home Phone Number: _____ **Alternate Phone Number:** _____

Relationship: _____

VERIFICATION OF TEACHING EXPERIENCE

SECTION I: TO BE COMPLETED BY APPLICANT. APPLICANT MUST SEND THIS FORM TO ALL EMPLOYERS TO VERIFY CONTRACTED TEACHING EXPERIENCE.

SOCIAL SECURITY NUMBER		
CURRENT NAME (LAST, FIRST, MIDDLE)		
ALL MAIDEN/ FORMER NAMES		
STREET ADDRESS		
CITY, STATE, ZIP CODE	EMAIL ADDRESS	
DATE OF BIRTH	MALE ☐ FEMALE ☐	PHONE NUMBERS H

I hereby give my former and/ or current employer permission to release any and all information required in Section II

LEGAL SIGNATURE OF APPLICANT	DATE

SECTION II: TO BE COMPLETED BY EMPLOYING SCHOOL SYSTEM

The above named individual was employed as a teacher in our school system as verified below

SUBJECT/AREA TAUGHT	GRADE LEVEL(S)	BEGINNING DATE	ENDING DATE	TOTAL YEARS AT THIS LEVEL

ADMINISTRATIVE EXPERIENCE:

POSITION/JOB TITLE	GRADE LEVEL(S) SERVED	BEGINNING DATE	ENDING DATE	TOTAL YEARS AT THIS LEVEL

SUMMATIVE EVALUATION DATE:

EFFECTIVE TEACHER STATUS:

	EFFECTIVE ☐		HIGHLY EFFECTIVE	☐

NAME OF SCHOOL SYSTEM		
SCHOOL ADDRESS		
CITY, STATE, ZIP CODE		
ADMINISTRATOR'S NAME (PRINT)	ADMINISTRATOR'S POSITION	SCHOOL PHONE NUMBER
ADMINISTRATOR'S SIGNATURE	DATE	

Please return this form to:

Palestine – Wheatley School District
Tammy Roberts, Assistant Bookkeeper
P.O. Box 790
Palestine, Arkansas 72372
Fax: 870-581-4420 OR
troberts@pwsd.k12.ar.us

AR4EC

STATE OF ARKANSAS
Employee's Withholding Exemption Certificate

Print Full Name _____ Social Security Number _____

Print Home Address _____ City _____ State _____ Zip _____

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

Employer: Keep this certificate with your records.

How to Claim Your Withholding
See instructions below

	Number of Exemptions Claimed
1. CHECK ONE OF THE FOLLOWING FOR EXEMPTIONS CLAIMED	
a. ☐ You claim yourself. *(Enter one exemption)* 1a	
b. ☐ You claim yourself and your spouse. *(Enter two exemptions)* 1b	
c. ☐ Head of Household, and you claim yourself. *(Enter two exemptions)* 1c	
2. NUMBER OF CHILDREN or DEPENDENTS. *(Enter one exemption per dependent)* 2	
3. TOTAL EXEMPTIONS. *(Add Lines 1a, b, c, and 2)* If no exemptions or dependents are claimed, enter zero 3	
4. Additional amount, if any, you want deducted from each paycheck. *(Enter dollar amount)* 4	
5. I qualify for the low income tax rates. *(See below for details)* ..... 5 Please check filing status: ☐ Single ☐ Married Filing Jointly ☐ Head of Household	☐ Yes ☐ No

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

Signature: _____ Date: _____

Instructions

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

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

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

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

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

(b) The support you provide to a dependent for whom you claimed an exemption is expected to be less than half of the total support for the year.

OTHER DECREASES in exemptions or dependents, such as the death of a spouse or a dependent, does not affect your withholding until next year, but requires the filing of a new certificate by December 1 of the year in which they occur.

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

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

(a) Single	$12,260	to	$15,900
(b) Married Filing Jointly (1 or less dependents)	$20,675	to	$25,500
(c) Married Filing Jointly (2 or more dependents)	$24,883	to	$31,800
(d) Head of Household/Qualifying Widow(er) (1 or less dependents)	$17,431	to	$22,500
(e) Head of Household/Qualifying Widow(er) (2 or more dependents)	$20,778	to	$25,400

For additional information consult your employer or write to:

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

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

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)*

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		
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		**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		

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.

Palestine – Wheatley School District
Direct Deposit Form

Employee Name: _____

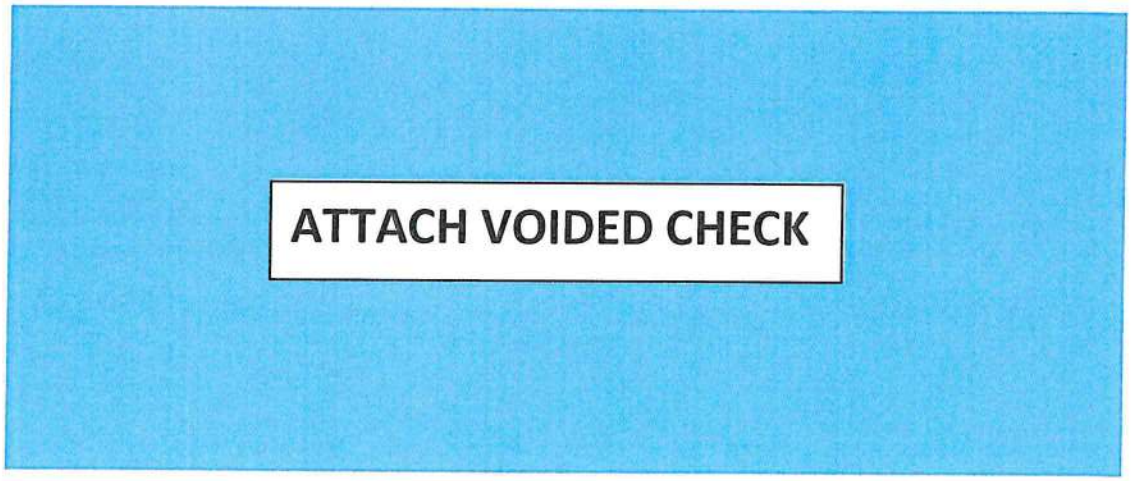
Social Security Number: _____

Name of Bank: _____

Routing Number: _____ **Account Number:** _____

Employee Signature: _____

VOIDED CHECK MUST BE ATTACHED. PLEASE RETURN TO TAMMY ROBERTS IN THE CENTRAL OFFICE AS SOON AS POSSIBLE.



***PLEASE NOTE: There are (2) Pre-notes required before your check will be deposited.**

****

CENTRAL OFFICE USE ONLY

1ST PRENOTE: _____ **2ND PRENOTE:** _____ **DEPOSIT:** _____

Affidavit of Spousal Health Care Coverage

ARBENEFITS

This Affidavit must be completed for consideration to cover a spouse.

Employee Name:		**Employee SSN:**	
Spouse Name:		**Spouse SSN:**	

To be completed by employee electing to enroll a spouse in coverage.

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

1. Is your spouse currently employed?

   ☐ **Yes** (If yes, please proceed to question #2)

   ☐ **No** (If no, sign and return this form along with your election form and a copy of your Marriage License.)

2. Is your spouse currently employed by an Arkansas state agency or public school district?

   ☐ **Yes** (If yes, sign and return this form along with your election form and a copy of your Marriage License.)

   ☐ **No** (If no, proceed to question #3)

3. Does your spouse's employer offer health insurance coverage?

   ☐ **Yes** ☐ **No**

4. Is your spouse covered by his/her employer sponsored health plan?
   ** If No, please submit information from your spouse's employer as to why your spouse is not covered.*

   ☐ **Yes** ☐ **No**

5. Does your spouse's employer sponsored coverage meet the Affordable Care Act (ACA) minimum guidelines?
   ** If No, please provide information from your spouse's employer stating that coverage does not meet ACA guidelines.*

   ☐ **Yes** ☐ **No**

For any questions or concerns, contact EBD Member Services at 1-877-815-1017x1

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

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

AR BENEFITS

RESET PRINT

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

ACTIVE STATE & PUBLIC SCHOOL ENROLLMENT ELECTION FORM

Part 1: Employee Information

First Name	MI	Last Name	Date of Birth	Gender ☐M ☐F	Social Security Number

Agency/School District Name (Required):	Group#	Home/Cell Phone Number	Work Phone Number
Palestine - Wheatley School District	046205		

Home Address	City	State	Zip Code

Part 2: Coverage

Reason for Enrollment

- ☐ Open Enrollment
- ☐ New Hire Period
- ☐ Qualifying Event

Type of Action

- ☐ Enroll in the Plan
- ☐ Decline Coverage
- ☐ Add/Drop Dependent

Select a Benefit Option

☐ Premium ☐ Classic ☐ Basic

Select a Coverage Level

☐ Employee Only ☐ Employee & Child(ren)
☐ Employee & Spouse ☐ Employee & Family

☐ *Please only check this box if you wish to have your premiums withheld on a post-tax basis.*

Part 3: Add Dependents

Check the appropriate column to ADD eligible dependents not currently covered and/or DROP currently covered dependents.

Proof of a dependent's eligibility must be submitted with this application for all dependents.

To complete the RELATIONSHIP column, use the number that describes your dependent(s).

Spouse - 1, Child - 2, Permanent Legal Guardianship - 3

Add	Drop	Name (First, MI, Last)	Date of Birth	Social Security Number	Male	Female	Relationship
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Part 4: Subscriber Certification

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

Employee Signature	Date	Email Address:

SUBMISSION TO EBD IS FINAL

ARBenefits • Department of Transformation and Shared Services • Employee Benefits Division
Post Office Box 15610 • Little Rock, AR 72231-5610 • Fax: 501.683.0983

Instruction Page

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

Social Security Numbers are required for enrollment. If you do not provide a Social Security Number for yourself or your dependents, health insurance coverage cannot be provided. Exception: A newborn's Social Security number will be accepted after enrollment but must be sent in once it is received.

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

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

You should receive plan information and ID cards in a timely manner from ARBenefits. If you do not, call ARBenefits at 1-877-815-1017 (When you hear the recording, Just Press One).

Your elections will remain in effect for the remainder of the calendar year unless you experience a qualifying status change event, as defined by the ARBenefits Summary Plan Description.

Your effective date of coverage will be the first of the month following date of application and following your qualifying event. Note: The qualifying event is not the date of eligibility.

Pre-tax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. You will automatically be in a pre-tax status unless you otherwise notify your payroll clerk.

Members who turn age 65 or become eligible for Medicare must send in a copy of their Medicare card to ARBenefits.

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

Adding a spouse:

* Copy of marriage license
* Completed ARBenefits Spousal Affidavit available at www.transform.ar.gov/employee-benefits

Adding a dependent child:

* Newborns - Birth certificate or hospital birth announcement that includes child's parents and date of birth (up to 6 months of age)
* Child - Copy of child's birth certificate
* Step-child - Copy of marriage license to the step-child's parent and a copy of the child's birth certificate
* Legal Guardianship - Court-approved guardianship papers (with signature & seal)

Completed election forms can be submitted to EBD by fax, mail, or online through the ARBenefits Member Portal at www.transform.ar.gov/employee-benefits/arbenefits.

For assistance, contact ARBenefits at 1-877-815-1017 Monday through Friday, from 8:00 a.m. to 4:30 p.m. CST. Learn more about plans, costs and provider at www.transform.ar.gov/employee-benefits

Palestine-Wheatley School District

NEW HIRE INFORMATION

Educational BENEFITS

Name _____ SS# _____ Gender _____

Home Address _____ City, State _____ Zip _____

Date of Birth _____ Job Title _____ Department _____

Work # _____ Cell # _____ Email _____

Date of Hire _____ Hours/week _____ Annual Salary _____

Certified/Classified _____ Employee ID# _____

Dependent Information					
First Name	Last Name	DOB	SSN	Gender	Relationship to Employee

DENTAL COVERAGE (DELTA DENTAL)

COVERAGE TIER	SEMI-MONTHLY RATES
☐ Employee	$17.24
☐ Employee/Spouse	$34.48
☐ Employee/Child(ren)	$39.65
☐ Family	$47.67

VISION COVERAGE (EYEMED)

COVERAGE TIER	SEMI-MONTHLY RATES
☐ Employee	$3.62
☐ Employee + Spouse	$6.87
☐ Employee + Child(ren)	$7.23
☐ Family	$10.63

FLEXIBLE SPENDING ACCOUNT (ACUITY)

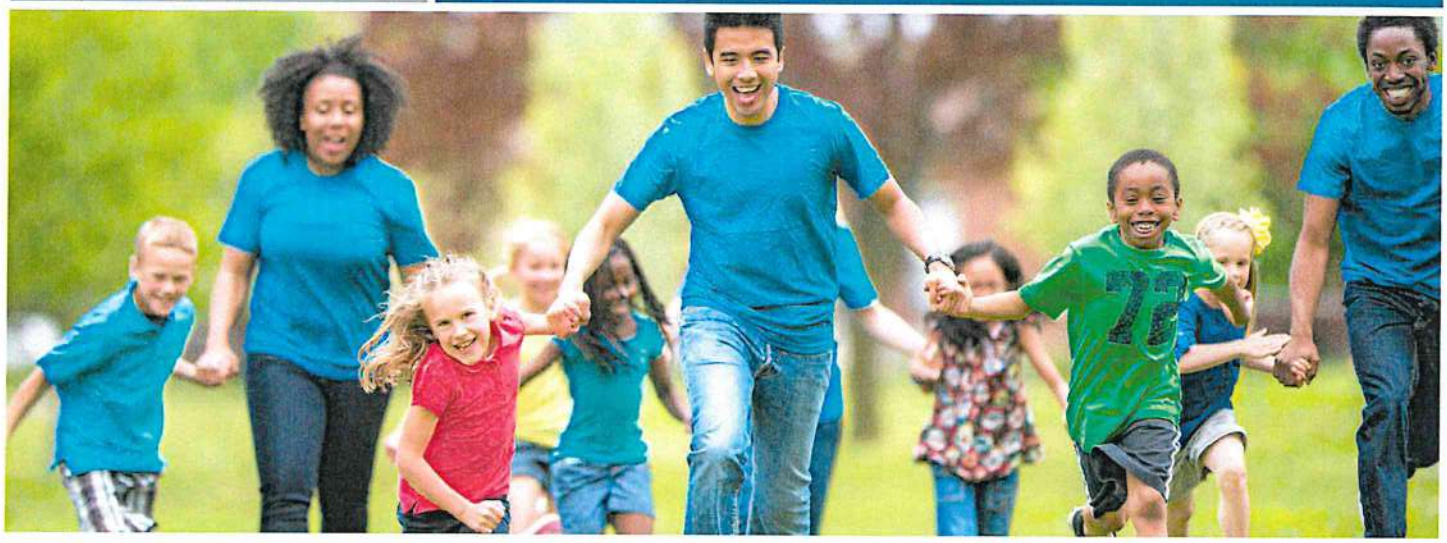
Elect FSA	AMOUNTS
☐ Medical Reimbursement	$2,750
☐ Dependent Care Reimbursement	$5,000
☐ Third Party Insurance	$9,999

Amount Per Month: _____

Signature _____ Date _____

Colonial Life

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



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

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

There are two convenient options to enroll:

1. Enroll with a telephonic Colonial Life benefits counselor.

Ask benefits questions and complete your enrollment by calling:

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

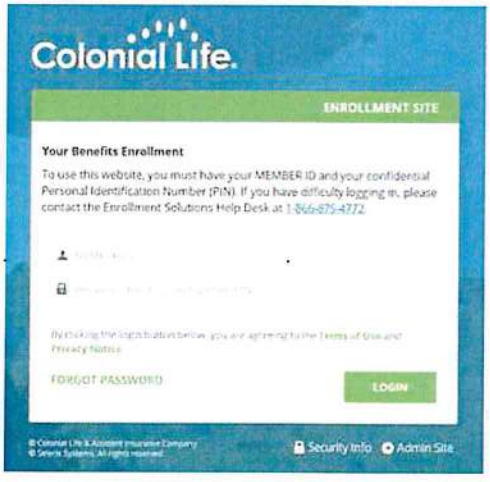
Benefit confirmation forms can be emailed to you at the conclusion of the enrollment.

2. Self-enroll online.

Access the enrollment site URL: Harmony.Benselect.com/SoA
Use the following login information:

- **Log In:** MEMBER ID (This is also your Health ID number.)
- **Personal Identification Number:** The last four digits of your Social Security number and the last two digits of your birth year (six digits total)

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



Enrollment opportunities:

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

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

Your basic and optional coverages

Coverage options	Who pays	Benefit amount(s)	
Basic group term life with AD&D insurance	Employer or Employee*	**$10,000**	You will be automatically enrolled if your district is participating in the Colonial Life group term life with AD&D insurance offering. A newly eligible employee may opt-out during the 60-day new hire eligibility period. Health questions are not asked during the 2023 plan year open enrollment and new hire enrollment.
Expanded basic group term life with AD&D insurance	Employee	**$1,000** increments up to **$40,000**	Health questions are not asked during the 2023 plan year open enrollment and new hire enrollment.
Supplemental employee group term life with AD&D insurance	Employee	**$1,000** increments up to **$250,000**	Health questions are not asked during the 2023 plan year open enrollment and new hire enrollment, for benefit amounts up to $100,000. Any benefit amount over $100,000 is subject to evidence of insurability.
****Supplemental spouse group term life with AD&D insurance**	Employee	**$1,000** increments up to **$50,000**	Health questions are not asked during the 2023 plan year open enrollment and new hire enrollment, for spouse benefit amounts up to $10,000. Any benefit amount over $10,000 is subject to evidence of insurability.
****Supplemental dependent child group term life with AD&D insurance**	Employee	**$1,000** increments up to **$50,000**	Health questions are not asked during the 2023 plan year open enrollment and new hire enrollment, for spouse and coverage up to $10,000. Any benefit amount over $10,000 is subject to evidence of insurability.

* *Some districts are not participating in the employer-paid basic group term life with AD&D insurance.*

** *Employee must elect supplemental group term life with AD&D insurance on themselves in order to elect supplemental group term life with AD&D insurance for the spouse or dependent child(ren). Effective 1/1/2020, the spouse and/or child supplemental group term life with AD&D benefit amount must be either equal to or lower than the employee's supplemental group term life with AD&D benefit amount.*

2023 Rates (per $1,000) Monthly cost of coverage

Basic group term life with AD&D insurance

$0.20 per $1,000

Expanded basic group term life with AD&D insurance

$0.19 per $1,000

Supplemental group term life with AD&D insurance

Age	Employee
Under 25	$0.10
25-29	$0.10
30-34	$0.13
35-39	$0.14
40-44	$0.22
45-49	$0.36
50-54	$0.57
55-59	$0.83
60-64	$1.24
65-69	$2.42
70-74	$ 3.94
75+	$ 7.85

Supplemental spouse group term life with AD&D insurance

All eligible ages	$0.75

Supplemental dependent child group term life with AD&D insurance

All eligible ages	$0.12

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

EXCLUSIONS AND LIMITATIONS

Losses Not Covered Under Your Life Insurance Benefit:

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

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

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

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

Losses Not Covered Under the AD&D Insurance Benefit:

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

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

Termination

Coverage terminates:

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

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

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

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

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

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

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC

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

ELIGIBILITY FOR GROUP TERM LIFE WITH AD&D INSURANCE IS DETERMINED BY ELIGIBILITY IN YOUR EMPLOYER'S HEALTH INSURANCE PLAN

District Name:				**District Code:**
SECTION 1: EMPLOYEE INFORMATION – Always complete				
Proposed Insured Name (First, MI, Last)		Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street	City State Zip Code			Member ID No.
Email Address			Primary Phone No. Secondary Phone No.	
Date Employed	Actively Employed by: AR Public School			Annual Salary

SECTION 2: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage.

- **Employee must have Supplemental Group Term Life with AD&D coverage to elect spouse and/or dependent children coverage.**
- **Spouse and/or dependent children Supplemental Group Term Life with AD&D coverage amount cannot exceed the amount of employee coverage.**
- **All eligible dependent children are covered with one premium.**
- **Names of eligible dependent children are not required.**

Spouse Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐		Spouse	
Are there any eligible dependent children applying for coverage?				☐ Yes ☐ No

SECTION 3: GUARANTEED ISSUE COVERAGE INFORMATION – Always complete – For any amount over the maximum benefit shown below, you must complete an Evidence of Insurability Form. Employee must have $10,000 Basic Group Term Life with AD&D to elect Expanded and/or Supplemental Group Term Life and AD&D.

				*Administrative use only
Coverage Type	**Tax Status**	**Coverage Amount**	***Plan Code**	***Monthly Premium**
☐ Basic Group Term Life with AD&D ($10,000) **This is automatic unless the employee opts out.**		$10,000	8L1B	$
☐ Expanded Basic Group Term Life with AD&D ($1,000 increments, up to $40,000)		$	8L1E	$
☐ Supplemental Group Life with AD&D ($1,000 increments, up to $100,000)	Post Tax	$	8F1S	$
☐ Spouse Supplemental Group Term Life with AD&D ($1,000 increments, up to $10,000)	Post Tax	$	8SP1	$
☐ Dependent Child(ren) Supplemental Group Term Life with AD&D ($1,000 increments, up to $10,000)	Post Tax	$	4CH1	$
☐ I do not wish to participate in the State of Arkansas Public School Employee (PSE) $10,000 Basic Group Term Life with AD&D plan. I understand that if I enroll later, I must provide evidence of insurability.			**Total Premium $**	

SECTION 4: BENEFICIARY INFORMATION – Please designate primary and/or contingent beneficiaries for the Employee's benefit.

Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Date of Birth	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Date of Birth	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Date of Birth	Benefit %	Relationship to Proposed Insured	Social Security No.

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. I have read this form and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this form will not be binding upon Colonial Life & Accident Insurance Company (Colonial Life) until both: 1) the certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this form are the basis for any certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the form.

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If I have elected to pay my premiums for Colonial Life & Accident Insurance Company's Group Term Life insurance with pre-tax dollars, I am aware of the tax savings I receive through a flexible benefits plan. While the Internal Revenue Service (IRS) allows me to receive tax savings on my premiums, the IRS also may require me to pay taxes on insurance benefits I receive from coverage purchased through a flexible benefits plan.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices.

Signed at: City_____ State _____ Date _____
mm/dd/yyyy

(x)_____
Signature of Proposed Insured

AGENT SECTION

Agent's Name (If Present) _____
Please Print

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this form. I further certify that I am a licensed agent in the state where this form is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

Date_____ x _____
mm/dd/yyyy Signature of Licensed Agent (full name as it appears on license)

License No._____ Code No._____

ARTRS
Arkansas Teacher Retirement System

Form # 1
Revised 07/2019
1400 West Third, Little Rock, AR 72201
Phone (501) 682-1517 or (800) 666-2877
Fax (501) 682-2359
Website - www.artrs.gov

Membership Data Form

To be Completed by Member

Member's Social Security Number _____ - _____ - _____

Name (Last, First, Middle) _____

Address _____

City _____ State _____ ZIP _____

County of Residence _____

❑ Male ❑ Female Date of Birth _____

Mobile Phone (_____) _____ Email _____

To be Completed by Employer

Employer _____ Employer Code _____

Employer Type: ❑ School ❑ College/State Agency

Employee's Primary Position _____

If school, Employee on contract? ❑ Yes ❑ No If yes, number of days on contract? _____

If college/state agency, Employee (Check One) : ❑ Full-Time ❑ Part-Time

Employee Enrolled as ❑ Contributory ❑ Noncontributory Verified by ATRS _____

Employee's first day of work (Month/Day/Year) _____

ARTRS
Arkansas Teacher Retirement System

Form # 9
Effective 7/1/2007
1400 West Third, Little Rock, AR 72201
Phone (501) 682-1517 or (800) 666-2877
Fax (501) 682-2359
Website - http://www.artrs.gov

LUMP SUM DEATH BENEFIT - BENEFICIARY DESIGNATION FORM

Arkansas Code Annotated § 24-7-720 provides that upon the death of an active or retired member of the Arkansas Teacher Retirement System (ATRS), with 10 or more years of actual service, a Lump Sum Death Benefit payment in an amount set by the Board of Trustees shall be paid to such person(s) as the member has designated in writing and filed with ATRS. Effective for a member dying after June 30, 2006, if there is no designated person surviving, the lump sum shall be paid to the member's estate.

Member's Name _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

PART 1 - Designation of Primary Beneficiary(ies)

I hereby designate the following as the primary beneficiary(ies) of the Lump Sum Death Benefit due from ATRS. In the event of my death, I authorize ATRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death. I understand that equal shares will be distributed among multiple surviving primary beneficiaries. At least one primary beneficiary must be listed.

Name of Primary Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

PART 2 - Designation of Contingent Beneficiary(ies) - OPTIONAL

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the member. I hereby designate the following as contingent beneficiary(ies) of the Lump Sum Death Benefit. I understand that equal shares will be distributed among multiple surviving contingent beneficiaries.

Name of Contingent Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Lump Sum Death Beneficiary Designations filed previously with ATRS.

Member Signature _____ Date _____

To Be Completed By Notary Public

State of _____)
County of _____)

(Notary Seal)

Subscribed and Sworn before me on this _____ day of _____, 20 ___.

Notary Signature _____ My commission expires: _____

ARTRS
Arkansas Teacher Retirement System

Form # 4
1400 West Third
Little Rock, AR 72201
Phone (501) 682-1517
Fax (501) 682-2359
www.artrs.gov

Disposition of Residue – Beneficiary Designation Form

Member Information

Member's Name_____ SSN_____

Mailing Address_____

City _____ State _____ Zip _____

Mobile Phone (____) _____ Email Address _____

If a member of the Arkansas Teacher Retirement System (ATRS) dies with residual account balance(s) standing to the member's credit at their death, the residual balance(s) will be paid to such person(s) as the member has designated in writing and filed with ATRS. The residual and T-DROP balances are only paid to beneficiaries if a survivor or retirement option annuity does not become payable at the member's death.

I hereby acknowledge that should I choose someone other than my spouse as one of my primary beneficiaries, I am electing to waive any right my spouse may have to a survivor benefit based on my service in the Arkansas Teacher Retirement System.

Part 1- Designation of Primary Beneficiary(ies) (At least one primary beneficiary must be listed)

I hereby designate the following as the primary beneficiary(ies) of any residual balance due from ATRS. In the event of my death, I authorize ATRS to make payment of the benefit to such beneficiary(ies) who are living at the time of my death.

Name of Primary Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

Part 2 – Designation of Contingent Beneficiary(ies) - Optional

A contingent beneficiary will receive all benefits upon the member's death only if all primary beneficiaries predecease the member. I hereby designate the following as contingent beneficiary(ies) of any residual balance.

Name of Contingent Beneficiary(ies)	SSN	Date of Birth	Relationship	Address

This Beneficiary Designation shall become effective on the date received by ATRS and shall supersede and cancel all Residue Designations filed previously with ATRS.

Member's Signature _____ **Date**_____

To Be Completed By Notary Public

State of _____)

(Notary Seal)

County of _____)

Subscribed and Sworn before me on this _____ day of _____, 20____.

Notary Signature _____ My commission expires: _____.

Arkansas New Hire Reporting Form

Visit Our Website: **www.ar-newhire.com**

Send completed form to:
PO BOX 2540
LITTLE ROCK, AR 72203
Or fax to: 1-800-259-3562
For more information: 1-800-259-2095

Employer Information

(Please Print or Type)

Federal Employer Identification Number 71-6021045

Employer Name Palestine - Wheatley School District

Street Address P.O. Box 790

City/State/Zip Code Palestine, Arkansas 72372

Contact Name/ Phone/Email Tammy Roberts, 870-581-2646, troberts@pwsd.k12.ar.us

Employee Information

(Please list first, last name)

REQUIRED

Name
SSN
Address
City/State/Zip
Start Date*

OPTIONAL

Date of Birth
State of Hire

REQUIRED

Name
SSN
Address
City/State/Zip
Start Date*

OPTIONAL

Date of Birth
State of Hire

REQUIRED

Name
SSN
Address
City/State/Zip
Start Date*

OPTIONAL

Date of Birth
State of Hire

REQUIRED

Name
SSN
Address
City/State/Zip
Start Date*

OPTIONAL

Date of Birth
State of Hire

*First day employee begins work for pay.

The New Hire Reporting Center is an authorized agent of Arkansas Department of Workforce Services

Arkansas State, FBI, and Child Maltreatment Central registry background checks are required for any person hired in our school district. Please initiate your background check process **ASAP**. You are responsible for paying all of the required fees for your background checks.

Please follow these steps – click on the link for each step and complete the required actions:

Background Check Process

https://dese.ade.arkansas.gov/Offices/educator-effectiveness/educator-licensure/background-check-process

Step One: Online Background Check Consent Form

Verification Code for Palestine – Wheatley School District is: **6205000**

Step Two: Background Check Payment

Steps 1-2 must be completed before you report for your Live Scan Fingerprinting. If you would like to complete your fingerprinting process at a site near you, please contact the site and schedule your Live Scan.

Step Three: List of approved Live Scan Locations are included in this packet.

- Applicants proceed to your nearest Approved Live Scan location to complete the fingerprinting process. Bring photo ID, copy of consent form and a copy of payment receipt with Transaction ID (electronic copy is acceptable).

LIVE SCAN LOCATIONS

EDUCATION SERVICE COOPERATIVES

Arch Ford Education Service Cooperative
101 Bulldog Drive
Plumerville, AR 72127
Phone: (501) 354-2269

Arkansas River Education Service Cooperative
912 West Sixth Avenue
Pine Bluff, AR 71601
Phone: 870-534-6129

Crowley's Ridge Education Service Cooperative
1606 Pine Grove Lane
Harrisburg, AR 72432
Phone: 870-578-5426

Dawson Education Service Cooperative
711 Clinton Street, Suite 201
Arkadelphia, AR 71923
Phone: 870-246-3077

DeQueen/Mena Education Service Cooperative
305 South Hornberg Avenue
Gillham, AR 71841
Phone: 479-385-4319

Great Rivers Education Service Cooperative
P.O. Box 2837
Helena-West Helena, AR 72390 Phone:
870-338-6461

Northcentral Arkansas Education Service Cooperative
99 Haley Street
Melbourne, AR 72556
PH. 870-368-7955

Northeast Arkansas Education Service Cooperative
211 West Hickory Service
Walnut Ridge, AR 72476
Phone: 870-886-7717

Northwest Education Service Cooperative
4 North Double Springs Road
Farmington, AR 72730
Phone: 479-267-7450

Ozarks Unlimited Resource Education Service Cooperative
5823 Resource Drive
Harrison, AR 72601
Phone: (870) 429-9145 or (870) 429-9100

South Central Education Service Cooperative 2235
California Avenue Southwest
Camden, AR 71701
Phone: 870-836-1600

Southeast Arkansas Education Service Cooperative
1022 Scogin Drive
Monticello, AR 71655
Phone: 870-367-6848

Southwest Arkansas Education Cooperative
2502 South Main
Hope, AR 71801
Phone: 870-777-3076

Guy Fenter Education Cooperative
3010 East Highway 22, Suite A
Branch, AR 72928
Phone: 479-965-2191

Wilbur D. Mills Educational Cooperative
P.O. Box 850 Beebe,
AR 72012
Phone: 501-882-5467

Arkansas Department of Education
To schedule fingerprints sign up here:

https://www.signupgenius.com/go/9040b4ba8a829aafd0-fingerprinting

Submitting an Arkansas Child Maltreatment Central Registry Background Check Request

There are three steps:

1. Request Form Generator for AR Child Maltreatment Central Registry
2. Upload Request Form for AR Child Maltreatment Central Registry
3. Pay Online

Details of each step are outlined below.

Stage/Step 1: Arkansas (AR) Child Maltreatment Central Registry Form Generator Process

1. After reading through all three steps below, access the Central Registry Request Form Generator
2. ➢ https://humanservices.arkansas.gov/divisions-shared-services/children-family-services/request-a-child-maltreatment-check/
3. Once you are on the AR Child Maltreatment Central Registry Form web page, under **Stage 1**: click the Central Registry Request Form Generator link
4. Complete each required field:
   - Choose: **YOU ARE THE TEACHER**
   - This will default an email address under Education Information (Do not change this)
   - **Contact Name: (First name) Palestine – Wheatley (last name) School District**
   - **Ph. 870-581-2646|Fax. 870-581-4420|LEA: 6205**
   - **P.O. Box 790|Palestine,AR 72372**
5. Under Applicant Information: (required fields denoted by an asterisk).
6. Once all required fields are completed, click 'Submit Form' button.
7. The completed request form will be emailed to the email address you entered on the AR Child Maltreatment Central Registry Request Form web page.
8. **Print this form and sign the completed copy in the presence of a notary.**

Stage/Step 2 Arkansas (AR) Child Maltreatment Central Registry Form Upload Process

1. Scan the notarized form to your computer and save it to a place you can easily locate it.
2. Once you have your form saved, under Stage 2: access the Central Registry Form Uploader link to send your file to the Central Registry team.
3. Under Please select: choose the one that applies to who you are (for Licensed/Classified positions, it will be the first option "You are the teacher"
4. Choose the correct "Applicant Type" at the drop down menu
5. Under "This is a resubmission?" choose "no" (unless you are resubmitting)
6. Complete required fields
   - Company/Requestor: **Dept. of Education (This auto fills, Do Not Change This)**
   - Contact Name: **Tammy Roberts**
   - Contact Email Address: troberts@pwsd.k12.ar.us
   - Finish completing Applicant Information required field areas
7. Under 'Notarized Request File' – Click 'Choose File' to search your computer and upload the notarized copy of the form.
8. Click 'Submit and Pay'
9. You will then be automatically redirected to the payment webpage (Ark Gov Pay)

Stage/Step 3: Online Payment

1. Select a Payment Type
2. Complete the customer information and payment information sections to pay the fee ($10.00 for the background check + $1.00 online processing fee.
3. Click 'Submit Payment'
4. You will receive a confirmation email verifying submission of your request and complete payment.
5. Registry check results are emailed via encrypted email to the entity identified in the 'Results Should Be Released To' section of the form submission request.