Human Resources

JACKSON PUBLIC SCHOOLS
Transforming lives through excellent education

Telephone (601) 960-8742
Facsimile (601) 960-8751

Dear New Employee,

It is with great pleasure that we welcome you to the Jackson Public School District. We are very pleased that you have chosen to accept our offer of employment.

Enclosed you will find forms that must be completed in order to finalize your employment. All forms must be completed in black or blue ink. Once we have received a favorable result from your background screening, you will receive a call from a Personnel Specialist who will schedule an appointment time to return all forms.

The following forms are included:

- Background Check Information and Directions
- On-Boarding Video Acknowledgment Form
- Employee Policy Form
- Employment Eligibility Verification (1-9 Form) (Must provide driver's license, social security card, birth certificate or passport.)
- Retirement Information Form
- Personal/Emergency Information Form
- BCBS Health Insurance Form (Must accept or waive coverage.)
- Life Insurance Forms:
    - United Healthcare (Free. District pays premium. Benefit pays two times annual salary.)
    - Minnesota Life (Optional. Must accept or waive coverage. Benefit pays two times annual salary.)
- PERS Membership Application and Beneficiary Designation Forms
    - Form 1 and 1 B - **Mandatory**
- Federal Tax Withholding (W-4 Form)
- MS State Employee's Withholding
- Direct Deposit Form (Attach voided check or letter from bank with routing/account number listed.)
- Acceptable Use and Internet Safety Contract
- Certified Employee Credit Experience Checklist, complete if applicable
- Classified Employee Credit Experience Checklist, complete if applicable
- Instructions for Email Set-up
- Instructions for Active Resources Set-up
- FMLA (Family Medical Leave Act) Fact Sheets

We are excited about you joining us and want to ensure that you are successful in your new role. Please don't hesitate to contact the Office of Human Resources at 601-960-8745 with any questions or concerns. We look forward to a positive working relationship!

Respectfully,

The Office of Human Resources Team

JACKSON
PUBLIC SCHOOLS

Office of Human Resources

624 South President Street
P.O. Box 2338
Jackson, MS 39225-2338

Phone: 601.960.8745
Facsimile: 601.352.4679
Website: www.jackson.k12.ms.us

TO: All Newly Hired JPS Employees

RE: Background Checks

- CIC (Criminal Investigation Check) fingerprints processing for State and Federal are performed for each newly hired employee.
- Employees hired in a safety sensitive position, will also be sent for drug testing at MEA.
- The new employee may not report to work until the results of the background check have been received and approved by the Human Resources.
- The current fee is $33.00 and payment is due at the time of processing.
- Payment must be in the form of a money order made payable to Jackson Public Schools.
-

BACKGROUND CHECK

REPORT TO
JACKSON PUBLIC SCHOOLS
OFFICE OF HUMAN RESOURCES
624 SOUTH PRESIDENT STREET JACKSON, MS 39201
601-960-8742
Open 8a.m.-5p.m.
Please have your $33.00 money order and Picture I.D.

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JPS Acknowledgement Form

On-Boarding Video

https://youtu.be/dOkfEMi7CII

I acknowledge that I have viewed the JPS On-Boarding Video in its entirety. I affirm that I understand the content presented and that if I have any questions, I will contact the office of Human Resources.

Respectfully,

Human Resources Specialist

Employee
Signature_____

Date_____

EMPLOYEE POLICY FORM

As an employee of the Jackson Public School District, I acknowledge that I will access a copy of the policies listed below on the Jackson Public Schools website. These policies can be obtained by visiting the Board Approved Policies page at www.jackson.k12.ms.us/BoardPolicies.

POLICIES

1. GACN/JCP – Sexual Harassment- Employees and Students
2. GAEE – Anti-Bullying Policy and Procedures for Employees
3. JCBAA – Anti-Bullying Policy and Procedures for Students
4. GAHA – Instructional and Support Staff Dress Code Policy
5. GBA – Staff Ethics
6. GBEM – Drug and Alcohol Policy and Procedures
7. GBF – Professional Development Policy and Procedures
8. JCIA – Prohibition of Corporal Punishment
9. GADB – Overtime and Compensatory Pay for Employees

I understand that it is my responsibility to read and adhere to these policies while employed with the district.

_____ _____

Employee Printed Name Date

Employee Signature

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
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		**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 the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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Office of Human Resources

624 South President Street
P.O. Box 2338
Jackson, MS 39225-2338

Phone: 601.960.8745
Facsimile: 601.352.4679
Website: www.jackson.k12.ms.us

RETIREMENT INFORMATON SHEET

Date: _____

Name: _____

Are you currently receiving compensation or benefits from the Retirement System of Mississippi (PERS)?

Please check one: _____YES _____NO

If YES, complete PERS Form 4B (Re-Employment of Retiree)

Are you currently receiving compensation or benefits from another state's retirement system?

Please check one: _____YES _____NO

Signature: _____

Note: Form must be complete and placed in employee's folder in OHR.

Human Resources

Telephone (601) 960-8742
Facsimile (601) 960-8751

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Personal Information

Full Name: _____

Address: _____
Street Address Apartment#

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Email Address: _____

Social Security Number: _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Emergency Contact Information

Full Name: _____
Last Name First Name Middle Initial

Address: _____
Address City State/Zip

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

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

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

Employer Name				
Social Security Number	**First Name**	**MI**	**Last Name**	
Home Address		**City**	**State**	**ZIP**
Primary Telephone Number	**Secondary Telephone Number**	**Personal Email Address**		
Marital Status ☐ Single ☐ Married	**Gender** ☐ Male ☐ Female	**Date of Birth (mm/dd/yyyy)**	**Date of Employment/Retirement**	

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

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

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

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

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

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

Enrollee Signature: _____ Date: _____

Section C: Coverage

Enrollee Type:	**Coverage Type**:	**Coverage Option:** (Choose Only One)	**Do you have Medicare?** ☐ Yes ☐ No
☐ Employee - Legacy	☐ Enrollee Only	◯ Select	**Medicare Number:** _____
☐ Employee - Horizon	☐ Enrollee + Spouse	◯ Base (HIGH DEDUCTIBLE)	☐ "A" Effective Date: _____
☐ Retiree	☐ Enrollee + Child		☐ "B" Effective Date: _____
☐ COBRA	☐ Enrollee + Children		**Reason for Entitlement:**
☐ Surviving Spouse	☐ Enrollee + Spouse & Child(ren)		☐ Age ☐ ESRD ☐ Disability

Are you a tobacco user? ☐ Yes ☐ No If yes, are you interested in participating in the Plan's free cessation program? ☐ Yes ☐ No

Section D: Other Coverage Information

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

	1.	2.	3.	4.
Name of Individual Covered:				
Policyholder's Name:				
Policyholder's Date of Birth:				
Policyholder's Insurance Effective Date:				
Policy Number:				
Policyholder's Employment Status:	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐
Insurance Company Name address & phone #:				
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:

Section E: Dependents

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

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

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

Section F: Change Information

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

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

☐ **Change Coverage:** ☐ Base Coverage ☐ Select Coverage

☐ **Drop Dependent(s)**: ☐ Divorce ☐ Deceased ☐ Other: _____
Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ **Other Changes** (Explain):

FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER:_____
New Legacy Employee, Requested Effective Date: _____
New Horizon Employee, Requested Effective Date: _____
Retiree, Requested Effective Date: _____
COBRA, Requested Effective Date: _____
Surviving Spouse, Requested Effective Date: _____
Change(s), Requested Effective Date: _____

ENTERED BY: _____
DATE: _____

VERIFIED BY: _____
DATE: _____

Print

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
Effective January 1, 2023

Legacy - Initially hired before 1/1/2006

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

	LEGACY EMPLOYEES				HORIZON EMPLOYEES			
	BASE		SELECT		BASE		SELECT	
ACTIVE EMPLOYEE	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	$437	$0	$457	$20	$437	$0	$483	$46
Employee + Spouse	$915	$478	$1,001	$564	$915	$478	$1,027	$590
Employee + Spouse & Child(ren)	$1,165	$728	$1,251	$814	$1,165	$728	$1,277	$840
Employee + Child	$561	$124	$648	$211	$561	$124	$674	$237
Employee + Children	$754	$317	$840	$403	$754	$317	$866	$429

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

	LEGACY RETIREES		HORIZON RETIREES	
RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	BASE	SELECT	BASE	SELECT
Retiree	$502	$525	$802	$830
Retiree + Spouse (Non-Medicare)	$1,052	$1,151	$1,608	$1,712
Retiree + Spouse & Child(ren) (Non-Medicare)	$1,339	$1,438	$1,797	$1,902
Retiree + Child	$645	$716	$945	$1,021
Retiree + Children	$866	$908	$1,166	$1,213
Retiree + Spouse (Medicare)	N/A	$738	N/A	$1,043
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$929	N/A	$1,234
RETIRED EMPLOYEE - MEDICARE ELIGIBLE	**BASE**	**SELECT**	**BASE**	**SELECT**
Retiree	N/A	$213	N/A	$213
Retiree + Spouse (Non-Medicare)	N/A	$839	N/A	$1,095
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	$1,126	N/A	$1,285
Retiree + Child	N/A	$404	N/A	$404
Retiree + Children	N/A	$596	N/A	$596
Retiree + Spouse (Medicare)	N/A	$426	N/A	$426
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$617	N/A	$617

	LEGACY		HORIZON	
COBRA	BASE	SELECT	BASE	SELECT
Participant	$445	$466	$445	$492
Participant + Spouse	$933	$1,021	$933	$1,047
Participant + Spouse & Child(ren)	$1,188	$1,276	$1,188	$1,302
Participant + Child	$572	$660	$572	$687
Participant + Children	$769	$856	$769	$883
COBRA DISABILITY EXTENSION	**BASE**	**SELECT**	**BASE**	**SELECT**
Participant	$655	$685	$655	$724
Participant + Spouse	$1,372	$1,501	$1,372	$1,540
Participant + Spouse & Child(ren)	$1,747	$1,876	$1,747	$1,915
Participant + Child	$841	$972	$841	$1,011
Participant + Children	$1,131	$1,260	$1,131	$1,299

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30 DAY INSURANCE ENROLLMENT NOTICE

New hires have 30 days from their date of hire to contact the below listed vendors and apply for any insurance product they are interested in purchasing.

JACKSON PUBLIC SCHOOL APPROVED VENDORS:

Company/Representative	**Product(s)**	**Phone Number**
AFLAC/Emily Speed	Accident/Cancer/Hospital	601-988-5974
American Fidelity DeMario Smith	Disability Insurance	769-572-3419
Blue Bonnet Life	Life Insurance	601-664-4451
Catchings Agency Elizabeth Veal Cynthia Parhm	Humana Dental Transamerica life United Healthcare Vision	601-355-7489
Colonial/Mike Norris	Cancer Critical Illness Hospital Short-term disability	601-594-3377
Creative Group Benefits Laurel Loflin-Welch Sandi Barnes	Delta Dental UNUM Vision	601-914-2121
Pre-paid Legal	Legal Service	601-906-0516
UNUM Provident Ruby Hendricks	UNUM Short-term disability	601-977-0039

Open enrollment is held in September of each year in the event you miss the 30-day window.

Qualified life changing events (must enroll no later than 60 days after change) are:

- Marriage and/or divorce
- Birth/adoption/court order
- Death
- Spouse changes job
- Loss of coverage

Beneficiary Form
Group Term Life Insurance

UnitedHealthcare®

Important Note: This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company			
Policyholder:			
Individual Covered Person	SSN# and DOB:	Phone#	
Street Address (please include apartment # as applicable)	City	State	Zip

THE BENEFICIARY FOR THE POLICY SHALL BE:

Primary Beneficiary				
Name	**Address**	**SSN# and DOB**	**Relationship to the Covered Person**	**% of Death Benefit Payable to Beneficiary (must total 100%)**
In the event, and only in the event, that all Primary Beneficiaries predecease me, then the proceeds shall be payable to the following Contingent Beneficiaries				
Contingent Beneficiary				
Name	**Address**	**SSN# and DOB**	**Relationship to the Covered Person**	**% of Death Benefit Payable to Beneficiary (must total 100%)**

Insured's Signature:_____
Insured's Printed Name: _____
Date: _____

In case I name more than one person in a group of beneficiaries, whether as the Primary beneficiaries or as the Contingent beneficiaries, then unless I otherwise direct in writing above, each designated beneficiary in a group shall share equally in the amount to be paid under the covering policy. In the event any designated beneficiary (ies) in a group predeceases me, then the remaining beneficiary (ies) in that group of beneficiaries shall share equally in the life insurance proceeds to be paid under the policy.

STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.

Policy 33683-G

SECTION A: Employee/Employer Information

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

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

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

☐ **New Employee** – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.

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

Date of Employment: _____

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

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

☐ **DISABLED EMPLOYEE:** Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months.

(Employee must also complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

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

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

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

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

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

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone

SECTION D: Authorization and Certification

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

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

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

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

_____ _____

Employee/Retiree Signature (Required) **Date**

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

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

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

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

_____ _____

Employee/Retiree Signature **Date**

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

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

Membership Application

Form 1 – Revised 07/01/2016

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

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

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

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

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

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

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

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

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

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

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

☐ Supplemental Legislative Retirement Plan (SLRP)

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

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

Spouse's Full Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Wedding Date** *mm/dd/ccyy*	**Gender**
				☐ M ☐ F

Dependent Child's Full Name – *Up to age 19, or 23 if unmarried and a full-time student*	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Gender**
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

❹ Member Certification – *If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

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

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

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

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

Employer Name: _____ Employer No.: _____ - _____

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

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

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, *Eligibility of Part-time Employees for State Retirement Annuity Service Credit*, and PERS Board of Trustees Regulation 36, *Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS)*.

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

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, *fax* www.pers.ms.gov

Beneficiary Designation

Form 1B – Revised 07/01/2016

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

❶ Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ ☐ Member ☐ Retiree

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ Gender: ☐ M ☐ F

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

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

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Beneficiary Information – *Use additional Form 1B,* Beneficiary Designation, *to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary and secondary beneficiary percentages must equal 100 percent.*

Beneficiary Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Beneficiary Percentage** *P=Primary, S=Secondary Use whole numbers*	**Gender**
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F

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

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

☐ **Retiree –** I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

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

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

Employer Name: _____ Employer No.: _____ - _____

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

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

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

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)

Form 89-350-12-2 Rev. 8/19

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

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

Employee's Name _____ **SSN** _____

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

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION

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

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

Employee's Signature: _____ **Date:** _____

INSTRUCTIONS

1. The personal exemptions allowed:

(a) Single Individuals	$6,000	(d) Dependents	$1,500
(b) Married Individuals (Jointly)	$12,000	(e) Age 65 and Over	$1,500
(c) Head of family	$9,500	(f) Blindness	$1,500

2. Claiming personal exemptions:

(a) Single Individuals enter $6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of $12,000.

If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of $500. For example, the taxpayer may claim $6,500 and the spouse claims $5,500; or the taxpayer may claim $8,000 and the spouse claims $4,000. The total claimed by the taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter $9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. Total Exemption Claimed:

Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION

6. IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL

7. To comply with the Military Spouse Residency Relief Act (PL111-97) signed into law

JACKSON PUBLIC SCHOOLS

Business Services • P.O. Box 2338 • Jackson, Mississippi 39225 • (601) 960-8700

☐ NEW EMPLOYEE

☐ CHANGE

Effective July 1, 2012, Jackson Public Schools no longer prints payroll checks for employees of the District. Direct Deposits can no longer be cancelled, only changed/updated with new account information.

I hereby authorize JACKSON PUBLIC SCHOOLS to initiate credit and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my:

☐ CHECKING

☐ SAVINGS

This authorization is to remain in full force and effect until JACKSON PUBLIC SCHOOLS has received written notification from me of a change in such time and in such manner as to afford JACKSON PUBLIC SCHOOLS and DEPOSITORY a reasonable opportunity to act on it (a minimum of five days) prior to date of payroll.

NAME _____ SOCIAL SECURITY NO. _____

SCHOOL/OFFICE _____

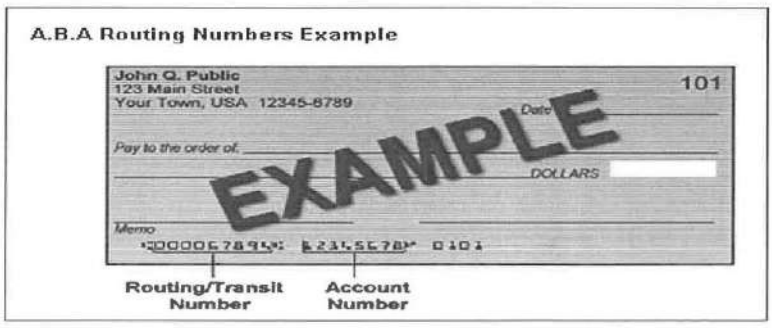
BANK (OR OTHER DEPOSITORY) _____

ROUTING NO. _____ ACCOUNT NO. _____

SIGNATURE _____ DATE _____

You may access and print any and all of your direct deposit stubs via the JPS Intranet (www.jackson.k12.ms./Intranet). Click the Resources tab and then click Active Resources.

****PLEASE ATTACH A VOIDED CHECK OR LETTER FROM YOUR INSTITUTION VERIFYING ROUTING AND ACCOUNT INFORMATION FOR THE ACCOUNT TO BE CREDITED.



JACKSON PUBLIC SCHOOL DISTRICT
OFFICE OF HUMAN RESOURCES
P.O. BOX 2338
JACKSON, MISSISSIPPI 39225-2338

VERIFICATION OF EMPLOYMENT

OFFICE OF SUPERINTENDENT DATE _____

_____

_____

_____

Dear _____:

Please complete the verification of employment form below and mail to: **Office of Human Resources**
Jackson Public Schools
P.O. Box 2338
Jackson, Mississippi 39225-2338

Please note that evidence of previous teaching experience received in the Office of Human Resources after November 1 will not be used for salary purposes until the following school year. Your promptness is appreciated.

My employment in your system was during the following school sessions:

DATES

The name under which I taught was _____ _____
(Please print) Social Security

Sincerely,

VERIFICATION OF PREVIOUS TEACHING EXPERIENCE

This is to certify that was employed in the

Public School as follows:

SCHOOL SESSION	POSITION, SUBJECT, OR GRADE	NUMBER OF MONTHS IN SCHOOL TERM	TOTAL NUMBER OF MONTHS TAUGHT

Signed _____

Title _____

Date _____

OFFICIAL STAMP OR SEAL

APPLICATION NOTICES:

Credit for previous teaching experience will be based on the following criteria. All five must be met before credit will be allowed:

1. A teaching license was required to hold your previous job.
2. A contract was issued by your employer.
3. The organization you were employed by was accredited by an appropriate agency.
4. Employment consisted of five days a week- six or more hours a day.
5. Employment consisted of an eight-month or longer work year.

Classified Employee
Credit Experience Pay Checklist

_____

Print Employee Name

The following topics on credit experience pay have been fully explained to me.

- **Have you worked in the exact same position in which you are being hired? If yes, please provide proof of experience.**
  Yes ☐ No ☐

Please place your initials on each line.

_____ The cut-off pay period for submission of credit experience pay is within five days of the date of hire on the letter of employment.

_____ Credit experience pay must be submitted on the original letterhead of the company or business that is verifying my work experience.

_____ Credit experience pay may be received ONLY ONE TIME as an employee with the District.

_____ The employee may receive up to 10 years of credit experience pay for work of the same kind.

_____ _____
Signature of Employee Date

_____ _____
Signature of Personnel Specialist Date

EMPLOYEE POLICY FORM

As an employee of the Jackson Public School District, I acknowledge that I will access a copy of the policies listed below on the Jackson Public Schools website. These policies can be obtained by visiting the Board Approved Policies page at www.jackson.k12.ms.us/BoardPolicies.

POLICIES

1. GACN/JCP – Sexual Harassment- Employees and Students
2. GAEE – Anti-Bullying Policy and Procedures for Employees
3. JCBAA – Anti-Bullying Policy and Procedures for Students
4. GAHA – Instructional and Support Staff Dress Code Policy
5. GBA – Staff Ethics
6. GBEM – Drug and Alcohol Policy and Procedures
7. GBF – Professional Development Policy and Procedures
8. JCIA – Prohibition of Corporal Punishment
9. GADB – Overtime and Compensatory Pay for Employees

I understand that it is my responsibility to read and adhere to these policies while employed with the district.

_____ _____

Employee Printed Name Date

_____

Employee Signature

The superintendent or the superintendent's designee has the authority to amend or revise the Acceptable Use and Internet Safety Contract as deemed necessary and appropriate consistent with this policy.

XI. EXAMPLES OF RESPONSIBLE USE

- Use school technologies for school---related activities.
- Follow the same guidelines for respectful, responsible behavior online that I am expected to follow offline.
- Treat school resources carefully and alert staff if there is any problem with their operation.
- Encourage positive, constructive discussion if allowed to use communicative or collaborative technologies.
- Alert a teacher or other staff member if I see threatening, inappropriate, or harmful content (images, messages, posts) online.
- Use school technologies at appropriate times, in approved places, for educational pursuits.

This is not intended to be an exhaustive list. Users should use their own good judgment when using school technologies.

XII. LIMITATIONS OF LIABILITY

JPSD will not be responsible for damage or harm to persons, files, data, or hardware.

While JPSD employs filtering and other safety and security mechanisms, and attempts to ensure their proper function, it makes no guarantees as to their effectiveness.

JPSD will not be responsible, financially or otherwise, for unauthorized transactions conducted over the school network.

Violations of this policy may have disciplinary consequences, including:

- Suspension of network, technology, or computer privileges;
- Notification of parents;
- Detention or suspension from school and school-related activities;
- Employment disciplinary action, up to and including termination of employment;
- Legal action and/or prosecution.

Staff, students and parents/guardians shall be required to sign Jackson Public Schools' Acceptable Use Policy annually before Internet or network access shall be allowed.

SOURCE: JACKSON PUBLIC SCHOOL DISTRICT, JACKSON, MISSISSIPPI
LEGAL REF.: 47 USC §254; 18 USC 1460; 20 USC 1232
DATE: AUGUST 19, 2002
REVISED: OCTOBER 21, 2014

JACKSON
PUBLIC SCHOOLS

Welcome to the JPS Email System!

Once you have completed the employment process in Human Resources, email and user accounts are automatically created for each employee.

Step 1: Sign the JPS Acceptable Use and Internet Safety Policy.
(www.jackson.k12.ms.us/AcceptableUse)

Step 2: Get your JPS user name. Go to the Jackson Public School Website. Click on the **Departments** tab, click on **Information Technology Services**. Look at the bottom of the page and follow instructions under **Retrieving Your Username.**

Step 3: Reset your password. Once your password has been reset successfully, you will be able to use your JPS email account and login into any computer that is connected to the Jackson Public Schools network.

Password reset directions:

- Go to the JPS Internet on any JPS computer.
- Go to Departments on main page.
- Click on Information Technology.
- Look under title "Recovering Your Password or Username."
- Look under **option 2 and** click the link that states "Self –Service Reset Password Management."
- Click Forgot my password.
- Enter your user name and click Continue.
- Correctly answer the three security questions.
- Click Reset Password.
- Carefully read and follow the password rules and enter your new password two times in the correct boxes.
- Click Reset Password and wait.
- If all is done correctly, it will say Congratulations!

Information Technology Contacts

Help Desk 601-973-8601
Joycelyn Linburgen 601-960-8831

Human Resources

Telephone (601) 960-8742
Facsimile (601) 960-8751

ELECTRONICALLY OBTAINING YOUR CHECK STUB AND W-2 PROCEDURES

1. Visit the Jackson Public Schools Intranet (www.jackson.k12.ms.us/Intranet).

2. Click Resources and then Active Resources.

3. Click **Sign up for an Account!**

4. Complete requested sections. Please note that Username and Password fields are case sensitive.

Please contact the Payroll Department at (601) 960-8700 if you have any additional questions or need assistance in accessing your Active Resources Account.

U.S. Wage and Hour Division
(Revised 2012)

Fact Sheet #28: The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. This fact sheet provides general information about which employers are covered by the FMLA, when employees are eligible and entitled to take FMLA leave, and what rules apply when employees take FMLA leave.

COVERED EMPLOYERS

The FMLA only applies to employers that meet certain criteria. A **covered employer** is a:

- Private-sector employer, with 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including a joint employer or successor in interest to a covered employer;
- Public agency, including a local, state, or Federal government agency, regardless of the number of employees it employs; or
- Public or private elementary or secondary school, regardless of the number of employees it employs.

ELIGIBLE EMPLOYEES

Only eligible employees are entitled to take FMLA leave. An **eligible employee** is one who:

- Works for a *covered employer*;
- Has worked for the employer for at least *12 months*;
- Has at least *1,250 hours* of service for the employer during the 12 month period immediately preceding the leave*; and
- Works at a location where the employer has at least *50 employees within 75 miles*.

* Special hours of service eligibility requirements apply to airline flight crew employees. *See* Fact Sheet 28J: Special Rules for Airline Flight Crew Employees under the Family and Medical Leave Act.

The 12 months of employment do not have to be consecutive. That means any time previously worked for the same employer (including seasonal work) could, in most cases, be used to meet the 12-month requirement. If the employee has a break in service that lasted seven years or more, the time worked prior to the break will not count *unless* the break is due to service covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), or there is a written agreement, including a collective bargaining agreement, outlining the employer's intention to rehire the employee after the break in service. *See* "FMLA Special Rules for Returning Reservists".

LEAVE ENTITLEMENT

Eligible employees may take up to **12 workweeks** of leave in a 12-month period for one or more of the following reasons:

- The birth of a son or daughter or placement of a son or daughter with the employee for adoption or foster care;
- To care for a spouse, son, daughter, or parent who has a serious health condition;
- For a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
- For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.

An eligible employee may also take up to **26 workweeks** of leave during a "single 12-month period" to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember. The "single 12-month period" for military caregiver leave is different from the 12-month period used for other FMLA leave reasons. *See* Fact Sheets 28F: Qualifying Reasons under the FMLA and 28M: The Military Family Leave Provisions under the FMLA.

Under some circumstances, employees may take FMLA leave on an intermittent or reduced schedule basis. That means an employee may take leave in separate blocks of time or by reducing the time he or she works each day or week for a single qualifying reason. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operations. If FMLA leave is for the birth, adoption, or foster placement of a child, use of intermittent or reduced schedule leave requires the employer's approval.

Under certain conditions, employees may choose, or employers may require employees, to "substitute" (run concurrently) accrued paid leave, such as sick or vacation leave, to cover some or all of the FMLA leave period. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

NOTICE

Employees must comply with their employer's usual and customary requirements for requesting leave and provide enough information for their employer to reasonably determine whether the FMLA may apply to the leave request. Employees generally must request leave 30 days in advance when the need for leave is foreseeable. When the need for leave is foreseeable less than 30 days in advance or is unforeseeable, employees must provide notice as soon as possible and practicable under the circumstances.

When an employee seeks leave for a FMLA-qualifying reason for the first time, the employee need not expressly assert FMLA rights or even mention the FMLA. If an employee later requests additional leave for the same qualifying condition, the employee must specifically reference either the qualifying reason for leave or the need for FMLA leave. *See* Fact Sheet 28E: Employee Notice Requirements under the FMLA .

Covered employers must:

(1) Post a notice explaining rights and responsibilities under the FMLA. Covered employers may be subject to a civil money penalty for willful failure to post. For current penalty amounts, see www.dol.gov/whd/fmla/applicable_laws.htm;

(2) Include information about the FMLA in their employee handbooks or provide information to new employees upon hire;

(3) When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA-qualifying reason, provide the employee with notice concerning his or her eligibility for FMLA leave and his or her rights and responsibilities under the FMLA; and

(4) Notify employees whether leave is designated as FMLA leave and the amount of leave that will be deducted from the employee's FMLA entitlement.

See Fact Sheet 28D: Employer Notice Requirements under the FMLA.

CERTIFICATION

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition. *See* Fact Sheet 28G: Certification of a Serious Health Condition under the FMLA. For information on certification requirements for military family leave, *See* Fact Sheet 28M(c): Qualifying Exigency Leave under the FMLA; Fact Sheet 28M(a): Military Caregiver Leave for a Current Servicemember under the FMLA; and Fact Sheet 28M(b): Military Caregiver Leave for a Veteran under the FMLA.

JOB RESTORATION AND HEALTH BENEFITS

Upon return from FMLA leave, an employee must be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot be counted against the employee under a "no-fault" attendance policy. Employers are also required to continue group health insurance coverage for an employee on FMLA leave under the same terms and conditions as if the employee had not taken leave. *See* Fact Sheet 28A: Employee Protections under the Family and Medical Leave Act .

OTHER PROVISIONS

Special rules apply to employees of local education agencies. Generally, these rules apply to intermittent or reduced schedule FMLA leave or the taking of FMLA leave near the end of a school term.

Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under the FLSA regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the "salary basis" requirements for FLSA's exemption extends only to an eligible employee's use of FMLA leave.

ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any

proceeding, related to the FMLA. *See* Fact Sheet 77B: Protections for Individuals under the FMLA . The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

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