Greenburgh Central School District
Our Children. Our Focus. Our Future.

Benefits
Darleen McNerney
T:914.761.6000 Ext. 3111
E: dmcnerney@greenburghcsd.org

Payroll
Victoria Lucas
T:914.761.6000 Ext. 3109
E: vlucas@greenburghcsd.org

NEW HIRE PACKET CHECKLIST - GTF

FULL TIME INSTRUCTIONAL & NON-INSTRUCTIONAL

	FORM	ACTION	
	Instructional : New York State Teacher's Retirement System **Optional for Part-Time** **Required for Full-Time**	Optional for coaches & substitutes. Required for Full-Time teachers, teachers assistants & administrators. Must **complete** a declination form or a completed application form and return to Payroll, notarized	☐
	Non-Instructional : New York State Employees Retirement System	Return completed form, notarized.	☐
Required	Information Sheet	Return completed form to Payroll	☐
	Tax Forms **Instructional:** (NYS, W-4) **Non-instructional**:(W-4, IT-2104)	Return completed form to Payroll	☐
	I-9 Employment Verification	Return completed form to Payroll with Driver's License and Social Security card	☐
	Employee Statement	Return completed form to Payroll	☐
	Technology Agreement	Read, Sign and Return	☐
	AESOP Form	Return completed form. Keep Instructions.	☐
	K-12 Alert Form	Return completed form. Keep FAQ page FYI	☐
	Paychecks Per Year Form (l 0 Month Full-Time Only)	Return completed form to Payroll	☐
	Emergency Contact Form	Return completed form.	☐
	Direct Deposit	Return completed form to Payroll with a copy of a voided check	☐
Optional	Tax Shelter: OMNI 403(b) (Please Return Form)	Instructional: Complete Part I and Part 5 (Choose Option I, 2 or 3) Non-Instructional: Complete Part I and Part 3 (Choose Option 1, 2 or 3) and Part 5 after account has been opened through OMNI For more information: www.omni403b.com or call 1.877.544.6664	☐
	Hudson River Financial Federal Credit Union	Complete enrollment form and submit to HRFFCU with a $6.00 check to open an account. Deductions will be made with account number Enrollment can be done at any time.	☐
	FSA Enrollment Form	FLEX Spending account for Health Dependent Care pre-tax deductions. Return completed form to Payroll within Thirty days of hire. www.fsastore.com	☐
	Health Insurance	Return completed enrollment form *or* waiver required	☐
	Dental & Optical	Teacher (GTF) Dental & Optical offered through GTF Welfare Fund	☐
	AFLAC Benefits	Accident, Dental. Short Term Disability, Cancer. Contact Larry Blum to enroll. Ljblum 19@.gma il.com 914.645.1115	☐
Keep	Educators' EAP	Low Cost Benefit Solutions & Information*(Darleen McNerney)*	☐
	FMLA & COBRA Info.	Keep for your records	☐
	Payroll Schedule	Keep for your records	☐
	Paid Leave Time Form	Keep for future use	☐

Return completed forms to: **Instructional** - Alyssa Larraguibel, alarraguibel@greenburghcsd.org, 914.761.6000 Ext. 3139
Return completed forms to : **Non-Instructional** - Laurie D'Amico, ldamico@greenburghcsd.org. 914.761.6000 Ext. 3106

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

2020

Step 1: Enter Personal Information

(a) First name and middle initial

Last name

(b) **Social security number**

Address

City or town, state, and ZIP code

▶ 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.*

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **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, when to use the online estimator, 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) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

If your 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 and 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)

For Privacy Act and Paperwork Reduction Act Notice, see page 3.

Married Filing Jointly or Qualifying Widow(er)

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	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

NEW YORK STATE
2020

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your Social Security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐ Married, but withhold at higher single rate ☐
City, village, or post office	State ZIP code	**Note:** If married but legally separated, mark an *X* in the *Single or Head of household* box.

Are you a resident of New York City? .... Yes ☐ No ☐

Are you a resident of Yonkers? .... Yes ☐ No ☐

Complete the worksheet on page 4 before making any entries.

1	Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 20)*	1	
2	Total number of allowances for New York City *(from line 35)*	2	

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3	New York State amount	3	
4	New York City amount	4	
5	Yonkers amount	5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature

Date

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: **Keep this certificate with your records.**

Mark an *X* in box A and/or box B to indicate why you are sending a copy of this form to New York State *(see instructions)*:

A Employee claimed more than 14 exemption allowances for NYS .... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see instr.)*:

Are dependent health insurance benefits available for this employee? .... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*:

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)*

Employer identification number

Instructions

Changes effective for 2020

Form IT-2104 has been revised for tax year 2020. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2020 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you do not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn $107,650 or more during the tax year.

Worksheet

See the instructions before completing this worksheet.

Part 1 – Complete this part to compute your withholding allowances for New York State and Yonkers (line 1).

6 Enter the number of dependents that you will claim on your state return *(do not include yourself or, if married, your spouse)* ..... 6 ________

For lines 7, 8, and 9, enter *1* for each credit you expect to claim on your state return.

7 College tuition credit .... 7 ________

8 New York State household credit .... 8 ________

9 Real property tax credit .... 9 ________

For lines 10, 11, and 12, enter *3* for each credit you expect to claim on your state return.

10 Child and dependent care credit .... 10 ________

11 Earned income credit .... 11 ________

12 Empire State child credit .... 12 ________

13 New York City school tax credit: If you expect to be a resident of New York City for any part of the tax year, enter *2* .... 13 ________

14 Other credits *(see instructions)* .... 14 ________

15 Head of household status and only one job *(enter 2 if the situation applies)* .... 15 ________

16 Enter an estimate of your federal adjustments to income, such as deductible IRA contributions you will make for the tax year. Total estimate $ ________. Divide this estimate by $1,000. Drop any fraction and enter the number ..... 16 ________

17 If you expect to be a covered employee of an employer who elected to pay the employer compensation expense tax in 2020, complete Part 3 below and enter the number from line 29 .... 17 ________

18 If you made contributions in 2019 to a New York Charitable Gifts Trust Fund (the Health Charitable Account or the Elementary and Secondary Education Account), complete Part 4 below and enter the amount from line 32 .... 18 ________

19 If you expect to itemize deductions on your state tax return, complete Part 2 below and enter the number from line 24. All others enter *0* .... 19 ________

20 Add lines 6 through 19. Enter the result here and on line 1. If you have more than one job, or if you and your spouse both work, see instructions for *Taxpayers with more than one job* or *Married couples with both spouses working.* .... 20 ________

Part 2 – Complete this part only if you expect to itemize deductions on your state return.

21 Enter your estimated NY itemized deductions for the tax year *(see Form IT-196 and its instructions; enter the amount from line 49)* 21 ________

22 Based on your federal filing status, enter the applicable amount from the table below .... 22 ________

Standard deduction table

Single (cannot be claimed as a dependent)	$ 8,000	Qualifying widow(er)	$16,050
Single (can be claimed as a dependent)	$ 3,100	Married filing jointly	$16,050
Head of household	$11,200	Married filing separate returns	$ 8,000

23 Subtract line 22 from line 21 *(if line 22 is larger than line 21, enter 0 here and on line 19 above)* .... 23 ________

24 Divide line 23 by $1,000. Drop any fraction and enter the result here and on line 19 above .... 24 ________

Part 3 – Complete this part if you expect to be a covered employee of an employer that has elected to participate in the Employer Compensation Expense Program (line 17).

25 Expected annual wages and compensation from electing employer in 2020 .... 25 ________

26 Line 25 minus $40,000 (if zero or less, stop) .... 26 ________

27 Line 26 multiplied by .03 .... 27 ________

28 Line 27 multiplied by .935 .... 28 ________

29 Divide line 28 by 65. Drop any fraction and enter the result here and on line 17 above .... 29 ________

Part 4 – Complete this part if you made contributions in 2019 to the Health Charitable Account or the Elementary and Secondary Education Account (line 18).

30 Contributions to these funds in 2019 .... 30 ________

31 Multiply line 30 by 85% (.85) .... 31 ________

32 Divide line 31 by 60. Drop any fraction and enter the result here and on line 18 above .... 32 ________

Part 5 – Complete this part to compute your withholding allowances for New York City (line 2).

33 Enter the amount from line 6 above .... 33 ________

34 Add lines 15 through 19 above and enter total here .... 34 ________

35 Add lines 33 and 34. Enter the result here and on line 2 .... 35 ________

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**
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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

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

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For 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.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B
Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C
Documents that Establish Employment Authorization

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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card (Form I-197)
6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
7. Employment authorization document issued by the Department of Homeland Security

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.

GCSD
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EMPLOYEE STATEMENT

State of New York)
County of Westchester) ss.

I, ______________________________, do hereby pledge and declare that I will support the Constitution of the United States and the Constitution of the State of New York, and that I will faithfully discharge the duties of the position of

____
for Greenburgh Central School District according to the best of my ability.

(Signed)______________________________

(Date)______________________________

RETURN TO: District Clerk
Greenburgh Central School District
475 W. Hartsdale Avenue
Hartsdale, NY 10530

NEW YORK STATE CIVIL SERVICE LAW

§62. Constitutional Oath upon Appointment

Every person employed by the state or any of its civil divisions, except an employee in the labor class, before he shall be entitled to enter upon the discharge of any of his duties, shall take and file an oath or affirmation . . . **In lieu of such oath administered by an officer, an employee may comply with the requirements of this section by subscribing and filing the following statement: "I do hereby pledge and declare that I will support the constitution of the United States, and the constitution of the state of New York, and that I will faithfully discharge the duties of the position of ...., according to the best of my ability."** Such oath or statement shall be required only upon original appointment or upon a new appointment following an interruption of continuous service, and shall not be required upon promotion, demotion, transfer, or other change of title during the continued service of the employee, or upon the reinstatement pursuant to law or rules of an employee whose services have been terminated and whose last executed oath or statement is on file. The oath of office heretofore taken by any employee as previously required by law, and the oath of office hereafter taken or statement hereafter subscribed by any employee pursuant to this section, shall extend to and encompass any position or title in which such person may serve as an employee during the period of his continuous service following the taking of such oath or subscribing of such statement, and his acceptance of such new title shall constitute a reaffirmance of such oath or statement. The oath or statement of every . . . employee of a municipal corporation [shall be filed in the office of] the clerk thereof. . . . **The refusal or willful failure of such employee to take and file such oath or subscribe and file such statement shall terminate his employment until such oath shall be taken and filed or statement subscribed and filed as herein provided.**

* * *

NEW YORK STATE EDUCATION LAW

Title IV Teachers and Pupils

Article 61 Teachers, and Supervisory and Administrative Staff

§ 3002. Oath to Support Federal and State Constitutions

It shall be unlawful for any citizen of the United States to serve as teacher, instructor or professor in any school or institution in the public school system of the state or in any school, college, university or other educational institution in this state, whose real property, in whole or in part, is exempt from taxation under section four of the tax law unless and until he or she shall have taken and subscribed the following oath or affirmation . . . **In lieu of the oath administered by an officer, person or member, an employee may comply with the requirements of this section by subscribing and filing the following statement: "I do hereby pledge and declare that I will support the constitution of the United States and the constitution of the State of New York, and that I will faithfully discharge the duties of the position of ---- according to the best of my ability."** Such oath or statement shall be filed with the clerk of a school district or with such officer or employee of any such college, university or other educational institution that shall be designated for such purpose. Such oaths or statements shall be available for public inspection and for transmittal to the commissioner of education upon his request. It shall be unlawful for an officer, person or board having control of the employment, dismissal or suspension of teachers, instructors or professors in such a school, college, university or institution, to permit a person to serve in any such capacity therein in violation of the provisions of this section. This section shall not be construed to require a person to take such oath or to execute such statement more than once during the time he or she is employed in the same school, college, university or institution, though there be a change in the title or duties of the position.

The provisions of section sixty-two of the civil service law shall not apply to a person who is required to take the oath or execute the statement prescribed by this section.

* * *

CASE ANNOTATION

Members and officers of school boards and library trustees are required to take a constitutional oath before assuming office and this must be filed in the office of either the clerk of the board or the county as the case may be. Teachers are required to take a similar oath which must be filed with the clerk of the school district, and a record thereof must be kept by the school district. 1967 Ops St Compt File #1016

Aesop

Employee/Substitute Placement & Absence Management System

New User Account Activation Form

Employee/Substitute

(Instructional & Non-Instructional Support Activation)

This Section May Be Completed By: HR Administrator or AESOP User

Please Print Clearly

First Name	**Middle Initial**	**Last Name**	**Date of Birth**
Preferred Phone #	**Email Address** (District Employees Must List Their District Email Address)		**Job Title**

To Be Completed By HR Office: Business Office or Curriculum Instruction Office

Please Print Clearly

Employee Type: Must Check One	☐ Admin ☐ Certified TA ☐ Certified Teacher ☐ Civil Service ☐ Sub		
Employee #:		**Gender:**	☐ M ☐ F
Certified TA:	☐ Yes ☐ No	**Level:**	
Certified Teacher:	☐ Yes ☐ No	**Is Substitute Active in other District:**	☐ Yes ☐ No
Proficient in Following Languages: Must Check One	☐ English ☐ Spanish ☐ French ☐ Chinese ☐ ________		

Assigned Building Location: ☐ ECP ☐ LFJ ☐ HV ☐ RJB ☐ WMS ☐ WHS ☐ Mansion
Must Check All That Apply

Please List Qualified *(or Preferred)* Subject Areas: ______________________________

____

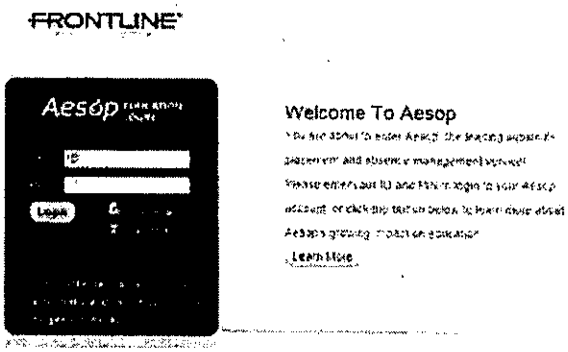
Additional Notes: ______________________________

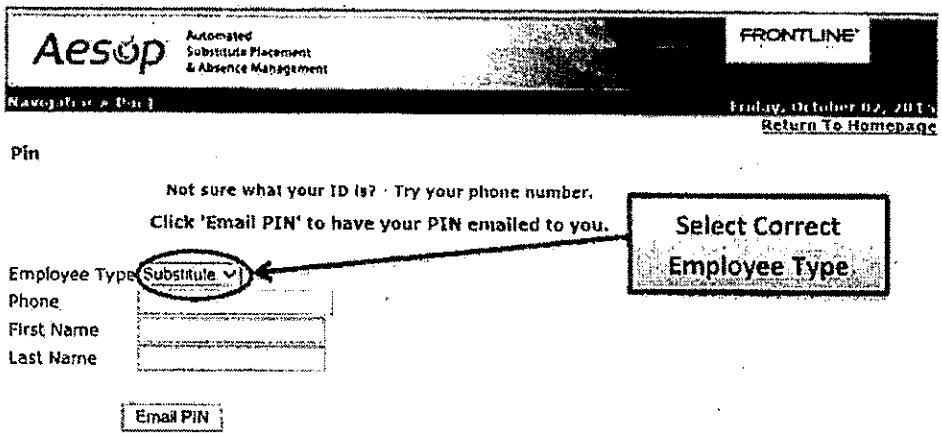
____

BOE Approved / Appointed On:	
HR Department Administrator: Please Initial / Sign	

Quick Start Instructions

1. If you do not recall your current PIN or you are getting an incorrect ID or PIN combination message, please click on the *PIN Reminder* options at the login. Select *Substitute* or *Employee* at the *Employee Type* drop down list. Enter the phone number you provided when your account was created. Enter your *First Name* and *Last Name*. Select *Email Pin*. The PIN will be emailed to your Greenburgh CSD address. The email will contain instructions on how to reset your PIN. Create a new PIN and return to the main AESOP login page at https://www.aesoponline.com/login2.asp.





Pin

Not sure what your ID is? · Try your phone number.

Click 'Email PIN' to have your PIN emailed to you.

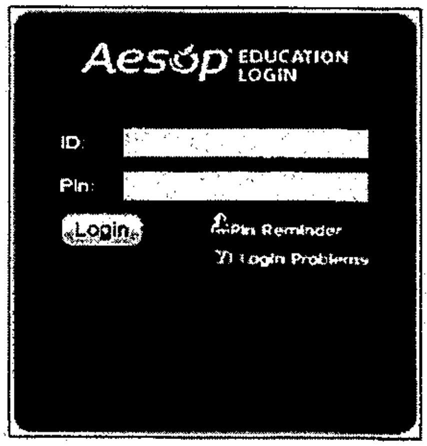
Employee Type Substitute
Phone
First Name
Last Name

2. If you are having difficulties resetting your PIN or do not recall your ID and PIN combination, or have any questions regarding using the ASOEP software application. please send an Email to aesophelp@greenburghcsd.org for assistance. **Please include in the Subject Field the topic for assistance. For example, if you cannot retrieve your PIN, please enter "PIN Retrieval" in the Subject Field of your email**. A member of the tech support staff will address your request promptly.

3. The ASEOP Support Help line is 914-761-6000 ext. 3000 or ext. 3000 if calling internally. Support Help Line hours are 7:30 a.m. to 4:00 p.m. **Please follow steps 1 and 2 for assistance before contacting the ASEOP Support Help Line.**

Logging in on the Web

To log into Aesop, type http://www.aesoponline.com in your web browser's address bar.



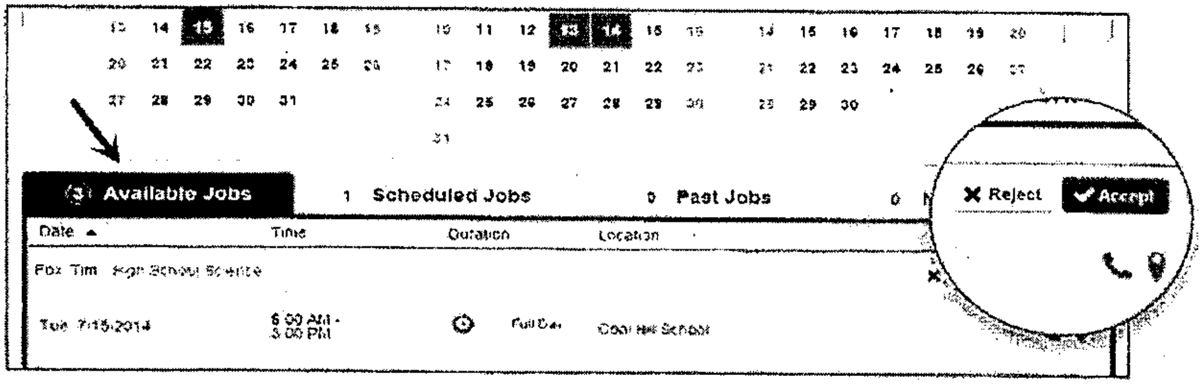
Enter your ID number and PIN; then, click **Login**.

Can't remember your login info?

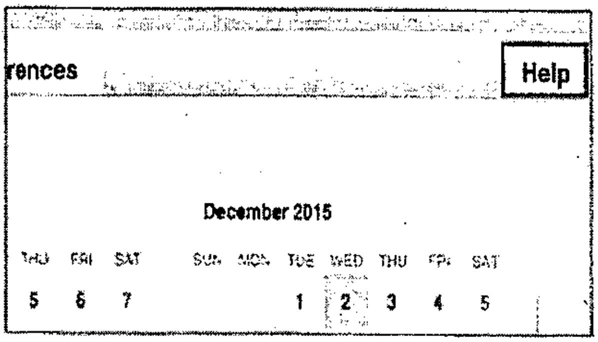
If you're having trouble logging in, click the **Login Problems** link next to the "Login" button for more information.

Finding Available Jobs

Aesop makes it easy to find available jobs right on the homepage. Jobs available for you to accept show in green on the calendar and in list form under the "Available Jobs" tab.



To accept a job, simply click the **Accept** button next to the absence. If you do not want to accept this job, click the **Reject** button, instead.



Getting Help and Training

If you have questions, want to learn more about a certain feature, or want more information about a specific topic, click the **Help** tab to go to the Aesop Learning Center to search Aesop's knowledge base of help and training materials.

Using Aesop on the Phone

Not only is Aesop available on the web, but you can also find and accept available jobs, manage personal information, change your PIN number, and more, all over the phone.

When You Call Aesop

To call Aesop, dial **1-800-942-3767**. You'll be prompted to enter your ID number (followed by the # sign), then your PIN number (followed by the # sign).

When calling Aesop, you can:

- Find available jobs - **Press 1**
- Review or cancel upcoming jobs - **Press 2**
- Review or cancel a specific job - **Press 3**
- Review or change your personal information - **Press 4**

When Aesop Calls You

If an available job has not been filled by another substitute two days before the absence is scheduled to start, Aesop will automatically start calling substitutes, trying to fill the job. Keep in mind, when Aesop calls you, it will be calling about one job at a time, even if you're eligible for other jobs. You can always call into Aesop (see "When You Call Aesop" section above) to hear a list of all available jobs.

> **Note:** When Aesop calls you, be sure to say a loud and clear "Hello" after answering the call. This will ensure that the system knows you picked up the call.

When you receive a call from Aesop, you can:

- Listen to available jobs - **Press 1**
- Prevent Aesop from calling again today - **Press 2**
- Tell Aesop the Sub it is trying to reach is not available - **Press 3**
- Prevent Aesop from ever calling again - **Press 9**

If you are interested in the available job, **Press 1.** You will be asked to enter your PIN number (followed by the # sign). At this point, Aesop will list the job details, and you will have the opportunity to accept or reject the job.

Greenburgh Central
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Carlos A. Ramirez, MS Ed
Director of Technology & CIO
T: 914.761.6000 ext. 3116
E: cramirez@greenburghcsd.org

Dr. Tahira A. DuPree Chase
Superintendent of Schools

K12 ALERTS

EMERGENCY NOTIFICATION – PHONE BROADCAST SYSTEM

Greenburgh Central School District utilizes **K12 Alerts®**, an automated Telephone, Email and Text message service, to inform you of school weather related emergency closings and other important notifications. The service has two (2) components: Telephone Calls and Email/Text Messages. While you may choose to enroll in either or both, we strongly encourage you to participate in both. Please complete the form below and return. Thank you.

EMPLOYEE CONTACT INFORMATION	
Date:	
* First Name:	
* Last Name:	
Title:	
* Gender	○ Male ○ Female
* Language:	○ English ○ Spanish
* Building/School:	○ Central Office ○ ECP ○ HES ○ LFJ ○ RJB ○ Transportation ○ WHS ○ WMS

EMAIL INFORMATION

Your district E-mail is already on file. However, you can also supply your Personal E-mail Address to receive Broadcasting Service

* District Email:	@greenburghcsd.org	Personal Email:

CELLULAR FOR TEXT MESSAGE

To receive a Text Message, your Cellular Phone Company/Provider's Name is required

Mobile Number:		Service Provider:	

LANDLINE AND CELL PHONE INFORMATION

Greenburgh Central School District requires at least one (1) Telephone Number on file for both Emergency and Important District Notificatio

* Home Number:		○ Emergency Message	○ Important District Notification
* Mobile Number:		○ Emergency Message	○ Important District Notification
Other Number:		○ Emergency Message	○ Important District Notification

****IMPORTANT****

Any changes regarding your contact information MUST be communicated to Victoria Lucas, Senior Payroll Clerk of the Business Office, at vlucas@greenburghcsd.org

Greenburgh Central School District
Our Children. Our Focus. Our Future.

Carlos A. Ramirez, MS Ed
Director of Technology & CIO
T: 914.761.6000 ext. 3116
E: cramirez@greenburghcsd.org

Dr. Tahira A. DuPree Chase
Superintendent of Schools

FREQUENTLY ASKED QUESTIONS

The power of a phone broadcast system is its ability to share information with our students' families in urgent situations:

- Weather-related closings
- Power outages
- Emergency safety measures
- Transportation changes
- Reminders and announcements

What you and your family need to know

Caller ID. Caller ID will display the district or school's phone number.

Live answers. Answer your phone as you normally would. Say "hello" only once and wait for the message to begin. Please note: Multiple "hello's" will delay the start of the message.

Answering machines. The system will detect that your machine has answered and will play the message to your machine. Please make sure your answering machine answers after 4 rings for optimal delivery of voice alerts from the school.

Morning & day calls. If the decision to cancel school is made the night before, or early in the morning, the broadcast message will be sent to all phone numbers listed. If the decision is made during the school day, the broadcast message will be sent to "home" and "cellular" numbers. General announcements will also be sent to numbers listed.

E-Mails. If you supply the school with your e-mail address, you can be included in the e-mail broadcasting service.

K12 Alerts® uses the best technology in the industry to detect the difference between a human answer and machine answer.

How detection works:

1. If within the first three seconds the system determines that it is a "live" answer, it will start playing the message. If you have a 1-2 second beginning pause in your recording this will lengthen message being played.
2. The system waits up to three seconds then if the system determines that it is a machine, it will wait up to 20 seconds before playing the message so the machine greeting can play first.

Possible reasons for false detection:

- Loud background noise: television, radio, noisy environment.
- Cordless phone that has static or other interference.
- Not saying hello, saying hello more than one time, or delaying saying hello.

Should you have any questions and/or concerns regarding K12 Alerts® please contact the Technology Department at 914.761.6000 Ext. 3000

** IMPORTANT NOTICE **

Any changes regarding your contact information MUST be communicated to Victoria Lucas, Senior Payroll Clerk of the Business Office, at vlucas@greenburghcsd.org

Greenburgh Central
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EMERGENCY CONTACT INFORMATION

In the event of an emergency, it is very important that we have on file the name(s) you would want to be contacted. In the space provided below, please fill in the information requested and return the completed form to the Office of Human Resources as soon as possible.

EMPLOYEE INFORMATION			
Name			
Home Address			
Home Phone		Cell Phone	
Alternative Email Address			

PRIMARY EMERGENCY CONTACT			
Name			
Home Address			
Home Phone		Cell Phone	
Work Phone		Email Address	
SECONDARY EMERGENCY CONTACT			
Name			
Home Address			
Home Phone		Cell Phone	
Work Phone		Email Address	

Please note: This information is confidential. It will only be used for the reasons stated above. Thank you for your cooperation.

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Payroll Schedule for 2019-2020

Payroll Date	*Timesheets, Vouchers and Timepiece Approvals Needed By:*		*Hourly and Per Diem Time Worked*	*12 Month*	*GTF*	*GCSO*	*CSEA*
07/15/19	07/08/19	10:30 AM	6/24 - 7/7	1			
07/30/19	07/22/19	10:30 AM	7/8 – 7/21	2			
08/15/19	08/05/19	10:30 AM	7/22 – 8/4	3			
08/30/19	08/19/19	10:30 AM	8/5 – 8/18	4			
09/13/19	09/03/19	10:30 AM	8/19 – 9/1	5	1	1	1
09/30/19	09/16/19	10:30 AM	9/2 – 9/15	6	2	2	2
10/15/19	10/02/19	10:30 AM	9/16 – 9/29	7	3	3	3
10/30/19	10/14/19	10:30 AM	9/30 – 10/13	8	4	4	4
11/15/19	10/28/19	10:30 AM	10/14 – 10/27	9	5	5	5
11/29/19	11/12/19	10:30 AM	10/28 – 11/10	10	6	6	6
12/13/19	12/02/19	10:30 AM	11/11 – 12/1	11	7	7	7
12/30/19	12/16/19	10:30 AM	12/2 – 12/15	12	8	8	8
01/15/20	01/06/20	10:30 AM	12/16 – 12/29	13	9	9	9
01/30/20	01/13/20	10:30 AM	12/30 – 1/12	14	10	10	10
02/14/20	01/27/20	10:30 AM	1/13 – 1/26	15	11	11	11
02/28/20	02/10/20	10:30 AM	1/27 – 2/9	16	12	12	12
03/13/20	03/02/20	10:30 AM	2/10 – 2/23	17	13	13	13
03/30/20	03/16/20	10:30 AM	2/24 – 3/15	18	14	14	14
04/15/20	03/30/20	10:30 AM	3/16 – 3/29	19	15	15	15
04/30/20	04/13/20	10:30 AM	3/30 – 4/12	20	16	16	16
05/15/20	04/27/20	10:30 AM	4/13 – 4/26	21	17	17	17
05/29/20	05/11/20	10:30 AM	4/27 – 5/10	22	18	18	18
06/15/20	06/01/20	10:30 AM	5/11 – 5/31	23	19	19	19
06/30/20	06/22/20	10:30 AM	6/1 – 6/21	24	20	20	20

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DIRECT DEPOSIT FORM

Employee Name ______________________________________

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS - *PLEASE PRINT NEATLY*

Type of Account	Routing/Transit Number	Checking/Savings Account Number	Financial Institution ("Bank") Name	I wish to deposit (check one):
☐ Checking ☐ Savings				☐_% of Net Pay ☐ Specific Dollar Amount $________.00 ☐ Remainder of Net Pay
☐ Checking ☐ Savings				☐_% of Net Pay ☐ Specific Dollar Amount $________.00 ☐ Remainder of Net Pay

Please attach a voided check for each account listed above.

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS - *PLEASE PRINT NEATLY*

Type of Account	Routing/Transit Number	Checking/Savings Account Number	Financial Institution ("Bank") Name	I wish to deposit (check one):
☐ Checking ☐ Savings				☐ From______% to______% of Net Pay ☐ From $________.00 to $________.00 ☐ Remainder of Net Pay
☐ Checking ☐ Savings				☐ From______% to______% of Net Pay ☐ From $________.00 to $________.00 ☐ Remainder of Net Pay

EMPLOYEE CONFIRMATION STATEMENT

I hereby authorize Greenburgh Central School District to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my checking or savings account. This authority is to remain in full effect until the Greenburgh Central School District has received written notification from me of its termination.

Employee Signature______________________________________ Date ____________________

GREENBURGH CENTRAL SCHOOL DISTRICT

SUMMARY OF HEALTH PLANS

1. State-Wide Schools Cooperative Health Plan (SWSCHP)

Provider network with direct access to specialists in the network and/or out of network plan.
Out of network plan (plan pays 70% and you pay 30% with deductible of $1,000 per person; $3, 000 per family)

Website: www.swschp.org (Empire Blue Cross Blue Shield POS network: Choose "Find In-Network Providers", then "Empire POS Network", then under "Search as a Member" enter alpha prefix TUR)

Doctor's Visit Copayment:		$ 30.00
Emergency Room Visit Copayment:		$ 75.00
Ambulance Copayment:		$ 50.00
Hospital Inpatient Copayment:		$200.00
Quest Lab or US Imaging Services Copayments :		$ 0.00
Outpatient Surgery, Labs, Radiology Copayments:		$ 30.00, 50.00, or 75.00
Prescription Copayment:	Generic:	$ 7.50
	Preferred Brand:	$ 30.00 *
	Non-preferred Brand	$ 50.00 *

* Additional costs may apply if you choose this over a less expensive alternative.

Mail Order Prescriptions: Get 3 months at the cost for 2 months with CVS Caremark

2. Health Insurance Plan (HIP)

HMO with provider network allowing direct access to specialists in the network

Website: www.emblemhealth.com (Under "Find a Doctor" choose "Visitor Search" and enter zip code, then "I know the specific plan I'm looking for", then under HMO choose HIPaccess I, and then Prime network)

Doctor's Visit Copayment:		$ 15.00
Emergency Room Visit Copayment:		$ 50.00
Hospital Inpatient Copayment		$100.00
Hospital Outpatient Copayment		$ 50.00
Prescription Copayment:	Generic:	$ 5.00
	Preferred Brand:	$ 15.00
	Non-preferred Brand:	$ 40.00

Mail Order Prescriptions: Get 3 months at 50% off with Express Scripts

ENROLLMENT

Proof of marriage and/or proof of birth, adoption, or legal custody of children are/is required when enrolling any dependents in all health plans. **Social Security Card** copies are required for all persons being covered under a plan.

Children are eligible for coverage as dependents on their parents' plan up to age 26.

Domestic Partner Coverage is provided for eligible same sex and opposite sex domestic partners. Packets containing eligibility requirements and enrollment applications are available.

IL 11/3/17

Greenburgh Central School District

2019-2020 Health Insurance Rates (Effective 7/1/19)

		GCSO			GTF Teachers			GTF Teaching Assistants			Administrators	
Plan	July 1, 2019 Annual Rate	Annual Employee Share	20 Pay	24 Pay	Annual Employee Share	20 Pay	24 Pay	Annual Employee Share	20 Pay	24 Pay	Annual Employee Share	24 Pay
SWSCHP Single	$12,268.08	$736.08	$36.80	$30.67	$920.11	$46.01	$38.34	$920.11	$46.01	$38.34	$920.11	$38.34
SWSCHP Dual	$25,884.84	$4,140.27	$207.01	$172.51	$4,324.30	$216.21	$180.18	$4,324.30	$216.21	$180.18	$4,324.30	$180.18
SWSCHP Family	$27,730.80	$4,601.76	$230.09	$191.74	$4,785.79	$239.29	$199.41	$4,785.79	$239.29	$199.41	$4,785.79	$199.41
Oxford Single	$14,722.08				$1,472.21	$73.61	$61.34	$1,104.16	$55.21	$46.01		
Oxford Dual	$28,413.60				$4,895.09	$244.75	$203.96	$4,527.04	$226.35	$188.63		
Oxford Family	$44,460.72				$8,906.87	$445.34	$371.12	$8,538.82	$426.94	$355.78		
HIP Single	$12,669.60	$760.18	$38.01	$31.67	$950.22	$47.51	$39.59	$950.22	$47.51	$39.59	$950.22	$39.59
HIP Dual	$23,134.32	$3,376.36	$168.82	$140.68	$3,566.40	$178.32	$148.60	$3,566.40	$178.32	$148.60	$3,566.40	$148.60
HIP Family	$36,830.64	$6,800.44	$340.02	$283.35	$6,990.48	$349.52	$291.27	$6,990.48	$349.52	$291.27	$6,990.48	$291.27

The Employee share is computed based upon the contractual language in the contract.
SWSCHP rates are in effect until 6/30/20
OXFORD & HIP rates are in effect until 12/31/19

mblemHealth

TRANSACTION FORM FOR GROUP ACCOUNTS

SUBSCRIBER INFORMATION

ast Name | First Name | M.I. | Sex | Social Security Number

treet Address | Apt. | City | State | ZIP Code

ere you ever a member of EmblemHealth? ☐ NO ☐ YES
YES, member ID ____________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner

Birth Date: Mo. Day Yr.

Home Tel. #: ____________
Work Tel. #: ____________
Cell Tel. # (see back of form*): ____________

Email Address: ____________
☐ **"GO PAPERLESS" and save trees (see back of form)¹**

pplicant's hours worked per week:
☐ at least 30 hours ☐ less than 30 hours ☐ COBRA
☐ Retiree (see back of form**)

Type of Coverage: ☐ Individual ☐ Employee & Spouse/DP ☐ Family ☐ Employee & Child

Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

rimary Care Physician Name: (Not required for EPO/PPO members) ____________ ID Number: ____________

B/GYN Selection Name: (Optional) ____________ ID Number: ____________

re you covered by any other health insurance or Medicare?
☐ NO ☐ YES If YES, indicate:
surance Co. Name: ____________
surance Co. Telephone #: ____________ Type of Coverage: ____________
licy #: ____________ Effective Date: ____________

Check One:
☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ EmblemHealth Group Change:
From: ____________
To: ____________

ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

ote: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date Mo.	Birth Date Day	Birth Date Yr.	✓ if Disabled¹	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
EPENDENT				☐ Spouse ☐ DP ☐ Child						
EPENDENT				☐ Child						
EPENDENT				☐ Child						

rrent Health Insurance Information: Carrier Name: ____________ Coverage Begin Date: ____________ Coverage End Date: ____________

rrent Health Insurance Information: Carrier Name: ____________ Coverage Begin Date: ____________ Coverage End Date: ____________

rrent Health Insurance Information: Carrier Name: ____________ Coverage Begin Date: ____________ Coverage End Date: ____________

dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

our signature is required to process this form. Your signature attests that you have read the reverse side of this form.
y person who knowingly and with intent to defraud 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 ncerning any material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

pplicant must sign here: ____________ **Date:** ____________

. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

ame of Group: Greenburgh CSD

Group Number: 1162140051 | Sub Group ID ____________ Class ID ____________ Plan ID ____________

☐ EmblemHealth ☐ GHI ☒ HIP

If you selected a small group metal plan, please check which type: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze

Plan Name: ____________

equested Effective Date: Medical: ____________ Dental: ____________

Hire Date: | Waiting Period: | Date Submitted: | Approved By: (Group Plan Administrator)

structions to Benefit Administrators or Group Representatives: For groups with 100 or fewer full-time equivalent eligible employees, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

2 Metro Park Rd. Suite 208
olonie, NY 12205-1139

STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN

EMPLOYEE BENEFITS ENROLLMENT FORM

INSTRUCTIONS: NEW EMPLOYEE - Complete all unshaded areas and sign the form. CHANGES - Enter new or corrected information.

ADD	CHANGE	GROUP	DIVISION

SOCIAL SECURITY NO. ___ — ___ — ___
HOME PHONE #
NAME (LAST, FIRST, M.I.)
ADDRESS (STREET, CITY, STATE, ZIP CODE)
BIRTH DATE / /
SEX M F
MARITAL STATUS (Married, Single, Divorced, Widow, Legally Sep.) M S D W L
MARRIAGE DATE
DO YOU HAVE MEDICARE COVERAGE Y N
IF YES, CHECK ☐ Part A / / ☐ Part B / / EFFECTIVE DATES
MEDICARE ID NO.
EMPLOYMENT DATE / /
IN ADDITION TO THIS NEW COVERAGE WILL YOU CONTINUE TO HAVE OTHER GROUP HEALTH INSURANCE? Y N
IF YES, NAME OF OTHER CARRIER / GROUP NO.
STATUS ☐ Active ☐ Survivor ☐ Retired ☐ Terminated ☐ COBRA ☐ On Leave ☐ Deceased
STATUS CODE
EFFECTIVE DATE / /
TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY
STATUS OF EMPLOYMENT ☐ ACTIVE ☐ RETIRED
EFFECTIVE DATE OF COVERAGE ____/____/____

SPOUSE ☐

OMESTIC ARTNER ☐

NAME (LAST, FIRST, M.I.)
BIRTH DATE / /
SEX M F
DISABLED Y N
MEDICARE COVERAGE? Y N
IF YES, CHECK ☐ PART A / / ☐ PART B / / EFFECTIVE DATES
SOCIAL SECURITY NO.
EMPLOYED: Y N
IF YES, NAME OF EMPLOYER (BE SPECIFIC)
OTHER GROUP HEALTH INSURANCE: Y N
IF YES, TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY
EFFECTIVE DATE OF COVERAGE / /
STATUS OF EMPLOYMENT ☐ ACTIVE ☐ RETIRED
NAME OF CARRIER
ADDRESS (STREET, CITY, STATE, ZIP CODE)
PHONE NO.
GROUP NO.

EASON FOR ADDITION OR DELETION: BIRTH ☐ BIRTH DATE: ____/____/____ ADOPTION ☐ ADOPTION DATE: ____/____/____ OTHER: ____________ DATE: ____/____/____
MARRIAGE ☐ MARRIAGE DATE: ____/____/____ DIVORCE ☐ DIVORCE DATE: ____/____/____ DOMESTIC PARTNERSHIP ☐ QUALIFYING DATE: ____/____/____

RELATIONSHIP TO EMPLOYEE	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	SEX	BIRTH DATE	DISABLED	STUDENT DEP.
					M F	/ /	Y N	Y N
					M F	/ /	Y N	Y N
					M F	/ /	Y N	Y N
					M F	/ /	Y N	Y N
					M F	/ /	Y N	Y N

IF MORE SPACE IS NEEDED TO LIST DEPENDENTS, ATTACH ANOTHER FORM. BE SURE TO ENTER YOUR SOCIAL SECURITY NUMBER.

TYPE	OPTION	SINGLE FAMILY	CODE	EFFECTIVE DATE	CANCELLATION DATE
HEALTH	SWS HEALTH PLAN				

ALL INFORMATION PROVIDED HEREON IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE MY EMPLOYER TO MAKE ANY REQUIRED PAYROLL DEDUCTIONS.

EMPLOYEE'S SIGNATURE DATE
EMPLOYER'S REPRESENTATIVE DATE

OFFICE USE ONLY

Greenburgh Central
School District
Our Children. Our Focus. Our Future.

DECLINATION OF HEALTH INSURANCE

I wish to decline the health insurance contractually provided by the school district. I understand that by declining to enroll at this time:

1. I may subject myself and/or my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.
2. I may be forfeiting the right to such coverage after my retirement.

I understand that I may later enroll in one of the health plans offered by the district:

1. during one of the district's open enrollment periods. Open Enrollment for all plans takes place during the month of November each year. This coverage would be effective January 1st.

   SWSCHP has an additional open enrollment period in May and HIP will usually hold an additional open enrollment at that time as well. This coverage would be effective July 1st.

   or

2. upon losing the benefits I have under my present health plan, providing I complete a health insurance enrollment application within 30 days of the event. This coverage would be effective the date of the event.

Name: ______________________________

Signature______________________________

Social Security Number: ____________________ Date: ________________

RAYMOND OPTICIANS

VIP VISION SAVINGS FOR MEMBERS, FAMILIES & FRIENDS

Greenburgh Civil Service Organization

How To Take Advantage of your VIP Savings:

Identify yourself as a member (or family member or friend) of Greenburgh Civil Service Organization at any participating Raymond Opticians Location to take advantage of these exclusive savings! Don't forget to refer your Aunts, Uncles, Parents & Grandparents too; Raymond Opticians will honor these special prices for your extended family!

Please Call In Advance To Schedule an Appointment If you require an Eye Examination

**See reverse side for Store Locations & Phone Numbers*

SINGLE VISION PACKAGE

WHAT'S INCLUDED:

- COMPREHENSIVE EYE EXAM *REQUIRES AN APPOINTMENT
- SINGLE VISION LENSES
- TRENDY EYEGLASS FRAME
- SCRATCH RESISTANT COATING
- TINT&UV PROTECTION UPON REQUEST
- **FREE SPARE PAIR** SINGLE VISION (EYEGLASSES OR SUNGLASSES)

YOU PAY ONLY: **$175** OVER $550 VALUE

BIFOCAL LENS PACKAGE

WHAT'S INCLUDED:

- COMPREHENSIVE EYE EXAM *REQUIRES AN APPOINTMENT
- BIFOCAL LENSES
- TRENDY EYEGLASS FRAME
- SCRATCH RESISTANT COATING
- TINT&UV PROTECTION UPON REQUEST
- **FREE SPARE PAIR** SINGLE VISION (EYEGLASSES OR SUNGLASSES)

YOU PAY ONLY: **$250** OVER $600 VALUE

PROGRESSIVE LENS PACKAGE

WHAT'S INCLUDED:

- COMPREHENSIVE EYE EXAM *REQUIRES AN APPOINTMENT
- PROGRESSIVE LENSES
- TRENDY EYEGLASS FRAME
- SCRATCH RESISTANT COATING
- TINT&UV PROTECTION UPON REQUEST
- **FREE SPARE PAIR** SINGLE VISION (EYEGLASSES OR SUNGLASSES)

YOU PAY ONLY: **$300** OVER $700 VALUE

CONTACT LENS PACKAGE

- COMPREHENSIVE EYE EXAM INCL. CONTACT LENS FITTING *REQUIRES AN APPOINTMENT
- $150 CONTACT LENS SUPPLY
- **FREE SPARE PAIR** SINGLE VISION (EYEGLASSES OR SUNGLASSES)

YOU PAY ONLY: **$200** OVER $500 VALUE

* FIRST TIME CL WEARERS HAVE AN ADDITIONAL COPAY FOR CONTACT LENS TRAINING. THIS COPAY STARTS AT $75. MULTIFOCAL WEARERS MAY HAVE ADDITIONAL COPAY FOR FITTING PROCESS. THIS COPAY STARTS AT $95.

+1 FREE 2ND PAIR!

WE WOULD LIKE TO **THANK YOU** FOR CHOOSING RAYMOND OPTICIANS BY OFFERING YOU A FREE SECOND PAIR OF EYEGLASSES OR SUNGLASSES EVERY TIME YOU TAKE ADVANTAGE OF THESE SPECIAL SAVINGS. FREE SECOND PAIR EXCLUDES DESIGNER FRAMES AND IS LIMITED TO SINGLE VISION OR BIFOCAL LENSES. (SPARE PAIR CAN BE USED FOR OTHER FAMILY MEMBERS)

RECEIVE $150 OFF

ANY **DESIGNER EYEGLASS FRAME**

WHEN TAKING ADVANTAGE OF THESE EXCLUSIVE VISION PACKAGES AT RAYMOND OPTICIANS

(OFFER NOT VALID ON FREE SPARE PAIR.)

WWW.RAYMONDOPTICIANS.COM
info@raymondopticians.com

SEE REVERSE FOR LOCATIONS

- THESE PRICES REFLECT UP TO 50% SAVINGS!
- TRANSITIONS, HI INDEX, ANTI REFLECTIVE AND POLARIZED LENSES ALL AVAILABLE AT DISCOUNTED PRICES
- MEMBERS ARE ELIGIBLE FOR NON-PRESCRIPTION SUNGLASS RECEIVE 15% OFF ON ALL NON PRESCRIPTION SUNGLASSES

RAYMOND OPTICIANS

CONVENIENT LOCATIONS

BEST OF WESTCHESTER
-Westchester Magazine

Family Owned & Operated
Since 1959

New York State
Optical Retailer of the Year
-New York State Society of Opticians

Questions? Email us:
info@raymondopticians.com

Northern Westchester County:

Jefferson Valley 3656 Lee Road (914) 245-1222
Katonah 198 Katonah Ave (914) 232-2400
Somers 10 Heritage 202 Ctr (914) 277-5656
Baldwin Place 80 Route 6 (914) 621-7700
Ossining Arcadian Shopping Center (914) 762-2800
Tarrytown 35 North Broadway (914) 631-1313
Thornwood Town Center (914) 741-2121
Mt Kisco 359 East Main St (914) 666-4202

Southern Westchester County:

Yonkers 652 Tuckahoe Road (914) 337-3322
North Yonkers 984 N Broadway (914) 375-0608
Larchmont 1923 Palmer Ave (914) 834-5576
Mamaroneck 307 Mamaroneck Ave (914) 698-2022
Dobbs Ferry 18 Ashford Ave (914) 693-4244
New Rochelle 521 Main St (914) 738-4500
White Plains 195 Mamaroneck Ave (914) 328-2020

Putnam County:

Carmel 1880 Route 6-Putnam Plaza (845) 228-5800
Brewster Route 22 (845) 279-2411

Dutchess County:

Hopewell Junction 827 Route 82 (845) 223-2010
Pawling 63 E Main St (845) 855-8200
Poughkeepsie 252 Hooker Ave (845) 471-3260

PREFERRED PG GROUP

The Preferred Group
PO Box 15136
Albany, NY 12212-5136
(866) 989-8995

Your Account Information Is Online
www.ThePreferredGroup.com

WLT10086

Greenburgh CSD
PG Blue - FSA Enrollment Form

— Please Read, Fill Out Carefully & Return to the Payroll Office by May 31, 2019

DIRECTIONS: Employee — Complete Sections 1, 2, 3 and 4 then return to your employer
Employer — Complete 'Change Type' Box and complete Section 5

Section 1 Employee Information

Employer Group #	Employer Group Name	Plan Year	Social Security Number
10086	Greenburgh CSD	7/1/2019 to 6/30/2020	___-___-___

Employee Name (First Name)
(Last Name)
Employee Address (Street, Apt. #)
Date of Birth (mm/dd/yyyy) ___/___/___
Employee Address (City, State, Zip Code)
Home Phone
Cell Phone
Email Address (Please allow email from benefitsinfo@thepreferredgroup.com)

Section 2 Flexible Spending Plan Benefit Elections

___ I accept the opportunity to have deductions withheld from my paycheck for eligible employer sponsored ___Medical and other health insurance related premiums on a pretax (before tax) basis for my entire share of my employer's group health insurance premiums, unless I indicate below not to do so. I understand that this election will be automatically renewed each year unless revoked by me in writing prior to the beginning of a new Plan Year.

___ I waive (do not want) the opportunity to have my ___ Medical insurance premium(s) withheld on a pretax (before tax) basis.

Account Type		Fund#		New Election		
MEDICAL FSA	($2,700 max)	1				
DEPENDENT DAY CARE	($5,000 max/$2,500 if married, filing separately)	2				

Section 3 Reimbursement Options

If you wish to have your reimbursements directly deposited to your bank account, please fill in the line below.

Direct Deposit Setup: Bank Name________________ Routing #________________ Acct #________________

Initial to Request Debit Card ________

Please note: By entering the above information you are enrolling into these specified programs and are validating your dependent information. For more information on these options including the timing of reimbursements, please see your Summary Plan Description.

Section 4 Signature and Acceptance of Rules of Flexible Spending Plan Rules

Salary Redirection Agreement (Please read and sign below): I have read and understand the explanation I have received regarding my options under this Flexible Benefits Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. I understand that I am only entitled to the amount of the above elections and cannot change any of my elections during the plan year (unless I have an acceptable change in status), and that any money left in my account(s) at the end of the plan year will be treated in accordance with my employer's FSA plan document.

Employee Signature
Date

Section 5 Employer's Section — Payroll Information for Salary Reduction Changes

 # Payrolls

Fund	First Payroll Date	Last Payroll Date	YTD Deductions	Per Payroll Deduct
FSA				
DCA				

Use 'First Payroll Date' and employer signature ONLY if the employee is making a *mid-year* election. Use the 'Last Payroll Date' and 'YTD Deductions' if changing an *old* election or termination.

Employer Signature
Date

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PG
GROUP

Flexible Spending Plan Reimbursement Voucher

Please read the back of this form for instructions on how to complete this voucher

EMPLOYER / GROUP NAME

YOUR NAME **S.S. NUMBER (Last 4 Digits)**

YOUR ADDRESS **CITY** **STATE** **ZIP**

☐ Please check this box if this is a change of address.
To ensure you receive notification of claim(s) status, please update you eMail address in the Benefits Portal at www.ThePreferredGroup.com.

Unreimbursed Medical Expenses

Receipts must include description of service, date of service, and amount.

Nature of Service	Date(s)	Amount
1		$
2		$
3		$
4		$
5		$
6		$
7		$
8		$
9		$
10		$
	TOTAL	$

Dependent/Child Care Expenses

Submit receipt including date of service, amount, and SS# or Tax ID#
OR have provider fill out and sign below

Name of Day Care Provider	Signature of Provider	SSN / Tax ID

Name of Dependent	Age	Disabled
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

Description of Service	Date(s)	Amount
1		
2		$
3		$
4		$
	TOTAL	$

Premium Expenses

(Privately held insurance policies)

Type of Insurance	Dates of Coverage	Amount
1		$
2		$
	Total	$

READ CAREFULLY AND SIGN

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for cafeteria plans, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for re-crediting to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

SIGNATURE *Date*

Send completed vouchers to:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
(518) 591-4960 (866) 989-8995
Fax: (518) 641-0325
www.ThePreferredGroup.com

Minimum Request:$25.00

**SEE REVERSE FOR DETAILS

PREFERRED PG GROUP

The Preferred Group
PO Box 15136
Albany, NY 12212-5136
(800) 573-7474
www.thepreferredgroup.com

Request for the Prepaid Benefits Card

Employer Name: ______________________________

Participant Name: ______________________________

SSN: ______________________________

Participant Email Address (Required): ______________________________

Date of Birth: ______________________________

The benefit card(s) are to be used for eligible expenses allowed through my employer's plan. I further understand that I am solely responsible for the validity of the charges and **I am to retain all originals or copies of all documents of which charges appear on the debit card.** I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health coverage or if the charges are deemed to be unreimbursable, I shall return the monies paid to me by this plan, for re-crediting of my account.

I will have on-line access to my account information. General communications regarding my account and any requests for the substantiation of charges will be done via email. Requests for the substantiation of charges that are not answered/validated may result in card suspension.

I will receive two (2) benefit cards that will expire after three years. I understand the information below **must contain my spouse and/or dependent information** in order to obtain a second benefit card. **Funds will automatically be reloaded each plan year unless you submit a Termination Request form.** Cards will be received in 7-10 business days from date of enrollment. I understand that a fee of $18.00 per year will be deducted from my account at the beginning of the plan year.

Dependent Name: ______________________________

Dependent SSN: ______________________________

Date of Birth: ______________________________

Home Address: ______________________________

____

Relationship to Participant: ______________________________

Please see reverse side for dependent information

⇒ ⇒ ⇒

In addition, please issue a debit card to the following dependents. I am aware that a $5 per card fee will be deducted from my Flexible Spending Account Balance.

Dependent Name: ____________________________

Dependent SSN: ____________________________

Date of Birth: ____________________________

Home Address: ____________________________

____

Relationship to Participant: ____________________________

Dependent Name: ____________________________

Dependent SSN: ____________________________

Date of Birth: ____________________________

Home Address: ____________________________

____

Relationship to Participant: ____________________________

I would like to request the Prepaid Benefits Debit Card. I intend to use the debit card for items and services that are reimbursable through my employer's flexible spending plan. I further understand that I am solely responsible for the validity of the charges and I am to retain all originals or copies of all documents of which charges appear on the debit card. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other heath or benefit coverage or if the charges are deemed to be unreimbursable, I shall return the monies paid to me by this plan, for re-crediting of my account. I understand that my employer does reserve the right to withhold these amounts from my pay. I understand that a pre-tax annual fee of $18.00 will be deducted from my Flexible Spending Account and an additional $5.00 for each Spousal/Dependent card.

Employee Signature________________________ **Date**____________

PREFERRED
PG
GROUP

Direct Deposit Authorization for Reimbursement

Mail to: The Preferred Group, P.O. Box 15136, Albany, NY 12212-5136

For more information visit www.ThePreferredGroup.com

Use this form to initiate or cancel direct deposit, or to change bank accounts. The authorization agreement must be sent to The Preferred Group two to three weeks before the direct deposit/change is activated. All requests for Direct Deposit must be submitted on this form and include a voided check for the account. This direct deposit form will not be processed if a voided check is not attached. Deposit slips are not acceptable as appropriate routing numbers may not be available.

Reimbursement will only occur if you have submitted a claim to The Preferred Group with receipts for eligible expenses. The Preferred Group does not guarantee payments on any date. The Preferred Group is not responsible for bank charges of any type that you may incur for direct deposit transactions. Do NOT assume that a payment has been made to your account at any time. You are solely responsible for checking with your bank as to the deposit amount and date of direct deposits made to your account.

By signing this direct deposit form, you understand that a direct deposit for your reimbursement expenses will be credited to your bank account within 2 business/banking days of the processing of your claim. (miss-posted funds will be corrected upon discovery) You are also authorizing The Preferred Group to initiate credit entries to your checking account and to *notify you of your direct deposit by e-mail only*. You are certifying that the information that you are supplying below is both accurate and valid and you will notify The Preferred Group as any changes occur. If this is a joint account, or in someone else's name, that individual must also sign and therefore agree to the terms of this direct deposit form.

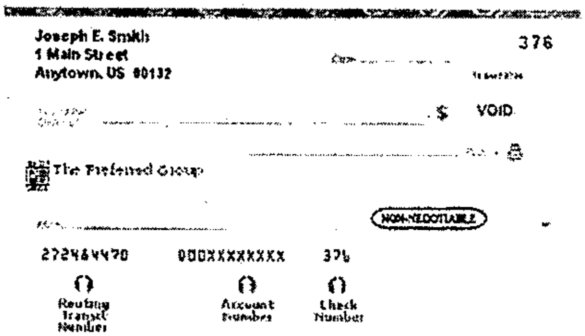
For Direct Deposit you MUST: ✓ Have an open checking account ✓ Have a valid e-mail address
✓ Provide a copy of a cancelled check (attach to this authorization)

Please check the appropriate box:

☐ Initiate Direct Deposit ☐ Change Account ☐ Cancel Direct Deposit

Employer Group Name	Participant ID Number (SSN)
Employee Name (First Name)	(Last Name)
Employee E-mail Address	
Bank Name	
Bank Routing Number	Bank Account Number
Authorizing Signature(s)	

For assistance in finding routing numbers please see below. **Please attach your cancelled check over the sample image.**



Hudson River Financial Federal Credit Union

3563 Mohegan Avenue
Mohegan Lake, N.Y. 10547
(914) 526-4015
www.hudsonriverfinancial.org

Membership Application

How did you hear about us?
- ○ Work
- ○ Family Member
- ○ Advertisement
- ○ Website
- ○ Other____________

A minimum of $5.00 is required to open an accountwhich includes a $5.00 minimum deposit. A copy of a picture ID in the form of either a Valid Drivers License, Government ID or Passport is also required. If opening through the mail, a second form of ID is required such as a copy of a Social Security Card, Paystub or Employer Photo ID

Member Name________________________________ Account#____________________

Account Ownership: ☐ *Individual* ☐ *Joint with Right of Survivorship*

Account Types & Services:

☐ Savings ☐ Kids Club ☐ Teen Club ☐ Holiday Club ☐ Vacation Club
☐ Checking ☐ Visa®Debit Card ☐ Payroll Deduction ☐ Custodial Account

Primary Owner Information

Full Name____________________________ Birthdate____________ SSN/Tax ID#______________
Street Address____
City__________________ State______ Zip_______ Email address_________________________
Home Phone__________________ Work Phone__________________ Cell Phone__________________
ID Type (Drivers License or other government ID)_________________________ ID#__________________
Issued by:__________________ Issue Date:________________ Expiration Date:________________

I am eligible for membership through my:
☐ Employer/School District Employer/School District Name________________________________
☐ Family Member Family Member Name______________________________________

Joint Owner Information

Full Name____________________________ Birthdate____________ SSN/Tax ID#______________
Street Address____
City__________________ State______ Zip_______ Email address_________________________
Home Phone__________________ Work Phone__________________ Cell Phone__________________
ID Type (Drivers License or other government ID) _________________________ ID#__________________
Issued by:__________________ Issue Date:________________ Expiration Date:________________

Beneficiaries

Payable on Death Beneficiaries are designated for all suffixes established with this form. If a beneficiary is not listed on this form, the new suffixes will not have a payable on death beneficiary.

Beneficiary Name__________________________ Relationship______________ SSN#__________________
Beneficiary Name__________________________ Relationship______________ SSN#__________________
Beneficiary Name__________________________ Relationship______________ SSN#__________________

Tax Certification

By signing below, I certify under penalty of perjury that: I am a U.S. person (including a U.S. resident alien), the Social Security Number shown above is my/the correct number, and I am NOT subject to backup withholding as a result of failure to report all dividends or interest, or because the IRS has notified me that I am no longer subject to backup withholding, or: (check if applicable)

☐ Certificate of Foreign Status. I am a foreign person (not a U.S. citizen or resident) Complete form W8BEN. ☐ Backup Withholding. I am subject to backup withholding.

Authorization

I/We agree to the terms and conditions of the Membership and Account Agreement, Rate and Fee Schedule, the Funds Availability Policy Disclosure, the Electronic Funds Transfer Disclosure and to any future amendment you make from time to time which are incorporated herein. I/We acknowledge receipt of a copy of the Agreement and Disclosures applicable to the accounts and services requested. I/We authorize HRFFCU to obtain credit information about me/us from a credit reporting agency for the purpose of considering my/our application for any account or service provided. If requested, I/We agree to the terms and conditions of the VISA® Debit card agreement and any future amendment you make from time to time.

The Internal Revenue Service does not require your consent to any provision of the Account Card other than the certifications required to avoid backup withholding or establish your status as a foreign person, and if applicable, obtain a reduced rate of withholding.

________________________________ ______________________________________
Primary Owner Signature ***Date*** ***Joint Owner Signature*** ***Date***

Custodial Account:

______________________, *as custodian for*______________________ *(minor) under the* ________ *state UTTMA.*

*Custodian's Signature*__________________________________ *Date*______________

For Credit Union Use Only
Membership Officer:________________________ Experian Authentication________________________

Hudson River Financial Federal Credit Union

PAYROLL DEDUCTION FORM-NEW

MEMBERSHIP # ____________________

MEMBER NAME (Print) ________________________________

ADDRESS ____

SIGNATURE OF MEMBER ______________________________

EFFECTIVE DATE ___________________

I have this day authorized the Payroll Supervisor of the

______________________ to deduct from my pay each payroll

until further notice $ ______________ to be applied as follows:

Savings $_________ Loan $ ________ Other $ ________

New York State
Deferred Compensation Plan
A Plan for Your Future

Account Executive #
04240
Internal Use Only

HELPLINE: 1-800-422-8463
WWW.NYSDCP.COM

ENROLLMENT APPLICATION

PERSONAL DATA

Name (Please Print) ☐ Male ☐ Female

Social Security Number

Home Address

Date of Birth

City State Zip

Home Telephone Number

Employer

Work Telephone Number

Email Address (**Required – Please see eDelivery section for additional detail**)

212631
Local Plan ID Number or State Department ID Code*

n/a
New York State Employee ID Number*

If you are unaware of this number, please contact your Payroll Center or the HELPLINE as your enrollment cannot be completed without it. Department ID can also be found on your State Paystub.

DEFERRAL INFORMATION

If your employer is a local town, village, or school, please check with your payroll department or the HELPLINE to determine whether to request a deferral dollar amount or percentage. Also, if your employer is a school and utilizes OMNI as a third-party payroll administrator please contact OMNI to complete the enrollment of your deferral request.
You may select both Pre-tax and Roth. Maximum combined deferral percentage is 100%. **If you are paid through the State Comptroller, please enter a deferral PERCENTAGE.**

Pre-Tax Deferral: ______% or $: ________ ~~**Roth Contribution: ______% or $:**~~
Your deferral cannot be less than 1% of your gross salary or less than $10 per pay period.

BENEFICIARY DESIGNATION

Please complete all requested information for each of your primary and contingent beneficiaries. A person may not be listed as both a primary and contingent beneficiary. If you select "Equal Percentage" for your beneficiaries, there may be some minor variance based upon the number of beneficiaries you have listed. For example, if you list three beneficiaries, the oldest beneficiary will be designated 33.34% and the other two will be 33.33%.

- Primary Beneficiary(ies): A primary beneficiary is the person or persons who receive your Plan benefits in the event of your death.
- Contingent Beneficiary(ies): A contingent beneficiary is the person or persons who would receive your Plan benefits if all of your primary beneficiaries predecease you.

Primary Beneficiary (ies) ***(must be in whole percentages and total 100%)***
☐ **Equal percentages for each primary beneficiary**

Beneficiary Name Relationship Date of Birth Social Security Number ______% Percent
Beneficiary Name Relationship Date of Birth Social Security Number ______% Percent
Beneficiary Name Relationship Date of Birth Social Security Number ______% Percent
Total = 100%

Contingent Beneficiary(ies) ***(must be in whole percentages and total 100%)***
☐ **Equal percentages for each contingent beneficiary**

Beneficiary Name Relationship Date of Birth Social Security Number ______% Percent
Beneficiary Name Relationship Date of Birth Social Security Number ______% Percent
Total = 100%

EDELIVERY OPT OUT

☐ By checking this box, I elect to receive my quarterly statements and other confirmations from the Plan by **regular mail.** I understand that by **not** checking this box, I elect eDelivery for quarterly statements, newsletters, investment performance reports and confirmations. With eDelivery, I will be emailed this information at the address provided under the Personal Data section when the information is posted to the Plan's Web site.

DEFERRAL ALLOCATION

Write the percentage you wish to allocate to each investment option. You may allocate your salary deferrals among any of the investment options listed below. The allocation of your contributions may be in any whole percentage and must total 100%.

DO IT FOR ME

The following investment options are professionally managed asset allocation funds based on your expected retirement date:

VRU#

______% (1776) TRP Retirement Date 2010 Trust (CIT)
______% (1777) TRP Retirement Date 2015 Trust (CIT)
______% (1778) TRP Retirement Date 2020 Trust (CIT)
______% (1779) TRP Retirement Date 2025 Trust (CIT)
______% (1780) TRP Retirement Date 2030 Trust (CIT)

VRU#

______% (1781) TRP Retirement Date 2035 Trust (CIT)
______% (1782) TRP Retirement Date 2040 Trust (CIT)
______% (1783) TRP Retirement Date 2045 Trust (CIT)
______% (1784) TRP Retirement Date 2050 Trust (CIT)
______% (1785) TRP Retirement Date 2055 Trust (CIT)
______% (1786) TRP Retirement Date 2060 Trust (CIT)

The following core investment options permit participants to create their own asset allocation:

DO IT YOURSELF

Stable Income Fund

______% (2756) NYSDCP Stable Income Fund

Bond Funds

______% (1788) NYSDCB US Debt Index U/A (CIT)
______% (1794) Voya Core Plus Trust Fund (CIT)

Balanced Funds

______% (8957) Vanguard Wellington Fund – Admiral (MF)

Large Cap Funds

______% (1789) NYSDCB Equity Index U/A (CIT)
______% (1787) Boston Partners Large-Cap Value Equity Fund (CIT)
______% (1791) T. Rowe Price Equity Income Trust (CIT)
______% (1792) T. Rowe Price Blue Chip Growth Trust (CIT)
______% (2765) Vanguard PRIMECAP Fund – Admiral (MF)

SMID Cap Funds

______% (1790) NYSDCB Russell 2500 Index U/A (CIT)
______% (653) Vanguard Strategic Equity Fund (MF)

Small Cap Funds

______% (1692) Delaware Small-Cap Value Fund CL I (MF)
______% (1793) T. Rowe Price QM US Small-Cap Growth Equity Fund CL I (MF)

International Funds

______% (5025) NYSDCP International Equity Fund - Active
______% (5030) NYSDCP International Equity Fund - Passive

Emerging Markets

______% (1458) MSIF Emerging Markets Portfolio – Institutional (MF)

Specialty Options

______% (7298) Pax World Balanced Fund – Institutional (MF)
______% (195) Fidelity OTC Fund (MF)

100 % (MUST TOTAL 100%)

Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses or factsheets carefully.

AUTHORIZATION

I agree to the terms of the New York State Deferred Compensation Plan. I authorize my employer to deduct the amount or percentage set forth herein until I provide further notice for the purposes of contributing it to my Plan account. I further authorize my employer to process any deferral changes I request through the Plan in the future. Deferrals made by participants who are not New York State residents may be subject to the state income tax in the year deferred in their state of residence. Please read your state income tax instructions carefully.

____
Participant Signature

____
Date

New York State
Deferred Compensation Plan
A Plan for Your Future

ENROLLMENT APPLICATION

Welcome to the New York State Deferred Compensation Plan. The Plan is a voluntary, long-term retirement savings program designed for your retirement needs. The amount you contribute to the Plan is deducted from your pay and any investment returns grow on a tax-deferred basis.

Contributions to the Plan: The minimum contribution to the Plan is 1% of your gross pay (at least $10 per pay period). The maximum contribution you may make in 2017 is $18,000. If you are at least age 50 prior to the end of the current calendar year, you are eligible to contribute a maximum of $24,000. If you are within four years of the date that you are able to retire without a reduction in pension benefits, you may be eligible to make additional contributions. Contact an Account Executive or HELPLINE Representative at 1-800-422-8463 for more information and the forms to use the higher limits.

Pre-Tax Deferrals: The amount you contribute to the Plan will be deducted from your pay on a pre-tax basis for federal and New York State income tax purposes, thereby reducing your taxable income for the calendar year. The investment returns also grow on a tax-deferred basis and income taxes are paid only when money is withdrawn from the Plan.

Roth Contributions: These deductions are made from your pay on an after-tax basis. Contributions grow tax deferred, but when money is distributed from the Plan, qualifying distributions are not subject to federal or New York State income taxes.

Processing Time Frame: Enrollments are processed upon receipt; however, federal law states that deferrals may not begin before the start of the next calendar month, unless you make your election prior to your first day of service. You may change or cancel your deferral amount at any time, but these changes may also be subject to these timing limits.

Next Steps: Please read the bullets below to understand the basics of the Plan and then complete your application.

I understand that:

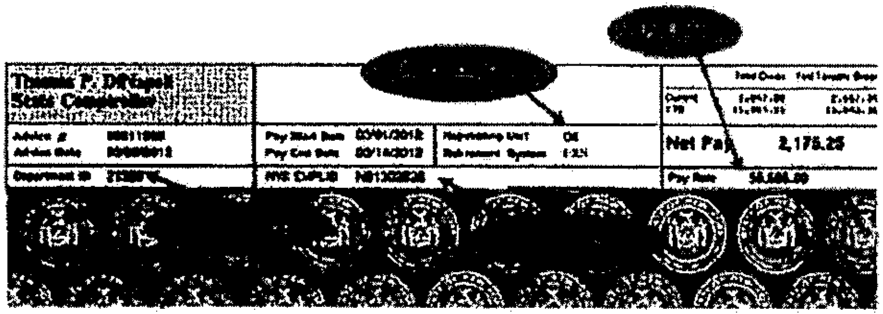
- Withdrawals from the Plan may be taken only upon separation from employment, absence due to qualified military service, death, an unforeseeable financial emergency, attainment of age 70½, from an account that has been in inactive status for two years and has a balance of $5,000 or less (inclusive of any outstanding loan balance but exclusive of assets in a rollover account) or as a loan.
- Participation in the Plan is not intended to replace a regular savings program necessary to cover day-to-day unanticipated financial expenses. Plan distributions for "Unforeseeable Financial Emergencies" are strictly regulated by federal laws. Should I need an unforeseeable emergency distribution, the request must be made in writing and detail the circumstances supporting the financial emergency. If my request is denied, I may appeal to the Review Committee.
- I may enroll in the Plan for the purpose of transferring assets from another 457(b) deferred compensation plan, a 403(b), 401(k), 401(a), Keogh plan, a traditional or rollover IRA without becoming an active participant.
- Unless I have opted for a paper statement, I will receive an email notification when my quarterly statement, Quarterly newsletter and investment performance report are available on the Web site. Please call the HELPLINE promptly with any changes.
- If my employer has opted to allow Roth contributions, contributions to the Roth account may not be reclassified after made. The investment allocation for Roth contributions will be the same as for any pre-tax deferrals. Distributions of Roth contributions must meet the same withdrawal requirements as pre-tax withdrawals.
- There is an administrative fee deducted from my Plan account on a semi-annual basis as outlined in the Plan's Investment Options Guide. These fees are subject to change.

Information relating to the Plan or a copy of the Plan Document may be obtained by calling the HELPLINE at 1-800-422-8463 or visiting the Plan's Web site at www.nysdcp.com.

Tips for Completing the Application

State Employees
If you are employed by a State Agency, please see the screen shot below to assist you with identifying the information necessary to complete the application.

This application will require you to include your five-digit Department ID, which is located on the upper left corner of your pay stub, and your NYS Employee ID that is listed next to the Department ID. If you do not have this information, your application cannot be processed.



Local Employees
If you are employed by a city, town, or library system that contains its own payroll department, the application requires your Local Plan ID. This six-digit number can be obtained by contacting your payroll department or our HELPLINE at 1-800-422-8463.

Deferral Information

State Employees
When entering your deferral amount, you must provide a percentage of your gross pay. This percentage must be a whole number. If you need assistance calculating a percentage for your deferral, please contact our HELPLINE at 1-800-422-8463.

Local Employees
Before completing your application, please check with your employer or our HELPLINE to find out if your employer requires deferrals to be entered as a dollar amount or as a percentage.

100% Deferrals
Please note that if you elect a deferral rate of 100%, you are authorizing the Plan to deduct the remaining balance of your paycheck after all other required pre-tax deductions have been taken. If you are electing this deferral percentage for a lump sum payment to the Plan, it is important to contact the HELPLINE with the exact date of the lump sum payment.

FORM RETURN

Return to: New York State Deferred Compensation Plan
Administrative Service Agency
P.O. Box 182797
Columbus, OH 43218-2797

Overnight Address: New York State Deferred Compensation Plan
Administrative Service Agency, DSPF-F2
3400 Southpark Place, Suite A
Grove City, OH 43123-4856

OR Fax to: 1-877-677-4329
When faxing paperwork, please allow two hours from receipt for it to be processed
If your fax is sent after 3 p.m. your paperwork will be processed on the next business day

Plan Highlights

Top Reasons to Participate in the Plan:

- Easy and convenient way to save for retirement
- Income tax benefits
- Diverse selection of investment options
- Flexible distribution options
- Low administrative and investment costs
- Dedicated participant services

Easy and convenient way to save for retirement

Who can participate?
All state employees and employees of localities and school districts that participate in the State Plan are eligible to participate

How do I contribute?
Contributions are deducted directly from your pay. Minimum contribution is 1% of compensation (but not less than $10 per pay)

How much can I contribute?

- Regular contributions - $18,500
- If age 50 or over - $24,500
- Special Retirement Catch up - up to $37,000

If your deferrals in previous years were less than the amount allowed by law, you may be eligible to make Retirement Catch-Up deferrals. Retirement Catch-up cannot be used in the same year as Age 50 and Over Catch-up

Deferral changes may be made at any time but, under federal law, will not be effective until the following month There are no fees to change your deferral percentage

Can I rollover money from previous plans and IRAs?
Yes, you can roll over money from a 457(b), 401(k), 403(b) or traditional IRA into your Plan account. Assets rolled over from a qualified plan or individual retirement account may be subject to a 10% tax penalty if withdrawn prior to age 59½

Income Tax Benefits

Do regular pre-tax deferral contributions reduce my taxable income?
Yes, for federal and New York State income tax purposes but not for FICA

Do I pay income taxes on any potential growth or income in the Plan?
Contributions and any investment earnings accumulate on a tax-deferred basis until withdrawn.

Do distributions receive any income tax benefits?
The first $20,000 in periodic benefit payments you receive each year may be exempt from New York State income tax if you are a New York State resident and at least age 59½. This includes payments from other retirement plans but not your State pension.

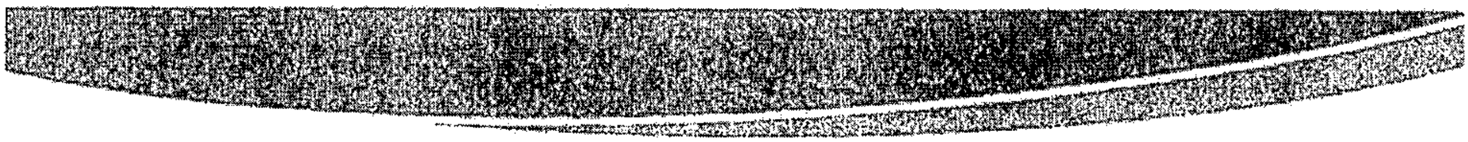
There is no premature distribution income tax penalty on the Deferred Compensation Plan benefit payments regardless of age.

If I am also eligible to contribute to a 403(b), can I do both?
Yes. You can contribute the maximum amount to your Plan account and the maximum amount to your 403(b) plan at the same time

May I make Roth contributions to the Plan?
Yes, Roth contributions are also available. You may make any combination of regular and Roth contributions up to the contribution limits mentioned above. Roth contributions are made after-tax and do not reduce your taxable income in the year of the deferral. However, qualifying distributions and growth would not be subject to income taxes when withdrawn

Can I convert existing Plan balances to Roth?
Yes, but the Plan strongly suggests that you consult your tax advisor before doing so

New York State
Deferred Compensation Plan
A Plan for Your Future



Types of investment options offered through the Plan

Mutual Funds are diversified portfolios of stocks, bonds and other investments chosen by a fund manager to achieve a stated objective. Each fund is assigned a five-letter ticker symbol that helps investors find information via financial Web sites and publications. In addition, each fund publishes a prospectus, a formal legal document filed with the SEC that provides details about its investment objective, fees, charges and expenses, and related information.

Collective Investment Trusts (CITs) are similar to mutual funds, offering many of the same diversification and management services as mutual funds but generally at a lower cost. Many CITs are designed specifically for retirement plan investors. Therefore, specific information about a CIT may be available solely through the Plan that offers it. Participants may request fact sheets about CITs offered through the Plan by calling the HELPLINE, or they may download them from www.nysdcp.com

Custom Funds are diversified investments created for the exclusive use of Plan participants. A custom fund may have several separate account investment management companies used together to create a fund for the Plan. Because of their custom nature, information about these funds is only available through the Plan. As with CITs, participants may request fact sheets about each of the Plan's custom funds from the HELPLINE or download them from www.nysdcp.com.

Three approaches to investing through the Plan

The Plan recognizes that your comfort with investing may not be the same as other participants. Therefore, we have created three approaches that are generally aligned with how comfortable or willing you are to manage how your retirement assets are invested through the Plan.

Do It For Me An approach that uses target date CITs based on when you plan to retire or begin taking withdrawals

Do It Yourself An approach to personally design and monitor your asset allocation and investment options

Specialty Options Options that represent special interest such as environmental, social and governance factors or other specialty investment strategies

Investing involves market risk, including possible loss of principal. No investment strategy—including asset allocation, diversification and dollar-cost averaging—can guarantee a profit or avoid loss. Actual results will vary depending on your investment and market experience.

Before you decide to direct investments under the Plan, carefully consider the fund's investment objectives, investment methods, risks, charges and expenses. This and other information is contained in the fund prospectus, which you should read carefully before investing. To get any prospectus, ask your Account Executive, call the HELPLINE at 1-800-422-8463 or access the Web site at www.nysdcp.com.

There is no prospectus for CITs and Custom Funds because these options are not mutual funds. You may obtain a fact sheet on each of these options from the HELPLINE or our Web site.

Flexible Distribution Options

When can I take distributions?
Distributions are available when you terminate service from your State or local government employer, if you are age 70 ½ or over or if absent due to qualifying military service. Distributions are not required until you reach age 70½ and may be delayed if still employed.

Are there other instances where I can take distributions while employed?
Yes, if you qualify for an unforeseeable emergency withdrawal, have a small inactive account, or if you have rolled over assets from a 401(k), 403(b), or an IRA. Distribution of assets rolled into the Plan continue to be subject to the distribution rules of the former plan, which could include a 10% early withdrawal penalty if they are received before age 59½.

How are they paid?
Benefit payments may be made in the form of a full withdrawal, partial withdrawals or periodic payments. Periodic payments may be received monthly, quarterly, semi-annually or annually. You may change your payment option at any time

Can I take a loan against my Plan account?
Yes. The Plan permits loans to participants who are currently employed by the State or a participating employer or who are on an approved leave of absence. The loan cannot exceed the lesser of 50% of your Plan account balance or $50,000.

When must I take distributions?
Benefit payments must begin at age 70½ or upon termination of employment from the employer that participates in the Plan, whichever is later, under the Required Minimum Distribution (RMD) rules. Otherwise, you are welcome to keep your assets in the Plan

Low administrative and investment costs

Administrative services are supported by an annual per-participant fee and an asset-based fee. The annualized asset-based fee is set by the Board each Plan Year and levied in two installments in April and October. The asset-based fee is determined based on estimated expenses and is levied on accounts with balances exceeding $20,000 and is capped at account balances of $200,000

Dedicated Participant Services

Web site and VRS — You have access to your account 24 hours a day, seven days a week via **www.nysdcp.com** and the Voice Response System. On either system, you may: check your account balance, change the investment of your future deferrals, exchange funds between the Plan's investment options, change your deferral rate and explore many online education resources.

Personal Assistance — Personal assistance is available through the HELPLINE from 8 a.m. to 11 p.m. Monday through Friday and 9 a.m. to 6 p.m. Saturday (EST) at 1-800-422-8463. Local Account Executives are also located throughout the state for one-on-one meetings and workshops

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Please visit www.nysdcp.com or call 1-800-422-8463 to learn more. Neither the Administrative Service Agency nor any of its representatives offer legal, investment or tax advice. For such guidance, you should consult your own legal or tax advisor.

Account Executives are registered representatives of Nationwide Investment Services Corporation, member FINRA

US OMNI

SRA MANAGEMENT TEAM
1099 Jay Street, Bldg F, 2nd Fl • Rochester, NY 14611
PH: 1.877.544.6664 · WEB: www.omni403b.com · FAX: 1.585.672.6194

403(b) SALARY REDUCTION AGREEMENT FORM (SRA) For Tax Sheltered Annuities and Custodial Accounts

403(b)

- Please supply the information requested below.
- Read all agreements on this form before submitting.
- Fields having an asterisk notation are required.

IMPORTANT NOTICE: Before You Sign, Read All Information on this form:
A Tax Sheltered Annuity ("TSA") is an investment account that is set aside for your retirement (only), and is paid for with "pre-tax" dollars. A Custodial Account ("CA") is the group or individual custodial account or accounts, established for each Employee, by the Employer, or by each Employee individually, to hold assets of the Plan. Unless utilizing the catch-up provisions, your Maximum Allowable Contribution ("MAC") cannot exceed $18,500 ($24,500 if age 50 or over). Both TSA & CA receive tax deferred treatment.

Part 1: Employee Information

☐ Please check here if you have contributed to another 403(b) or 401(k) plan with another employer this calendar year. If so, please provide the amount of the year-to-date contributions you have made to the other employer's plan: $ ____ and the name of the other employer: ____

* Social Security Number: ____ * First Name: ____ MI: ____ * Last Name: ____

*Address: ____

* City: ____ *State ____ *Zip: ____

* Date of Birth: ____ * Phone: ____ *Email address: ____

Part 2: Employer Information

* Full Organization Name, City and State: ____ * Date of Hire: (mm/dd/yyyy) ____

Part 3: Contribution Information

OPTION 1: Recurring Contributions

WARNING!!! Any new recurring contributions will supercede all current recurring contributions to your employer's 403(b) plan administered by OMNI. If you are currently contributing to multiple service providers under your employer's 403(b) plan, please be sure to list all contributions you wish to continue. Any active 403(b) contributions found in our records, but not listed below WILL BE DISCONTINUED.

Also, a contribution may be discontinued by listing it below with an amount of zero.

Please withhold funds from my pay for the following 403(b) contributions until further notice:

Plan Type		Service Provider	Account #	Effective Date	Amount Per Pay	OR	Percent Per Pay Period
☐ 403(b)	☐ ROTH 403(b)						
☐ 403(b)	☐ ROTH 403(b)						
☐ 403(b)	☐ ROTH 403(b)						
☐ 403(b)	☐ ROTH 403(b)						
☐ 403(b)	☐ ROTH 403(b)						

If you have requested a percentage amount for any of the contributions above, please supply:
Your Annual Salary: ____ Number of Pay Periods Per Year: ____

☐ Please check here if you are NOT a full-time employee

OPTION 2: One-Time Contributions (Elective Contributions Only)

Plan Type		Service Provider	Account #	Effective Date	Amount	After this contribution, any 403(b) recurring contributions to this service provider should be:	
☐ 403(b)	☐ ROTH 403(b)					☐ DISCONTINUED	☐ RESUMED
☐ 403(b)	☐ ROTH 403(b)					☐ DISCONTINUED	☐ RESUMED
☐ 403(b)	☐ ROTH 403(b)					☐ DISCONTINUED	☐ RESUMED
☐ 403(b)	☐ ROTH 403(b)					☐ DISCONTINUED	☐ RESUMED
☐ 403(b)	☐ ROTH 403(b)					☐ DISCONTINUED	☐ RESUMED

☐ Please check here if you are NOT a full-time employee

OPTION 3: Participation Opt Out

☐ **I do not wish to participate at this time.** I understand that I may participate in the future simply by filling out a new Salary Reduction Agreement form.

Continued on next page

Part 4: Agreements and Acknowledgements

The above named Employee where applicable, agrees as follows:

1. To modify his/her salary reduction as indicated above.
2. That his/her Employer transfers the above stated funds on Employee's behalf to OMNI for remittance to the selected Service Provider(s).
3. This SRA is legally binding and irrevocable with respect to amounts paid.
4. This SRA may be changed with respect to amounts not yet paid.
5. This SRA may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new SRA is submitted.
6. (a) That OMNI does not choose the annuity contract or custodial account in which your contributions are invested.
   (b) OMNI does not endorse any authorized Service Provider, nor is it responsible for any investments.
   (c) OMNI makes no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the TSA and/or CA described herein.
   (d) (i) OMNI shall not have any liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the TSA and/or CA, its terms, the selection of any service provider, the financial condition, operation of or benefits provided by said service provider, or his/her selection and purchase of shares by any service provider. Nothing herein shall affect the terms of employment between Employer and Employee.
   (ii) Employee acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account described herein.
   (iii) The Employer shall not have any liability for any and all losses suffered by an Employee with regard to the selection(s) of any TSA and/or CA, any related terms and conditions, the selection of any service provider, the financial condition, operation of or benefits provided by any service provider or the selection and purchase of shares by any service provider.
7. To be responsible for setting up and signing the legal documents necessary to establish a TSA or CA
8. To be responsible for naming a death beneficiary under their TSA or CA. This is normally done at the time the contract or account is established. Beneficiary designations should be reviewed periodically.
9. When provided all required information in a timely manner, OMNI is responsible for determining that salary reductions do not exceed the allowable contribution limits under applicable law, and will complete MAC calculations as required by law.
10. To contact OMNI and complete the appropriate OMNI forms for any requests for distributions, loans, hardship withdrawals, account exchanges plan-to-plan transfers or rollover contributions. Processing fees for the foregoing transactions may apply.
11. This SRA is subject to the terms of the Services Agreement between OMNI and Employer, and to the Information Sharing Agreement between OMNI and the Service Providers.
12. This agreement supercedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

Part 5: Employee Signature (Mandatory)

I certify that I have read this complete agreement and that my requested salary reduction(s), if in excess of my base limit, represent(s) my wish to utilize any catch-up provisions for which I may be eligible. I further certify that my salary reductions do not exceed contribution limits as determined by applicable law I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the TSA or CA established by me under the Plan are enforceable solely by my beneficiary, my authorized representative or me.

Employee Signature: Date:

Part 6: Acknowledgement and Representation of Sales Agent/Representative (Not Required to Submit SRA)

I agree to comply with all pertinent written directives regarding the solicitation of Employee. In the event I provide OMNI with an Employee's date of birth ("DOB"), I acknowledge and agree that I must provide accurate information based on documentation provided to me by the Employee. Furthermore, I understand that any DOB information I provide to OMNI is utilized by OMNI to calculate the Employee's Maximum Allowable Contribution limits, which must be accurate to keep the Employer's plan in compliance with IRS regulations. All indemnification or other responsibility for a claim or demand arising from an error in employee DOB I provide will be governed by the Information Sharing Agreement between my employer and OMNI.

Sales Agent/Representative Name: Phone:

Email:

Signature: Date:

☐ I wish the above named agent to be copied on all e-mail communications sent to the plan participant, including certificate(s) of approval, which may be associated with this transaction.

Part 7: Employer Acknowledgement (If Applicable)

Salary: # of TSA/CA Pay Periods: Effective Payroll Date:

Employer Name & Title:

Employer Signature: Date:

Please return this agreement to Omni Financial Group, Inc., unless otherwise advised by your employer:

Omni Financial Group, Inc.
Water Tower Park • 1099 Jay Street, Building F • Rochester, NY 14611
Toll Free: (877) 544-OMNI ® • Fax: (585) 672-6194
Please visit our website at www.omni403b.com

Greenburgh Central School District

ARE YOU AWARE OF YOUR 403(b) BENEFIT

The opportunity

Your Employer offers a 403(b) retirement plan as a benefit to employees

The Plan allows employees to save and invest by making tax-deferred contributions directly from their paycheck

Why save with 403(b)?

> You do not pay income tax on contributions until you begin making withdrawals from the plan, usually after your retirement.

> Investment gains in the plan are not taxed until distributed.

> Benefit from saving and investing

Sample Future retirement savings value assuming 6% yield on investment **

Monthly Contributions	5 yrs	15 yrs	20 yrs
$50	$3,489	$14,541	$23,102
$200	$13,954	$58,164	$92,408
$500	$34,885	$145,409	$231,020

** OMNI does not offer financial advice. Always consult your financial advisor before investing. For more information about 403(b) Plans, visit the IRS website

How can I participate?

1. Complete a Salary Reduction Agreement (SRA). This can be done Online at www.omni403b.com.
2. Open an account with an investment provider. The list of your available providers is on the right.

How much can I contribute annualy?

Employees can contribute up to $18,500 in 2018. Employees who are age 50 or older can contribute an additional $6,000.

Employees with 15 years of service may contribute up to an additional $3,000.

U.S OMNI administers the Plan and is available to answer questions at (877) 544-6664, or visit www.omni403b.com.

Want to learn more about your investment options?

Click the link below for an investment provider to contact you.
https://www.omni403b.com/spinforeq.aspx

Want to start contributing or learn more about your employer's plan?

Click the link below to visit your Plan-page.
(Not available for all providers. Visit your Plan-page for a complete listing.)
https://www.omni403b.com/PlanDetail.aspx?tml=156

New accounts may be opened with following approved service providers

AMERIPRISE FINANCIAL SERVICES INC
AXA EQUITABLE LIFE INSURANCE COMPANY
CONFIDENTIAL PLANNING - MULTICHOICE
GWN/EMPLOYEE DEPOSIT ACCT
MASS MUTUAL VA
METLIFE
MUTUAL INC/PLANMEMBER SERVICES
OPPENHEIMER SHAREHOLDER SVCS
RIVERSOURCE LIFE INSURANCE CO OF NY
THE LEGEND GROUP/ADSERV
VOYA FINANCIAL (NATL NY)
HARTFORD LIFE INS CO - 457

US OMNI

Greenburgh Central
School District
Our Children. Our Focus. Our Future.

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child"

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Greenburgh Central School District, 475 West Hartsdale Avenue, Hartsdale, NY 10530, Attention: Immacolata Loffredo.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to Employee Benefits Systems, 214 N. Main Street, PO Box 1053, Burlington, IA, 52601.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Information about the and COBRA coverage can be obtained on request from:

Greenburgh Central School District
475 West Hartsdale Avenue
Hartsdale, NY 10530
Attn: Immacolata Loffredo