Employee # :_____(to be filled out by Human Resource Office)

Account #: _____ (To be completed by Director)

Dept #:_____

Job #:_____

CITY OF STRONGSVILLE

DEPARTMENT OF HUMAN RESOURCE

NEW EMPLOYEE CHECK LIST

(To be completed by Department Head or Supervisor)

Please check completed information for all new employees prior to returning to Human Resource Office. All information must be completed and checked off.

Employee Name: _____

Position: _____

Rate of Pay: _____

Starting Date: _____

- ☐ **Payroll Change Form (must be signed by Director)**
- ☐ **Pre-Employment Application; Authorization for Release of Information; Equal Employment Opportunity**
- ☐ **Terms and Conditions of regular, part-time employment (provide the director immediately upon completion)**
- ☐ **OPERS Personal History Form**
- ☐ **Medical Mutual Application& Policy Change Form (FULL-TIME ONLY EMPLOYEES)**
- ☐ **COBRA Notice of Continuation Coverage Rights (FULL-TIME ONLY EMPLOYEES)**
- ☐ **I-9 Form (Employment eligibility Verification)**
- ☐ **Form SSA-1945 Statement Concerning Employment in a Job not Covered by Social Security**
- ☐ **W-4 Form**
- ☐ **Form IT-4 State Withholding Form**
- ☐ **Request for Direct Deposit and voided check**
- ☐ **Ohio Deferred Compensation Supplemental Retirement Account Election Form**
- ☐ **Copy of Employees Social Security Card**
- ☐ **City of Strongsville Policy Acknowledgement Form signed by new employee**
- ☐ **Auditor of State Acknowledgement of Receipt of Fraud Reporting System Information**
- ☐ **Receipt of Ohio Ethics Law and Related Statues signed and Witnessed**
- ☐ **Cellular Phone Usage Policy**
- ☐ **City owned Vehicle Usage Policy**
- ☐ Provided Affirmative Action Report:
- ☐ Provided Electronic Mail (E-mail) Policy
- ☐ Public Media Policy
- ☐ Provided City's' Drug-free Policy
- ☐ Provided Sexual Harassment Policy
- ☐ Public Records Policy
- ☐ City computer Policy
- ☐ Protection of All city-Owned Property Policy
- ☐ SCO Chapter 266 Employees Generally

MINOR FORMS (IF APPLICABLE):

- ☐ Work Permit
- ☐ Minor wage agreement and parent/guardian consent form

EMPLOYEES MUST NOT START WORKING UNTIL ALL OF THE ABOVE INFORMATION IS COMPLETED AND RETURNED TO THE HUMAN RESOURCE OFFICE.

NEW EMPLOYEE FORMS AND INFORMATION PACKET CHECK LIST

FULL-TIME

Welcome to the City of Strongsville. We are happy to have you as an employee for our City. It is our intent to process your paperwork as quickly and efficiently as possible. In order to do so, we need your help in completing the following forms. These forms are **MANDATORY** in order to process your first paycheck.

FORMS MUST BE COMPLETED PRIOR TO YOUR FIRST DAY OF WORK WITH THE CITY.

Please make sure the following forms are **COMPLETED, SIGNED, DATED AND RETURNED** to your supervisor who will then forward the information to the Human Resources Department.

EMPLOYMENT FORMS:

- City of Strongsville Pre-Employment Application
- Ohio Public Employees Retirement System (OPERS) Personal History Record form
- Statement Concerning your Employment in a job not covered by Social Security
- Medical Mutual Employee Application/Change Form
- Form I-9, Employment Eligibility Verification form
- Form W-4 Employee's withholding allowance certificate
- Form IT-4 State withholding tax form
- City of Strongsville Direct Deposit Authorization (with voided check attached)
- Ohio Deferred Compensation Supplemental Retirement Account Election Form
- Consumers Life Insurance Employee Enrollment Form & Beneficiary Designation Form
- Social Security Card

POLICY FORMS

- City of Strongsville Policy Acknowledgement form
- Auditor of State Acknowledgement of Receipt of State Fraud Reporting System Information
- Receipt of Ohio Ethics Law and Related Statutes
- Annual Non-Tobacco Use Certification
- Receipt of Cellular Phone Usage Policy
- Receipt of City-Owned Vehicle Usage Policy

City of Strongsville Pre-employment Application

You must complete this form to apply for employment. Answers must be complete and legible.
Applications lacking sufficient information will not be processed

The City of Strongsville is an Equal Opportunity Employer and provider of ADA services

Applicant Information

Applicant's Name (Last, First, M.I.)			Position/Department Interested in Employment	
Street Address			Area Code/Telephone No.	
City	State	Zip Code	Alt. Telephone No./Mobile No.	
E-mail Address			County	Referral Source

Are you a citizen of the United States or an alien authorized to work in the United States on a full or part-time basis?
☐ Yes ☐ No If No, please explain:

Have you ever been employed by the City of Strongsville before?	If yes, when?	Driver License No./State
☐ Yes ☐ No		

Are any of your employment records under a different name? ☐ Yes ☐ No

If yes, please provide names:

Education and Training

Check all Applicable boxes.		School	Grade Completed
☐	Elementary		
☐	High School Graduate/GED		
		College & Major	Date of Completion
☐	Associates Degree		
☐	Bachelor's Degree		
☐	Master's Degree		
☐	Other		

Occupational Licenses, Registration, Certificates

License/Certificates Issued By	Field/Trade/Specialization	License/Certification No.	Issue Date	Expiration Date

Can you travel if the job requires it? ☐Yes ☐ No

Do you have the use of a motor vehicle? (If required in the performance of job duties) ☐Yes ☐ No

Have you ever been discharged or suspended by an employer or resigned in lieu of dismissal? ☐Yes ☐No

If Yes, please explain:

Do you have supplemental employment that could be a potential conflict with the position you are applying for? ☐Yes ☐No

If Yes, please explain:

Are you related to anyone who currently works for the City of Strongsville? ☐Yes ☐No

If Yes, please indicate names of relatives and where they work:

Employment History

Please list below all work-related experience, starting with the most recent employment and working backwards. Provide a detailed description of regularly assigned ongoing duties for each job. Additional sheets may be attached if necessary. Please attach a current resume (if available) to this application.

Classification	Job Title	Dates of Employment (Month & Year) From:	To:
Employer		Supervisor Name and Title	
Business Address		Starting/Current Salary	Telephone No.
Description of job duties and give approximate percentage of major duties		Reason for leaving	

Classification	Job Title	Dates of Employment (Month & Year) From:	To:
Employer		Supervisor Name and Title	
Business Address		Beginning/Ending Salary	Telephone No.
Description of job duties and give approximate percentage of major duties		Reason for leaving	

Classification	Job Title	Dates of Employment (Month & Year) From:	To:
Employer		Supervisor Name and Title	
Business Address		Beginning/Ending Salary	Telephone No.
Description of job duties and give approximate percentage of major duties		Reason for leaving	

Classification	Job Title	Dates of Employment (Month & Year) From:	To:
Employer		Supervisor Name and Title	
Business Address		Beginning/Ending Salary	Telephone No.
Description of job duties and give approximate percentage of major duties		Reason for leaving	

Special Skills: List training, licenses, office machines you can operate, typing speed, languages you speak fluently, etc. and any other skills which add to your qualifications.
Do you have computer skills? Please list software programs you have used:
Do we have permission to contact your present employer? ☐ Yes ☐ No
Do we have permission to contact your previous employer? ☐ Yes ☐ No
Date available for employment:

References (List three PROFESSIONAL references who may be contacted)

Name and Address (Number, Street, City, State and Zip Code)	Telephone Number	Occupation
Name and Address (Number, Street, City, State and Zip Code)	Telephone Number	Occupation
Name and Address (Number, Street, City, State and Zip Code)	Telephone Number	Occupation

The City of Strongsville will not discriminate against any individual or group because of race, gender, sexual orientation, religion, age, height, weight, genetic information, national origin, color, marital status, political beliefs or disability. Applicants with a disability who may need an accommodation to complete the pre-employment application or participate in the interview process should make such a request to the City of Strongsville Human Resource Department.

Visit our Internet site www.strongsville.org

Applicant Certification

I certify that all information above is true and complete and I agree and understand that any falsification of material facts will result in forfeiting any rights to consideration for employment with the City of Strongsville. I understand that if accepted by the City of Strongsville, my employment is voluntarily entered into and I am free to resign at any time. Similarly, the City of Strongsville is free to conclude my employment at any time. I further recognize that this application is not a contract and cannot create a contract, and that if hired I will be an employee at will, subject to discharge without cause unless otherwise specified by law.

Applicant Signature	Date

CITY OF STRONGSVILLE

AUTHORIZATION FOR RELEASE OF INFORMATION

My signature below authorizes the City of Strongsville to conduct a background investigation and authorizes release of information in connection with my application for employment. This investigation may include but is not limited to, such information as criminal or civil convictions or civil cases, driving records, information from previous employers and educational institutions, personal references, professional references, and other appropriate sources.

I waive my right of access to any such information, and without limitation hereby release the City of Strongsville, its officials, employees and representatives, and the reference source from any liability in connection with its release or use. This release includes the sources cited above and specifically provides for any and all information from: the local police department, information from the Ohio Criminal Investigation and the Federal Bureau of Investigation of either data on all criminal convictions or certification that no data on criminal convictions are maintained, information from any federal, state or local agency to which the City may contact for release of information pertaining to any findings involving me.

Furthermore, I certify that I have made true, correct and complete answers and statements on this application in the knowledge that they may be relied upon in considering my application. I understand that any omission or falsely answered statement made by me on this application, or any supplement to it will be sufficient grounds for failure to employ or for my discharge should I become employed with the City of Strongsville.

Signature of Applicant: _____

Print Name: _____

Date: _____

CITY OF STRONGSVILLE
EQUAL EMPLOYMENT OPPORTUNITY

Responses to the questions below are **OPTIONAL**. These questions are included to assist our equal employment opportunity efforts. Providing this information is **VOLUNTARY** and will in no way affect the processing of your application or your being considered for employment. Human Resources will process your responses to these confidential questions separately. Responses will be used for statistical purposes only.

Position Applied For _____ Date_____

OPTIONAL: Sex

___Male ___Female

OPTIONAL: Please select your age group.

___ Under 18

___ 18-25

___ 26-39

___ 40-54

___ 55-69

___ 70+

OPTIONAL: Race/Ethnicity

___ **WHITE**: All persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

___ **BLACK or AFRICAN AMERICAN**: All persons having origins in any of the Black racial groups of Africa.

___ **HISPANIC** or **LATINO**: All persons of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish culture or origin, regardless of race.

___ **ASIAN**: All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent (for example, China, India, Japan and Korea).

___ **NATIVE HAWAIIAN** or **PACIFIC ISLANDER**: All persons having origins in any of the original peoples of the Hawaiian Islands and Pacific Islands (for example, Hawaii, Philippine Islands and Samoa).

___ **AMERICAN INDIAN** or **ALASKAN NATIVE**: All persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.

___ **OTHER**: Please self define. _____

OPTIONAL: Are you an individual with a physical or mental impairment which substantially limits one or more of your major life activities?

___Yes ___No

OPTIONAL: Are you a veteran?

___Yes ___No

OPTIONAL: If you answered Yes to the previous question, please indicate if one or more of the following apply.

___ **MILITARY STATUS**: The performance of duty in a uniformed service, to include active duty, active duty for training, initial active duty for training, inactive duty for training, full-time National Guard duty.

___ **DISABLED VETERAN**: A person whose discharge or release from active duty was for a disability incurred or aggravated in the line of duty.

___ **DESERT STORM/SHIELD VETERAN**: A person whose active duty was performed after August 2, 1990, in the Persian Gulf Conflict.

___ **VIETNAM ERA VETERAN**: A person served on active duty for a period of more than 180 days, any part of which occurred between August 5, 1964, and May 7, 1975.

Ohio Public Employees Retirement System

277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377) www.opers.org

Personal History Record

INSTRUCTIONS

1. As a public employee you are required to complete and file this Form within 30 days of commencing employment. Failure to do so may limit the options available to you as well as delay transactions. Please fill out the form in **blue or black ink.**
2. For elected officials: An elected official, or person appointed to a publicly elected position, who is not retired from an Ohio retirement system and does not have contributions on deposit with OPERS through previous elected service, has the option of contributing to OPERS or Social Security. Elected officials who choose OPERS membership are required to contribute to OPERS for all subsequent elected positions.
3. Be sure your date of birth and Social Security Number, which are used to identify your account, are entered correctly.
4. Sign the form in SECTION 4 - **EMPLOYEE CERTIFICATION**. DO NOT print or type.
5. The employer is required to complete SECTION 5 - **EMPLOYER CERTIFICATION.**
6. The employer is required to mail the ***completed*** form to OPERS at the above address immediately upon hire.

Section 1 - Personal Information

Social Security Number

Last Name **First Name** **MI**

Street or Mailing Address **Apt. Number**

City **State** **ZIP Code**

State: OH

Province **Country** **Postal Code**

Date Of Birth **Gender** **Male** **Female**

Are you legally married? **Yes** **No** **Maiden Name**

Work Phone Number **Home Phone Number** **Cell Phone Number**

E-mail Address

Section 2 - Current Employment Information

Job Title

If this is an elected position or if you have been appointed to an elected position, provide date present elective service began.

Please turn page to complete remainder of form

Section 3 - Prior Service Information

1. Have you previously worked in public employment in Ohio? **Yes** ☐ **No** ☐ If "yes," give first date of public service: ☐☐☐☐☐☐☐☐

If "yes," list employer(s)

2. Do you have previous public service for which OPERS contributions were not submitted? **Yes** ☐ **No** ☐
If "Yes" and you wish to request a determination relative to your non-contributing service, please provide OPERS with a completed *Certification of Unreported Public Service (Form AA)*.

3. Are you currently a member of, have you been a member of, or are you receiving a disability benefit from any of the following retirement systems? *(If applicable, check Refunded, Receiving a Disability Benefit or Receiving a Retirement Benefit.)*

	Yes	No	Refunded	Receiving a Disability Benefit	Receiving a Retirement Benefit
Ohio Public Employees Retirement Systems (OPERS)	☐	☐	☐	☐	☐
State Teachers Retirement Systems (STRS)	☐	☐	☐	☐	☐
School Employees Retirement System (SERS)	☐	☐	☐	☐	☐
Ohio Police and Fire Pension Fund (OP&F)	☐	☐	☐	☐	☐
State Highway Patrol Retirement System (HPRS)	☐	☐	☐	☐	☐
Cincinnati Retirement System (CRS)	☐	☐	☐	☐	☐

Section 4 - Employee Certification

I state that the information contained in this form is complete and true to the best of my knowledge and belief.

Today's Date

_____ _____

Employee Signature (Do not print or type.)

Section 5 - Employer Certification

Employer Code ☐☐☐☐ - ☐☐ Start Date ☐☐☐☐☐☐☐☐

Is this an elected position? **Yes** ☐ **No** ☐ If "yes," provide Employer Code for elected position ☐☐☐☐ - ☐☐

Elected Position Title

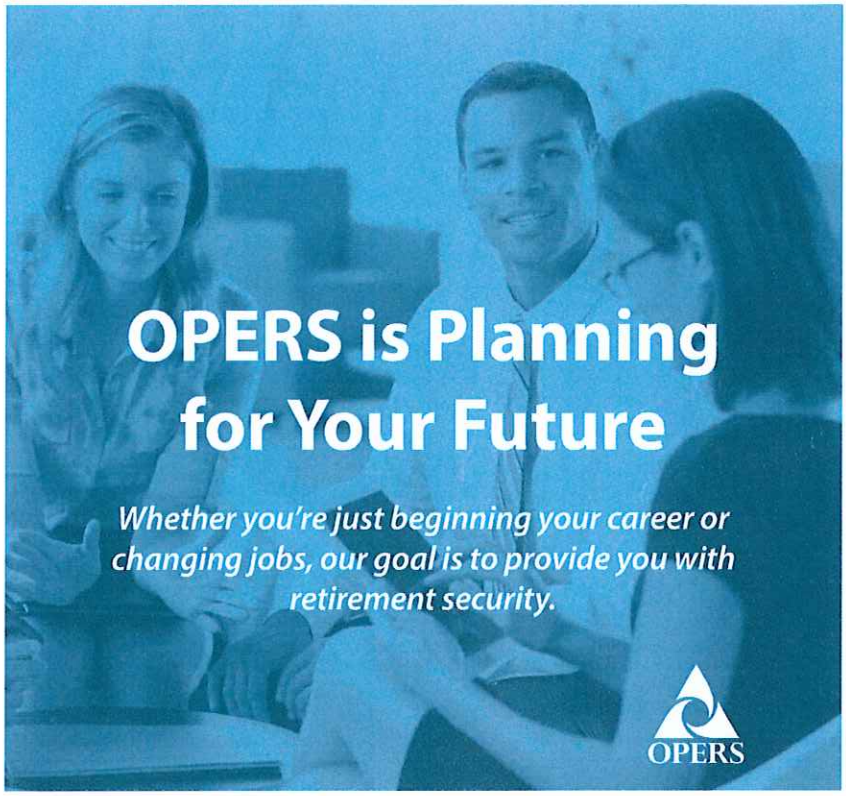
Is this a law enforcement position? **Yes** ☐ **No** ☐ **Full-Time** ☐ **Part-Time** ☐

I hereby certify that _____ began earning salary from which OPERS
Employee Name

retirement contributions are deducted with the above employer on the start date indicated above and the statements set forth are true and accurate as disclosed by the records of

_____
Signature of Certifying Officer

Print Certifying Officer's Name



OPERS is Planning for Your Future

Whether you're just beginning your career or changing jobs, our goal is to provide you with retirement security.

OPERS

You're in good company

OPERS serves more than 1 million past and present Ohio public workers.

We are a large network of employers

We cover over 3,700 employers across Ohio – from libraries and counties to state universities and hospitals. That means you can change jobs and may still be covered by OPERS.

We are your pension system

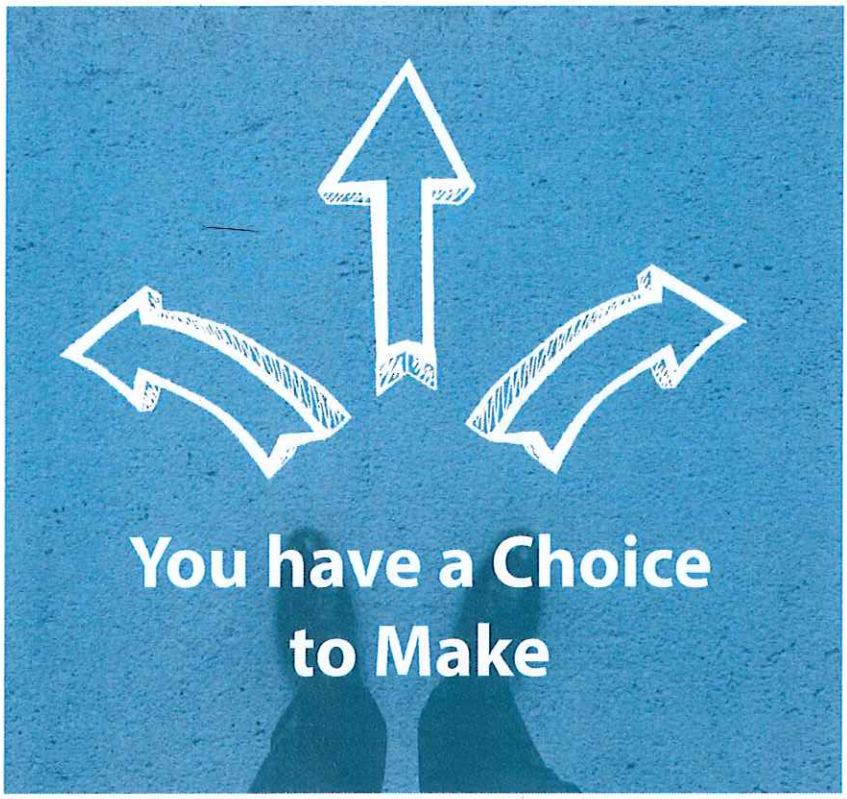
An OPERS pension offers a secure retirement benefit and the longer you work, the more retirement income you will receive.

What is a pension?

As an OPERS member, you do not pay into Social Security. Instead, you contribute 10% of your salary and your employer contributes 14% to OPERS. **That means nearly 24% of your salary is being invested for your future.**

We've been providing retirement security since 1935...

...And we've never failed to pay a member what they've earned. We're the largest state pension fund in Ohio, and the 11th largest public retirement system in the U.S.



You have a Choice to Make

OPERS offers you three retirement plans from which to choose: the **Traditional Pension Plan**, the **Member-Directed Plan** and the **Combined Plan**. Each plan has unique features so you can pick the one that will best help you meet your retirement goals.

What's next

You will have 180 days from your start date to choose an OPERS retirement plan. More information about plan selection will be coming soon!

Your trusted partner

If you have any questions you can call us at 1-800-222-7377 Monday through Friday form 8 a.m. to 4:30 p.m., or stop by our office to meet with a highly trained Member Services Representative.

Visit www.opers.org to get to know us more.

Ohio Public Employees Retirement System
277 E. Town St.
Columbus, OH 43215

OPERS

EDU_AO (Revised 081116)

OPERS EMPLOYER Notice

December 9, 2004

Ohio Public Employees Retirement System • 277 East Town Street • Columbus, Ohio 43215

SSA Requires New Form from Public Employers

Who should read this notice
Human resources professionals, payroll professionals

What's happening
Effective January 1, 2005, the Social Security Administration (SSA) will require all state and local government employers to inform newly hired employees of the potential impact of the Social Security Windfall Elimination and the Government Pension Offset Provisions. This requirement applies to newly hired employees not covered by Social Security.

The law requires newly hired public employees to sign a notice, *Statement Concerning Your Employment in a Job Not Covered by Social Security (Form SSA-1945),* acknowledging they are aware of a possible reduction in their future Social Security benefits and submit the signed statement to their employer. Employers are responsible for sending a copy of the signed notice to the appropriate retirement system.

What you need to do
An example of Form SSA-1945 is attached for your reference. Following is the process for handling this notice:

- As of January 1, 2005, all newly hired employees not covered by Social Security must be given this statement. The statement explains how the Windfall Elimination and the Government Pension Offset Provisions may result in a reduction of Social Security benefits. It also explains the maximum reduction amount.
- Employers must provide the statement to all new employees in positions not covered by Social Security, even those who have had previous public service.
- Employees must sign the statement stating they have received this information.
- A copy of the statement must be submitted to OPERS along with each newly hired employee's Personal History Record (Form A).

Special note: The form must be accurately and completely filled out. The "employee identification number" requested is the employee's Social Security number.
The "employer identification number" requested is your OPERS-assigned employer code.

As required by law, OPERS will retain the form in the employee's new member case file. Social Security Administration advises the employer to retain the original statement in their employee files as well. If a Personal History Record is submitted to OPERS without the signed statement, OPERS will contact the employer by letter and request the document.

(More information on back)

Important:
The "employee identification number" requested is the employee's Social Security number. The "employer identification number" requested is your OPERS-assigned employer code.

OPERS
1-888-400-0965
www.opers.org

How to get the form
The form, SSA-1945, may be obtained from Social Security Administration in three ways:

- The form is available online via the Social Security Web site, www.socialsecurity.gov/form1945. You may download copies as needed.
- Paper copies can be requested by e-mail at oplm.oswm.rqct.orders@ssa.gov.
- You may also send a fax requesting hard copies of the form to 410-965-2037.

Requests by e-mail or fax must include the name, complete address and telephone number of the employer and, if appropriate, the name of the individual to whom the forms are to be delivered. Forms will not be sent to a post office box. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Form SSA-1945 will not be available from OPERS.

Why this is important
Please be aware this documentation is required by law. The changes provided for in the Social Security Protection Act of 2004 may have a significant impact on your employees' or their spouses' retirement benefits. By giving your employees complete information at the start of their public employment; they will have time to consider planning options.

Who to contact for more information
For more information about the Windfall Elimination and Government Pension Offset Provisions, please review SSA Publication No. 05-10007, or you can:

- Visit the SSA Web site at www.socialsecurity.gov,
- Call the SSA at 1-800-772-1213, or
- Contact your local Social Security office.

After you review this *Employer Notice*, contact Employer Outreach with questions or comments at 888-400-0965 or via the Internet at employeroutreach@opers.org.

This Employer Notice is written in plain language for use by public employers who are subject to coverage under the Ohio Public Employees Retirement System. It is not intended as a substitute for the federal or state law, namely the Ohio Revised Code, the Ohio Administrative Code, or the Internal Revenue Code, nor will its interpretation prevail should a conflict arise between it and the Ohio Revised Code, Ohio Administrative Code, or Internal Revenue Code. Rules governing the retirement system are subject to change periodically either by statute of the Ohio General Assembly, regulation of the Ohio Public Employees Retirement Board, or regulation of the Internal Revenue Code. If you have questions about this material, please contact our office or seek legal advice from your attorney.

OPERS

Social Security Administration

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** (SSN)

Employer Name City of Strongsville **Employer ID#** 34-6002751

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

MEDICAL MUTUAL

Employee Application / Change Form
(For 51+ Groups Only)

(PLEASE USE BALL POINT PEN)

☐ New Enrollee Date of Hire ____________ ☐ Re-hire Date ____________ ☐ Coverage Change Date ____________

BASIC INFORMATION

GROUP NO.:	SECTION NO.:	LEVEL OF BENEFITS: ☐ Single ☐ Family ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Two Persons ☐ Medicare Supplemental	EMPLOYMENT STATUS: ☐ Active ☐ Retired ☐ COBRA

EMPLOYEE CLOCK NUMBER:	EMPLOYEE DEPT. NO.:	PAYROLL LOCATION:

CHANGES: ☐ Add Dependents due to: ☐ Marriage ☐ Birth ☐ Adoption
☐ Drop Dependents Due To: ☐ Divorce ☐ Death ☐ Other ____________
☐ New Name ☐ New Address ☐ Change to Medicare Elig. ☐ Change Coverage
☐ Other ____________

DATE OF EVENT — MO. — DAY — YR.

COV. OR CHANGE EFF. DATE — MO. — DAY — YR.

Last Name	First Name	M Initial	E-mail Address

Street Address	City	State	Zip	Phone No.

Employee Date of Birth MO. DAY YR.	Sex ☐ M ☐ F	Employee Social Security Number	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legal Separation	Date Married MO. DAY YR.

Employer or Group Name	Date of Hire-Full Time MO. DAY YR.	Job Title
City of Strongsville		

Check Coverage Desired: ☐ Health: Benefit Option or Product Desired ____________ ☐ Prescription Drug ☐ Dental ☐ Vision

For HMO and Point-of-service plans, complete the following:
Primary Care Physician Name ____________ State ____________ Current Patient? ☐ YES ☐ NO

MEDICARE INFORMATION

Are you covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ________ Effective Date: ________ ☐ Hemodialysis
Is your spouse covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ________ Effective Date: ________ ☐ Hemodialysis

OTHER INSURANCE INFORMATION

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? ☐ YES ☐ NO IF YES, COMPLETE THE SECTION BELOW.

NAME OF POLICY HOLDER	NAME AND ADDRESS OF OTHER INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

What date did your most recent health insurance program become effective (check box if no prior/current coverage)?____/____/____ ☐ No coverage
What date did/will this health insurance program terminate (check box if no prior/current coverage)?____/____/____

DEPENDENT INFORMATION

RELATIONSHIP	BIRTHDATE	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOC. SEC. NO.	OVER AGE DEPENDENT STATUS
Spouse	MO. DAY YR.	☐M ☐F				
☐ Child ☐ Adopted Stepchild ☐ Other¹		☐M ☐F				☐ F/T Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other¹		☐M ☐F				☐ F/T Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other¹		☐M ☐F				☐ F/T Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other¹		☐M ☐F				☐ F/T Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability

1. Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked other.

PRE-EXISTING CONDITION NOTICE

The following is applicable if your group imposes a pre-existing condition exclusion: This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within no more than a six-month "look-back" period. Generally, this look-back period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the look-back period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the maximum 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to CustomerService@MedMutual.com or your sales representative.

TERMS AND CONDITIONS

I hereby apply for the coverage indicated on this Application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for my coverage to Medical Mutual, any affiliates or division of Medical Mutual, and/or the sponsor of my group health plan; (2) release of information, without limitation, from any medical/medically-related facility, prior health carrier, the Medical Information Bureau (MIB), government agency or person to Medical Mutual and/or any affiliates or division of Medical Mutual: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities; and/or (d) for credentialing purposes. I authorize Medical Mutual and/or the sponsor of my group health plan to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

My dependents and I understand and agree that any information obtained will not be released by Medical Mutual to any person or organization, except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any Application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. My revocation must be in writing. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application or a pending insurance action.

I understand and acknowledge that this authorization extends to all medical records, including records that may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.

If applying for either a health maintenance organization (HMO) or point of service (POS) plan, I understand that: (1) Enrollee access is restricted to network health care providers; (2) I am required to have a network physician provide or arrange for all medical services (except maternity or life-threatening emergencies) to receive any benefits, in the case of an HMO plan, or the highest level of benefits, in the case of a POS plan; and (3) I will receive a list of plan physicians and plan facilities upon enrollment and/or request.

SIGNATURE

I have read all of the statements contained in this Application and declare by signing this Application that I am an active, eligible, compensated, full-time employee or member of the group and that the information I have provided is true and complete to the best of my knowledge.

_____ _____

Employee Signature Date

Note: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

WAIVER

COMPLETE THE WAIVER SECTION BELOW ONLY if you do not want any coverage or want to waive some of the coverage options.

A. Waived coverages: I do not want (Check all that apply)

☐ Self: ☐ Health ☐ Drug ☐ Dental ☐ Vision through Medical Mutual®

☐ Dependent: ☐ Health ☐ Drug ☐ Dental ☐ Vision through Medical Mutual for the following spouse and/or dependent(s) only:

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Please indicate reason for waiving coverage:

☐ No coverage

☐ Employee/dependent has existing coverage. Insurance company name: _____

B. Terms and Declarations:

I understand that if I check any box in Question A of this Waiver, I am choosing not to have those persons covered under the health coverage designated, and any later Application for enrollment and acceptance will be subject to all underwriting requirements.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

I have read and understand the above terms:

Current Employer: _____

Print Employee Name: _____ Employee Social Security No.: _____

Print Spouse Name: _____ Spouse Social Security No.: _____

Employee Signature: _____ Date: _____

WARNING: If you or your family members are covered by more than one healthcare plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Medical Mutual : Plan 1

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: Single or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at MedMutual.com/SBC or by calling 800.232.7400.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100**/single,**$200**/family Tier 1 Provider **$350**/single,**$700**/family Tier 2 Provider $500/single,$1000/family Tier 3 Provider Doesn't apply to coinsurance, copays and network preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	**Yes, Coinsurance Limit:** **$0**/single,**$0**/family Tier 1 Provider **$750**/single,**$1,000**/family Tier 2 Provider $1,250/single, $1,500/family Tier 3 Provider **Out-of-pocket Limit:** **$1,100**/single,**$1,700**/family Tier 1 Provider **$1,100**/single,**$1,700**/family Tier 2 Provider $1,750/single,$2,500/family Tier 3 Provider	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The coinsurance limit is included in the **out-of-pocket limit**.
What is not included in the out-of-pocket limit?	Cost sharing for prescription drugs, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the insurer pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for **specific** covered services, such as office visits.

Questions: Call 800.232.7400 or visit us at MedMutual.com/SBC.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800.232.7400 to request a copy.

Does this plan use a network of providers?	Yes, See MedMutual.com/SBC or call 800.232.7400 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Tier 1 **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost if You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Specialist visit	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Other practitioner office visit (Chiropractic)	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Other practitioner office visit (Acupuncture)	Not Covered			Excluded Service
	Preventive care/ screening/ immunization	No charge	No charge	20% coinsurance	-------none-------

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800.232.7400 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost if You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Provider	Limitations & Exceptions
If you have a test	Imaging (CT/PET scans, MRIs)	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Drug Out of Pocket Limit - Single	$1,500	Does Not Apply		-------none-------
	Drug Out of Pocket Limit - Family	$3,000	Does Not Apply		-------none-------
	Generic copay - retail Tier 1	$20	Does Not Apply		Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	$40	Does Not Apply		Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	$30	Does Not Apply		Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	$60	Does Not Apply		Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	$60	Does Not Apply		Covers up to a 30-day supply.
	Non-preferred brand copay - home delivery Tier 3	$120	Does Not Apply		Covers up to a 90-day supply.
	Specialty drugs	Applicable drug tier copay applies	Does Not Apply		Covers up to a 30-day supply.
	Out of Network RX	Does Not Apply			-------none-------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Physician/surgeon fees (Outpatient)	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost if You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	No charge			-------none-------
	Emergency medical transportation	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Urgent care	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Physician/ surgeon fee (inpatient)	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits			-------none-------
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits			-------none-------
	Substance use disorder outpatient services (alcoholism)	Benefits paid based on corresponding medical benefits			-------none-------
	Substance use disorder inpatient services (alcoholism)	Benefits paid based on corresponding medical benefits			-------none-------
	Substance use disorder outpatient services (drug use)	Benefits paid based on corresponding medical benefits			-------none-------
	Substance use disorder inpatient services (drug use)	Benefits paid based on corresponding medical benefits			-------none-------
If you are pregnant	Prenatal and postnatal care	No charge after deductible	10% coinsurance	20% coinsurance	(Prenatal Visits are covered at no charge with in-network providers)
	Delivery and all inpatient services	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost if You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Rehabilitation services (Physical Therapy)	No charge after deductible	10% coinsurance	20% coinsurance	(10 visits ten Medical Review, combined with Occupational Therapy and Chiropractic-Professional; unlimited Institutional)
	Habilitation services (Occupational Therapy)	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Habilitation services (Speech Therapy)	No charge after deductible	10% coinsurance	20% coinsurance	(10 visits, then Medical Review - Professional; unlimited - Institutional)
	Skilled nursing care	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Durable medical equipment	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
	Hospice service	No charge after deductible	10% coinsurance	20% coinsurance	-------none-------
If your child needs dental or eye care	Eye exam (Child)	No charge	No charge	20% coinsurance	-------none-------
	Glasses	Not Covered			Excluded Service
	Dental check-up (Child)	Not Covered			Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental check-up (Child)
- Glasses
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Private-Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800.232.7400. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 X61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at 800.232.7400. You may also contact your State Department of Insurance at 800.686.1526.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does meet the minimum value standard for the benefits it provides.**

----------*To see examples of how this plan might cover costs for sample medical situations, see the next page*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan Pays $6,520**
- **Patient Pays $1,020**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$100
Copays	$20
Coinsurance	$0
Limits or exclusions	$900
Total	**$1,020**

These numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower. For more information about your HRA or FSA, please contact your employer group.

Managing Type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan Pays $4,300**
- **Patient Pays $1,100**

Sample care cost:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedure	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$100
Copays	$800
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,100**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 800.232.7400.

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**,and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

× **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

× **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summaries of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box on each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 800.232.7400 or visit us at MedMutual.com/SBC.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800.232.7400 to request a copy.

Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL®

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة،فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم 711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  (800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

MEDICAL MUTUAL™

City of Strongsville SuperDental Effective 1/1/17

SuperDental

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	Same as Medical	
Benefit Period Maximum (per member)	$1,600	
Benefit Period Deductible[1]	$50 per person	$50 per person
Preventive Services		
Oral Exams – two per benefit period	90%	80%
Bite Wing X-Rays – two sets per benefit period	90%	80%
Full Mouth X-Rays/ Panorex – one every 36 months	90%	80%
Prophylaxis (cleaning) – two per benefit period	90%	80%
Fluoride Treatment – One treatment per benefit period, limited to dependents up to age 19	90%	80%
Sealants – one every rolling 36 months per tooth	90%	80%
Space Maintainers- limited to eligible dependents up to age 19	90%	80%
Emergency Palliative Treatment – includes emergency oral exam	90%	80%
Essential Services		
Consultations and Other Exams by Specialist	90%	80%
Diagnostic X-Rays	90%	80%
Minor Restorative Services	90%	80%
Endodontics/Pulp Services	90%	80%
Periodontal Services	90%	80%
Repairs, Relines & Adjustments of Prosthetics	90%	80%
Simple Extractions	90%	80%
Impactions	90%	80%
Minor Oral Surgery Services	90%	80%
Biopsy and examination of oral tissue	90%	80%
Microscopic Examination	90%	80%
General Anesthesia	90%	80%
Complex Services		
Gold Foil Restoration	60% after deductible	50% after deductible
Inlays, Onlays – one every five years	60% after deductible	50% after deductible
Crowns – one every five years	60% after deductible	50% after deductible
Bridgework (Pontics & Abutments) – one every five years	60% after deductible	50% after deductible
Partial and Complete Dentures – one every five years	60% after deductible	50% after deductible
Orthodontics Option (eligible children under age 19 only)		
Orthodontic Lifetime Maximum (per member)	$1000	
Orthodontic Diagnostic Services	50%	50%
Minor Treatment for Tooth Guidance	50%	50%
Minor Treatment for Harmful Habits	50%	50%
Interceptive Orthodontic Treatment	50%	50%
Comprehensive Orthodontic Treatment	50%	50%

Note: Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Medical Mutual may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

[1] 3-month carryover applies.

City of Strongsville
Vision
Effective 1-1-2017

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	Same as Medical
Examinations	**One per benefit period**
Vision Examinations	$20 per exam
Frames	**One per two benefit periods**
Basic Frames	$50 per frame
Prescription Lenses	**One per benefit period**
Single Vision Lenses	$75 per pair
Bifocal Lenses	$125 per pair
Trifocal Lenses	$175 per pair
Lenticular Lenses	$350 per pair
Contacts In Lieu of Lenses	**One per benefit period**
Medically Necessary	$150 per pair
Cosmetic	$150 per pair

Note: Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Medical Mutual may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

Important Notices Related to your Benefits Coverage

Revised January, 2017

Model 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 must 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: Human Resources Department

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.

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.

Newborns' and Mothers' Health Protection Act (NMHPA)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Uniformed Services Employment and Reemployment Rights Act

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within ***30 days*** after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact the Human Resources Department.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Instructions for Form I-9, 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

Anti-Discrimination Notice. It is illegal to discriminate against work-authorized individuals in hiring, firing, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) the employee may present to establish employment authorization and identity. The employer must allow the employee to choose the documents to be presented from the Lists of Acceptable Documents, found on the last page of Form I-9. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TTY), or visit www.justice.gov/crt/about/osc.

What is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011.

General Instructions

Both employers and employees are responsible for completing their respective sections of Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors, as defined in section 3 of the Migrant and Seasonal Agricultural Worker Protection Act, Public Law 97-470 (29 U.S.C. 1802). An "employee" is a person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term "Employee" does not include those who do not receive any form of remuneration (volunteers), independent contractors or those engaged in certain casual domestic employment. Form I-9 has three sections. Employees complete Section 1. Employers complete Section 2 and, when applicable, Section 3. Employers may be fined if the form is not properly completed. See 8 USC § 1324a and 8 CFR § 274a.10. Individuals may be prosecuted for knowingly and willfully entering false information on the form. Employers are responsible for retaining completed forms. **Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).**

These instructions will assist you in properly completing Form I-9. The employer must ensure that all pages of the instructions and Lists of Acceptable Documents are available, either in print or electronically, to all employees completing this form. When completing the form on a computer, the English version of the form includes specific instructions for each field and drop-down lists for universally used abbreviations and acceptable documents. To access these instructions, move the cursor over each field or click on the question mark symbol (?) within the field. Employers and employees can also access this full set of instructions at any time by clicking the Instructions button at the top of each page when completing the form on a computer that is connected to the Internet.

Employers and employees may choose to complete any or all sections of the form on paper or using a computer, or a combination of both. Forms I-9 obtained from the USCIS website are not considered electronic Forms I-9 under DHS regulations and, therefore, cannot be electronically signed. Therefore, regardless of the method you used to enter information into each field, you must print a hard copy of the form, then sign and date the hard copy by hand where required.

Employers can obtain a blank copy of Form I-9 from the USCIS website at https://www.uscis.gov/sites/default/files/files/form/i-9.pdf. This form is in portable document format (.pdf) that is fillable and savable. That means that you may download it, or simply print out a blank copy to enter information by hand. You may also request paper Forms I-9 from USCIS.

Certain features of Form I-9 that allow for data entry on personal computers may make the form appear to be more than two pages. When using a computer, Form I-9 has been designed to print as two pages. Using more than one preparer and/or translator will add an additional page to the form, regardless of your method of completion. You are not required to print, retain or store the page containing the Lists of Acceptable Documents.

The form will also populate certain fields with N/A when certain user choices ensure that particular fields will not be completed. The Print button located at the top of each page that will print any number of pages the user selects. Also, the Start Over button located at the top of each page will clear all the fields on the form.

The Spanish version of Form I-9 does not include the additional instructions and drop-down lists described above. Employers in Puerto Rico may use either the Spanish or English version of the form. Employers outside of Puerto Rico must retain the English version of the form for their records, but may use the Spanish form as a translation tool. Additional guidance to complete the form may be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274) and on USCIS' Form I-9 website, I-9 Central.

Completing Section I: Employee Information and Attestation

You, the employee, must complete each field in Section 1 as described below. Newly hired employees must complete and sign Section 1 no later than the first day of employment. Section 1 should never be completed before you have accepted a job offer.

Entering Your Employee Information

Last Name *(Family Name)*: Enter your full legal last name. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the Last Name field. *Examples of correctly entered last names include De La Cruz, O'Neill, Garcia Lopez, Smith-Johnson, Nguyen.* If you only have one name, enter it in this field, then enter "Unknown" in the First Name field. You may not enter "Unknown" in both the Last Name field and the First Name field.

First Name *(Given Name)*: Enter your full legal first name. Your first name is your given name. *Some examples of correctly entered first names include Jessica, John-Paul, Tae Young, D'Shaun, Mai.* If you only have one name, enter it in the Last Name field, then enter "Unknown" in this field. You may not enter "Unknown" in both the First Name field and the Last Name field.

Middle Initial: Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any. If you have more than one middle name, enter the first letter of your first middle name. If you do not have a middle name, enter N/A in this field.

Other Last Names Used: Provide all other last names used, if any (e.g., maiden name). Enter N/A if you have not used other last names. For example, if you legally changed your last name from Smith to Jones, you should enter the name Smith in this field.

Address (Street Name and Number): Enter the street name and number of the current address of your residence. If you are a border commuter from Canada or Mexico, you may enter your Canada or Mexico address in this field. If your residence does not have a physical address, enter a description of the location of your residence, such as "3 miles southwest of Anytown post office near water tower."

Apartment: Enter the number(s) or letter(s) that identify(ies) your apartment. If you do not live in an apartment, enter N/A.

City or Town: Enter your city, town or village in this field. If your residence is not located in a city, town or village, enter your county, township, reservation, etc., in this field. If you are a border commuter from Canada, enter your city and province in this field. If you are a border commuter from Mexico, enter your city and state in this field.

State: Enter the abbreviation of your state or territory in this field. If you are a border commuter from Canada or Mexico, enter your country abbreviation in this field.

ZIP Code: Enter your 5-digit ZIP code. If you are a border commuter from Canada or Mexico, enter your 5- or 6-digit postal code in this field.

Date of Birth: Enter your date of birth as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 1980 as 01/08/1980.

U.S. Social Security Number: Providing your 9-digit Social Security number is voluntary on Form I-9 unless your employer participates in E-Verify. If your employer participates in E-Verify and:

1. You have been issued a Social Security number, you must provide it in this field; or
2. You have applied for, but have not yet received a Social Security number, leave this field blank until you receive a Social Security number.

Employee's E-mail Address (Optional): Providing your e-mail address is optional on Form I-9, but the field cannot be left blank. To enter your e-mail address, use this format: name@site .domain. One reason Department of Homeland Security (DHS) may e-mail you is if your employer uses E-Verify and DHS learns of a potential mismatch between the information provided and the information in government records. This e-mail would contain information on how to begin to resolve the potential mismatch. You may use either your personal or work e-mail address in this field. Enter N/A if you do not enter your e-mail address.

Employee's Telephone Number (Optional): Providing your telephone number is optional on Form I-9, but the field cannot be left blank. If you enter your area code and telephone number, use this format: 000-000-0000. Enter N/A if you do not enter your telephone number.

Attesting to Your Citizenship or Immigration Status

You must select one box to attest to your citizenship or immigration status.

1. **A citizen of the United States.**

2. **A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

3. **A lawful permanent resident**: An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. This term includes conditional residents. Asylees and refugees should not select this status, but should instead select "An Alien authorized to work" below.

   If you select "lawful permanent resident," enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or USCIS Number in the space provided. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

4. **An alien authorized to work**: An individual who is not a citizen or national of the United States, or a lawful permanent resident, but is authorized to work in the United States.

   If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the document(s) evidencing your employment authorization. Refugees, asylees and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other aliens whose employment authorization does not have an expiration date should enter N/A in the Expiration Date field. In some cases, such as if you have Temporary Protected Status, your employment authorization may have been automatically extended; in these cases, you should enter the expiration date of the automatic extension in this space.

   Aliens authorized to work must enter one of the following to complete Section1:

   1. Alien Registration Number (A-Number)/USCIS Number; or
   2. Form I-94 Admission Number; or
   3. Foreign Passport Number and the Country of Issuance

   Your employer may not ask you to present the document from which you supplied this information.

   Alien Registration Number/USCIS Number: Enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or your USCIS Number in this field. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. If you do not provide an A-Number or USCIS Number, enter N/A in this field then enter either a Form I-94 Admission Number, or a Foreign Passport and Country of Issuance in the fields provided.

   Form I-94 Admission Number: Enter your 11-digit I-94 Admission Number in this field. If you do not provide an I-94 Admission Number, enter N/A in this field, then enter either an Alien Registration Number/USCIS Number or a Foreign Passport Number and Country of Issuance in the fields provided.

   Foreign Passport Number: Enter your Foreign Passport Number in this field. If you do not provide a Foreign Passport Number, enter N/A in this field, then enter either an Alien Number/USCIS Number or a I-94 Admission Number in the fields provided.

   Country of Issuance: If you entered your Foreign Passport Number, enter your Foreign Passport's Country of Issuance. If you did not enter your Foreign Passport Number, enter N/A.

Signature of Employee: After completing Section 1, sign your name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing this form, you attest under penalty of perjury (28 U.S.C. § 1746) that the information you provided, along with the citizenship or immigration status you selected, and all information and documentation you provide to your employer, is complete, true and correct, and you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties, removal proceedings and may adversely affect an employee's ability to seek future immigration benefits. If you cannot sign your name, you may place a mark in this field to indicate your signature. Employees who use a preparer or translator to help them complete the form must still sign or place a mark in the Signature of Employee field on the printed form.

If you used a preparer, translator, and other individual to assist you in completing Form I-9:

- Both you and your preparer(s) and/or translator(s) must complete the appropriate areas of Section 1, and then sign Section 1. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to sign these fields. You and your preparer(s) and/or translator(s) also should review the instructions for **Completing the Preparer and/or Translator Certification** below.
- If the employee is a minor (individual under 18) who cannot present an identity document, the employee's parent or legal guardian can complete Section 1 for the employee and enter "minor under age 18" in the signature field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The minor's parent or legal guardian should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on completion of Form I-9 for minors. If the minor's employer participates in E-Verify, the employee must present a list B identity document with a photograph to complete Form I-9
- If the employee is a person with a disability (who is placed in employment by a nonprofit organization, association or as part of a rehabilitation program) who cannot present an identity document, the employee's parent, legal guardian or a representative of the nonprofit organization, association or rehabilitation program can complete Section 1 for the employee and enter "Special Placement" in this field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The parent, legal guardian or representative of the nonprofit organization, association or rehabilitation program completing Section 1 for the employee should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on completion of Form I-9 for certain employees with disabilities.

Today's Date: Enter the date you signed Section 1 in this field. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014. A preparer or translator who assists the employee in completing Section 1 may enter the date the employee signed or made a mark to sign Section 1 in this field. Parents or legal guardians assisting minors (individuals under age 18) and parents, legal guardians or representatives of a nonprofit organization, association or rehabilitation program assisting certain employees with disabilities must enter the date they completed Section 1 for the employee.

Completing the Preparer and/or Translator Certification

If you did not use a preparer or translator to assist you in completing Section 1, you, the employee, must check the box marked **I did not use a Preparer or Translator**. If you check this box, leave the rest of the fields in this area blank.

If one or more preparers and/or translators assist the employee in completing the form using a computer, the preparer and/or translator must check the box marked **"A preparer(s) and/or translator(s) assisted the employee in completing Section 1"** , then select the number of Certification areas needed from the dropdown provided. Any additional Certification areas generated will result in an additional page. Form I-9 Supplement, Section 1 Preparer and/or Translator Certification can be separately downloaded from the USCIS Form I-9 webpage, which provides additional Certification areas for those completing Form I-9 using a computer who need more Certification areas than the 5 provided or those who are completing Form I-9 on paper. The first preparer and/or translator must complete all the fields in the Certification area on the same page the employee has signed. There is no limit to the number of preparers and/or translators an employee can use, but each additional preparer and/or translator must complete and sign a separate Certification area. Ensure the employee's last name, first name and middle initial are entered at the top of any additional pages. The employer must ensure that any additional pages are retained with the employee's completed Form I-9.

Signature of Preparer or Translator: Any person who helped to prepare or translate Section 1of Form I-9 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. The Preparer and/or Translator Certification must also be completed if "Individual under Age 18" or "Special Placement" is entered in lieu of the employee's signature in Section 1.

Today's Date: The person who signs the Preparer and/or Translator Certification must enter the date he or she signs in this field on the printed form. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Last Name *(Family Name):* Enter the full legal last name of the person who helped the employee in preparing or translating Section 1 in this field. The last name is also the family name or surname. If the preparer or translator has two last names or a hyphenated last name, include both names in this field.

First Name (*Given Name*): Enter the full legal first name of the person who helped the employee in preparing or translating Section 1 in this field. The first name is also the given name.

Address (Street Name and Number): Enter the street name and number of the current address of the residence of the person who helped the employee in preparing or translating Section 1 in this field. Addresses for residences in Canada or Mexico may be entered in this field. If the residence does not have a physical address, enter a description of the location of the residence, such as "3 miles southwest of Anytown post office near water tower." If the residence is an apartment, enter the apartment number in this field.

City or Town: Enter the city, town or village of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the residence is not located in a city, town or village, enter the name of the county, township, reservation, etc., in this field. If the residence is in Canada, enter the city and province in this field. If the residence is in Mexico, enter the city and state in this field.

State: Enter the abbreviation of the state, territory or country of the preparer or translator's residence in this field.

ZIP Code: Enter the 5-digit ZIP code of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the preparer or translator's residence is in Canada or Mexico, enter the 5- or 6-digit postal code.

Presenting Form I-9 Documents

Within 3 business days of starting work for pay, you must present to your employer documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before Thursday of that week. However, if you were hired to work for less than 3 business days, you must present documentation no later than the end of the first day of employment.

Choose which unexpired document(s) to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which document(s) you may present from the Lists of Acceptable Documents. You may present either one selection from List A or a combination of one selection from List B and one selection from List C. Some List A documents, which show both identity and employment authorization, are combination documents that must be presented together to be considered a List A document: for example, the foreign passport together with a Form I-94 containing an endorsement of the alien's nonimmigrant status and employment authorization with a specific employer incident to such status. List B documents show identity only and List C documents show employment authorization only. If your employer participates in E-Verify and you present a List B document, the document must contain a photograph. If you present acceptable List A documentation, you should not be asked to present, nor should you provide, List B and List C documentation. If you present acceptable List B and List C documentation, you should not be asked to present, nor should you provide, List A documentation. If you are unable to present a document(s) from these lists, you may be able to present an acceptable receipt. Refer to the Receipts section below.

Your employer must review the document(s) you present to complete Form I-9. If your document(s) reasonably appears to be genuine and to relate to you, your employer must accept the documents. If your document(s) does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documents from the Lists of Acceptable Documents. Your employer may choose to make copies of your document(s), but must return the original(s) to you. Your employer must review your documents in your physical presence.

Your employer will complete the other parts of this form, as well as review your entries in Section 1. Your employer may ask you to correct any errors found. Your employer is responsible for ensuring all parts of Form I-9 are properly completed and is subject to penalties under federal law if the form is not completed correctly.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on minors and certain individuals with disabilities.

Receipts

If you do not have unexpired documentation from the Lists of Acceptable Documents, you may be able to present a receipt(s) in lieu of an acceptable document(s). New employees who choose to present a receipt(s) must do so within three business days of their first day of employment. If your employer is reverifying your employment authorization, and you choose to present a receipt for reverification, you must present the receipt by the date your employment authorization expires. Receipts are not acceptable if employment lasts fewer than three business days.

There are three types of acceptable receipts:

1. A receipt showing that you have applied to replace a document that was lost, stolen or damaged. You must present the actual document within 90 days from the date of hire or, in the case of reverification, within 90 days from the date your original employment authorization expires.
2. The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and a photograph of the individual. You must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of admission.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. You must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security Card within 90 days from the date of hire or, in the case of reverification, within 90 days from the date your original employment authorization expires.

Receipts showing that you have applied for an initial grant of employment authorization, or for renewal of your expiring or expired employment authorization, are not acceptable.

Completing Section 2: Employer or Authorized Representative Review and Verification

You, the employer, must ensure that all parts of Form I-9 are properly completed and may be subject to penalties under federal law if the form is not completed correctly. Section 1 must be completed no later than the end of the employee's first day of employment. You may not ask an individual to complete Section 1 before he or she has accepted a job offer. Before completing Section 2, you should review Section 1 to ensure the employee completed it properly. If you find any errors in Section 1, have the employee make corrections, as necessary and initial and date any corrections made.

You or your authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete Section 2 on or before Thursday of that week. However, if you hire an individual for less than 3 business days, Section 2 must be completed no later than the end of the first day of employment.

Entering Employee Information from Section 1

This area, titled, "Employee Info from Section 1" contains fields to enter the employee's last name, first name, middle initial exactly as he or she entered them in Section 1. This area also includes a Citizenship/Immigration Status field to enter the number of the citizenship or immigration status checkbox the employee selected in Section 1. These fields help to ensure that the two pages of an employee's Form I-9 remain together. When completing Section 2 using a computer, the number entered in the Citizenship/Immigration Status field provides drop-downs that directly relate to the employee's selected citizenship or immigration status.

Entering Documents the Employee Presents

You, the employer or authorized representative, must physically examine, in the employee's physical presence, the unexpired document(s) the employee presents from the Lists of Acceptable Documents to complete the Document fields in Section 2.

You cannot specify which document(s) an employee may present from these lists. If you discriminate in the Form I-9 process based on an individual's citizenship status, immigration status, or national origin, you may be in violation of the law and subject to sanctions such as civil penalties and be required to pay back pay to discrimination victims. A document is acceptable as long as it reasonably appears to be genuine and to relate to the person presenting it. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

List A documents show both identity and employment authorization. Some List A documents are combination documents that must be presented together to be considered a List A document, such as a foreign passport together with a Form I-94 containing an endorsement of the alien's nonimmigrant status.

List B documents show identity only, and List C documents show employment authorization only. If an employee presents a List A document, do not ask or require the employee to present List B and List C documents, and vice versa. If an employer participates in E-Verify and the employee presents a List B document, the List B document must include a photograph.

If an employee presents a receipt for the application to replace a lost, stolen or damaged document, the employee must present the replacement document to you within 90 days of the first day of work for pay, or in the case of reverification, within 90 days of the date the employee's employment authorization expired. Enter the word "Receipt" followed by the title of the receipt in Section 2 under the list that relates to the receipt.

When your employee presents the replacement document, draw a line through the receipt, then enter the information from the new document into Section 2. Other receipts may be valid for longer or shorter periods, such as the arrival portion of Form I-94/ I-94A containing a temporary I-551 stamp and a photograph of the individual, which is valid until the expiration date of the temporary I-551 stamp or, if there is no expiration date, valid for one year from the date of admission.

Ensure that each document is an unexpired, original (no photocopies, except for certified copies of birth certificates) document. Certain employees may present an expired employment authorization document, which may be considered unexpired, if the employee's employment authorization has been extended by regulation or a Federal Register Notice. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) or I-9 Central for more guidance on these special situations.

Refer to the M-274 for guidance on how to handle special situations, such as students (who may present additional documents not specified on the Lists) and H-1B and H-2A nonimmigrants changing employers.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the M-274 for more guidance on minors and certain persons with disabilities. If the minor's employer participates in E-Verify, the minor employee also must present a List B identity document with a photograph to complete Form I-9.

You must return original document(s) to the employee, but may make photocopies of the document(s) reviewed. Photocopying documents is voluntary unless you participate in E-Verify. E-Verify employers are only required to photocopy certain documents. If you are an E-Verify employer who chooses to photocopy documents other than those you are required to photocopy, you should apply this policy consistently with respect to Form I-9 completion for all employees. For more information on the types of documents that an employer must photocopy if the employer uses E-Verify, visit E-Verify's website at www.dhs.gov/e-verify. For non-E-Verify employers, if photocopies are made, they should be made consistently for ALL new hires and reverified employees.

Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or another federal government agency. You must always complete Section 2 by reviewing original documentation, even if you photocopy an employee's document(s) after reviewing the documentation. Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. You are still responsible for completing and retaining Form I-9.

List A - Identity and Employment Authorization: If the employee presented an acceptable document(s) from List A or an acceptable receipt for a List A document, enter the document(s) information in this column. If the employee presented a List A document that consists of a combination of documents, enter information from each document in that combination in a separate area under List A as described below. All documents must be unexpired. If you enter document information in the List A column, you should not enter document information in the List B or List C columns. If you complete Section 2 using a computer, a selection in List A will fill all the fields in the Lists B and C columns with N/A.

Document Title: If the employee presented a document from List A, enter the title of the List A document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviation to enter the document title or issuing authority. If the employee presented a combination of documents, use the second and third Document Title fields as necessary.

Full name of List A Document	Abbreviations
U.S. Passport	U.S. Passport
U.S. Passport Card	U.S. Passport Card
Permanent Resident Card (Form I-551)	Perm. Resident Card (Form I-551)
Alien Registration Receipt Card (Form I-551)	Alien Reg.Receipt Card (Form I-551)
Foreign passport containing a temporary I-551 stamp	1. Foreign Passport 2. Temporary I-551 Stamp
Foreign passport containing a temporary I-551 printed notation on a machine-readable immigrant visa (MRIV)	1. Foreign Passport 2. Machine-readable immigrant visa (MRIV)
Employment Authorization Document (Form I-766)	Employment Auth. Document (Form I-766)
For a nonimmigrant alien authorized to work for a specific employer because of his or her status, a foreign passport with Form I/94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Foreign Passport, work-authorized non-immigrant 2. Form I-94/I94A 3. "Form I-20" or "Form DS-2019" Note: In limited circumstances, certain J-1 students may be required to present a letter from their Responsible Officer in order to work. Enter the document title, issuing authority, document number and expiration date from this document in the Additional Information field.
Passport from the Federated States of Micronesia (FSM) with Form I-94/I-94A	1. FSM Passport with Form I-94 2. Form I-94/I94A
Passport from the Republic of the Marshall Islands (RMI) with Form I-94/I94A	1. RMI Passport with Form I-94 2. Form I-94/I94A
Receipt: The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and photograph	Receipt: Form I-94/I-94A w/I-551 stamp, photo
Receipt: The departure portion of Form I-94/I-94A with an unexpired refugee admission stamp	Receipt: Form I-94/I-94A w/refugee stamp
Receipt for an application to replace a lost, stolen or damaged Permanent Resident Card (Form I-551)	Receipt replacement Perm. Res. Card (Form I-551)
Receipt for an application to replace a lost, stolen or damaged Employment Authorization Document (Form I-766)	Receipt replacement EAD (Form I-766)
Receipt for an application to replace a lost, stolen or damaged foreign passport with Form I-94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Receipt: Replacement Foreign Passport, work-authorized nonimmigrant 2. Receipt: Replacement Form I-94/I-94A 3. Form I-20 or Form DS-2019, if presented
Receipt for an application to replace a lost, stolen or damaged passport from the Federated States of Micronesia with Form I-94/I-94A	1. Receipt: Replacement FSM Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A
Receipt for an application to replace a lost, stolen or damaged passport from the Republic of the Marshall Islands with Form I-94/I-94A	1. Receipt: Replacement RMI Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A

Issuing Authority: Enter the issuing authority of the List A document or receipt. The issuing authority is the specific entity that issued the document. If the employee presented a combination of documents, use the second and third Issuing Authority fields as necessary.

Document Number: Enter the document number, if any, of the List A document or receipt presented. If the document does not contain a number, enter N/A in this field. If the employee presented a combination of documents, use the second and third Document Number fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the Student and Exchange Visitor Information System (SEVIS) number in the third Document Number field exactly as it appears on the Form I-20 or the DS-2019.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List A document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. If the document uses text rather than a date to indicate when it expires, enter the text as shown on the document, such as "D/S"(which means, "duration of status"). For a receipt, enter the expiration date of the receipt validity period as described above. If the employee presented a combination of documents, use the second and third Expiration Date fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the program end date here.

List B - Identity: If the employee presented an acceptable document from List B or an acceptable receipt for the application to replace a lost, stolen, or destroyed List B document, enter the document information in this column. If a parent or legal guardian attested to the identity of an employee who is an individual under age 18 or certain employees with disabilities in Section 1, enter either "Individual under age 18" or "Special Placement" in this field. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on individuals under age 18 and certain person with disabilities.

If you enter document information in the List B column, you must also enter document information in the List C column. If an employee presents acceptable List B and List C documents, do not ask the employees to present a List A document. No entries should be made in the List A column. If you complete Section 2 using a computer, a selection in List B will fill all the fields in the List A column with N/A.

Document Title: If the employee presented a document from List B, enter the title of the List B document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority.

Full name of List B Document	Abbreviations
Driver's license issued by a State or outlying possession of the United States	Driver's license issued by state/territory
ID card issued by a State or outlying possession of the United States	ID card issued by state/territory
ID card issued by federal, state, or local government agencies or entities	Government ID
School ID card with photograph	School ID
Voter's registration card	Voter registration card
U.S. Military card	U.S. Military card
U.S. Military draft record	U.S. Military draft record
Military dependent's ID card	Military dependent's ID card
U.S. Coast Guard Merchant Mariner Card	USCG Merchant Mariner card
Native American tribal document	Native American tribal document
Driver's license issued by a Canadian government authority	Canadian driver's license
School record (for persons under age 18 who are unable to present a document listed above)	School record (under age 18)
Report card (for persons under age 18 who are unable to present a document listed above)	Report Card (under age 18)
Clinic record (for persons under age 18 who are unable to present a document listed above)	Clinic record (under age 18)
Doctor record (for persons under age 18 who are unable to present a document listed above)	Doctor record (under age 18)
Hospital record (for persons under age 18 who are unable to present a document listed above)	Hospital record (under age 18)
Day-care record (for persons under age 18 who are unable to present a document listed above)	Day-care record (under age 18)
Nursery school record (for persons under age 18 who are unable to present a document listed above)	Nursery school record (under age 18)

Full name of List B Document	Abbreviations
Individual under age 18 endorsement by parent or guardian	Individual under Age 18
Special placement endorsement for persons with disabilities	Special Placement
Receipt for the application to replace a lost, stolen or damaged Driver's License issued by a State or outlying possession of the United States	Receipt: Replacement driver's license
Receipt for the application to replace a lost, stolen or damaged ID card issued by a State or outlying possession of the United States	Receipt: Replacement ID card
Receipt for the application to replace a lost, stolen or damaged ID card issued by federal, state, or local government agencies or entities	Receipt: Replacement Gov't ID
Receipt for the application to replace a lost, stolen or damaged School ID card with photograph	Receipt: Replacement School ID
Receipt for the application to replace a lost, stolen or damaged Voter's registration card	Receipt: Replacement Voter reg. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military card	Receipt: Replacement U.S. Military card
Receipt for the application to replace a lost, stolen or damaged Military dependent's ID card	Receipt: Replacement U.S. Military dep. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military draft record	Receipt: Replacement Military draft record
Receipt for the application to replace a lost, stolen or damaged U.S. Coast Guard Merchant Mariner Card	Receipt: Replacement Merchant Mariner card
Receipt for the application to replace a lost, stolen or damaged Driver's license issued by a Canadian government authority	Receipt: Replacement Canadian DL
Receipt for the application to replace a lost, stolen or damaged Native American tribal document	Receipt: Replacement Native American tribal doc
Receipt for the application to replace a lost, stolen or damaged School record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement School record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Report card (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Report card (under age 18)
Receipt for the application to replace a lost, stolen or damaged Clinic record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Clinic record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Doctor record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Doctor record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Hospital record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Hospital record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Day-care record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Day-care record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Nursery school record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Nursery school record (under age 18)

Issuing Authority: Enter the issuing authority of the List B document or receipt. The issuing authority is the entity that issued the document. If the employee presented a document that is issued by a state agency, include the state as part of the issuing authority.

Document Number: Enter the document number, if any, of the List B document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List B document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

List C - Employment Authorization: If the employee presented an acceptable document from List C, or an acceptable receipt for the application to replace a lost, stolen, or destroyed List C document, enter the document information in this column. If you enter document information in the List C column, you must also enter document information in the List B column. If an employee presents acceptable List B and List C documents, do not ask the employee to present a list A document. No entries should be made in the List A column.

Document Title: If the employee presented a document from List C, enter the title of the List C document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority. If you are completing the form on a computer, and you select an Employment authorization document issued by DHS, the field will populate with List C#8 and provide a space for you to enter a description of the documentation the employee presented. Refer to the M-274 for guidance on entering List C #8 documentation.

Full name of List C Document	Abbreviations
Social Security Account Number card without restrictions	(Unrestricted) Social Security Card
Certification of Birth Abroad (Form FS-545)	Form FS-545
Certification of Report of Birth (Form DS-1350)	Form DS-1350
Original or certified copy of a U.S. birth certificate bearing an official seal	Birth Certificate
Native American tribal document	Native American tribal document
U.S. Citizen ID Card (From I-197)	Form I-197
Identification Card for use of Resident Citizen in the United States (Form I-179)	Form I-179
Employment authorization document issued by DHS (List C #8)	Employment Auth. document (DHS) List C #8
Receipt for the application to replace a lost, stolen or damaged Social Security Account Number Card without restrictions	Receipt: Replacement Unrestricted SS Card
Receipt for the application to replace a lost, stolen or damaged Original or certified copy of a U.S. birth certificate bearing an official seal	Receipt: Replacement Birth Certificate
Receipt for the application to replace a lost, stolen or damaged Native American Tribal Document	Receipt: Replacement Native American Tribal Doc.
Receipt for the application to replace a lost, stolen or damaged Employment Authorization Document issued by DHS	Receipt: Replacement Employment Auth. Doc. (DHS)

Issuing Authority: Enter the issuing authority of the List C document or receipt. The issuing authority is the entity that issued the document.

Document Number: Enter the document number, if any, of the List C document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List C document. The document is not acceptable if it has already expired, unless USCIS has extended the expiration date on the document. For instance, if a conditional resident presents a Form I-797 extending his or her conditional resident status with the employee's expired Form I-551, enter the future expiration date as indicated on the Form I-797. If the document has no expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

Additional Information: Use this space to notate any additional information required for Form I-9 such as:

- Employment authorization extensions for Temporary Protected Status beneficiaries, F-1 OPT STEM students, CAP-GAP, H-1B and H-2A employees continuing employment with the same employer or changing employers, and other nonimmigrant categories that may receive extensions of stay
- Additional document(s) that certain nonimmigrant employees may present
- Discrepancies that E-Verify employers must notate when participating in the IMAGE program
- Employee termination dates and form retention dates
- E-Verify case number, which may also be entered in the margin or attached as a separate sheet per E-Verify requirements and your chosen business process.
- Any other comments or notations necessary for the employer's business process

You may leave this field blank if the employee's circumstances do not require additional notations.

Entering Information in the Employer Certification

Employee's First Day of Employment: Enter the employee's first day of employment as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy).

Signature of Employer or Authorized Representative: Review the form for accuracy and completeness. The person who physically examines the employee's original document(s) and completes Section 2 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing Section 2, you attest under penalty of perjury (28 U.S.C. § 1746) that you have physically examined the documents presented by the employee, the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 2 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who signs Section 2 must enter the date he or she signed Section 2 in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print the form to write the date in this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Title of Employer or Authorized Representative: Enter the title, position or role of the person who physically examines the employee's original document(s), completes and signs Section 2.

Last Name of the Employer or Authorized Representative: Enter the full legal last name of the person who physically examines the employee's original documents, completes and signs Section 2. Last name refers to family name or surname. If the person has two last names or a hyphenated last name, include both names in this field.

First Name of the Employer or Authorized Representative: Enter the full legal first name of the person who physically examines the employee's original documents, completes, and signs Section 2. First name refers to the given name.

Employer's Business or Organization Name: Enter the name of the employer's business or organization in this field.

Employer's Business or Organization Address (Street Name and Number): Enter an actual, physical address of the employer. If your company has multiple locations, use the most appropriate address that identifies the location of the employer. Do not provide a P.O. Box address.

City or Town: Enter the city or town for the employer's business or organization address. If the location is not a city or town, you may enter the name of the village, county, township, reservation, etc. that applies.

State: Enter the two-character abbreviation of the state for the employer's business or organization address.

ZIP Code: Enter the 5-digit ZIP code for the employer's business or organization address.

Completing Section 3: Reverification and Rehires

Section 3 applies to both reverification and rehires. When completing this section, you must also complete the Last Name, First Name and Middle Initial fields in the Employee Info from Section 1 area at the top of Section 2, leaving the Citizenship/ Immigration Status field blank. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the new name in Block A.

Reverification

Reverification in Section 3 must be completed prior to the earlier of:

- The expiration date, if any, of the employment authorization stated in Section 1, or
- The expiration date, if any, of the List A or List C employment authorization document recorded in Section 2 (with some exceptions listed below).

Some employees may have entered "N/A" in the expiration date field in Section 1 if they are aliens whose employment authorization does not expire, e.g. asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau. Reverification does not apply for such employees unless they choose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

You should not reverify U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551). Reverification does not apply to List B documents.

For reverification, an employee must present an unexpired document(s) (or a receipt) from either List A or List C showing he or she is still authorized to work. You CANNOT require the employee to present a particular document from List A or List C. The employee is also not required to show the same type of document that he or she presented previously. See specific instructions on how to complete Section 3 below.

Rehires

If you rehire an employee within three years from the date that the Form I-9 was previously executed, you may either rely on the employee's previously executed Form I-9 or complete a new Form I-9.

If you choose to rely on a previously completed Form I-9, follow these guidelines.

- If the employee remains employment authorized as indicated on the previously executed Form I-9, the employee does not need to provide any additional documentation. Provide in Section 3 the employee's rehire date, any name changes if applicable, and sign and date the form.
- If the previously executed Form I-9 indicates that the employee's employment authorization from Section 1 or employment authorization documentation from Section 2 that is subject to reverification has expired, then reverification of employment authorization is required in Section 3 in addition to providing the rehire date. If the previously executed Form I-9 is not the current version of the form, you must complete Section 3 on the current version of the form.
- If you already used Section 3 of the employee's previously executed Form I-9, but are rehiring the employee within three years of the original execution of Form I-9, you may complete Section 3 on a new Form I-9 and attach it to the previously executed form.

Employees rehired after three years of original execution of the Form I-9 must complete a new Form I-9.

Complete each block in Section 3 as follows:

Block A - New Name: If an employee who is being reverified or rehired has also changed his or her name since originally completing Section 1 of this form, complete this block with the employee's new name. Enter only the part of the name that has changed, for example: if the employee changed only his or her last name, enter the last name in the Last Name field in this Block, then enter N/A in the First Name and Middle Initial fields. If the employee has not changed his or her name, enter N/A in each field of Block A.

Block B - Date of Rehire: Complete this block if you are rehiring an employee within three years of the date Form I-9 was originally executed. Enter the date of rehire in this field. Enter N/A in this field if the employee is not being rehired.

Block C - Complete this block if you are reverifying expiring or expired employment authorization or employment authorization documentation of a current or rehired employee. Enter the information from the List A or List C document(s) (or receipt) that the employee presented to reverify his or her employment authorization. All documents must be unexpired.

Document Title: Enter the title of the List A or C document (or receipt) the employee has presented to show continuing employment authorization in this field.

Document Number: Enter the document number, if any, of the document you entered in the Document Title field exactly as it appears on the document. Enter N/A if the document does not have a number.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the document you entered in the Document Title field as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). If the document does not contain an expiration date, enter N/A in this field.

Signature of Employer or Authorized Representative: The person who completes Section 3 must sign in this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to sign your name in this field. By signing Section 3, you attest under penalty of perjury (28 U.S.C. §1746) that you have examined the documents presented by the employee, that the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 3 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who completes Section 3 must enter the date Section 3 was completed and signed in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to enter the date in this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Name of Employer or Authorized Representative: The person who completed, signed and dated Section 3 must enter his or her name in this field.

What is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the "USCIS Privacy Act Statement" below.

USCIS Forms and Information

For additional guidance about Form I-9, employers and employees should refer to the *Handbook for Employers: Guidance for Completing Form I-9 (M-274)* or USCIS' Form I-9 website at www.uscis.gov/I-9Central.

You can also obtain information about Form I-9 by e-mailing USCIS at I-9Central@dhs.gov, or by calling 1-888-464-4218 or 1-877-875-6028 (TTY).

You may download and obtain the English and Spanish versions of Form I-9, the *Handbook for Employers*, or the instructions to Form I-9 from the USCIS website at https://www.uscis.gov/i-9. To complete Form I-9 on a computer, you will need the latest version of Adobe Reader, which can be downloaded for free at http://get.adobe.com/reader/. You may order USCIS forms by calling our toll-free number at 1-800-870-3676. You may also obtain forms and information by contacting the USCIS National Customer Service Center at 1-800-375-5283 or 1-800-767-1833 (TTY).

Information about E-Verify, a fast, free, internet-based system that allows businesses to determine the eligibility of their employees to work in the United States, can be obtained from the USCIS website at http://www.uscis.gov/e-verify, by e-mailing USCIS at E-Verify@dhs.gov or by calling 1-888-464-4218 or 1-877-875-6028 (TTY).

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling 1-888-897-7781 or 1-877-875-6028 (TTY).

Photocopying Blank and Completed Forms I-9 and Retaining Completed Forms I-9

Employers may photocopy or print blank Forms I-9 for future use. All pages of the instructions and Lists of Acceptable Documents must be available, either in print or electronically, to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer and for a specified period after employment has ended. Employers are required to retain the pages of the form on which the employee and employer entered data. If copies of documentation presented by the employee are made, those copies must also be retained. Once the individual's employment ends, the employer must retain this form and attachments for either 3 years after the date of hire (i.e., first day of work for pay) or 1 year after the date employment ended, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is 3 years after the date of hire (i.e., first day of work for pay).

Forms I-9 obtained from the USCIS website that are not printed and signed manually (by hand) are not considered complete. In the event of an inspection, retaining incomplete forms may make you subject to fines and penalties associated with incomplete forms.

Employers should ensure that information employees provide on Form I-9 is used only for Form I-9 purposes. Completed Forms I-9 and all accompanying documents should be stored in a safe, secure location.

Form I-9 may be generated, signed, and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

USCIS Privacy Act Statement

AUTHORITIES: The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC § 1324a).

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Providing the information collected by this form is voluntary. However an employer should not continue to employ an individual without a completed form. Failure of the employer to prepare and/or ensure proper completion of this form for each employee hired in the United States after November 6, 1986 or in the Commonwealth of the Mariana Islands after November 27, 2011, may subject the employer to civil and/or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer must retain this form for the required period and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, when completing the form manually, and 26 minutes per response when using a computer to aid in completion of the form, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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

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

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

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

City of Strongsville Employee Direct Deposit Authorization Form

Print Employee Full Name: _____ **Last 4 of SSN#** _____

Please deposit my paycheck directly to my account(s) as indicated. I agree to notify the City immediately of any changes to the information so that my paycheck may be properly distributed. I understand that in the event my financial institution is not able to deposit my paycheck into my account due to any action I take; that I am responsible for any resulting bank fees incurred, and that the City cannot reissue the funds to me until the funds are returned to the City by my financial institution.

Changes to direct deposit accounts must be given to the payroll department no later than the ***Friday prior to a pay week,*** changes received after Friday will not be applied until the following payroll. Please do not close your account(s) without giving us prior notice of the change.

Employee Signature: _____ **Date:** _____

(Form not valid unless signed)

Main Account (mandatory) – This section must be filled in.

This account will receive your entire net check. If you list any optional accounts below, this main account will receive the remainder of your check once the optional accounts are funded.

*****Unless otherwise noted, this account will be used for all misc. employee reimbursements.***

Name of Financial Institution	Routing Number	Account Number	Checking or Savings

Optional Accounts - Please list specific dollar amounts and banking information. Your optional account(s) will be funded first in the order listed and the remaining amount will be deposited into your main account.

1.					
2.					
	Name of Financial Institution	Routing Number	Account Number	Amount	Checking or Savings

CHECKING ACCOUNTS: Please attach a voided check. Deposit slips **CANNOT** be used.

SAVINGS ACCOUNTS: Please obtain the required information from your financial institution. Routing numbers **are still required** on savings accounts. Deposit slips **CANNOT** be used.

IT 4
Rev. 5/07

Notice to Employee

1. For state purposes, an individual may claim only natural dependency exemptions. This includes the taxpayer, spouse and each dependent. Dependents are the same as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year for which the taxpayer would have been permitted to claim had the taxpayer filed such a return.

2. You may file a new certificate at any time if the number of your exemptions ***increases*.**

   You must file a new certificate within 10 days if the number of exemptions previously claimed by you ***decreases*** because:
   (a) Your spouse for whom you have been claiming exemption is divorced or legally separated, or claims her (or his) own exemption on a separate certificate.
   (b) The support of a dependent for whom you claimed exemption is taken over by someone else.
   (c) You find that a dependent for whom you claimed exemption must be dropped for federal purposes.

   The death of a spouse or a dependent does not affect your withholding until the next year but requires the filing of a new certificate. If possible, file a new certificate by Dec. 1st of the year in which the death occurs.

   For further information, consult the Ohio Department of Taxation, Personal and School District Income Tax Division, or your employer.

3. If you expect to owe more Ohio income tax than will be withheld, you may claim a smaller number of exemptions; or under an agreement with your employer, you may have an additional amount withheld each pay period.

4. A married couple with both spouses working and filing a joint return will, in many cases, be required to file an individual estimated income tax form IT 1040ES even though Ohio income tax is being withheld from their wages. This result may occur because the tax on their combined income will be greater than the sum of the taxes withheld from the husband's wages and the wife's wages. This requirement to file an individual estimated income tax form IT 1040ES may also apply to an individual who has two jobs, both of which are subject to withholding. In lieu of filing the individual estimated income tax form IT 1040ES, the individual may provide for additional withholding with his employer by using line 5.

✂ please detach here

Ohio | Department of Taxation

Employee's Withholding Exemption Certificate

IT 4
Rev. 5/07

Print full name _____ Social Security number _____

Home address and ZIP code _____

Public school district of residence _____ School district no. _____
(See *The Finder* at tax.ohio.gov.)

1. Personal exemption for yourself, enter "1" if claimed ..... _____

2. If married, personal exemption for your spouse if not separately claimed (enter "1" if claimed) ..... _____

3. Exemptions for dependents ..... _____

4. Add the exemptions that you have claimed above and enter total ..... _____

5. Additional withholding per pay period under agreement with employer ..... $ _____

Under the penalties of perjury, I certify that the number of exemptions claimed on this certificate does not exceed the number to which I am entitled.

Signature _____ Date _____

City of Strongsville

16099 Foltz Parkway
Strongsville, Ohio 44149-5598
Phone: 440-580-3137
Fax: 440-238-5467
www.strongsville.org

Department of Human Resources
Stephen F. Kilo, Director

Thomas P. Perciak
Mayor

Dear New Employee,

In the fall of 2009, House Bill 1 made changes that required the State of Ohio to modify its new-hire process. The statute requires the following steps when new employees complete initial employment paperwork:

- Provide each new employee with materials provided by Ohio Deferred Compensation regarding the benefits of long-term savings through deferred compensation;
- Secure an election form from the employee regarding the employee's desire to participate or not participate in Ohio Deferred Compensation.

The advantages include:

- All new employees learn about tax-deferred saving for retirement.
- The employer maintains a high standard of fiduciary responsibility.
- The ability for the employer to attract and retain key employees because of increased awareness of their comprehensive benefits package.

Other public employers which offer Ohio Deferred Compensation may alter the new-hire process to include this form. More information about the Ohio Deferred Compensation Program can be found at www.ohio457.org. Please sign and the return form to Human Resources with 45 days of hire.

Sincerely,

Stephan F. Kilo
Human Resources Director

Start building a brighter future today!

The time is right — now

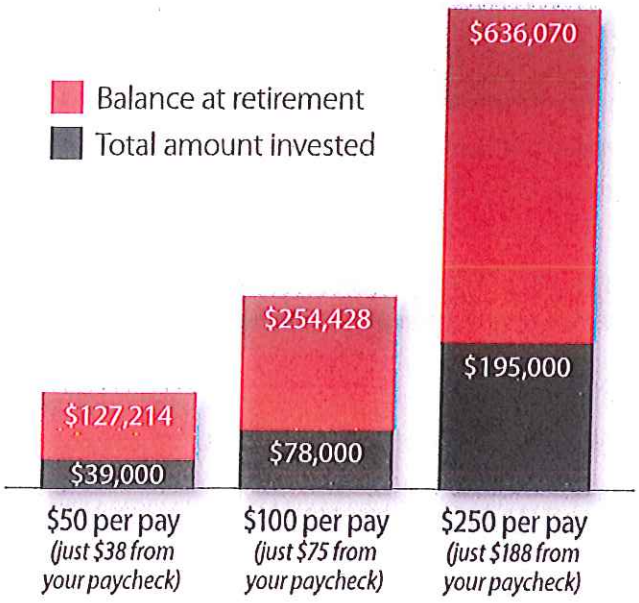
It's never too soon (or too late) to begin investing. And time is your new best friend. No matter what your age, you should be financially preparing for retirement. The more time money has to grow, the more you could potentially have later. That's why it's important to start now.

The power of time

We've provided the hypothetical illustration here to show you how much different deferral amounts per biweekly paycheck could accumulate over 30 years, given a 7% annual effective rate of return. The black sections show how much is actually deferred in, and the red shows how much your account could be worth after 30 years.

The tax-deferred advantage

Ohio Deferred Compensation is tax-deferred, which means the money that goes into your account comes out of your paycheck **before** it is subject to State and Federal income taxes. By putting the power of tax-deferral to work for you, **more goes into your account than comes out of your paycheck.** Plus, the assets in your account, including any earnings, will have the opportunity to grow tax-deferred until you decide to withdraw them — usually in retirement. *Withdrawals will be taxed as ordinary income.*



This illustration is a hypothetical compounding example that assumes biweekly deferrals (for 30 years) at a 7% annual effective rate of return. It illustrates the principle of time and compounding. It is not intended to predict or project the investment results of any specific investment. Investment returns are not guaranteed and will vary depending on investments and market experience. If fees, taxes, and expenses were reflected, the hypothetical returns would be less.

Remember, there are no guarantees. Investing involves risk, including possible loss of principal.

Upon enrollment, you will be mailed a Welcome Kit that will include a copy of the Cancellation Form, Beneficiary Form, Memorandum of Understanding, and Plan Document with more detailed information on the provisions outlined below:

- My account balance will be held by Ohio Deferred Compensation in trust on behalf of my employer for the exclusive benefit of me or my beneficiaries.
- I may cancel my participation, before my forms are processed, by calling 1-877-644-6457 within seven days from the date that I signed this election form.
- Based on market fluctuations, the rate of return on my account could be either positive or negative. This could result in my account balance being worth less than my contributions.
- Investments have underlying expenses or management fees that will reduce the investment results. Information on these expenses can be found in the investment profiles or the respective prospectus(es).
- Fund prospectuses can be obtained by calling 1-877-644-6457. Before investing, carefully consider the fund's investment objectives, risks, charges, and expenses. The fund prospectus contains this and other important information. Read the prospectuses carefully before investing.

The Internal Revenue Service imposes rules that limit the times I can make changes or receive withdrawals from the Program.

- At any time, I may change the amount I defer or the allocation of future investment options.
- I may withdraw funds from the Program only upon:
  1. Severance from employment (including termination or death)
  2. An Unforeseeable Emergency (as defined by Section 457 of the IRC)
  3. Small Balance Distribution (see Plan Document for eligibility)
- Withdrawals may begin after my severance from employment and the Program's receipt of my employer's verification of severance, final deferral, and Withdrawal Election form.
- Distributions must satisfy certain minimum requirements upon attaining age 70½.
- The funds in my account may be eligible for rollover to a traditional IRA or to an eligible retirement plan upon severance from employment.
- I realize my participation is for long-term retirement savings and I should maintain separate, available emergency funds to cover day-to-day, unanticipated, financial shortages.
- An Unforeseeable Emergency is defined by the IRS as a severe financial hardship. Please see the Program Plan Document for specific details. The purchase of a home, credit card debt, and the need to send your children to college are not qualifying events.

OHIO DEFERRED COMPENSATION

OHIO PUBLIC EMPLOYEES DEFERRED COMPENSATION PROGRAM

SUPPLEMENTAL RETIREMENT ACCOUNT ELECTION FORM

Instructions

1. **You are required to complete and file this form within 45 days of beginning employment. Please use blue or black ink.**
2. Sign the form in Section 4.
3. Your employer is required to send the completed form to Ohio Deferred Compensation immediately upon your hiring.

Section 1: Personal Information

Last Name _____ First Name _____

Gender: ☐ Male ☐ Female Date of Birth ____/____/____ (MM/DD/YYYY)

Address _____

City _____ State _____ Zip _____

Email Address _____

Work Phone _____ Home Phone _____ Cell Phone _____

Section 2: Employer Information

Employer Name _____ Pays Per Year _____

Department Name _____

Pension System: *(circle one)* OPERS STRS SERS OP&F HPRS Other _____

Section 3: Election

☐ Yes, I would like to enroll in the Ohio Deferred Compensation Program today and begin contributing:

☐ $50 per pay period, or ☐ _____ per pay period (minimum $15)

A pre-tax deduction will be invested in a LifePath Portfolio closest to the year in which I turn age 65. My payroll deductions will begin on the next pay period following 30 days from the date my form is received by the Program. Upon receipt of this form I will be mailed a Program Welcome Kit with additional details. I can make changes to mydeduction and my investment selection at any time.

Social Security Number (required) _____ Hire Date _____

☐ No, I have received information about the Program and choose to decline the opportunity to save tax-deferred money for retirement.

Section 4: Signature & Acknowledgment

☐ I acknowledge that I have read the terms and conditions on the reverse side of this form.

_____ _____

Signature Date

Ohio Deferred Compensation
257 East Town Street, Suite 457
Columbus, Ohio 43215-4626
1-877-644-6457
614-222-9457 (fax)
www.Ohio457.org

CITY OF RESIDENCE - EMPLOYEE INCOME TAX WITHHOLDING

The City of Strongsville withholds Strongsville employment tax @ 2% of your gross automatically.

You can also withhold your City of Residence Income Tax. This is a voluntary payroll deduction.

To sign up, fill out the information below.

DO NOT FILL OUT THIS FORM IF YOU LIVE IN STRONGSVILLE AND/OR YOU ARE UNDER THE AGE OF 18

☐ **New City Tax** - City of Residence: _____

☐ **Change City Tax** - From City of: _____ To City of: _____

☐ **Cancel City Tax** - Discontinue deduction completely.

Employee Name: _____ Employee SSN: (last 4 digits) _____

Department: _____ Date: _____

Signed: _____

It is the employee's responsibility to contact your Residence City Hall with these questions:

- What is your city's current tax rate? _____%
- What is the current tax credit given for your city of residence? _____%
- What is the maximum limit of tax credit? _____%

It is employee's responsibility to file a new form IF one or more of the following occur:

1. Your city of residence tax rate changes.
2. Your tax credit given by your city of residence changes.
3. Your City of Residence changes.

Once this information is verified by the payroll department, your deductions will begin with the next scheduled payroll. If you have questions, you can contact the finance department at 440-580-3125.

Thank You.

CITY OF STRONGSVILLE, OHIO

NOTICE OF EMPLOYMENT ACCOMMODATION

TO: All Strongsville Applicants for Employment

Any current employee or applicant for employment with a disability, as defined in The Americans with Disabilities Act of 1990 (ADA), who requires reasonable accommodation in order to better perform the essential functions and tasks of his/her job or to fully participate in the employment process, may VOLUNTARILY request such need.

Under the ADA, an INDIVIDUAL WITH A DISABILITY is a person who has:

- A physical or mental impairment that substantially limits one or more major life activities;
- A record of such impairment; or
- Is regarded as having such an impairment

CURRENT EMPLOYEES may VOLUNTARILY advise of circumstances and make such request at any time.

APPLICANTS FOR EMPLOYMENT may VOLUNTARILY advise of circumstances and make such request AFTER an offer of employment with the City to assure that the employment decision criteria used accurately reflects their abilities.

A REASONABLE ACCOMMODATION request may be, however, VOLUNTARILY made by either any time during employment interaction with the City.

The City will make every attempt to accommodate a bona fide need through a REASONABLE ACCOMMODATION process in consultation with you. The City may require documentation supporting the need for the requested accommodation and may refuse an accommodation (requested or provided by you) if it is NOT REASONABLE or causes undue hardship to the City in its public service delivery.

If you require an accommodation, you may advise the Human Resources Director.

ALL REQUESTS ARE MAINTAINED AND EVALUATED CONFIDENTIALLY BETWEEN YOU, YOUR CURRENT OR POTENTIAL SUPERVISOR, AND THE HUMAN RESOURCES DIRECTOR.

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

17800 Royalton Road
Strongsville, Ohio 44136-5149

Employee Enrollment Form

Please Type or Print All Information

☐ New Enrollment ☐ Change

Effective Date	Group Number
	535671

Last Name	First Name	M.I.	Date of Birth	Social Security Number
			/ /	

Street Address	City	State	Zip Code

Phone ( )	E-mail

Employer	Occupation/Job Title	Class	Gender
City of Strongsville			☐ male ☐ female

Original Date of Hire	Date of Rehire (If Applicable)	Earnings
		☐ Weekly ☐ Monthly ☐ Annual $ _____

COVERAGE SELECTION: Your group insurance program may not include all the benefits listed below. **Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to submit evidence of insurability.**

BASIC COVERAGE(S)		(A)dd (D)elete	Total Amount of Coverage Applied for
Basic Life	☐ YES ☐ NO		
Basic AD&D	☐ YES ☐ NO		
Supplemental/Voluntary Life	☐ YES ☐ NO		
Supplemental/Voluntary AD&D	☐ YES ☐ NO		
Short-Term Disability	☐ YES ☐ NO		
Long-Term Disability	☐ YES ☐ NO		
Dependent Life	☐ YES ☐ NO		

BENEFICIARY DESIGNATION (For Employee Only: Must be completed if you have applied for life and/or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

LAST NAME FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary	/ /		%
Primary	/ /		%
Contingent	/ /		%
Contingent	/ /		%

TERMS AND CONDITIONS

I hereby apply to Consumer's Life Insurance Company (CLIC) for the coverage indicated on this Application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to CLIC, and/or any affiliates or divisions of CLIC; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), government agency or person to CLIC and/or any affiliates or division of CLIC: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; and/or; (c) for credentialing purposes. I authorize CLIC to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true; and (d) I did not sign a blank or partially completed Application.

I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information CLIC requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning benefits that is inconsistent with, or different from, any written information provided by CLIC; (d) to bind CLIC in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage. All contract terms must be in writing and signed or accepted in writing by an authorized representative of CLIC to be binding on CLIC.

I agree that: (a) any untrue or incomplete information, statement or answers on this Application (whether intentional or not), can result in denial of a claim or rescission of coverage and may subject me to legal action by CLIC; (b) to be eligible for life and/or disability income coverage, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life and/or disability income coverage would become effective, my coverage will not begin until the day I return to work; (c) if coverage is issued, it will be based on full reliance on the information contained in this Application.

My dependents and I understand and agree that any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any Application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to CLIC's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by CLIC's Privacy Office.

I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I have read all of the statements contained in this Application, and declare by signing this Application that I am an active, eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge. I understand that I should not cancel any current insurance coverage until I receive an approval letter and insurance certificate from CLIC.

Employee Signature: _____ Date: _____

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY
17800 Royalton Road • Strongsville, Ohio 44136-5149

Beneficiary Designation Form

Telephone: 866-925-2542
Fax: 440-878-6916
Email Address: Claims@ConsumersLife.com

☐ Initial ☐ Change

Group Number
535671

Insured's Name	Social Security No.	Date of Birth
		/ /
Group Name **CITY OF STRONGSVILLE**	Marital Status (check one) ☐ Married ☐ Widowed ☐ Single ☐ Divorced	

COVERAGE TYPE – The Beneficiary designation will apply to all death benefits for the above named Insured, unless they designate otherwise by checking a specific coverage:

☐ Basic Term Life ☐ Basic AD&D ☐ Supp Life ☐ Supp AD&D ☐ Voluntary Life ☐ Voluntary AD&D ☐ All

Definitions:

Primary Beneficiary: The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary. ***If you specify benefit percentages, the total must equal 100%.*** If you do not specify benefit percentages, proceeds will be paid in equal shares to the primary beneficiaries who survive you.

Contingent Beneficiary: The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. ***If you specify benefit percentages, the total must equal 100%.***

PRIMARY BENEFICIARY(IES):

In accordance with the provisions of the Policy and/or Certificate, I hereby request the benefits payable for loss of life to be issued as follows:

First Name	Last Name	Date of Birth	Relationship	Benefit %
		/ /		
		/ /		
		/ /		
		/ /		

CONTINGENT BENEFICIARY(IES):

First Name	Last Name	Date of Birth	Relationship	Benefit %
		/ /		
		/ /		
		/ /		
		/ /		

I hereby revoke all former beneficiary designations and I reserve the right to make further changes at any time, subject to Policy provisions.

Signature of Insured _____ Date Signed _____

Important Note for Married Employees: If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, and you name someone other than your spouse as primary beneficiary, your spouse's consent will be necessary to allow your spouse to waive his or her rights to any community property interest in the benefits. We have provided a space below for your spouse's signature. Payment of this benefit may be delayed or disputed unless your spouse signs below.

Spousal Consent for Community Property States Only: I hereby consent to the Primary Beneficiary designated by my spouse and understand that this consent supersedes any prior spousal consent under this plan.

Signature of Spouse _____ Date Signed _____

CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY

City of Strongsville

Supplemental Life Insurance Highlights

What is supplemental life insurance?

Supplemental life insurance is coverage that you pay for in addition to the basic life insurance your employer provides to you. Life insurance pays a benefit to your designated beneficiary (see below for definition) if you die while you are covered by the policy.

How much supplemental life insurance can I purchase?

You as an employee can purchase supplemental life: $10,000 to $250,000 in increments of $10,000.

Am I guaranteed coverage?

Yes. When you as an employee enroll, you are guaranteed supplemental life coverage valued at $100,000.

You must provide evidence of insurability and be approved by Consumers Life Insurance Company to receive coverage above the guaranteed amount. The evidence of insurability application is available from Consumers Life or your employer.

What is a designated beneficiary?

Your designated beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while insured. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.

Are there other limitations to enrollment?

If you do not enroll in supplemental life insurance within 31 days of your first day of eligibility, you will be considered a "late entrant" and must provide evidence of insurability.

Can I purchase supplemental life insurance for my spouse?

Yes. You may purchase supplemental life insurance coverage for your spouse: $5,000 to $100,000 in increments of $5,000, not to exceed 100% of employee benefit. This coverage is only available when you elect and are approved for coverage for yourself. When a spouse enrolls, he or she is guaranteed supplemental life coverage valued at $10,000.

Can I purchase supplemental life insurance for my children?

Yes. You may purchase supplemental life insurance coverage for your children age's birth to 20 years (age 24 if full time student): $5,000 not to exceed 100% of the employee benefit. This coverage is only available when you elect and are approved for coverage for yourself. . When a child (ren) enrolls, he or she is guaranteed supplemental life coverage valued at $5,000.

Important Details
This information provides an overview of your supplemental life insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

Supplemental life and AD&D insurance includes certain limitations and exclusions.

- The amount of your supplemental life and AD&D insurance coverage may be reduced when you reach certain ages.

Note
Benefits will be determined based on the administrative policies and procedures of Consumers Life.

This document is only a partial listing of benefits. This is not a contract of insurance. The contract or certificate will contain the complete listing of covered benefits.

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CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY

City of Strongsville

Supplemental Life Insurance Rate Chart

Supplemental Life Insurance

Supplemental life insurance provides a lump-sum benefit to your designated beneficiary if you die while covered by the policy, or a lesser benefit to you if you sustain certain accidental injuries while covered by the policy. Premiums may be paid through your employer on a payroll-deduction basis. The chart below contains applicable premium rates based on your age and the level of coverage you wish to purchase.

Your eligibility

You may enroll in the same amount of coverage you currently have in place without providing additional information. If you wish to increase your level of coverage upon enrolling with Consumers Life, please contact your employer for the appropriate forms.

Your benefit (employee)

$10,000 to $250,000 in $10,000 increments; with a guaranteed issue amount of $100,000.

Spouse coverage

$5,000 to $100,000 in $5,000 increments, not to exceed 100% of the employee benefit; with a guaranteed issue amount of $10,000.

Child coverage

$5,000 not to exceed 100% of the employee benefit; with a guaranteed issue amount of $5,000. Children ages birth to 20 years (age 24 if fulltime student) are eligible.

Supplemental Life – Monthly Rates per $1,000	
Age	Rates
< 30	$0.079
30-34	$0.085
35-39	$0.111
40-44	$0.165
45-49	$0.266
50-54	$0.403
55-59	$0.673
60-64	$0.773
65-69	$1.517
70-74	$2.601
75+	$8.576

Your monthly premium rates

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.79	$0.85	$1.11	$1.65	$2.66	$4.03	$6.73	$7.73	$15.17	$26.01	$85.76
$20,000	$1.58	$1.70	$2.22	$3.30	$5.32	$8.06	$13.46	$15.46	$30.34	$52.02	$171.52
$30,000	$2.37	$2.55	$3.33	$4.95	$7.98	$12.09	$20.19	$23.19	$45.51	$78.03	$257.28
$40,000	$3.16	$3.40	$4.44	$6.60	$10.64	$16.12	$26.92	$30.92	$60.68	$104.04	$343.04
$50,000	$3.95	$4.25	$5.55	$8.25	$13.30	$20.15	$33.65	$38.65	$75.85	$130.05	$428.80
$60,000	$4.74	$5.10	$6.66	$9.90	$15.96	$24.18	$40.38	$46.38	$91.02	$156.06	$514.56
$70,000	$5.53	$5.95	$7.77	$11.55	$18.62	$28.21	$47.11	$54.11	$106.19	$182.07	$600.32
$80,000	$6.32	$6.80	$8.88	$13.20	$21.28	$32.24	$53.84	$61.84	$121.36	$208.08	$686.08
$90,000	$7.11	$7.65	$9.99	$14.85	$23.94	$36.27	$60.57	$69.57	$136.53	$234.09	$771.84
$100,000	$7.90	$8.50	$11.10	$16.50	$26.60	$40.30	$67.30	$77.30	$151.70	$260.10	$857.60

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CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY

July 25, 2012

STEVE KILO
CITY OF STRONGSVILLE
16099 FOLTZ PKWY
STRONGSVILLE, OH 44149

Subject: Group #: 535671
Renewal Date: 1/1/2013

Dear Group Official,

Thank you for allowing us to provide your employees with valuable group insurance protection during the past year. We have completed a comprehensive review of your benefit plan to determine the appropriate premium rates for your upcoming renewal effective 1/1/2013. Our review included an analysis of your group's demographic information, industry classification, and overall benefit package to establish your renewal rates illustrated below.

Benefit	Current Rates	Renewal Rates	
Basic Life	$0.165	$0.165	per $1,000
Basic AD&D	$0.03	$0.03	per $1,000
Supplemental Life – Child(ren)	$0.30	$0.30	per family unit

Supplemental Life – Employee

Age	Current Rates	Renewal Rates	
Under 30	$0.079	$0.079	per $1,000
30 – 34	$0.085	$0.085	
35 – 39	$0.111	$0.111	
40 – 44	$0.165	$0.165	
45 – 49	$0.266	$0.266	
50 – 54	$0.403	$0.403	
55 – 59	$0.673	$0.673	
60 – 64	$0.773	$0.773	
65 – 69	$1.517	$1.517	
70 – 74	$2.601	$2.601	
75 and over	$8.576	$8.576	

CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY

Subject: Group #: 535671
Renewal Date: 1/1/2013

Supplemental Life – Spouse

Age	Current Rates	Renewal Rates	
Under 30	$0.074	$0.074	per $1,000
30 – 34	$0.079	$0.079	
35 – 39	$0.100	$0.100	
40 – 44	$0.135	$0.135	
45 – 49	$0.214	$0.214	
50 – 54	$0.315	$0.315	
55 – 59	$0.498	$0.498	
60 – 64	$0.771	$0.771	
65 – 69	$2.856	$2.856	
70 – 74	$1.513	$1.513	
75 – 79	$2.594	$2.594	
80 and over	$8.551	$8.551	

Based on your current benefit plan, your renewal rate[s] are guaranteed until 1/1/2015.

Thank you for choosing Consumers Life Insurance Company and we look forward to serving the insurance needs of you and your employees in the future.

If you have any questions regarding your insurance plan, please contact Harry Brownfield at 216-328-8080.

Sincerely,

Mary E. Crivello

Mary E. Crivello
Director of Underwriting Operations

Cleveland Clinic
Wellness

LIFESTYLE EAP

Wellness at Work

EMPLOYEE ASSISTANCE PROGRAM

Empowering Employees to Lead Happier, Healthier Lives

At Lifestyle EAP we understand that everyone is affected by life-changing issues. As an employer-sponsored service, Lifestyle EAP provides confidential counseling and a broad range of services to help guide you and your family toward better health, wellness and life balance.

Face-to-face counseling sessions are available to provide a confidential assessment, short-term solution focused counseling, referral assistance, and support when experiencing life changing events such as substance abuse, family or marital concerns, psychological or emotional upset, financial or legal problems. **Lifestyle EAP offers 24/7/365 phone support from licensed mental health professionals through our EAP line at 800.989.3277.**

The Lifestyle Employee Assistance Program offers:

- 800.989.3277 telephonic support is available 24/7/365 from licensed mental health professionals
- Face-to-face counseling sessions
- Manager Consultations
- Eldercare resources and referrals
- Childcare resources and referrals
- Identity Theft Recovery and Prevention
- Legal and Financial Consultations
- www.lifestyleeap.com
- Critical Incident Stress Management (on-site counseling; grief groups; trauma debriefings)
- Wellness Programs
- Management Trainings

For more information, call Lifestyle EAP today at 800.989.3277 or visit www.lifestyleEAP.com

LIFESTYLE EAP

Wellness at Work

EMPLOYEE ASSISTANCE PROGRAM

Legal, Financial and ID Recovery

When a legal issue, financial matter, or an instance of identity fraud disrupts your life, it can create substantial stress for you and your family.

To help minimize the impact, your employee assistance program will assist you with managing the many complexities of these events. Through professional consultation, these programs can save you time, while providing valuable information and peace of mind.

LEGAL ASSIST
Provides a free half-hour consultation with an attorney on most legal issues. In most cases, discounted rates are available if further legal representation is required.

FINANCIAL ASSIST
Provides a free telephonic consultation with a financial professional.

ID THEFT PREVENTION AND RECOVERY
Provides a free telephonic consultation with an ID theft prevention and recovery professional. It also provides free registration to Control Your ID, an online ID monitoring program. If your identity is stolen while you are registered with Control Your ID, an ID theft professional will help you restore it.

The Lifestyle Employee Assistance Program offers:

- 800.989.3277 telephonic support is available 24/7/365 from licensed mental health professionals
- Face-to-face counseling sessions
- Manager Consultations
- Eldercare resources and referrals
- Childcare resources and referrals
- Identity Theft Recovery and Prevention
- Legal and Financial Consultations
- www.lifestyleeap.com
- Critical Incident Stress Management (on-site counseling; grief groups; trauma debriefings)
- Wellness Programs
- Management Trainings

For more information, call Lifestyle EAP today at 800.989.3277 or visit www.lifestyleEAP.com