



New Hire Packet

Welcome! We are excited to have you join our team & wish you the best as you launch your career here at City of Avondale!

➤ Day 1 In-Processing

The following list of required documents are enclosed in this packet for your review & completion.

- I-9 Form
- Emergency Contact Form
- Federal Tax Withholding (Form W-4)
- Arizona Tax Withholding (Arizona Form A-4)
- Direct Deposit Form
- Personnel Policy & Procedure Manual-Acknowledgment Form
- Administrative Policy 58-Acknowledgement Form
- Confidential Matters-Acknowledgement Form
- IT Technology Policy-Acknowledgement Form
- Benefit Enrollment/Change Form
- Securian Life Insurance
- Employee HSA Payroll Deduction Form (optional, if electing)
- Certificate of HSA Eligibility (optional, if electing)
- Sheakley- Flex Spending Information Packet (optional, if electing)
- Declaration of Domestic Partnership (optional, if electing)

➤ Supplemental Information

These documents are for your information only & will assist you when making your benefit elections. As well as, include copies of the policies that you must acknowledge.



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):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
<p><i>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.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> QR Code - Section 1 Do Not Write In This Space </div>	

Signature of Employee	Today's Date (mm/dd/yyyy)
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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



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
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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
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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

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

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

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

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

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

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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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
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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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



City of Avondale

Employee Information

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Alternative Emergency Contacts

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

***Please note:** All future updates must be completed on the ADP website (<https://workforcenow.adp.com/public/index.htm>).

Employee's Withholding Certificate

▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
▶ Give Form W-4 to your employer.
▶ Your withholding is subject to review by the IRS.

2020

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Multiple Jobs or Spouse Works Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶

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

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____		
	Multiply the number of other dependents by \$500 ▶ \$ _____		
	Add the amounts above and enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Sign Here

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

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
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General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 and you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3. 1 \$
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a. 2a \$
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b. 2b \$
c Add the amounts from lines 2a and 2b and enter the result on line 2c. 2c \$
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld). 4 \$

Step 4(b)—Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income. 1 \$
2 Enter: { \$24,800 if you're married filing jointly or qualifying widow(er)
\$18,650 if you're head of household
\$12,400 if you're single or married filing separately } 2 \$
3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-". 3 \$
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information. 4 \$
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4. 5 \$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

Type or print your Full Name		Your Social Security Number	
Home Address – number and street or rural route			
City or Town		State	ZIP Code

Choose either box 1 or box 2:

- 1** Withhold from gross taxable wages at the percentage checked (**check only one percentage**):
- 0.8%
 1.3%
 1.8%
 2.7%
 3.6%
 4.2%
 5.1%
- Check this box and enter an extra amount to be withheld from each paycheck \$
- 2** I elect an Arizona withholding percentage of zero, and I certify that I expect to have no Arizona tax liability for the current taxable year.

I certify that I have made the election marked above.	
SIGNATURE _____	DATE _____

Employee's Instructions

Arizona law requires your employer to withhold Arizona income tax from your wages for work done in Arizona. The amount withheld is applied to your Arizona income tax due when you file your tax return. The amount withheld is a percentage of your gross taxable wages from every paycheck. You may also have your employer withhold an extra amount from each paycheck. Complete this form to select a percentage and any extra amount to be withheld from each paycheck.

What are my "Gross Taxable Wages"?

For withholding purposes, your "gross taxable wages" are the wages that will generally be in box 1 of your federal Form W-2. It is your gross wages less any pretax deductions, such as your share of health insurance premiums.

New Employees

Complete this form within the first five days of your employment to select an Arizona withholding percentage. You may also have your employer withhold an extra amount from each paycheck. If you do not give this form to your employer the department requires your employer to withhold 2.7% of your gross taxable wages.

Current Employees

If you want to change your current amount withheld, you must file this form to change the Arizona withholding percentage or to change the extra amount withheld.

What Should I do With Form A-4?

Give your completed Form A-4 to your employer.

Electing a Withholding Percentage of Zero

You may elect an Arizona withholding percentage of zero if you expect to have no Arizona income tax liability for the current year. Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, or credits for taxes paid to other states. If you make this election, your employer will not withhold Arizona income tax from your wages for payroll periods beginning after the date you file the form. Zero withholding does not relieve you from paying Arizona income taxes that might be due at the time you file your Arizona income tax return. If you have an Arizona tax liability when you file your return or if at any time during the current year conditions change so that you expect to have a tax liability, you should promptly file a new Form A-4 and choose a withholding percentage that applies to you.

Voluntary Withholding Election by Certain Nonresident Employees

Compensation earned by nonresidents while physically working in Arizona for temporary periods is subject to Arizona income tax. However, under Arizona law, compensation paid to certain nonresident employees is not subject to Arizona income tax withholding. These nonresident employees need to review their situations and determine if they should elect to have Arizona income taxes withheld from their Arizona source compensation. Nonresident employees may request that their employer withhold Arizona income taxes by completing this form to elect Arizona income tax withholding.

Direct Deposit Form

I _____ authorize the City of Avondale to initiate electronic credit entries to my checking (attach voided check) and/or savings account(s) (attach a statement from your institution that shows your account and routing number) as follows:

Initiate New Direct Deposit

Financial Institution	Account Number	Routing Number	Account Type		Dollar Amount
			Checking	Savings	
1.					
2.					
3.					

Stop Current Direct Deposit

Financial Institution	Account Number	Routing Number	Account Type		Dollar Amount
			Checking	Savings	
1.					
2.					
3.					

Change to Existing Direct Deposit

Financial Institution	Account Number	Routing Number	Account Type		Dollar Amount
			Checking	Savings	
1.					
2.					
3.					

Important! Please read and sign before completing and submitting.

I hereby authorize my employer (hereinafter "Company") to deposit any amounts owed me by initiating credit entries to my accounts at the financial institutions (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Company to my accounts. Unless prohibited by applicable law, in the event that Employer deposits funds erroneously into my account, I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until Company has received written notice from me of its termination in such time and in such manner as to afford Company reasonable opportunity to act on it.

Employee Signature

Employee ID #

Date

Attach voided check(s) here

***Note: If you close an account that is being used for direct deposit, you must notify Human Resources in writing immediately to avoid a delay in processing your paycheck. Activating a new direct deposit account takes approximately 2 pay periods. You will receive a live check until the account has been activated.



EMPLOYEE ACKNOWLEDGEMENT FORM

I, _____, hereby
(Print Employee Name)

I accept responsibility for familiarizing myself with the City of Avondale Policies and Procedures Manual and will seek verification of, or clarification of, its terms.

I acknowledge that I received notice of the current City of Avondale Policies and Procedures Manual available on the internet under Human Resources Department, Policy & Procedure Manual. This Manual includes Chapters 1 through 22 (as adopted by the City Council) and Administrative Policies.

I understand it is my responsibility to read the City of Avondale Policies and Procedures Manual and ask questions of the Human Resources Department for clarification.

I understand the City of Avondale can modify, eliminate, or revise, the guidelines and information in the City of Avondale Policies and Procedures Manual as circumstances or situations warrant.

I also understand any changes made to the City of Avondale with respect to the City of Avondale Policies and Procedures Manual, can supersede, modify or eliminate any of the policies and procedures outlined in this manual.

Furthermore, I understand I should consult with my supervisor or a representative of Human Resources Department if I have any questions that are not answered in the City of Avondale Policies and Procedures Manual.

Employee Signature _____ Date _____



City of Avondale Policy Regarding Confidential Matters

Departments within the City of Avondale are exposed to various records and data, which include personal and confidential information. The City of Avondale employees (including any and all interns and volunteers) are entrusted with maintaining the security of confidential documents, information and knowledge within each Department. Because of the confidential environment of the City Manager's Department it is necessary that all City of Avondale employees (including any and all interns and volunteers) understand and acknowledge the ***absolute necessity*** to confine all information about confidential matters to the Department. The credibility of each Department and City staff entrusted with this information, are at risk when there is a breach in confidentiality. Further, a breach in confidentiality may subject the City to legal liability. **Failure to follow this policy subjects you to dismissal from employment with the City of Avondale.**

Furthermore, it is the policy of the City of Avondale that all matters of a confidential nature whether seen or heard while you are at the Department are not to be discussed with, or revealed to, anyone outside the Department. This includes confidential meetings Department staff may have with employees. **All meetings with employees are to be considered completely confidential unless the City Manager informs you otherwise.** Discussions regarding these matters within the Department shall only take place between employees with a ***work-related need to know***. **Failure to follow this policy shall result in disciplinary action up to and including dismissal.**

If you have any questions regarding this policy, please see the Human Resources Director.

I acknowledge receipt of the confidentiality policy.

Employee Name (Print)

Employee Signature

Date

**City of Avondale
AP 58 Sexual Abuse Policy
Employee Acknowledgement**

The City of Avondale does not tolerate any act by its employees that would constitute sexual abuse under state or federal laws that is committed on City property or while a City employee is on-duty.

Any employee, who commits sexual abuse, as that term is defined under state or federal law, shall be subject to discipline, up to and including termination.

All allegations of sexual abuse committed on City property or while on-duty as a City official, employee or volunteer will promptly be reported to the City Human Resources Department and to the appropriate authorities, as designated by statute. If the appropriate authorities decline to investigate the allegations, the City may conduct an independent investigation.

By signing below, I acknowledge that I have read, understand, and will abide by the City of Avondale's AP 58 Sexual Abuse Policy.

Name (Print): _____

Signature: _____

Date: _____

EMPLOYEE ACKNOWLEDGEMENT FORM

I, _____, hereby
(Print Employee Name)

acknowledge that I have received a copy of Chapter 16 – “Information Technology Policy” of the City of Avondale’s Personnel Policy and Procedures Manual adopted by the City Council. I also acknowledge that a representative from Human Resources has presented this information in person and I was provided the opportunity to ask questions for clarification and understanding.

I understand that the City of Avondale can, modify, eliminate, OR revise, the guidelines and information in this Personnel Policies and Procedures Manual as circumstances or situations warrant.

I also understand that any changes made by the City of Avondale with respect to this Personnel Policies and Procedures Manual, can supersede, modify, or eliminate any of the policies and procedures outlined in this manual. I accept responsibility for familiarizing myself with the Personnel Policies and Procedures Manual and will seek verification or clarification of its terms or guidance where necessary.

Furthermore, I understand that I should consult with my supervisor or a representative of the Human Resources Department if I have any questions that are not answered in the City of Avondale Personnel Policies and Procedures Manual.

Employee Signature _____ Date _____

	EMPLOYMENT STATUS			EFFECTIVE DATE OF COVERAGE/CHANGE			
	<input type="checkbox"/> Active Employee <input type="checkbox"/> Elected Official <input type="checkbox"/> COBRA						
SOC. SEC. #	EMPLOYEE'S LAST NAME		FIRST NAME		MIDDLE INITIAL		
MAILING ADDRESS			CITY	STATE	ZIP CODE	HOME PHONE NUMBER	
MARITAL STATUS			GENDER		DATE OF BIRTH	DATE OF FULL TIME HIRE	HOURS WORKED PER WEEK (ACTIVE EMPLOYEES ONLY)
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DOMESTIC PARTNER			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<small>MONTH DAY YEAR</small>	<small>MONTH DAY YEAR</small>	
COVERAGE OPTIONS							
MEDICAL - EPO <i>(Dependent children are eligible up to age 26*)</i>				<input type="checkbox"/> Employee <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage**			
MEDICAL - PPO <i>(Dependent children are eligible up to age 26*)</i>				<input type="checkbox"/> Employee <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage**			
MEDICAL - HDHP <i>(Dependent children are eligible up to age 26*)</i>				<input type="checkbox"/> Employee <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage**			
ENROLL IN HSA? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please complete separate forms available from Human Resources)</i> <i>(Only available for those enrolling in the HDHP)</i>							
DENTAL <i>(Dependent children are eligible up to age 26)</i>				<input type="checkbox"/> Employee <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Child(ren) <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage**			
VISION <i>(Dependent children are eligible up to age 26)</i>				<input type="checkbox"/> Employee <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Child(ren) <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage**			
<p><i>*NOTE: Eligible children include natural, step, adopted, or children for which you have legal guardianship. Please refer to your current Summary Plan Document for full eligibility requirements.</i></p> <p>**Employees waiving coverage must complete the Waiver of Coverage located on Page 2 of this Benefit Enrollment/Change Form</p>							

IMPORTANT: YOU MUST FULLY COMPLETE THE FOLLOWING IF SPOUSE/DOMESTIC PARTNER AND/OR DEPENDENT COVERAGE IS BEING REQUESTED

ADD	DEL	NAME	DATE OF BIRTH	SOCIAL SECURITY # (REQUIRED)	RELATION	PLAN
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision

OTHER INSURANCE INFORMATION	
Do you or your dependents currently have other: Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, give name of policyholder, policy #, name of insured, insurance company and, if applicable, termination date.
If anyone is currently on Medicare please provide the following:	ID Number _____ Part A Effective Date ____/____/____ Part B Effective Date ____/____/____ Part D Effective Date ____/____/____

AUTHORIZATION AND SIGNATURE
<p>The group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits. I hereby apply for benefits to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the policyholder. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this benefit.</p> <p>The information provided above is correct to the best of my knowledge. I certify under penalty of perjury that the dependents listed on this form fully meet the listed definition of eligibility. I will provide, if requested, documentation regarding my relationship (birth certificate, adoption certificate, etc.) to any dependent and his/her age. I will notify my employer within 31 days of a change in my listed dependents eligibility for employer-provided health benefits. I understand that if I do not enroll myself or my dependents, I must read and sign the waiver portion of this form.</p>
<p>_____</p> <p>Signature of Employee Date</p>

WAIVER OF COVERAGE (COMPLETE AND SIGN THIS SECTION IF YOU ARE WAIVING COVERAGE)
<p><input type="checkbox"/> Medical/Rx benefits are being waived for (Name) _____ for the following reason(s): _____</p> <ul style="list-style-type: none"> Group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits. I waive coverage for myself and/or my dependents and elect not to participate. I understand that I am waiving this coverage even though my employer may be providing the coverage at little or no cost to me. I understand that by waiving enrollment because of other health insurance coverage, I may in the future be able to enroll in this plan, provided that I request enrollment within 31 days after other coverage ends. In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself or my dependents provided that I request enrollment within 31 days of the status change. I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.
<p>_____</p> <p>Signature of Employee Date</p>

TO BE COMPLETED BY ADMINISTRATION ONLY		
<input type="checkbox"/> New Employee/Rehire	Hire/Rehire Date ____/____/____	Effective Date ____/____/____
<input type="checkbox"/> Add/Delete Dependents	Effective Date of Change ____/____/____	Qualifying Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Termination of Employment
<input type="checkbox"/> Termination of Insurance	Termination Date ____/____/____	<input type="checkbox"/> Loss of Dependent Status <input type="checkbox"/> Death of Employee <input type="checkbox"/> Other
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Name/Address Change	Date of Qualifying Event ____/____/____ Name _____
		HR Dept. Initials _____ Date ____/____/____

Group Life Insurance Program

Your employer provides benefit eligible employees Term Life and Accidental Death & Dismemberment (AD&D) Insurance through Securian Financial - administered by Ochs, Inc.

LIFE and AD&D INSURANCE

Protect yourself and your family from the unexpected loss of life and income during working years. Life Insurance provides a financial benefit to beneficiaries upon death; AD&D Insurance provides additional financial protection if the insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere.

HOW MUCH LIFE INSURANCE DO YOU NEED?

Check out the life insurance calculator at LifeBenefits.com/Insuranceneeds



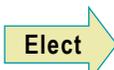
Insurance helps cover

- Funeral/burial costs
- Medical bills
- Taxes & living expenses (i.e. mortgage, childcare)

Automatically Enrolled Coverage - employer paid

Employee Basic Term Life and AD&D		2x annual salary , up to \$200,000 maximum*	<ul style="list-style-type: none"> • Includes a matching AD&D benefit
Dependent Life Package		\$5,000 spouse and \$2,500 children	<ul style="list-style-type: none"> • Insures your spouse and all dependent children - live birth to age 26

Elect Supplemental Coverage - employee paid

Employee Term Life		up to \$500,000 maximum	<ul style="list-style-type: none"> • Elect in \$10,000 increments
Spouse Term Life		up to \$250,000 maximum (not to exceed 100% of employee's total basic & supplemental coverage)	<ul style="list-style-type: none"> • Elect in \$5,000 increments
Child Term Life		up to \$10,000 maximum each child	<ul style="list-style-type: none"> • Elect in \$2,500 increments • One premium insures all eligible children from live birth to age 26
Voluntary AD&D Employee or Family		up to \$500,000 maximum	<ul style="list-style-type: none"> • Elect in \$10,000 increments • Family benefit is a percentage of the employee's elected AD&D amount: Spouse with children - 40%; no children - 50%, Each child with spouse - 10%; no spouse - 15%

If your spouse or child is eligible for employee coverage under any AzMT location, they cannot be covered as a dependent. Only one employee may cover a dependent child.

*Coverage reduces to 50% at age 75.

Over

MONTHLY COST
Employee or Spouse
Supplemental Term Life

See rate grid for easy cost calculation.

Age	Employee Rate per \$1,000	Spouse Rate per \$1,000
<25	\$0.060	\$0.049
25-29	\$0.060	\$0.049
30-34	\$0.080	\$0.050
35-39	\$0.090	\$0.066
40-44	\$0.124	\$0.093
45-49	\$0.201	\$0.141
50-54	\$0.307	\$0.214
55-59	\$0.496	\$0.356
60-64	\$0.660	\$0.538
65-69	\$1.270	\$0.914
70-74	\$2.060	\$1.624
75*	\$7.532	\$3.340

*Rates beyond age 75 are available upon request.
 Rates increase with age and all rates are subject to change.

Child Term Life

\$0.13 per \$1,000

one premium insures
 all eligible children

Voluntary AD&D

Employee: \$0.030
Family: \$0.045

Rate per \$1,000

ENROLL NOW

Turn in your completed forms to your employer by the enrollment deadline. Premiums will be automatically deducted from your paycheck.

BENEFICIARY DESIGNATIONS

Naming a beneficiary is an important right of life insurance ownership; this determines who receives the death benefit. It is recommended that you review and update your elections periodically.

ADDITIONAL FEATURES

- **Waiver of Premium** - If you become totally and permanently disabled, life insurance premiums may be waived.
- **Accelerated Benefit** - If an insured person becomes terminally ill, he/she may be eligible to request early payment of life insurance in force.
- **Continuation** - If you are no longer eligible for coverage as an active employee, you may be eligible to continue your coverage, if elected during the limited enrollment period. Premiums may be higher than those paid by active employees. Contact your employer or Ochs for information.

NEWLY HIRED EMPLOYEES

A special guaranteed issue opportunity is available for newly hired employees during their initial 31 day enrollment period. No evidence of insurability is required for the following **guaranteed amounts**:

- **Employee** - up to **\$150,000**
- **Spouse** - up to **\$30,000**
- **Child** - **all coverage**
- **Voluntary AD&D** - **all coverage**

Evidence of insurability is required for elections above the guaranteed amounts.

ANNUAL ENROLLMENT

During your employer's designated annual enrollment period, no evidence of insurability is required for the following **guaranteed amounts**:

- **Employee** - add or increase by **\$10,000** (provided the resulting amount does not exceed \$150,000 of total coverage)
- **Child** - **all coverage**
- **Voluntary AD&D** - **all coverage**

Evidence of insurability is required for elections above the guaranteed amounts and all other elections.

OTHER ENROLLMENT

If your policy or employer allows enrollment outside of their designated enrollment periods, **elections will require evidence of insurability.** If you experience a family status change, check with your employer within 31 days to confirm guaranteed issue eligibility.



Contact Ochs

ochs@ochsinc.com
 651-665-3789 or 1-800-392-7295

This is a summary of plan provisions related to the insurance policy underwritten by Minnesota Life Insurance Company. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations and terms of coverage.

Securian Financial is the marketing name for Securian Financial Group, Inc. and its affiliates. Minnesota Life is an affiliate of Securian Financial Group, Inc.

Policy forms are offered under policy form series MHC-96-13180.2 and 02-30428.

Ochs, Inc.
 A Securian Company
 400 Robert Street N, Ste. 1880, St. Paul, MN 55101



Email: ochs@ochsinc.com
Phone: 651-665-3789 • 1-800-392-7295
Web: ochsinc.com

EMPLOYEE



Supplemental Term Life Monthly Rates (based on employee's age)

Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*
Rate per \$1,000	\$0.060	\$0.060	\$0.080	\$0.090	\$0.124	\$0.201	\$0.307	\$0.496	\$0.660	\$1.270	\$2.060
Coverage											
\$10,000	\$0.60	\$0.60	\$0.80	\$0.90	\$1.24	\$2.01	\$3.07	\$4.96	\$6.60	\$12.70	\$20.60
\$20,000	\$1.20	\$1.20	\$1.60	\$1.80	\$2.48	\$4.02	\$6.14	\$9.92	\$13.20	\$25.40	\$41.20
\$30,000	\$1.80	\$1.80	\$2.40	\$2.70	\$3.72	\$6.03	\$9.21	\$14.88	\$19.80	\$38.10	\$61.80
\$40,000	\$2.40	\$2.40	\$3.20	\$3.60	\$4.96	\$8.04	\$12.28	\$19.84	\$26.40	\$50.80	\$82.40
\$50,000	\$3.00	\$3.00	\$4.00	\$4.50	\$6.20	\$10.05	\$15.35	\$24.80	\$33.00	\$63.50	\$103.00
\$60,000	\$3.60	\$3.60	\$4.80	\$5.40	\$7.44	\$12.06	\$18.42	\$29.76	\$39.60	\$76.20	\$123.60
\$70,000	\$4.20	\$4.20	\$5.60	\$6.30	\$8.68	\$14.07	\$21.49	\$34.72	\$46.20	\$88.90	\$144.20
\$80,000	\$4.80	\$4.80	\$6.40	\$7.20	\$9.92	\$16.08	\$24.56	\$39.68	\$52.80	\$101.60	\$164.80
\$90,000	\$5.40	\$5.40	\$7.20	\$8.10	\$11.16	\$18.09	\$27.63	\$44.64	\$59.40	\$114.30	\$185.40
\$100,000	\$6.00	\$6.00	\$8.00	\$9.00	\$12.40	\$20.10	\$30.70	\$49.60	\$66.00	\$127.00	\$206.00
\$110,000	\$6.60	\$6.60	\$8.80	\$9.90	\$13.64	\$22.11	\$33.77	\$54.56	\$72.60	\$139.70	\$226.60
\$120,000	\$7.20	\$7.20	\$9.60	\$10.80	\$14.88	\$24.12	\$36.84	\$59.52	\$79.20	\$152.40	\$247.20
\$130,000	\$7.80	\$7.80	\$10.40	\$11.70	\$16.12	\$26.13	\$39.91	\$64.48	\$85.80	\$165.10	\$267.80
\$140,000	\$8.40	\$8.40	\$11.20	\$12.60	\$17.36	\$28.14	\$42.98	\$69.44	\$92.40	\$177.80	\$288.40
\$150,000	\$9.00	\$9.00	\$12.00	\$13.50	\$18.60	\$30.15	\$46.05	\$74.40	\$99.00	\$190.50	\$309.00
\$160,000	\$9.60	\$9.60	\$12.80	\$14.40	\$19.84	\$32.16	\$49.12	\$79.36	\$105.60	\$203.20	\$329.60
\$170,000	\$10.20	\$10.20	\$13.60	\$15.30	\$21.08	\$34.17	\$52.19	\$84.32	\$112.20	\$215.90	\$350.20
\$180,000	\$10.80	\$10.80	\$14.40	\$16.20	\$22.32	\$36.18	\$55.26	\$89.28	\$118.80	\$228.60	\$370.80
\$190,000	\$11.40	\$11.40	\$15.20	\$17.10	\$23.56	\$38.19	\$58.33	\$94.24	\$125.40	\$241.30	\$391.40
\$200,000	\$12.00	\$12.00	\$16.00	\$18.00	\$24.80	\$40.20	\$61.40	\$99.20	\$132.00	\$254.00	\$412.00
\$210,000	\$12.60	\$12.60	\$16.80	\$18.90	\$26.04	\$42.21	\$64.47	\$104.16	\$138.60	\$266.70	\$432.60
\$220,000	\$13.20	\$13.20	\$17.60	\$19.80	\$27.28	\$44.22	\$67.54	\$109.12	\$145.20	\$279.40	\$453.20
\$230,000	\$13.80	\$13.80	\$18.40	\$20.70	\$28.52	\$46.23	\$70.61	\$114.08	\$151.80	\$292.10	\$473.80
\$240,000	\$14.40	\$14.40	\$19.20	\$21.60	\$29.76	\$48.24	\$73.68	\$119.04	\$158.40	\$304.80	\$494.40
\$250,000	\$15.00	\$15.00	\$20.00	\$22.50	\$31.00	\$50.25	\$76.75	\$124.00	\$165.00	\$317.50	\$515.00
\$260,000	\$15.60	\$15.60	\$20.80	\$23.40	\$32.24	\$52.26	\$79.82	\$128.96	\$171.60	\$330.20	\$535.60
\$270,000	\$16.20	\$16.20	\$21.60	\$24.30	\$33.48	\$54.27	\$82.89	\$133.92	\$178.20	\$342.90	\$556.20
\$280,000	\$16.80	\$16.80	\$22.40	\$25.20	\$34.72	\$56.28	\$85.96	\$138.88	\$184.80	\$355.60	\$576.80
\$290,000	\$17.40	\$17.40	\$23.20	\$26.10	\$35.96	\$58.29	\$89.03	\$143.84	\$191.40	\$368.30	\$597.40
\$300,000	\$18.00	\$18.00	\$24.00	\$27.00	\$37.20	\$60.30	\$92.10	\$148.80	\$198.00	\$381.00	\$618.00
\$310,000	\$18.60	\$18.60	\$24.80	\$27.90	\$38.44	\$62.31	\$95.17	\$153.76	\$204.60	\$393.70	\$638.60
\$320,000	\$19.20	\$19.20	\$25.60	\$28.80	\$39.68	\$64.32	\$98.24	\$158.72	\$211.20	\$406.40	\$659.20
\$330,000	\$19.80	\$19.80	\$26.40	\$29.70	\$40.92	\$66.33	\$101.31	\$163.68	\$217.80	\$419.10	\$679.80
\$340,000	\$20.40	\$20.40	\$27.20	\$30.60	\$42.16	\$68.34	\$104.38	\$168.64	\$224.40	\$431.80	\$700.40
\$350,000	\$21.00	\$21.00	\$28.00	\$31.50	\$43.40	\$70.35	\$107.45	\$173.60	\$231.00	\$444.50	\$721.00
\$360,000	\$21.60	\$21.60	\$28.80	\$32.40	\$44.64	\$72.36	\$110.52	\$178.56	\$237.60	\$457.20	\$741.60
\$370,000	\$22.20	\$22.20	\$29.60	\$33.30	\$45.88	\$74.37	\$113.59	\$183.52	\$244.20	\$469.90	\$762.20
\$380,000	\$22.80	\$22.80	\$30.40	\$34.20	\$47.12	\$76.38	\$116.66	\$188.48	\$250.80	\$482.60	\$782.80
\$390,000	\$23.40	\$23.40	\$31.20	\$35.10	\$48.36	\$78.39	\$119.73	\$193.44	\$257.40	\$495.30	\$803.40
\$400,000	\$24.00	\$24.00	\$32.00	\$36.00	\$49.60	\$80.40	\$122.80	\$198.40	\$264.00	\$508.00	\$824.00
\$410,000	\$24.60	\$24.60	\$32.80	\$36.90	\$50.84	\$82.41	\$125.87	\$203.36	\$270.60	\$520.70	\$844.60
\$420,000	\$25.20	\$25.20	\$33.60	\$37.80	\$52.08	\$84.42	\$128.94	\$208.32	\$277.20	\$533.40	\$865.20
\$430,000	\$25.80	\$25.80	\$34.40	\$38.70	\$53.32	\$86.43	\$132.01	\$213.28	\$283.80	\$546.10	\$885.80
\$440,000	\$26.40	\$26.40	\$35.20	\$39.60	\$54.56	\$88.44	\$135.08	\$218.24	\$290.40	\$558.80	\$906.40
\$450,000	\$27.00	\$27.00	\$36.00	\$40.50	\$55.80	\$90.45	\$138.15	\$223.20	\$297.00	\$571.50	\$927.00
\$460,000	\$27.60	\$27.60	\$36.80	\$41.40	\$57.04	\$92.46	\$141.22	\$228.16	\$303.60	\$584.20	\$947.60
\$470,000	\$28.20	\$28.20	\$37.60	\$42.30	\$58.28	\$94.47	\$144.29	\$233.12	\$310.20	\$596.90	\$968.20
\$480,000	\$28.80	\$28.80	\$38.40	\$43.20	\$59.52	\$96.48	\$147.36	\$238.08	\$316.80	\$609.60	\$988.80
\$490,000	\$29.40	\$29.40	\$39.20	\$44.10	\$60.76	\$98.49	\$150.43	\$243.04	\$323.40	\$622.30	\$1,009.40
\$500,000	\$30.00	\$30.00	\$40.00	\$45.00	\$62.00	\$100.50	\$153.50	\$248.00	\$330.00	\$635.00	\$1,030.00

*Additional rates beyond age 74 are available upon request. Rates change according to attained age brackets.

SEE REVERSE SIDE FOR SPOUSE LIFE RATES

SPOUSE



Supplemental Term Life Monthly Rates (based on spouse's age)

Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*
Rate per \$1,000	\$0.049	\$0.049	\$0.050	\$0.066	\$0.093	\$0.141	\$0.214	\$0.356	\$0.538	\$0.914	\$1.624
Coverage											
\$5,000	\$0.25	\$0.25	\$0.25	\$0.33	\$0.47	\$0.71	\$1.07	\$1.78	\$2.69	\$4.57	\$8.12
\$10,000	\$0.49	\$0.49	\$0.50	\$0.66	\$0.93	\$1.41	\$2.14	\$3.56	\$5.38	\$9.14	\$16.24
\$15,000	\$0.74	\$0.74	\$0.75	\$0.99	\$1.40	\$2.12	\$3.21	\$5.34	\$8.07	\$13.71	\$24.36
\$20,000	\$0.98	\$0.98	\$1.00	\$1.32	\$1.86	\$2.82	\$4.28	\$7.12	\$10.76	\$18.28	\$32.48
\$25,000	\$1.23	\$1.23	\$1.25	\$1.65	\$2.33	\$3.53	\$5.35	\$8.90	\$13.45	\$22.85	\$40.60
\$30,000	\$1.47	\$1.47	\$1.50	\$1.98	\$2.79	\$4.23	\$6.42	\$10.68	\$16.14	\$27.42	\$48.72
\$35,000	\$1.72	\$1.72	\$1.75	\$2.31	\$3.26	\$4.94	\$7.49	\$12.46	\$18.83	\$31.99	\$56.84
\$40,000	\$1.96	\$1.96	\$2.00	\$2.64	\$3.72	\$5.64	\$8.56	\$14.24	\$21.52	\$36.56	\$64.96
\$45,000	\$2.21	\$2.21	\$2.25	\$2.97	\$4.19	\$6.35	\$9.63	\$16.02	\$24.21	\$41.13	\$73.08
\$50,000	\$2.45	\$2.45	\$2.50	\$3.30	\$4.65	\$7.05	\$10.70	\$17.80	\$26.90	\$45.70	\$81.20
\$55,000	\$2.70	\$2.70	\$2.75	\$3.63	\$5.12	\$7.76	\$11.77	\$19.58	\$29.59	\$50.27	\$89.32
\$60,000	\$2.94	\$2.94	\$3.00	\$3.96	\$5.58	\$8.46	\$12.84	\$21.36	\$32.28	\$54.84	\$97.44
\$65,000	\$3.19	\$3.19	\$3.25	\$4.29	\$6.05	\$9.17	\$13.91	\$23.14	\$34.97	\$59.41	\$105.56
\$70,000	\$3.43	\$3.43	\$3.50	\$4.62	\$6.51	\$9.87	\$14.98	\$24.92	\$37.66	\$63.98	\$113.68
\$75,000	\$3.68	\$3.68	\$3.75	\$4.95	\$6.98	\$10.58	\$16.05	\$26.70	\$40.35	\$68.55	\$121.80
\$80,000	\$3.92	\$3.92	\$4.00	\$5.28	\$7.44	\$11.28	\$17.12	\$28.48	\$43.04	\$73.12	\$129.92
\$85,000	\$4.17	\$4.17	\$4.25	\$5.61	\$7.91	\$11.99	\$18.19	\$30.26	\$45.73	\$77.69	\$138.04
\$90,000	\$4.41	\$4.41	\$4.50	\$5.94	\$8.37	\$12.69	\$19.26	\$32.04	\$48.42	\$82.26	\$146.16
\$95,000	\$4.66	\$4.66	\$4.75	\$6.27	\$8.84	\$13.40	\$20.33	\$33.82	\$51.11	\$86.83	\$154.28
\$100,000	\$4.90	\$4.90	\$5.00	\$6.60	\$9.30	\$14.10	\$21.40	\$35.60	\$53.80	\$91.40	\$162.40
\$105,000	\$5.15	\$5.15	\$5.25	\$6.93	\$9.77	\$14.81	\$22.47	\$37.38	\$56.49	\$95.97	\$170.52
\$110,000	\$5.39	\$5.39	\$5.50	\$7.26	\$10.23	\$15.51	\$23.54	\$39.16	\$59.18	\$100.54	\$178.64
\$115,000	\$5.64	\$5.64	\$5.75	\$7.59	\$10.70	\$16.22	\$24.61	\$40.94	\$61.87	\$105.11	\$186.76
\$120,000	\$5.88	\$5.88	\$6.00	\$7.92	\$11.16	\$16.92	\$25.68	\$42.72	\$64.56	\$109.68	\$194.88
\$125,000	\$6.13	\$6.13	\$6.25	\$8.25	\$11.63	\$17.63	\$26.75	\$44.50	\$67.25	\$114.25	\$203.00
\$130,000	\$6.37	\$6.37	\$6.50	\$8.58	\$12.09	\$18.33	\$27.82	\$46.28	\$69.94	\$118.82	\$211.12
\$135,000	\$6.62	\$6.62	\$6.75	\$8.91	\$12.56	\$19.04	\$28.89	\$48.06	\$72.63	\$123.39	\$219.24
\$140,000	\$6.86	\$6.86	\$7.00	\$9.24	\$13.02	\$19.74	\$29.96	\$49.84	\$75.32	\$127.96	\$227.36
\$145,000	\$7.11	\$7.11	\$7.25	\$9.57	\$13.49	\$20.45	\$31.03	\$51.62	\$78.01	\$132.53	\$235.48
\$150,000	\$7.35	\$7.35	\$7.50	\$9.90	\$13.95	\$21.15	\$32.10	\$53.40	\$80.70	\$137.10	\$243.60
\$155,000	\$7.60	\$7.60	\$7.75	\$10.23	\$14.42	\$21.86	\$33.17	\$55.18	\$83.39	\$141.67	\$251.72
\$160,000	\$7.84	\$7.84	\$8.00	\$10.56	\$14.88	\$22.56	\$34.24	\$56.96	\$86.08	\$146.24	\$259.84
\$165,000	\$8.09	\$8.09	\$8.25	\$10.89	\$15.35	\$23.27	\$35.31	\$58.74	\$88.77	\$150.81	\$267.96
\$170,000	\$8.33	\$8.33	\$8.50	\$11.22	\$15.81	\$23.97	\$36.38	\$60.52	\$91.46	\$155.38	\$276.08
\$175,000	\$8.58	\$8.58	\$8.75	\$11.55	\$16.28	\$24.68	\$37.45	\$62.30	\$94.15	\$159.95	\$284.20
\$180,000	\$8.82	\$8.82	\$9.00	\$11.88	\$16.74	\$25.38	\$38.52	\$64.08	\$96.84	\$164.52	\$292.32
\$185,000	\$9.07	\$9.07	\$9.25	\$12.21	\$17.21	\$26.09	\$39.59	\$65.86	\$99.53	\$169.09	\$300.44
\$190,000	\$9.31	\$9.31	\$9.50	\$12.54	\$17.67	\$26.79	\$40.66	\$67.64	\$102.22	\$173.66	\$308.56
\$195,000	\$9.56	\$9.56	\$9.75	\$12.87	\$18.14	\$27.50	\$41.73	\$69.42	\$104.91	\$178.23	\$316.68
\$200,000	\$9.80	\$9.80	\$10.00	\$13.20	\$18.60	\$28.20	\$42.80	\$71.20	\$107.60	\$182.80	\$324.80
\$205,000	\$10.05	\$10.05	\$10.25	\$13.53	\$19.07	\$28.91	\$43.87	\$72.98	\$110.29	\$187.37	\$332.92
\$210,000	\$10.29	\$10.29	\$10.50	\$13.86	\$19.53	\$29.61	\$44.94	\$74.76	\$112.98	\$191.94	\$341.04
\$215,000	\$10.54	\$10.54	\$10.75	\$14.19	\$20.00	\$30.32	\$46.01	\$76.54	\$115.67	\$196.51	\$349.16
\$220,000	\$10.78	\$10.78	\$11.00	\$14.52	\$20.46	\$31.02	\$47.08	\$78.32	\$118.36	\$201.08	\$357.28
\$225,000	\$11.03	\$11.03	\$11.25	\$14.85	\$20.93	\$31.73	\$48.15	\$80.10	\$121.05	\$205.65	\$365.40
\$230,000	\$11.27	\$11.27	\$11.50	\$15.18	\$21.39	\$32.43	\$49.22	\$81.88	\$123.74	\$210.22	\$373.52
\$235,000	\$11.52	\$11.52	\$11.75	\$15.51	\$21.86	\$33.14	\$50.29	\$83.66	\$126.43	\$214.79	\$381.64
\$240,000	\$11.76	\$11.76	\$12.00	\$15.84	\$22.32	\$33.84	\$51.36	\$85.44	\$129.12	\$219.36	\$389.76
\$245,000	\$12.01	\$12.01	\$12.25	\$16.17	\$22.79	\$34.55	\$52.43	\$87.22	\$131.81	\$223.93	\$397.88
\$250,000	\$12.25	\$12.25	\$12.50	\$16.50	\$23.25	\$35.25	\$53.50	\$89.00	\$134.50	\$228.50	\$406.00

*Additional rates beyond age 74 are available upon request. Rates change according to attained age brackets.

SEE REVERSE SIDE FOR EMPLOYEE LIFE RATES

Group Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
Group Customer Service • 400 Robert Street North • St. Paul, Minnesota 55101-2098



A Securian Company

MINNESOTA LIFE

EMPLOYERNAME: AzMT - City of Avondale

POLICY NUMBER: 34488

1. Return completed and signed form to your benefits office.
2. Please complete the Group Life Evidence of Insurability form for coverage that is not guaranteed.

A. EMPLOYEE INFORMATION

First name		Middle initial	Last name	
Email address				
Street address		City	State	Zip code
Date of birth	Social security number	Date of employment	Salary	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Basic Life Insurance

Basic Life Amount: \$ _____ Insurance Class: _____ Effective Date: _____

Add Basic Dependent Life Package - \$5,000 spouse/\$2,500 children Effective Date: _____

Supplemental Life Insurance

Employee Increase
Current Amount \$ _____ Decrease Amount \$ _____ Grand Total \$ _____ Effective Date _____

NOTE: EOI form is required if elected coverage is: 1) over \$10,000 during annual enrollment period or 2) over \$150,000 during initial new hire period

Spouse Increase
Current Amount \$ _____ Decrease Amount \$ _____ Grand Total \$ _____ Effective Date _____

NOTE: EOI form is required if elected coverage is: 1) elected during annual enrollment period or 2) over \$30,000 during qualifying event/initial new hire period

Child Increase
Current Amount \$ _____ Decrease Amount \$ _____ Grand Total \$ _____ Effective Date _____

Please complete below spouse and children information sections, even if supplemental life coverage is not elected.

B. SPOUSE INFORMATION Is your spouse also an employee covered under this policy? Yes No

First name		Middle initial	Last name	
Email address			Marriage date	
Date of birth	Social Security number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

C. CHILDREN INFORMATION

List of names and dates of birth for your eligible children:

D. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage. I understand it is my responsibility to notify my employer if a dependent is no longer eligible for coverage.

Employee signature X	Daytime phone number	Evening phone number	Date signed
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Group Accidental Death and Dismemberment Insurance Employee and Family Enrollment

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • 18-3789 • St. Paul, Minnesota 55101-2098

Employer name AzMT - City of Avondale		Policy number 34488	Unit
Employee name		Social Security number	Date of birth
Street address		City	State Zip code
Occupation	Employee location		Insurance class
Date employed	Monthly salary \$	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you actively working at your employer's normal place of business at least <u>40</u> hours per week?
Beneficiary		Relationship	
<input type="checkbox"/> I would like to enroll in the Employee Plan OR <input type="checkbox"/> I would like to enroll in the Family Plan		Total amount of voluntary AD&D insurance requested \$ _____ Effective Date: _____	

I understand that Minnesota Life Insurance Company shall incur no liability until the first premium is paid, and that premiums for the contributory insurance will be deducted from my pay.

Applicant signature X	Daytime telephone number	Date signed
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Group Life Insurance Evidence of Insurability

Minnesota Life Insurance Company - A Securian Company
 400 Robert Street North • B2-4930 • St. Paul, Minnesota 55101-2098 • Fax 651-665-3791



EMPLOYERNAME: AzMT - City of Avondale

POLICY NUMBER: 34488

EMPLOYEE INFORMATION (always complete for coverage that requires evidence of insurability)

First name	Middle initial	Last name	Email address			
Street address		City		State	Zip code	
Date of birth	Employee ID	Annual salary	Date of employment		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Total amount of insurance requested						

SPOUSE INFORMATION (only complete if coverage requires evidence of insurability)

First name	Middle initial	Last name	Email address			
Date of birth		Social Security number			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Total amount of insurance requested						

CHILDREN INFORMATION (only complete if coverage requires evidence of insurability; list names and dates of birth)

Total amount of insurance requested					
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HEALTH QUESTIONS (always complete for coverage that requires evidence of insurability)

Employee Yes No	Spouse Yes No	Children Yes No	Employee		Spouse		
			Height	Weight	Height	Weight	Occupation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s) or been hospitalized?				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?				

If you answer "Yes" to any question, please provide additional information below or on a separate sheet of paper.

ADDITIONAL HEALTH INFORMATION (provide details for every "Yes" answer to the health questions)

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

FOR OFFICE USE ONLY:

Employee		Spouse		Children		Dependent Life Package - Coverage Code 94	
Current in force	U/W applied for	Current in force	U/W applied for	Current in force	U/W applied for	U/W applied for	U/W applied for
\$	\$	\$	\$	\$	\$	Spouse \$	Child \$

PLEASE READ & SIGN NEXT PAGE & SEND ALL PAGES TO YOUR BENEFITS OFFICE

AUTHORIZATION

To determine my insurability or for claim purposes, I authorize any physician, practitioner, hospital, clinic, or other medical or medically-related facility, the Veteran’s Administration or other government support facility, insurance company or Medical Information Bureau (MIB) to give information about me or my physical or mental health, including alcohol or drug abuse, to Minnesota Life Insurance Company ("the Company") and its reinsurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

I also authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

This protected health information is to be disclosed under this Authorization so the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand I am entitled to receive a copy of this Authorization. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to the Company’s legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

CONSUMER PRIVACY NOTICE

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send the Company a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

For further information about your file or your rights, you may contact:

Group Division Underwriting
 Minnesota Life Insurance Company
 400 Robert Street North
 St. Paul, Minnesota 55101-2098
 Telephone: (800) 872-2214

For information about the MIB, you may contact:

MIB
 50 Braintree Hill, Suite 400
 Braintree, MA 02184-8734
 MIB Telephone: (866) 692-6901
 MIB TTY: (866) 346-3642
 Website: www.mib.com

I have read this Authorization and Consumer Privacy Notice and I understand I or my authorized representatives can receive copies. The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I authorize my employer to withdraw premiums from my salary to pay for this coverage. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

Employee name (please print)		Date of birth	
Employee signature X	Daytime phone number	Evening phone number	Date signed
Spouse name (please print)		Date of birth	
Spouse signature X	Daytime phone number	Evening phone number	Date signed

Beneficiary Designation

Securian Financial Group, Inc.
 Minnesota Life Insurance Company
 Securian Life Insurance Company, a New York authorized insurer
 400 Robert Street North • St. Paul, Minnesota 55101-2098

Group Customer Service
 1-866-293-6047



EMPLOYERNAME: AzMT - City of Avondale

POLICY NUMBER: 34488

Insured's name (last, first, middle initial)	Social Security number/ID
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Address (street, city, state, zip)

Insured's date of birth	Policyowner (if different than the insured)	Policyowner's phone number	Email address
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This beneficiary designation applies to all eligible coverages.

INSTRUCTIONS:

1. Clearly print or type the information below.
2. **Sign and date the completed form.**
3. Return to: Minnesota Life Group Insurance Department, Station #B2-2012, 400 Robert Street North, St. Paul, MN 55101 or fax to 651-665-4827.

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children", without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

SIGNATURE REQUIRED

Policyowner's signature X	Date
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EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY (IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%
					Total = 100%

CONTINGENT BENEFICIARY (IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%
					Total = 100%

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY (IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	03-03-1980	123 4th Street, Anywhere, MN 12345, 651-665-3456	XXX-XX-XXXX	Daughter	40%
Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%
					Total = 100%

CONTINGENT BENEFICIARY (IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Jones	06-06-1980	5 Main Street, Anywhere, MN 45685, 651-665-6789	XXX-XX-XXXX	Sister	50%
Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 58978, 651-665-7890	XXX-XX-XXXX	Brother	50%
					Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY (IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Doe - Trustee, his successors or successor in trust under the John Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008.			N/A	Trust	100%
					Total = 100%

Employee HSA payroll deduction form



Return completed forms to:

Company name: _____

Attn: _____

Fax: _____

Email address: _____

Annual employer contribution information

Self-only	Family	Other (optional)

For mid-year enrollees, contact your HR department for your pro-rated employer election amount.

Notes

HSA contribution limits and contribution calculator

2019 annual HSA contributions			2020 annual HSA contributions		
Coverage type	Total annual contribution*	Per month	Coverage type	Total annual contribution*	Per month
Self-only	\$3,500	\$291.67	Self-only	\$3,550	\$295.83
Family	\$7,000	\$583.33	Family	\$7,100	\$591.67

*Catch-up contribution (age 55+): additional \$1,000/year

*Catch-up contribution (age 55+): additional \$1,000/year

Total annual contribution	- (MINUS)	Total annual employer contribution	=	Total eligible amount
<input type="text"/>		<input type="text"/>		<input type="text"/>
Total eligible amount	/ (DIVIDED)	Enter number of pay periods remaining in the year from form submittal date	=	Per-pay period max withholding
<input type="text"/>		<input type="text"/>		<input type="text"/>

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high-deductible health plan (HDHP). If you're covered as of December 1, you're considered an eligible individual for the entire year and you're not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any funding over the prorated amount is considered an excess contribution and subject to a penalty and income tax. For further information or to review eligibility, please contact HealthEquity Member Services at 866.346.5800.

Employee information and authorization

Employee name	Last 4 of SSN or employee ID
Please withhold \$ _____ from my (weekly/bi-weekly/monthly) payroll and apply the funds to my HealthEquity HSA.	
Signature	Date

CERTIFICATE OF HSA ELIGIBILITY

First: _____ Last: _____

(Please Print)

I understand that in order for The City of Avondale to contribute to a health savings account (HSA) on my behalf, I must meet all of the following HSA eligibility conditions.

I have coverage under a City of Avondale High Deductible Health Plan, which I understand qualifies as a high-deductible health plan (HDHP).

I am not claimed as a dependent on someone else's tax return.

I am not enrolled in Medicare.

I am not covered under any other health insurance plan unless it is another HDHP.

By signing this form and returning it to the City of Avondale, I certify that all of the statements above are true. I agree that I will notify the City of Avondale immediately in writing if I cease to meet any of these conditions. I also understand that the City of Avondale will make contributions to an HSA on my behalf on the basis of my certification and that the City of Avondale's HSA contributions and my own HSA contributions (if any) are subject to certain aggregate limits under federal tax laws.

Signature: _____ Date: _____

Beneficiary Designation Form

Please mail or fax completed forms to:

Address: HealthEquity, Attn: Member Services
15 W Scenic Pointe Dr, Ste 100 Draper, UT 84020
Fax: 801.727.1005



Complete this information online under “My Profile” in your member portal.

Note: If married, living in a community property state (for example AL, AZ, CA, ID, LA, NV, NM, TX, WA, or WI), and want to designate a primary beneficiary other than your spouse, your spouse must agree in writing to your designation and you must submit a physical copy of this form by mail or fax.

You should consult your legal/tax advisor when completing this form, as there may be tax and/or legal consequences to your designation.

You have the option to list one or more persons to be the primary and contingent beneficiaries for your HSA (including your estate or a trust, as applicable). If designating multiple primary or contingent beneficiaries, indicate the percentage share each should receive, ensuring the total of each adds up to 100%.

Designations are effective upon receipt by HealthEquity and, unless otherwise specified, cancel all previous HSA beneficiary designations on file.

Account Holder Information (all fields are required)			
Last Name	First Name	M.I.	
E-Mail Address	Daytime Phone ()	SSN or HealthEquity ID Number (6 or 7 digits)	

Primary Beneficiary(ies)
To ensure timely completion of your request, please complete all fields for each beneficiary you designate.

Primary Beneficiary 1 Estate/Trust <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Primary Beneficiary 2 Estate/Trust <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Primary Beneficiary 3 Estate/Trust <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Primary Beneficiary 4 Estate/Trust <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Contingent Beneficiary(ies)

Contingent beneficiaries receive your HSA assets in the event that all of your primary beneficiaries pass away before you.

Contingent Beneficiary 1 Estate/Trust Yes No

Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Contingent Beneficiary 2 Estate/Trust Yes No

Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Total 100%

Authorization

Participant Signature	Name (please print)	Date
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If you're a resident of a community or marital property state and have designated a beneficiary other than, or in addition to, your spouse, have your spouse authorize the designation by signing below.

Spousal Consent: I am the legal spouse of the HSA account holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the tax consequences of giving up my interest in this HSA, I have been advised to see a qualified tax professional. I hereby consent to the beneficiary designation(s) indicated above.

Spouse's Signature	Name (please print)	Date
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18-19
PLAN
YEAR

The City of Avondale



Flexible Benefits

EMPLOYEE INFORMATION PACKET

What are “Flexible Benefits”?

Flexible Benefits started when Congress passed Section 125 of the Internal Revenue Code in 1978. Section 125 allows a certain amount, estimated for a given year, to be deducted directly from your paycheck and claimed for reimbursement when used for qualified expenses. These deductions are taken before taxes, reducing your total taxable income.

Example:

Mary is single with three children and Mary earns \$3,000.00 per month. She pays \$300.00 a month in childcare expenses and \$25.00 a month for prescriptions. The calculations below show how much Mary will save by participating in the Flexible Benefit Plan her company offers.

Mary with 125

\$3,000.00 Income
- \$325.00 Expenses
= \$2,675.00 Taxable Income
- \$ 229.12 Federal Tax
- \$81.36 State Tax
- \$207.69 Social Sec/Medicare
= \$2,156.83 Mary's Income

*Mary's savings
of \$79.69 per
month will save
her \$956.28 total
for the whole
year!*

Mary without 125

\$3,000.00 Income
- \$271.25 Federal Tax
- \$97.11 State Tax
- \$229.50 Social Sec/Medicare
= \$2,402.14 Net Income
- \$325.00 Expenses
= \$2,077.14 Mary's Income

Healthcare Reimbursement

Healthcare Reimbursement enables you to deduct medical, dental and vision expenses before taxes, up to the maximum annual amount set by your employer. A claim is then filed to receive reimbursements for the expense(s). Eligible expenses include, but are not limited to, charges for medical, dental or vision office visits, prescription drugs, x-rays, laboratory work, orthodontia, periodontics, bridges, crowns, eye exams, glasses, contacts, LASIK eye surgery, ambulance and emergency room fees, diabetic supplies and many other products and services.

****A more complete list of eligible and ineligible goods and services can be found later in this packet.***

Dependent Care Reimbursement

Dependent Care Reimbursement enables you to deduct childcare (day care), babysitting or elder care expenses before taxes, up to a maximum of \$5,000 per family or \$2,500 if married and filing separately. A claim is then filed to receive reimbursement for the expense(s). Eligible expenses include charges for before or after school care or programs (that are custodial in nature and not educational, i.e. tutoring), babysitting, day care, summer camps and elder care.

The following rules apply:

- Documentation must be provided for the expense with a receipt showing the date(s) of service, amount charged and the provider's name and federal tax ID or social security number.
- A dependent must be under the age of 13 or disabled (at any age).
- The service must be provided while you and your spouse work or attend school full-time.
- Expenses cannot exceed the lower income of either spouse.
- If using a day care center, it must be licensed.
- Babysitting services provided by a relative under the age of 19 are ineligible.
- Overnight camps and food costs for day camps are not eligible.



Procedures & Services

- All expenses for the Plan Year should be conservatively estimated. Any funds left in the account at the end of the claims run-out period for the Plan Year will be forfeited back to your employer.
- During Open Enrollment for each new Plan Year, you will be given the opportunity to participate in the Plan. **Elections are not carried over. You MUST re-enroll.**
- Your election cannot be changed during the Plan Year unless there is a change in status that is a qualifying event. All changes must be consistent with your new election choice and must be made within 30 days of the qualifying event. For a full list of events and to discuss options for a specific event, please contact your Benefits Department or Sheakley's Customer Service team.
- As the contribution amount you elected is deducted from your paycheck, it is posted to your Healthcare and/or Dependent Care Reimbursement Account(s) based on the pay schedule provided by your employer.
- To receive funds from your account(s), you must complete and submit an online claim form, complete a manual claim form and fax or email it in along with all supporting receipts/documentation for your claim or submit a claim via the mobile app. Documentation must show 1) the date of service (not date of payment), 2) the specific type of service, and 3) the amount you have paid or owe. **Cancelled checks, bank statements, and credit/debit card receipts are not considered valid documentation.**
- Once your claim is reviewed and approved, a reimbursement will be issued in the form of a check or, if applicable, a direct deposit. Checks are mailed the next business day following the date of processing. Direct deposit reimbursements may take 2-4 business days to post to your account, depending on your employer's chosen processing timeframe.
- In general, claims are processed for reimbursement twice per week, on Wednesday and Friday. Claims received by 5:00pm EST on Monday are processed on Wednesday. Claims received by 5:00pm EST on Wednesday are processed on Friday. These are our guaranteed processing timeframes. Claims may be processed more quickly depending on claim volume and the time of year.
- All claims must be for services incurred during your coverage period within the Plan Year. "Incurred" is defined as the date in which services are provided (not paid). "Coverage Period" is defined as the first of the month in which your first contribution is deducted and the last day of the month in which your last contribution is deducted.
- **In the event you terminate employment, the end of the month in which you made your final contribution to the Plan becomes your termination date. Services incurred after your termination date are not eligible for reimbursement.**
- Be sure to notify your employer and/or Sheakley's Customer Service team of any change in address. You can do so by updating it via the employee web portal, by completing a Change Form (available through your employer) or by emailing us at 125@sheakley.com.
- Access to your online account is available 24 hours a day, 7 days a week at:

<https://sheakleyCDHee.lh1ondemand.com/Login.aspx>

Account registration instructions are included later in this packet and in the "Quick Start Guide" available from your employer. We strongly urge all participants to register their online account because important updates regarding the Plan, accounts status letters, claims denied/dismissed letters and other important information is posted regularly.

For specific information regarding your Plan, the grace period, yearly limits, Plan Year dates, etc., please refer to your Summary Plan Description (on file with your employer) or contact our Customer Service team. Customer Service representatives are available to assist you from 8:00am to 5:00pm EST, Monday through Friday, except on holidays.

Sheakley Flexible Benefits Division
One Sheakley Way, Cincinnati, OH 45246
Phone: 800.877.6630
Fax: 513.326.8082
Email: 125@sheakley.com



The Healthcare F.S.A.



The Healthcare F.S.A. allows participants to set aside pre-tax dollars to pay for eligible medical, dental and vision expenses that are not covered by your insurance. Expenses for you, your spouse, your child(ren) and any other dependents you claim on your taxes are eligible for reimbursement under this plan.

The IRS considers medical expenses to be “unpredictable”, so the full annual election is available on the first day of the Plan Year. If the entire annual election is reimbursed early in the Plan Year, the remaining contributions that are made will go towards “paying back” the funds that were advanced.

A list of common eligible and ineligible expenses is included with this packet. If a specific item or service is not listed, please contact our Customer Service team to check the eligibility prior to the item’s purchase or the rendering of services.

Note to H.S.A. Owners

If you currently participate in a high-deductible health plan and have a Health Savings Account (H.S.A.), contact your employer to determine your F.S.A. eligibility. If you are eligible to participate, the Healthcare F.S.A. will be a Limited Healthcare F.S.A. and may only be used for dental and vision expenses. All medical expenses must be paid for with your H.S.A. until your deductible has been met. After that, you may submit healthcare expenses for reimbursement through your F.S.A.

Important Note Regarding Over-the-Counter Items

Please note that, due to a change in the IRS code in 2011, claims for over-the-counter (OTC) products containing any kind of medicine can only be reimbursed when accompanied by a doctor’s note stating the medical necessity.

Healthcare Claim Reimbursement

It is important to remember that healthcare claims are paid out based on the date of service, **not the date of payment**. Pre-payments for services are not eligible for reimbursement until the service has been rendered. Additionally, payments made for services where the date of service is in a previous Plan Year are ineligible for reimbursement using current Plan Year funds.

When submitting claims, third-party documentation must be provided for each expense being claimed. The documentation must provide the following three items:

1. **The Date of Service (not Date of Payment)**
2. **The Specific Type of Service**
3. **The Amount Paid or Owed**

****Credit/debit card receipts, copies of checks, online payment confirmations and bank statements are not valid forms of documentation per IRS regulations.**



Eligible Items & Services

Dental & Vision Services

Artificial Teeth
Contact Lenses
Crowns/Bridges
Dental Implants
Dental Sealants
Dental X-Rays
Dentures
Exams/Cleanings
Extractions
Fillings
Occlusal/Bite Guards
Orthodontia
Eye Exam
Glasses/Contacts
LASIK/PRK
Prescription Sunglasses

Insurance Related Items

Copay Amounts
Deductibles
Differential
Expenses (medical)
Pre-Existing Conditions
Private Hospital Room

Lab Exams/Tests

Blood Tests
Body Scan
Cardiograph
Colonoscopy
CT Scan
EKG
Endoscopy
Fluoroscopy
Laboratory Fees
Metabolism Tests
MRI
PET Scan
Sweat Tests
Ultrasound
Urine/Stool Analysis
X-Rays

Obstetric Services

Childbirth Classes (Lamaze)
Lactation Consultation
Midwife Expenses
OB/GYN Exams
Pre/Post-natal Treatment
Prepaid Maternity Fees

Other Medical Treatments

Abortion (legal)
Acupuncture
Alcoholism (inpatient treatment)
Ambulance Services
Anesthesiology
Breast Reconstruction Surgery
Cancer Screening
Clinical Trials
Counseling (Psychiatry/Psychology)
Dialysis
Drug Addiction Treatment
Gastric Bypass Surgery
Genetic Testing
Hearing Exams
Hospital Services
Infertility Treatment
In-vitro Fertilization
Norplant Insertion or Removal
Patterning Exercises
Physical Exam (if not employment related)
Physical/Occupational Therapy
Smoking Cessation Program
Speech Therapy
Sterilization Procedures
Temporary Cord Blood Storage
Temporary Egg & Sperm Storage
Transplants (including Organ Donor)
Treatment for Handicapped
Tubal Ligation
Vaccinations/Immunizations
Vasectomy
Well Baby Care

Practitioners

Allergist
Cardiologist
Chiropractor
Dermatologist
Endocrinologist
Gastroenterologist
Genetic Counselor
Homeopath (office visit only)
Naturopath (office visit only)
Nephrologist
Oncologist
Ophthalmologist/Optomtrist
Osteopath (office visit only)
Physician (licensed)
Physician Assistant
Psychiatrist/Psychologist

Other Equipment, Supplies & Services

Abdominal/Back Supports
Ankle/Wrist Supports
Automated External Defibrillator
Birth Control & Contraceptives
Blood Pressure Monitoring Device
Blood Sugar Test Kits & Supplies
Braille Books & Magazines
Breast Pump & Lactation Supplies
Compression Hose/Stockings
Contact Lens Equipment/Solution
Cold/Hot Packs for Injuries
Condoms
CPAP Devices and Supplies
Crutches / Walkers / Wheelchairs
Diabetic Supplies / Insulin
Ear Plugs
Elastic Bandages
Erectile Dysfunction Treatment
First Aid Kits / Bandages
Flu Shots
Glucose Monitoring Equipment
Guide Dog, Care & Training
Hearing Aids and Batteries
Heart Rate Monitor
Heating Pads
Hospice Care
Hospital Bed
Incontinence Supplies
Learning Disability Assistance
Lodging for Medical Care (limited)
Mastectomy-related Bra
Medical Alert Bracelet or Necklace
Medical Care outside the U.S. (if eligible)
Orthotics, Inserts & Supports
Ostomy, Colostomy Supplies
Ovulation Monitor
Oxygen Equipment
Pregnancy Test Kits
Prosthesis
Reading Glasses
Splints/Casts
Sunscreen (SPF 30 or higher)
Support Braces
Syringes (for medical use)
Thermometer
Transportation Expenses (essential to care)
Vaporizer/Humidifier (for medical care)

Medications

Prescription Drugs

***This is not a complete list of all eligible goods and services. If a particular item or service is not listed, please contact Sheakley Customer Service (800.877.6630 or 125@sheakley.com) to determine the eligibility prior to incurring the expense.**



Items Requiring a Note / Ineligible Items

Items Requiring a Doctor's Note or Prescription

These items and services can only be covered when accompanied by a doctor's note or prescription. Items and services must be used to treat a specific medical condition.

Acid Controllers	Equipment, Supplies & Materials related to Physical or Mental Handicap	Nasal Strips or Sprays
Acne Medications	Expectorants	Nutritionist
Allergy & Sinus Medications	Feminine Anti-Fungal Treatments	Orthopedic Shoes (you may only be reimbursed for the extra cost over buying normal, non-orthopedic shoes)
Antacids	Fever-Reducing Medications	Pain Relievers (Pills, Creams, Gels)
Analgesics	Fiber Supplements	Personal Trainer Fees
Anti-Diarrheal Medication	First Aid Creams	Prenatal Vitamins (OTC)
Anti-Gas Products	Glucosamine & Chondroitin	Probiotics
Anti-Itch & Insect Bite Creams	Gym or Health Club Membership Fees	Respiratory Treatments (OTC)
Antihistamines	Hand Sanitizer	Sleep Aids and Sedatives
Antibiotic Ointment	Headache/Migraine Medications (OTC)	Stomach Remedies
Aspirin/Ibuprofen	Hemorrhoid Preparations	Supplements (including Vitamins)
Baby Rash Ointment & Cream	Hormone Therapy	Throat Lozenges
Cosmetic Surgery – covered only when treating a congenital abnormality, a personal injury resulting from an accident, trauma or disease	Laxatives	Toothache Relievers
Cough, Cold & Flu Medicine	Lip Products, medicated	Varicose Vein Treatment
Decongestants	Marriage Counseling	Visine and other medicated Eye Drops
Dietary or Herbal Medicines	Massage Therapy	Wart Removal Medication & Kits
Digestive Aids	Medicated Shampoos & Soaps (unless prescribed by a medical practitioner for a specific scalp/skin infection/condition)	Weight Loss Drugs
Ear Wax Removal Treatments	Menstrual Pain Relievers	Wigs (for hair loss due to disease)
Eczema Treatments	Motion Sickness Medications	Yeast Infection Medications

Ineligible Items & Services

These items are not eligible for reimbursement through the F.S.A.

Baby Formula	Exercise Equipment for general health	Personal Hygiene Products
Breast Implants (cosmetic)	Feminine Hygiene Products	Prepayments for Services
Burial Expenses	Facial Creams & Cleansers	Propecia/Rogaine for cosmetic hair growth
COBRA Premiums	Financing Charges	Premiums for Health Insurance
Concierge/Boutique Practice Fees	Home Drug Testing Kits	Special Foods
Cosmetic Surgery	Hot Tubs / Jacuzzis	Sports Drinks (Gatorade, Powerade, etc.)
Cosmetics	Household Help (Maid Service)	Suntan Lotion
CPR Classes	Illegal Operations, Treatments & Medicine	Tanning Salon Fees
Dehumidifier	Items Paid by Insurance	Teeth Whitening Kits
Dental Bleaching/Whitening	Late Fees	Toiletries
Diet Foods	Maternity Clothing	Toothpaste & Toothbrushes (electric or otherwise, even if a dentist recommends them)
Dietary Supplements (for general health)	Mattresses	Ultrasound (voluntary, not ordered)
Discount Plan Expenses	Missed/Cancelled Appointment Fees	Veneers (for cosmetic reasons)
Ear Piercing	Moisturizers	Warranties (for vision/hearing equipment)
Educational Classes	Newborn Care Classes	Wig Maintenance (for styling/cleaning)
Electrolysis / Hair Removal	Nursing Pillows	
Electronic Cigarettes	Nursing Home Fees	

***This is not a complete list of all eligible goods and services. If a particular item or service is not listed, please contact Sheakley Customer Service (800.877.6630 or 125@sheakley.com) to determine the eligibility prior to incurring the expense.**



The Dependent Care F.S.A.



The Dependent Care Flexible Spending Account allows participants to set aside pre-tax dollars to pay for eligible daycare, preschool, babysitting and certain care expenses for disabled or elderly parents.

The IRS considers dependent care expenses to be “predictable”, so, unlike the healthcare F.S.A., the full annual election is **not** available on the first day of the Plan Year. It’s a “pay-as-you-go” program where you can only be reimbursed the balance of your contributions at the time of your claim submission.

- **Daycare Expenses**
Childcare expenses incurred while both parents are working, actively seeking work or going to school full time are eligible for reimbursement. These expenses are covered until the child reaches the age of 13, at which time they are ineligible and the participant **MUST** cease participation in the Plan.
- **Pre-School Tuition**
Since this Plan is designed to reimburse expenses for care and not education, the IRS allows pre-school tuition to be reimbursed as it is not deemed to be educational. Once your child enters kindergarten, only before and after school programs and childcare are eligible for reimbursement.
- **Before and After School Care**
The cost of before and after school care is eligible for reimbursement as long as the care is custodial and not educational in nature.
- **Babysitting**
Care provided by a relative, friend or neighbor may be reimbursed as long as the care is work-related and not for personal/recreational reasons. The provider cannot be the participant’s child or stepchild who is under the age of 19 or someone that the participant claims on their taxes.
- **Camps**
Summer day camps are eligible to the extent that the primary purpose is custodial in nature and not educational. Programs specifically designed to tutor are not eligible for reimbursement. **Overnight camps and food costs associated with a camp are not eligible for reimbursement.**
- **Custodial and Elder Care**
These expenses may only be covered if they are **not** for medical care and the individual cared for spends at least 8 hours each day in the participant’s household.

Dependent Care Reimbursement

As indicated above, dependent care reimbursement differs from healthcare reimbursement in that it’s a “pay-as-you-go”, meaning that claims are only paid out based on the amount you’ve contributed to the Plan at the time of your submission. **Your full annual election is NOT available on the first day of the Plan Year.**

Example: If you submit a claim for \$500, but have only contributed \$250 to your account thus far, you will only be reimbursed a total of \$250 right now. However, as you continue to contribute to your account, additional reimbursements will be processed until the original claim amount is paid in full.

Dependent care reimbursements are based on date of service and **not** date of payment. If your provider requires you to pre-pay for care, you will only be reimbursed after that month has passed and the service is incurred. When submitting for reimbursement, we recommend that you break down each monthly expense into a weekly amount so that you can receive funds at the end of each week instead of the end of each month.



The Reimbursement Process



To ensure that reimbursements are processed as quickly and efficiently as possible, it's important to remember that there are certain IRS and Department of Labor guidelines regarding the F.S.A. claims process and the documentation provided with your claims.

Reimbursements are based on Date of Service, not Date of Payment

One of the biggest misconceptions is that if you pay for a service, it is eligible to be reimbursed. This isn't necessarily true. It is once a service has been rendered, regardless of whether or not payment has been made, that it becomes eligible for reimbursement.

Additionally, bills for services and items with dates in a previous Plan Year cannot be submitted for reimbursement with funds from the current Plan Year.

Please remember that all services for which you are seeking reimbursement **MUST** have been incurred while you were actively covered by the Plan. **Services incurred before or after your coverage period are ineligible for reimbursement.**

Providing correct Documentation ensures speedy Reimbursement

When submitting a claim for reimbursement, either online or manually, IRS regulations require that you provide third-party documentation for all expenses. A service invoice from the provider, a cash register receipt listing purchased items or an Explanation of Benefits (EOB) from your insurance provider are all acceptable forms of third-party documentation.

The documentation submitted with your claim **MUST** include the following:

1. **The Date of Service** (not the Date of Payment)
2. **The Specific Type of Service or Item Purchased**
3. **The Amount Paid or Owed** (proof of payment is not required)
4. **The Federal Tax ID or Social Security Number of the Provider** (Dependent Care Claims Only)

****Credit/debit card receipts, copies of checks, online payment confirmations and bank statements are not valid forms of documentation per IRS regulations.***

If a claim does not have the correct documentation, it will be denied and you will receive a notice in your online account providing the reason for the denial. You may then submit the required additional documentation for review. Please do not submit the claim again or it may be denied as a duplicate claim.

Payment Processing and Disbursement of Payments

In general, claims are processed for payment twice per week, on Wednesday and Friday (except for holidays or if your employer has an alternate processing schedule).

Any claims received Monday by 5:00pm EST are processed on Wednesday. Any claims received Wednesday by 5:00pm EST are processed on Friday. This is our guaranteed processing schedule, however claims may be processed more quickly depending on claim volume and the time of year.

Check reimbursements, if applicable, are mailed on the next business day immediately following the date of processing (except for holidays). Direct deposit reimbursements, if applicable, take 2 or 4 business days to post to your account, depending on the schedule chosen by your employer.



The \$500 Rollover



In October of 2013, the IRS issued Notice 2013-71 that changed the “Use It or Lose It” Rule to allow a limited amount of unused Healthcare F.S.A. funds to carry over into the Immediately following Plan Year.

Your employer has chosen to provide you with the \$500 Rollover option for your Flexible Benefit Plan. This allows you to carry over up to \$500.00 of unused funds at the end of the Plan Year into the next Plan Year. Funds that are rolled over can be used through the next Plan Year and any claims that are submitted will be reimbursed from carryover funds before using any current Plan Year funds.

Any amount left in the previous Plan Year, in excess of \$500.00, must be claimed by the end of the run-out period or they will be forfeit under the “Use It or Lose It” rule.

Although the rollover will happen on the first day of the new Plan Year, you may still submit claims for the previous Plan Year and be reimbursed from funds that were carried over, up until the last day of the run-out period.

****Please note that the \$500 Rollover applies only to unused Healthcare F.S.A. funds and does not apply to unused Dependent Care F.S.A. funds.***





Authorization for Direct Deposit Reimbursement

To set up direct deposit for your Flexible Spending Account, you may complete this form and submit it to Sheakley for processing OR you may log in to your online account and set it up there.

****If you currently have direct deposit set up with Sheakley, you do not need to submit a form for each new Plan Year.****

Account Information

Employer Name	Employee Name	Last 4 of SSN
Name of Bank	Routing Number (9 digits)	Account Number

This is a checking account.

This is a savings account.

**If possible, please attach a voided check with this completed form.
If you do not have a check, please confirm the routing and account numbers before sending.**

Acceptance of Terms

I authorize Sheakley Pension Administration to send Flexible Spending reimbursements electronically, or by any other commercially accepted method, to my account indicated above. I understand that payments may be delayed by bank closures due to national holidays.

If my banking information changes for any reason and at any time during my participation, I understand that I must provide this updated information to Sheakley. I understand that if a reimbursement is delayed due to outdated information, I will not hold Sheakley Pension Administration accountable.

PARTICIPANT SIGNATURE: _____ DATE: _____

Completed forms may be faxed to 513.326.8082 or emailed to 125@sheakley.com. If you have any questions, please contact us at 800.877.6630.

OFFICE USE ONLY

Date Received: _____

Entered By: _____ on _____

Verified by: _____ on _____



The F.S.A. Benefit Card



Your employer has chosen to provide you with the Sheakley benefits card as part of their F.S.A. program. The card provides instant reimbursement for eligible goods and services at point-of-sale, eliminating the need to submit manual claims. The card can be used to pay for eligible expenses including copays, prescriptions, hospital charges, dental procedures, vision exams, day care fees (if allowed by your employer) and parking/transit passes (if applicable to your Plan).

Although use of the card eliminates the need to submit a claim form, it does not mean that you won't have to submit documentation for any expenses paid for with the card. Due to your privacy rights, the information provided on card transactions is limited to the merchant information present in the card machine. If the nature of the transaction isn't apparent or could possibly be for an ineligible expense, IRS regulations require Sheakley to request documentation to substantiate (validate) the expense.

If a transaction requires additional documentation, you will receive and email with the request. Additional documentation must be provided within 30 days or the transaction will be deemed ineligible, your account suspended and your card blocked until you repay the Plan or submit the requested documentation. While the card is blocked, any manual claims submitted will offset the ineligible card swipe until it is "paid" in full.

Sheakley will not contact providers to obtain additional information on card transactions. It is the participant's responsibility to contact their providers and provide the documentation upon request.

Important Things to Remember about the Benefit Card

- When a completed card agreement is received, you will be provided with 2 cards (in the primary account holder's name) to use with the account when you enroll.
- If you wish to have more than 2 cards, you may request additional cards online.
- **Since all Benefit Card communication is done via email, a valid email address is required in order to receive a card.**
- If your card is lost, a replacement can be requested online.
- When you use your card for any transaction over \$50.00, make sure to obtain a receipt or invoice showing the date of service, type of service and amount swiped on the card in case additional documentation is requested.
- If you opt-in via your online account, you will receive an email confirmation each time you use your card. If you feel a transaction is fraudulent, you must notify Sheakley as soon as possible. We cannot remove the charge from your account, but we can provide you with information on how to dispute the charge. **A fraudulent claim notice must be filed with the card company within 30 days of the original transaction.**
- **The Benefit Card is good for up to 3 consecutive Plan Years and should not be discarded at the end of the Plan Year or when you exhaust your funds.**



Benefit Card Enrollment Agreement

As a participant in your Employer's Flexible Benefit plan, you will receive a Benefit Card MasterCard benefits card issued by Benefit Bank and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used *exclusively* for Qualified Expenses as defined by the Plan(s) in which you participate. If the Card is issued pursuant to your Employer's Plan and you use the Card for an expense that is not a Qualified Expense, you are indebted to your Employer and must repay the full amount of the non-qualified expense.

You agree to obtain and save all invoices and receipts related to any expense paid with the Card. Upon request, you agree to submit these documents for review by the Plan Service Provider (Sheakley). Failure to submit the receipt(s) in the allowed timeframe will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your Employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck or other option(s) established by your Employer.

**For proper Cardholder identification, please complete the following information.
Your card will not be issued until this completed form is received. ALL FIELDS ARE REQUIRED.**

Employer Name The City of Avondale			
Name on Primary Card (please print)			
Address	City	State	ZIP Code
Email Address (REQUIRED ; forms without a valid email address will not be processed)			

By signing below, you acknowledge that you have read, understand and agree to the terms and conditions regarding the use of the card as described above.

PARTICIPANT SIGNATURE: _____ DATE: _____

If you currently have a Benefit Card, you are not required to complete this form.

****The Benefit Card is good for 3 consecutive Plan Years and should not be discarded at the end of the Plan Year or when funds are exhausted.****



Online Account Registration Instructions

To: City of Avondale Flexible Benefits Participants

Below are instructions to register your online Flexible Benefits account once you have enrolled in the Plan and the Plan Year has started. This is a password-protected website where you can keep up with various benefit news and information, including your Account Balance, Claims Submitted and Year-to-Date Payments. It is highly recommended that you register your account as soon as possible because the majority of Sheakley's communication to participants is done via this website.

To register your account and log in for the first time, follow the steps below.

- Go to <https://sheakleyCDHee.lh1ondemand.com/Login.aspx>

1. Under "Existing User?" enter your username and temporary password in the fields provided and click **LOGIN**.

- a. Your **username** is your first initial + your last name + the last 4 digits of your SSN. (example: jsample1234)
- b. Your **temporary password** is the last 5 digits of your SSN + your first name + your Zip Code + your last name. (example: 01234john45246sample)

Existing User?
Login to your account

Username [Forgot Username?](#)

Password [Forgot Password?](#)

2. Next, please choose 3 security questions and enter the answers in the fields provided and the click **NEXT**.
3. You will then be prompted to create a password of your own. Once done, click **SUBMIT**.

***Passwords must have a minimum of 6 characters, not be one of your last 3 passwords, contain upper and lowercase letters and contain at least one number.**

You are now logged into the Sheakley FSA portal!

If you have any questions or are unable to register, please call Customer Service any time Monday through Friday from 8:00am – 5:00pm EST at 800.877.6630.



F.S.A. Enrollment Form

Section 1: Participant Data

Please write legibly using black ink.

Employee Name (First/Last)			Social Security # (REQUIRED)	
Home Address		City	State	ZIP Code
Hire Date	Birth Date	Email Address (REQUIRED)		
Employer Name The City of Avondale			Division	

Section 2: Elections

Enter the amount(s) you wish to be withheld for your Annual Election(s). Determine the Per Pay Contribution amount by dividing your Annual Election by the number of pay periods in the Plan Year. Also enter the date of the first paycheck in which a deduction will be withheld.

Plan Year: 7/1/2018 – 6/30/2019	Annual Election	# of Pay Periods	Per Pay Contribution	Eff. Paycheck Date
Healthcare Reimbursement (Annual Limit: \$2,650.00)	\$		\$	
Dependent Care Reimbursement (Annual Limit: \$5,000 per household or \$2,500 if married, filing separately)	\$		\$	

Section 3: Pre-Tax Premiums

I understand that my insurance premiums, for benefits offered by my employer only, will be deducted on a pre-tax basis unless I note otherwise, in writing, to my Human Resources Office.

Section 4: Plan Information

Please read the following regarding this enrollment. If you do not wish to participate in the Flexible Benefit Plan, sign the declination line below. If you wish to enroll in the Flexible Benefit Plan, sign the participation line.

I wish to participate in and deposit funds into a Flexible Spending Account (F.S.A.) as show above. I understand that my election may not be terminated or changed unless I have a qualifying life event as outlined by the IRS. I understand that all claims must be for services provided (not paid) during my coverage period. I further understand that the IRS requires a forfeiture of any remaining balance in my account as of the last day of the run-out period in which I am allowed to submit claims. I understand that, upon termination of my coverage (due to a qualifying life event or termination of employment), I cannot continue to incur additional expenses and that I may only submit claims for services performed prior to my effective termination date. Upon termination of my Healthcare Flexible Spending Account, I may be able to elect COBRA to continue my coverage. In order to receive reimbursement from this account, I must complete and sign a claim form and attach all necessary documentation for myself, my spouse and/or my dependent(s). I understand the plan provisions that have been outlined in the Summary Plan Description available to me from my employer.

In addition, I understand that, if I have a Health Savings Account (H.S.A.), it is my responsibility to review the F.S.A. plan information to ensure my eligibility to participate in both the H.S.A. and the F.S.A. If my plan allows for participation in both, I understand that I can only submit dental and vision expenses to my F.S.A. until my deductible has been met.

PARTICIPATION SIGNATURE: _____ DATE: _____

Waiver: At this time, I wish to waive participation in the Flexible Benefit Plan.

DECLINATION SIGNATURE: _____ DATE: _____

All Enrollment Forms must be submitted to your HR or Benefits Department for processing. **Do not send directly to Sheakley.**

EMPLOYER SIGNATURE: _____ DATE: _____



DECLARATION OF DOMESTIC PARTNERSHIP

I. Declaration

We, _____ and _____, each
(print or type employee name) (print or type name)
certify and declare that we are domestic partners meeting all of the following requirements:

- a. We currently reside together in an exclusive mutual commitment similar to marriage and have done so for at least the last 12 consecutive months and each intend to continue the relationship indefinitely;
- b. We are not married to each other or any other individual (statutory or common law), and neither of us is a member of another domestic relationship;
- c. We are both at least 18 years of age;
- d. We are not related by blood or a degree of closeness which would prohibit marriage under the laws of the State of Arizona;
- e. Each of us is the other's sole domestic partner and is responsible for the other's common welfare;
- f. We are jointly responsible for basic living expenses;
- g. We were both mentally competent to consent to contract when the domestic partnership began and remain so for purposes of contracting for domestic partner health insurance coverage or the dependent life insurance benefit;
- h. We are financially interdependent, jointly responsible for the other's basic living expenses and are able to provide documents providing at least three of the following situations to demonstrate that such interdependence has existed for a minimum of the last 12 consecutive months:
 1. Joint mortgage, joint property tax identification or joint tenancy on a residential lease;
 2. Joint bank, investment or credit account;
 3. Joint liabilities (e.g., credit cards, car loans);
 4. Joint ownership of real property of a common leasehold, interest in real property, such as a residence or business, or common ownership of an automobile;
 5. A will which designates the other as the primary beneficiary or a beneficiary designation form currently in effect for a retirement plan or life insurance policy setting forth that one partner is the beneficiary of the other;
 6. Designation of one partner as holding power of attorney for health care or durable property for the other; and/or

7. Written agreement(s) or contract(s) regarding your relationship showing mutual support obligations.

III. Change in Domestic Partnership

We understand and agree that we have an obligation to notify the Arizona Metropolitan Trust (AzMT), in writing, if any of the above criteria are no longer met. Examples of changes that could affect eligibility for coverage of one or more of the domestic partners and any eligible children include:

- a. Termination of the domestic partnership through death or dissolution;
- b. A change in one of the domestic partner's residence;
- c. A change in the financial interdependence as described above; or
- d. Loss of employment of the eligible employee.

III. Dependent Children of the Non-Eligible Employee Domestic Partner

We understand and agree that the following dependent child(ren) (print name(s) of the child(ren) of domestic partner) _____ of _____ (print name of non-eligible employee domestic partner) are eligible for coverage if the child(ren) meet(s) the following criteria:

- a. Unmarried;
- b. Primarily dependent on the domestic partner for support (meaning over half of their support for the calendar year was received from the domestic partnership);
- c. Living with the domestic partners in a regular parent child relationship; and
- d. Is/are defined as an eligible child by the Internal Revenue Code Section 152.

IV. Acknowledgements

- a. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in the Declaration or for failure to notify AzMT of changed circumstances as required above. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify AzMT of changed circumstances affecting eligibility for coverage for my domestic partner and their children may lead to disciplinary action against me, including discharge from employment
- b. We have provided the information in this Declaration for use by AzMT for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand that the information provided in this Declaration will be treated as confidential by AzMT but will be subject to disclosure: 1) upon the express written authorization of one or both of the undersigned; or 2) as required by law.

- c. We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.
- d. We understand and agree that AzMT will send Explanation of Benefits for medical services received to the employee for all covered members under the insurance contract and that such Explanation of Benefits may contain personal, private and confidential information.

We affirm under penalty of perjury, that the statements in this Declaration are true and correct.

EMPLOYEE

DOMESTIC PARTNER

(Last, First, MI)

(Last, First, MI)

Signature

Signature

Social Security No.

Social Security No.

Common Residence Address (Street, City, State, Zip)

Mailing Address (Street, City, State, Zip)

State of Arizona)
ss.)
County of _____)

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20____.

by _____ and _____.

Notary Public

My Commission Expires:



DOMESTIC PARTNER TAX ACKNOWLEDGEMENT

I, _____ (employee) acknowledge and understand that the medical benefits provided to my domestic partner and/or children or my domestic partner will be treated as taxable income to me unless my domestic partner and/or children of my domestic partner qualifies as a dependent under Section 152 of the Internal Revenue Code.

Employee Signature: _____

Date: _____

Domestic Partner Signature: _____

Date: _____