University of Massachusetts Amherst

Checklist for New Postdoctoral Employees

***Mandatory payroll forms*:**

- ☐ Personal Data Questionnaire
- ☐ Voluntary Self-Identification of Veterans
- ☐ State and Federal Tax Forms
  Note: international employees will receive an e-mail regarding the University's Glacier international tax information program. Please use that program to help us ensure taxes are withheld appropriately.
- ☐ Statement of Conditional Employment
- ☐ I-9 Confirmation of Identity & Eligibility to work in the United States
- ☐ Direct Deposit Form (you may attach a voided check for verification of account information)
- ☐ Statement Concerning Your Employment in a Job Not Covered by Social Security
- ☐ Voluntary Self-Identification of Disability

Insurance-related forms:

☐ UMass/PostDoctoral Health Insurance Enrollment form
AND
☐ Premium Deduction Authorization form

OR

☐ I am waiving my option to purchase Health Insurance

I have received, read, understood and acknowledge my responsibility to conduct myself consistent with University and Commonwealth requirements outlined online (https://bit.ly/UMA_Policies). Policies received include, but are not limited to, the following:

- Principles of Employee Conduct; Policy Against Intolerance; UMass Statement on Bullying
- Policy Against Discrimination, Harassment and Related Interpersonal Violence
- Drug Free Workplace Policy; Tobacco Free Campus Policy; Firearms and Weapons Policy
- Policy on Fraudulent Financial Activities
- Policy on Consensual Relationships
- Overview of Health Insurance Marketplaces (ACA)
- Public Records: Your Responsibilities as a Public Employee
- Summary of the Conflict of Interest Law for State Employees
- Affirmative Action and Equal Opportunity Statement
- Equal Employment Opportunity notices
- Family Medical Leave Act, MA Pregnant Workers Fairness Act, Small Necessities Leave Act & Employment Leave to Address an Abusive Situation notices
- MA Right to Know Workplace Notice
- Export Control Policy & related employee obligations
- MA Earned Sick Time & MA Paid Family and Medical Leave notices

☐ I acknowledge receipt of the PFML notice **or** ☐ I decline to acknowledge receipt of the PFML notice

I hereby request a printed copy of the policies listed above ☐ Provided on _____ by _____

I hereby acknowledge that:

- I have read and understand the attached and referenced materials.
- Following receipt of my first University payment I will log onto the HR Direct system (from umass.edu/humres) to verify receipt of the attached Summary of the Conflict of Interest Law for State Employees.
- Based on Massachusetts law, I have thirty (30) days from my date of hire in order to complete the mandatory Massachusetts State Ethics Commission on-line training program.
- Within the first six months of employment I will register for, and attend, the Harassment Prevention and the Introduction to Anti-Bullying workshops.

Links to the required training are available on-line at: http://www.umass.edu/humres/new-employee-required-workshops

_____ _____
Signature Date

_____ _____
Printed Name Employing Department

University of Massachusetts Amherst

EmplID _____ Rcd ____
Please leave this field blank if you are a first-time UMass employee.

Personal Data Sheet

General Employee Information

Name: _____ Date of Birth:
First Middle Initial Last Suffix Month Day Year

Gender: ☐ Female ☐ X ☐ Male

Highest Level of Education Completed:

- ☐ Less than High School Graduate
- ☐ High School Grad/Equivalent
- ☐ Technical School
- ☐ Some College (Undergraduate)
- ☐ Associate's Degree (2 year college)
- ☐ Bachelor's Degree
- ☐ Some Graduate School
- ☐ Master's Degree
- ☐ Ph.D.
- ☐ Professional Degree (e.g. MD, JD, DDS)

List the schools you have attended beyond high school. Include business, technical, military, professional, college, & university.
Please begin by listing your *highest* level of education.

School Name	Major	Degree or Certificate	Year Awarded

Personal Information

Marital Status: ☐ Married ☐ Single

Social Security Number ___ ___ ___ ___ ___ ___ ___ ___ ___
Leave this field blank if you do not yet have an SSN

Home Address:
Number Street Apt #
City State Postal Code Country (if not U.S.A.)

Mailing Address: (if different)
Number Street Apt #
City State Postal Code Country (if not U.S.A.)

Home Telephone: _____

***Voluntary* disclosure/self identification of race/ethnicity:** Please answer *both* questions:

1) Do you consider yourself Hispanic or Latino? ☐ Yes ☐ No

2) Please select one or more of the following racial categories to describe yourself:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander

Please also complete second page of this form and sign & date at the bottom >>>

EmplID _____ Rcd ____

***Voluntary* selection of pronouns:** you can update chosen pronouns in HR Direct at any time when your employment record is active. Please feel free to choose one of the following:

- ☐ she/her
- ☐ xe/xem
- ☐ he/she (he/him & she/her)
- ☐ he/ze (he/him & ze/zir)
- ☐ she/xe (she/her & xe/xem)
- ☐ they/xe (they/them & xe/xem)
- ☐ xe/ze (xe/xem & ze/zir)
- ☐ name only
- ☐ he/him
- ☐ ze/zir
- ☐ he/they (he/him & they/them)
- ☐ she/any (she/her or any pronoun)
- ☐ she/ze (she/her & ze/zir)
- ☐ they/ze (they/them & ze/zir)
- ☐ ze/any (ze/zir or any pronoun)
- ☐ choose not to disclose
- ☐ they/them
- ☐ he/any (he/him or any pronoun)
- ☐ he/xe (he/him & xe/xem)
- ☐ she/they (she/her & they/them)
- ☐ they/any (they/them or any pronoun)
- ☐ xe/any (xe/xem or any pronoun)
- ☐ any pronoun

Pronouns selected here will be reflected in HR Direct. For more information about these pronouns and where this data appears please refer to the HR Direct Employee Data webpage (www.umass.edu/hr/benefits-and-pay/hr-direct-employee-data).

Emergency Contact(s) – who should be notified in case of emergency?

Primary Emergency Contact

Name : _____
(first name, last name)

Relationship to you: _____

Address: ☐ Same address as employee

_____

_____

Telephone number: ☐ Same phone as employee

_____

Secondary Emergency Contact (optional)

Name : _____
(first name, last name)

Relationship to you: _____

Address: ☐ Same address as employee

_____

_____

Telephone number: ☐ Same phone as employee

_____

Privacy & Confidentiality of your personal information: Under the University's Fair Information Practices Regulations (Doc. T77-059), you may request that certain personal data, regarded as "Directory Information," *not* be disseminated to anyone other than University personnel or where required by statute, court order, or legitimate University purpose.

Do you want to ***restrict*** dissemination of your personal data?

☐ Yes ☐ No

If yes, please check each personal data item you would like to ***restrict***:

- ☐ Home Address
- ☐ Home Phone Number
- ☐ Marital Status
- ☐ Date of Birth

Social security number, citizenship, and education are either: a) automatically restricted unless dissemination is required by statute/regulation/legitimate University purpose, or b) not maintained on the employee data base.

_____ _____

Signature Date Signed

University of Massachusetts Amherst

EmplID _____
Please leave this field blank if you are a first-time UMass employee.

Voluntary Identification of Gender Identity

General Employee Information

Legal Name: _____ Date of Birth: _____
First Middle Last Suffix Month Day Year

***Voluntary* gender identity:** you can update gender identity in HR Direct at any time after your employment record is activated. Please feel free to choose one of the following:

☐ Agender	An individual who identifies as not having a gender. Agender people may identify as neutrois, genderless, or gender neutral, having an unknown or indefinable gender, or deciding not to label their gender.
☐ Cisgender (non-trans) man	An individual who identifies as a man and was assigned male at birth.
☐ Cisgender (non-trans) woman	An individual who identifies as a woman and was assigned female at birth.
☐ Demigender	An individual who feels a partial connection to a particular gender identity. Examples of demigender identities include demigirl, demiboy, and demiandrogyne.
☐ Genderfluid	An individual whose gender varies over time. A genderfluid person may at any time identify as male, female, genderless, or any nonbinary gender identity, or as some combination of gender identities.
☐ Genderqueer	An umbrella term and a specific identity for an individual who identifies as neither male nor female (but as another gender), as somewhere in between or beyond genders, or as a combination of genders.
☐ Nonbinary	An umbrella term and a specific identity for an individual who does not fit into traditional “male” and “female” gender categories. Nonbinary people include individuals who identify as bigender, genderfluid, genderqueer, pangender, and many additional genders.
☐ Questioning	An individual who is uncertain about how they identify their gender.
☐ Trans man	An individual who identifies as a man but was assigned female at birth.
☐ Trans woman	An individual who identifies as a woman but was assigned male at birth.
☐ I prefer not to respond	

_____ _____
Signature Date Signed

Voluntary Self-Identification of Veterans

Definitions

This employer is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

A "disabled veteran" is one of the following:

- A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
- A person who was discharged or released from active duty because of a service-connected disability.

A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA—the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at 1-866-4-USA-DOL.

Self-Identification

As a Government contractor subject to VEVRAA, we are required to submit a report to the United States Department of Labor each year identifying the number of our employees belonging to each specified "protected veteran" category. If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. If you are not a veteran, select box 1 OR select the box(s) that apply to your veteran status.

☐ I am not a veteran. (I did not serve in the military.)

☐ I belong to the following classifications of protected veterans (Choose all that apply):

- ☐ DISABLED VETERAN
- ☐ RECENTLY SEPARATED VETERAN Military Discharge Date (MM/DD/YYYY): _____
- ☐ ACTIVE WARTIME OR CAMPAIGN BADGE VETERAN
- ☐ ARMED FORCES SERVICE MEDAL VETERAN

☐ I am NOT a protected veteran. (I served in the military but do not fall into any veteran categories listed above.)

☐ I choose not to identify my veteran status.

_____ _____

Your Name / Z# Today's Date

Voluntary Self-Identification of Veterans

Reasonable Accommodation Notice

If you are a disabled veteran it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations. This information will assist us in making reasonable accommodations for your disability.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

FORM M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 11/19

Print full name ..... Social Security no. .....

Print home address..... City..... State..... Zip .....

Employee:

File this form with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" .....
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C. ....
3. Write the number of your qualified dependents. See Instruction D. ....
4. Add the number of exemptions which you have claimed above and write the total. .....
5. Additional withholding per pay period under agreement with employer $_____

A. ☐ Check if you will file as head of household on your tax return.

B. ☐ Check if you are blind. C. ☐ Check if spouse is blind and not subject to withholding.

D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed $8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

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

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. The more exemptions you claim on this certificate, the less tax withheld from your employer. If you claim more exemptions than you are entitled to, civil and criminal penalties may be imposed. However, you may claim a smaller number of exemptions without penalty. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income. Underwithholding may result in owing additional taxes to the Commonwealth at the end of the year.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholdingg exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a spouse, write "4" in line 2. Entering "4" makes a withholding system adjustment for the $4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
University of Massachusetts Amherst **181 President's Dr, 325 Whitmore Admin. Bldg.** **Amherst, MA 01003**		**04-6002284**

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. 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.

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; 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 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

University of Massachusetts Amherst
Division of Human Resources
325 Whitmore Administration Building
181 President's Drive
Amherst, MA 01003-9313

Required Statement of Conditional Employment

I, _____, understand that this employment offer and my subsequent employment at the University on _____ (today's date) are conditioned upon my authorization and successful completion of a background check, including the following information:

- satisfactory professional reference checks, including verification of present and prior employment
- verification of academic credentials
- verification of any stated and/or required licenses or certifications
- criminal background check
- Any necessary additional checks requested by the Hiring Authority (e.g. credit, motor vehicle)

The University of Massachusetts Amherst has contracted with Creative Services, Inc. (CSI) to conduct its background checks. CSI will contact you directly for additional information and authorization.

By signing this conditional job offer, I attest that the information provided to the University during the selection process is true and accurate to the best of my knowledge and that I understand that falsification of any such information, whenever it is discovered, could result in termination. I understand if I do not satisfactorily complete my background check prior to starting employment this offer will be withdrawn. I also understand that if I commence employment it will be conditioned on successful completion of a background check and I will be terminated if the background check is not successfully completed.

_____ _____

Signature Date

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
University of Massachusetts Amherst	325 Whitmore Bldg. 181 Presidents Dr. Amherst MA 01003

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

University of Massachusetts Amherst

Direct Deposit Authorization Form

Bring completed form with Picture ID to Room 325 Whitmore Admin. Bldg.

ID verified:_____

EmplID: _____

Your EmplID is the 8-digit number appearing on your pay statement.

Name (Last Name, First Name): _____,_____

Phone: _____ E-mail:_____

Please write clearly. Note: the following direct deposit will overwrite all prior direct deposit information on record and you will receive an e-mail confirming when the information has been processed into HR Direct.

Action Requested (check one) ☐ Start Direct Deposit ☐ Change* (add/delete a bank, increase/decrease fixed amount or select new balance acct.)

Bank Name	Routing #: / Acct#:			
_____	_____ / _____	☐ Checking or ☐ Savings	☐ Full Deposit or ☐ Fixed Amount: $ _____	☐ Balance Account Deposit any balance of net pay to this acct.

If depositing into more than one (1) bank you must choose one Balance Account.

Bank Name	Routing #: / Acct#:			
_____	_____ / _____	☐ Checking or ☐ Savings	☐ Full Deposit or ☐ Fixed Amount: $ _____	☐ Balance Account Deposit any balance of net pay to this acct.
Bank Name _____	Routing #: _____ / Acct#: _____	☐ Checking or ☐ Savings	☐ Full Deposit or ☐ Fixed Amount: $ _____	☐ Balance Account Deposit any balance of net pay to this acct.
Bank Name _____	Routing #: _____ / Acct#: _____	☐ Checking or ☐ Savings	☐ Full Deposit or ☐ Fixed Amount: $ _____	☐ Balance Account Deposit any balance of net pay to this acct.

I authorize the University of Massachusetts to deposit my net pay via direct deposit into the account(s) indicated above. If funds to which I am not entitled are deposited into my account(s), I authorize the University to direct the financial institution(s) to return said funds.

I understand it is my responsibility to verify that payments have been credited to my account(s) and that the University assumes no liability for overdrafts for any reason. I understand that in the event my financial institution(s) is/are not able to deposit any electronic transfer into my account due to any action I take, the University cannot reissue funds to me until the funds are returned to the University by my financial institution(s).

I understand this authorization will override any previous authorization and will remain in effect until replaced by an updated direct deposit authorization.

I understand I must immediately notify University Human Resources before I close any/all account(s) listed above while this authorization is in effect.

Employee Signature: _____ Date: _____

Bring the completed Direct Deposit Authorization form with a picture ID to:
Human Resources, 325 Whitmore Administration Building
Questions? Call the HR Operations Team at 413.545.3761 or 413.545.0391

Tips for Completing the Direct Deposit Form

Action Requested:

- Start — To initiate your first direct deposit with the University.
- Change — To add or delete a bank account, increase or decrease a fixed amount, and/or change the Balance Account. Allow at least one (1) payperiod for the change to take effect. A change replaces all direct deposit account information and authorizations on file. Please complete all rows of information.

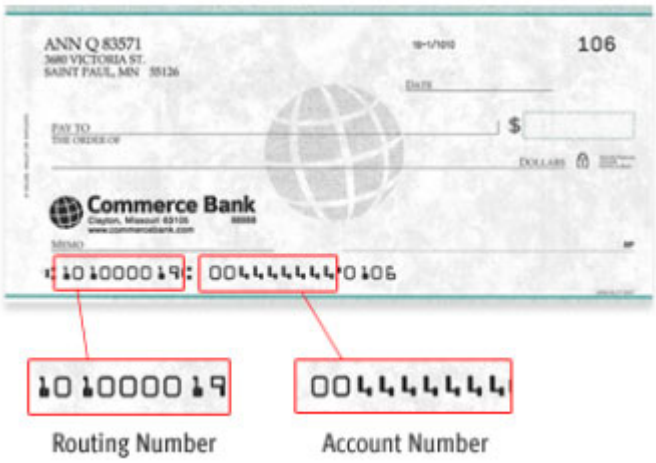
Deposit Options:

Your entire net pay must be direct deposited (full or partial payment via check & partial payment via Global Cash Card are not allowed). There are two deposit options available:

1. Deposit 100% of your net pay into one checking or savings account.
2. Assign a fixed dollar amount to go into as many as four (4) different banks with one bank as the Balance Account.

Account Information

- Please provide the name of each banking institution.
- Routing # - enter the nine digit Electronic/Paper ABA Routing number (NOT the Wire Transfer Routing number).
- Indicate if the account is a checking or savings account



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

Employee Name _____ **Social Security#** xxx-xx-____

Employer Name University of Massachusetts Amherst **Employer ID#** 04-6002284

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ **Date** _____

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

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

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

Employers must:

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

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

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

Additional Information for Individuals Employed by the University of Massachusetts Amherst

Optional Retirement Program
Social Security Administration Windfall Elimination Provision and Government Pension Offset calculations for Commonwealth Optional Retirement Program (ORP) members account are based on the balance of the ORP account at the time Commonwealth employment ends. We recommend that ORP members obtain an account balance statement from their vendor at the time Commonwealth employment ends and retain this document for Social Security purposes.

Exemption from Windfall Elimination Provision
Individuals with 30+ years of significant earnings under Social Security, or who were first eligible to retire from the Massachusetts, State Employees Retirement System prior to January 1, 1986, are currently exempt from the Windfall Elimination Provision. Social Security,s definition of "significant earnings" changes yearly (e.g. significant earnings is defined as $5,100 in 1980, $16,725 in 2005.) Please contact Social Security directly to confirm your years of significant earnings. http://www.ssa.gov/pubs/10045.html#exceptions.

Contact Information for Local Social Security Offices:
Social Security Administration
200 High Street, 2nd Floor
Holyoke, MA 01040
Telephone: (413) 536-3649 TTY: (413) 534-0901

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: Date:

Employee ID:
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- ☐ Yes, I have a disability, or have had one in the past
- ☐ No, I do not have a disability and have not had one in the past
- ☐ I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: Date of Hire:

Postdoctoral Employee Health Insurance

New PostDoctoral employees employed in a half-time or greater (50^{+}%) position covered by the University's collective bargaining agreement with the PostDoctoral Researchers Organizing (PRO/UAW) are eligible to enroll in health insurance effective their first day of employment.

Information about the PostDoctoral health insurance plan appears under Health Insurance benefits on the Human Resources website.

Eligible employees can enroll by submitting an enrollment form and a premium deduction authorization form to UMass Amherst Human Resources upon hire, during spring open enrollment for coverage effective the following July 1 or within 60 calendar days of a qualifying event (eg, involuntary loss of coverage under another health insurance plan).

Coverage can be provided to one's spouse, dependent child/ren and (effective July 1, 2023) domestic partner. Supporting documentation is required to establish coverage for an eligible dependent. Premiums are payroll deducted twice monthly.

Level of Coverage	Twice monthly premium eff. July 1, 2023	Twice monthly premium eff. July 1, 2024	Supporting documentation required
Employee only	$54.04	$51.34	
Employee and Child/ren	$97.04	$73.75	Proof of relationship for each covered child, eg certificate of birth or adoption, is required.
Employee and Spouse/Domestic Partner	$134.63	$102.31	Proof of Marriage / Domestic Partnership Agreement is required.
Employee, Spouse/Domestic Partner and Child/ren	$231.67	$176.07	Proof of Marriage / Domestic Partnership Agreement and proof of relationship for each covered child, eg certificate of birth or adoption, are required.

University of Massachusetts Amherst

Office of Human Resources

PostDoctoral Health Insurance Plan
Premium Payment Agreement Form

Name: _____ HR EmplID: _____

E-Mail Address: _____ Tel. Phone #: _____

☐ I am a PostDoctoral employee of the University of Massachusetts Amherst thus:

1. I hereby authorize the University of Massachusetts to withhold all employee contributions consistent with my health insurance enrollment on a pre-tax basis through payroll deduction.

2. Employee contributions will not be withheld if I have insufficient income in a pay period to cover the required contribution in addition to other required deductions (e.g. OBRA retirement). If the contributions are not withheld, I remain responsible for making timely payment(s) to the University in order to maintain my coverage intact.

3. I acknowledge that health insurance premiums and employee contributions are subject to change based on the health insurance contract and the University's bargaining agreement with the union representing my University position.

☐ I am a Postdoctoral Research Fellow at the University of Massachusetts Amherst. I acknowledge my portion of the health insurance premium will be charged to my fellowship at the University in order to secure and retain coverage:

Speedtype:	Fund:
Finance Dept. ID:	Sponsored Project Number:

If you are uncertain about any of these identifiers please obtain this information from your faculty sponsor or department's fellowship contact.

Signature: _____ Date: _____

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transfering To:
University of Massachusetts Amherst	2357680	

Current BCBS ID #, If any	Requested Effective Date (MM DD YYYY)	Date of Hire (MM DD YYYY)	Current Dental Group #:	Dental Group #, Transferring To

Type of Transaction
❒ ADD ❒ CANCEL
❒ CHANGE Three digit
❒ TRANSFER termination code ☐☐☐

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

❒ Open Enrollment ❒ New Hire ❒ COBRA

Change to Family ❒ Add Spouse ❒ Add Dependent

❒ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
❒ Other: _____

2. Yourself (Member 1)

What products? ❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England ❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue ❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group) ❒ Network Blue ☑ PPO ❒ Saver Blue

Membership Type (Medical) ❒ Individual ❒ Family

Membership Type (Dental) ~~❒ Individual ❒ Family~~

Your First Name	M.I.	Last Name	Sex	Date of Birth

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Home Phone ( )	Cell Phone (	Email

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	City / State

PCP ID # (see instructions) (not required)	Name of PCP (not required)	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Divorced Spouse (court ordered) Plan Type: ❒ Medical ❒ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone (	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	City / State

PCP ID # (see instructions) (not required)	Name of PCP (not required)	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions) (not required)	Name of PCP (not required)

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions) (not required)	Name of PCP (not required)

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions) (not required)	Name of PCP (not required)

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Please check if you are using separate forms for additional dependent children ☐ Total # of dependents: _____

5. Personal Savings Account

6. Signature (Employer & Employee)

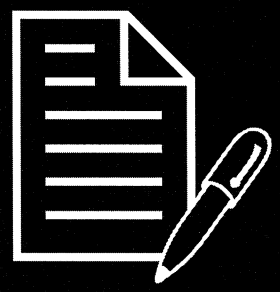
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

MASSACHUSETTS

Enrollment Form



Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

Before You Begin

Please read the instructions carefully.

For members of HMO Blue,® Network Blue,® Blue Choice,® HMO Blue New England,℠ or Blue Choice New England℠: You are required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting **www.bluecrossma.com** and selecting **Find a Doctor.**

For Access Blue℠ Members: Although you are not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

Important: Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance. Please be sure to circle either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Section 2 and 3. If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

Print two copies, one for your records and one for your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you are seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298

147569MB
36-3630

Instructions

Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

Type of Transaction—Check the box(es) that apply.

Subscriber Cancellation Codes. If the subscriber will not be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling
041	• Changing to other health plan • Voluntary termination • COBRA cancellation (under 18 months or nonpayment)
042	• Over 65, changing to Group Medex® plan. (Requires Medicare A and B) • Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) • Over 65, changing to Medicare supplement other than Medex plans.
043	• Medicare (age =< 65)

Code #	Reason for Canceling
061	• Left employment • COBRA ending
063	• Transfer
064	• Cancellation as of original effective date
070	• Deceased
071	• Moved out of state (out of HMO service area)
076	• Military service

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if person lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions contact your account service representative.
- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., Court Order, Adoption, New Dependent Law under HCR, Legal Guardianship, etc.). Include supporting documentation. If you have questions contact your account service representative.

Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID#—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (***not*** the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at **1-800-821-1388**. A representative will be happy to help you select a doctor. PCP ID number can be found at **www.bluecrossma.com**, select **Find a Doctor**.

Other Insurance—Do you have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*)) in the correct box. If you have other insurance, please write the name of the other insurance company and its location (city and state).

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Member 2

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an **Individual** membership.)

Other Insurance—Does your spouse have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If your spouse has other insurance, please write the name of the other insurance company and its location (city and state).

Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a **Family** membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: Dependents cannot be covered under an **Individual** membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

For each option:

Start Date: Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated and submitted the completed application for these accounts on or before that date.

End Date: Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions please see your employer.

Note: If you are transferring from one medical/dental plan to another medical/dental plan, please provide notification that you will be continuing your personal savings account by completing Section 5 of the Enrollment and Change form.

Section 6 Signatures (Employer & Employee)

Employee: Please sign & date the application and return it to your employer. Employer: Please sign & date the application and return to Blue Cross Blue Shield of Massachusetts.

(REQUIRED)* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

POSTDOC EMPLOYEE BENEFITS 2024-25

UAW/ UMass HEALTH & WELFARE TRUST FUND

Apply for benefits at portal.hwtf.org/login within the first 30 days of employment to avoid waiting periods. Benefits are made possible through a provision in your union contract. Postdocs are eligible for benefits from the Trust Fund while employed and for 30 days after employment ends. After the 30 days, Postdocs are eligible to apply for COBRA continuation coverage.

Dental & Vision Insurance

- FREE for you/ inexpensive for families
- 100% coverage for dental exams, x-rays and 4 cleanings/yr
- Free vision exam; $150 contact & $185 frame benefit
- Nationwide network of providers

Reimbursements

- $150 wellness reimbursement for gyms, equipment & more
- $90K+ fund available to reimburse families for childcare
- Prepaid rock climbing, yoga, massage therapy & outdoor memberships

Extras

- Free MetLife prepaid legal plan
- Free $10K Basic Life Insurance Policy
- Free access to the Calm app & Daily Burn
- Free access to MetLife's financial wellness

BENEFITS SOCIAL Aug 29, 2024 4-6pm Old UMass Chapel
Free food – ask questions – sign up for benefits
prizes – meet new folks

New Employee Informational Session

Please attend as an opportunity to meet with PRO/UAW Local 2322 union representatives and to learn about the UAW Health and Welfare Trust benefits available to you.

Date	Time	Location
Tuesday, September 24, 2024	10:00am-11:00am	Campus Center room 805-9
Tuesday, October 15, 2024	10:00am-11:00am	Campus Center room 805-9
Tuesday, November 19, 2024	10:00am-11:00am	Campus Center room 805-9
Tuesday, December 17, 2024	10:00am-11:00am	Campus Center room 805-9
Tuesday, January 21, 2025	10:00am-11:00am	Campus Center room 805-9
Tuesday, February 18, 2025	10:00am-11:00am	Campus Center room 805-9
Tuesday, March 18, 2025	10:00am-11:00am	Campus Center room 805-9
Tuesday, April 15, 2025	10:00am-11:00am	Campus Center room 805-9
Tuesday, May 20, 2025	10:00am-11:00am	Campus Center room 805-9
Tuesday, June 17, 2025	10:00am-11:00am	Campus Center room 805-9
Tuesday, July 15, 2025	10:00am-11:00am	Campus Center room 805-9
Tuesday, August 19, 2025	10:00am-11:00am	Campus Center room 805-9
Tuesday, September 16, 2025	10:00am-11:00am	Campus Center room 805-9

FICA/OBRA

The Federal Insurance Contribution Act (FICA) is a mandatory Social Security and Medicare contribution paid by everyone receiving a paycheck in Massachusetts. FICA withholdings are 1.45% of gross pay.

The Omnibus Budget Reconciliation Act (OBRA) is a mandatory employee funded retirement contribution plan for all part-time, seasonal and temporary employees in Massachusetts. OBRA withholdings are 7.50% of gross pay.

Graduate student employees receiving a paycheck in graduate hourly and/or graduate assistantship positions *will* have FICA/OBRA deductions made from their paychecks, *unless they qualify for an exemption*.

Exemptions:

During the academic year, graduate student employees are *exempted* from FICA/OBRA withholdings if:

- They are enrolled half-time or more, that is *6 or more credits*, OR
- They are enrolled in *1-5 credits with full or half time status declared* and reported by the academic department. [This is submitted by the academic department to the Graduate Student Service Center.]

During the summer*, graduate student employees are exempted from FICA/OBRA withholdings if:

- They are enrolled in *6 or more credits* through *Continuing Education*, OR
- They are enrolled in *1-5 credits* through *Continuing Education* *with full or half time status declared* and reported by the academic department. [This is submitted by the academic department to the Graduate Student Service Center.]

*Summer registration must be completed by May 15, to qualify for the exemptions.

No Exemptions:

Graduate student employees who are not enrolled through Continuing Education during the summer, are *not* eligible for FICA/OBRA exemptions.

Other instances where graduate student employees do **NOT** qualify for FICA/OBRA exemptions:

- Graduate student employment work exceeds 34 hours/week, OR
- Graduate student employee is registered for Continuous Enrollment (Program Fee).

International students on J-1 or F-1 visa status *are exempt* from FICA/OBRA withholdings regardless of the number of credit hours they are enrolled in or whether their employment work exceeds 34 hours/week, *until* they have been present in the U.S. for more than 4 calendar years.

Late Summer Enrollment in Continuing Education credits, i.e. after May 15, and/or **late submission** by the academic department, i.e. after May 15, declaring enrollment status override may make you ineligible for FICA/OBRA exemptions. Please notify the Graduate Assistantship Office (GAO) as soon as possible of your change in enrollment and to request the FICA/OBRA exemption. Exemptions are not guaranteed and will not be retroactive.

Massachusetts Deferred Compensation SMART Plan

PARTICIPATE

OBRA INFORMATION GUIDE

Basic facts about OBRA and the Massachusetts Deferred Compensation SMART Plan

As a part-time, seasonal or temporary employee of the Commonwealth of Massachusetts — or a part-time, seasonal or temporary employee of a participating Massachusetts local government employer not eligible to participate in the employer's retirement program or not covered under a Section 218 Agreement — you are required to participate in the Massachusetts Deferred Compensation SMART Plan (SMART Plan).[1] The SMART Plan is an alternative to Social Security as permitted by the federal Omnibus Budget Reconciliation Act of 1990 (OBRA). OBRA, passed by the U.S. Congress, requires that beginning July 1, 1991, employees not eligible to participate in their employer's retirement program be placed in Social Security or another program meeting federal requirements. The SMART Plan meets those federal requirements.

Mandatory contributions

As an OBRA employee, you must contribute at least 7.5% of your gross compensation per pay period to the SMART Plan. This contribution is deducted on a pretax basis, reducing your current taxable income. This means that you will not pay any tax on this money until it is distributed from your account.

Your human resources or payroll center representative will provide you with an OBRA Mandatory Participation Agreement. Please complete and return the form to either your human resources or payroll center representative.

Investment option

The qualified default investment option (QDIA) for OBRA mandatory accounts is the SMART Capital Preservation Fund. The SMART Capital Preservation Fund is designed to help protect your principal and maximize potential earnings. Your account will earn interest based upon the prevailing rates for this type of investment. Mandatory contributions may not be transferred out of the SMART Capital Preservation Fund.[2]

Additional information regarding the SMART Capital Preservation Fund may be obtained online at **www.mass-smart.com** > *Investing* > *Investment Options* or via the SMART Plan Service Center at **877-457-1900**.

Carefully consider the investment option's objectives, risks, fees and expenses. Contact Empower for a prospectus, summary prospectus for SEC-registered products or disclosure document for unregistered products, if available, containing this information. Read each carefully before investing.

All mandatory contributions to the Massachusetts Deferred Compensation SMART Plan – Mandatory OBRA will be invested in the SMART Capital Preservation Fund unless an election is made into SMARTPath Retirement Funds or Empower Advisory Services. To learn more about these investment options, visit the **OBRA page** on the SMART Plan **website**.

Voluntary contributions

You may make additional contributions (voluntary contributions) above the mandatory contribution of 7.5% of compensation per pay period. Any voluntary contributions that you elect to make may be invested among the SMART Plan's wide array of investment options and are freely transferable among options in accordance with the terms of the SMART Plan. OBRA voluntary contributions will not be charged an additional administrative fee.

To set up voluntary contributions or to learn more, please contact your local SMART Plan Retirement Plan Advisor by calling **877-457-1900** and saying "representative."

Account management

Once you are enrolled in the SMART Plan, you will have access to your account 24 hours a day, seven days a week through the website at **www.mass-smart.com** or via the SMART Plan Service Center at **877-457-1900**. To register your account for the first time, click on the *REGISTER* button.

Through either the website or SMART Plan Service Center, you can:

- Obtain your account balance(s), allocations and transaction history.
- Obtain investment option information and returns.
- Update your beneficiary information as needed.

Statements

You will receive quarterly statements that show your contributions as well as any earnings, fees or distributions and the total value of your account. Please review your statement carefully to ensure your information is correct. It is extremely important that you keep the SMART Plan administrator advised of your current address.

To update your mailing or email address, call the SMART Plan Service Center at **877-457-1900** or visit **www.mass-smart.com**. Once you log in to your account, click on your name in the top right corner to update your personal account information.

Distributions

Distribution of your SMART Plan benefits can only be made upon:

- Severance from employment.
- Unforeseeable emergency (OBRA voluntary plan only).
- Attainment of age 59½.
- Your death.

Severance from employment occurs because of your voluntary or involuntary termination of employment. There is no early withdrawal penalty for taking a distribution of your account upon separation of service, regardless of your age.[2]

If you no longer work for the Commonwealth of Massachusetts or a Massachusetts local government employer, you may leave the assets in your OBRA account; take a lump-sum distribution (payable to you or to your beneficiary upon your death); or roll over your assets into another eligible employer-sponsored plan or traditional individual retirement account.

As with any financial decision, you are encouraged to discuss moving money between accounts, including rollovers, with a financial advisor and to consider costs, risks, investment options and limitations prior to investing.

A leave of absence is not a severance from employment. Also, a change from part-time to full-time employment, or any similar change, is not considered an event that could result in a distribution from the SMART Plan. Benefits attributable to your voluntary contribution account may be distributed under other options available in the SMART Plan.

You may elect to receive your distribution immediately upon severance from employment. For more information or to access a Distribution Request form, please contact the SMART Plan Service Center at **877-457-1900** or visit **www.mass-smart.com** > *About your plan* > *OBRA* > *Forms*.

Beneficiaries and death

If you die before receiving all of your SMART Plan assets, the funds will go to your designated beneficiary. If you do not designate a beneficiary, your funds will be paid to your estate and will be distributed in accordance with Massachusetts probate law. It is essential that you designate a beneficiary on the Enrollment form to ensure your assets will pass on as you intended.

Updating your beneficiary is quick and easy. There are two ways:

Online
Log in to the SMART Plan website at **www.mass-smart.com**. Then go to *My Accounts* > *Beneficiaries*.

Paper
Go to **www.mass-smart.com** > *About your plan* > *OBRA* > *Forms*. Click on the OBRA Mandatory Beneficiary Designation form. Mail or fax the completed form to the address or fax number provided on the form.

You will receive a written confirmation after your beneficiary information has been updated. It is extremely important that you keep the SMART Plan administrator advised of your beneficiary changes.

Converting to full-time status

If you become a permanent, full-time employee and at one time made contributions to an OBRA mandatory account, you may elect to transfer your OBRA mandatory account to your voluntary account in the SMART Plan. In order to take advantage of this option, you cannot be actively contributing to the OBRA mandatory plan. To implement this change or to learn more, please contact your local Retirement Plan Advisor by calling **877-457-1900** and saying "representative."

Service buyback

If you reach a point where you are no longer making OBRA mandatory contributions but you're still working for a Commonwealth of Massachusetts state agency or municipality, you may be eligible for a service buyback of your creditable years of service to your qualified governmental defined benefit retirement plan. Service buybacks may be funded from transferred assets from the OBRA mandatory and/or voluntary contribution accounts.

OBRA and Social Security

Distributions from payments from your OBRA plan may reduce Social Security benefits under the provisions of the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO). Additional information is available in footnote 1 below or on Form SSA-1945 available on the Social Security Administration website.

To obtain additional information, please call the SMART Plan Service Center at **877-457-1900** weekdays from 8 a.m. to 10 p.m. and Saturdays from 9 a.m. to 5:30 p.m. Eastern time.

Fees

Annual recordkeeping and communication fees are charged at the following rates:

Account balance under $1,000
- $12 annually per account

Account balance over $1,000
- $14.40 annually per account
- An annual administration fee of 0.13825% of your account balance not to exceed $125.00 annually

These fees are capped at $139.40 annually and assessed monthly.

1 The Social Security Administration website at www.socialsecurity.gov/form1945 reminds state and local governmental employers of the requirement under the Social Security Protection Act of 2004 to disclose the effect of the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO) to employees hired on or after January 1, 2005, in jobs not covered by Social Security. Some jobs may not be covered under Social Security because they are not subject to mandatory coverage and there is no Section 218 agreement that covers them. The GPO provision impacts the amount of Social Security benefits received as a spouse or as an ex-spouse. The WEP affects the retirement or disability benefits received under Social Security if an individual has worked for an employer who does not withhold Social Security taxes. The law requires newly hired public employees to sign a statement, Form SSA-1945, that they are aware of a possible reduction in their future Social Security benefit entitlement. A copy of Form SSA-1945 is available at www.socialsecurity.gov/form1945/SSA-1945.pdf.

2 Withdrawals may be subject to income tax.

Investing involves risk, including possible loss of principal.

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University of Massachusetts Amherst

Human Resources

University of Massachusetts Payroll Schedule

Pay Period Begin Date	Pay Period End Date	Paydate	No Insurance Deduction
11/03/24	11/16/24	11/22/24	
11/17/24	11/30/24	12/06/24	*
12/01/24	12/14/24	12/20/24	
12/15/24	12/28/24	01/03/25	
12/29/24	01/11/25	01/17/25	
01/12/25	01/25/25	01/31/25	
01/26/25	02/08/25	02/14/25	
02/09/25	02/22/25	02/28/25	
02/23/25	03/08/25	03/14/25	
03/09/25	03/22/25	03/28/25	
03/23/25	04/05/25	04/11/25	
04/06/25	04/19/25	04/25/25	
04/20/25	05/03/25	05/09/25	
05/04/25	05/17/25	05/23/25	
05/18/25	05/31/25	06/06/25	*
06/01/25	06/14/25	06/20/25	
06/15/25	06/28/25	07/04/25	
06/29/25	07/12/25	07/18/25	
07/13/25	07/26/25	08/01/25	
07/27/25	08/09/25	08/15/25	
08/10/25	08/23/25	08/29/25	
08/24/25	09/06/25	09/12/25	
09/07/25	09/20/25	09/26/25	
09/21/25	10/04/25	10/10/25	
10/05/25	10/18/25	10/24/25	
10/19/25	11/01/25	11/07/25	
11/02/25	11/15/25	11/21/25	
11/16/25	11/29/25	12/05/25	*
11/30/25	12/13/25	12/19/25	

University of Massachusetts Amherst
HR Direct Access Your Pay Statement Online

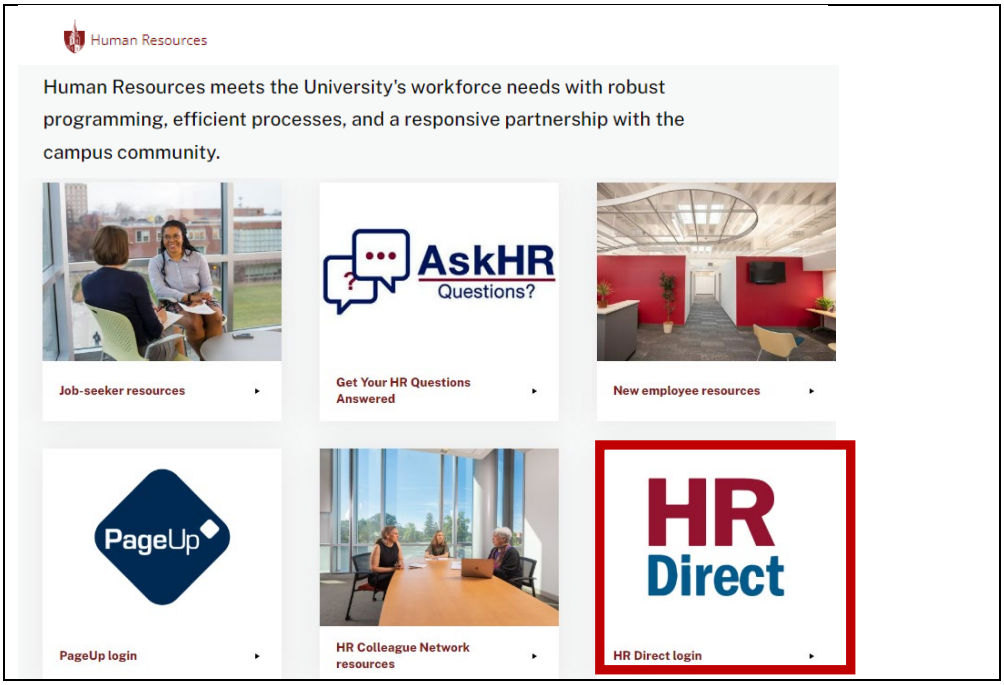
To access your UMass pay statement online you must:

1. Know your UMass NetID and password
2. Enroll in two-step multi-factor authentication (www.umass.edu/it/authentication) to access the University's payroll system, HR Direct
3. Disable your pop-up blockers for the HR Direct website in your internet browser to access your UMass pay statement as a PDF.

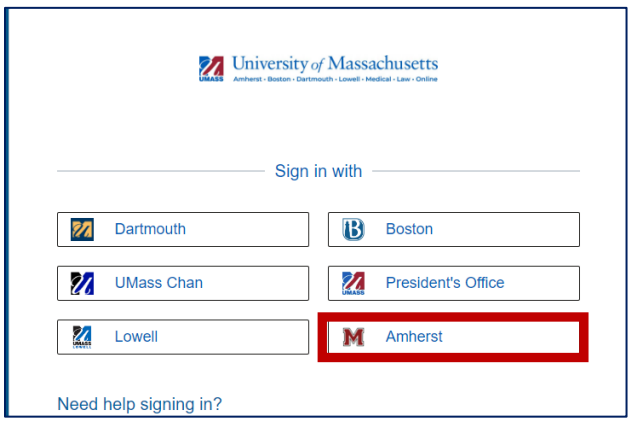
Please consult the University's Information Technology helpdesk (A109 Lederle Graduate Research Center/ telephone: 413-545-9400) if you require assistance with your NetID, authentication or pop-up blockers.

To access your UMass pay statement online:

Navigate to www.umass.edu/hr in an internet browser and click on "HR Direct Login"

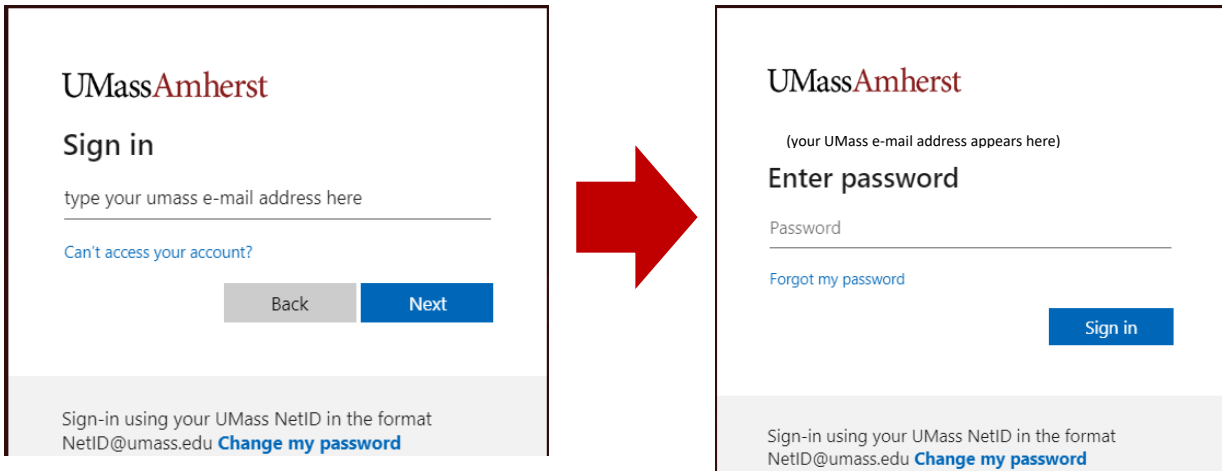


Click on "Sign in with"

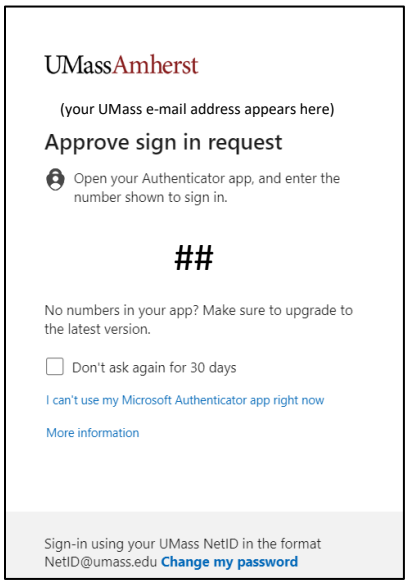


University of Massachusetts Amherst
HR Direct Access Your Pay Statement Online

Sign in using your University NetID & password (your SPIRE ID & password).



You will be prompted to **authenticate** your identity. Open your Authenticator app and enter the number that appears on the screen (sample below):

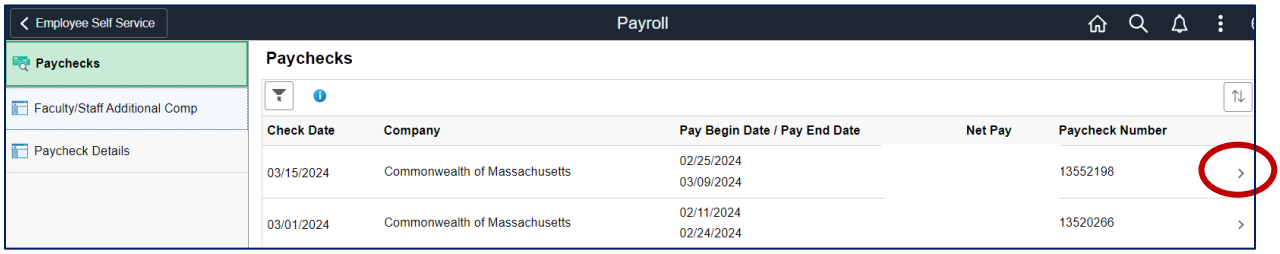


From the **Employee Self Service Homepage** select Payroll to access your pay statements:

University of Massachusetts Amherst
HR Direct Access Your Pay Statement Online

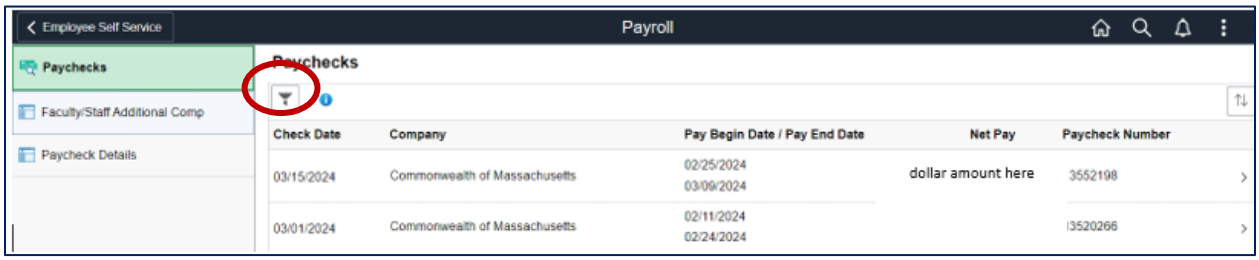
A list of pay statements will be displayed.

Click on the arrow to the right of the paycheck you wish to view:



Your bi-weekly paystatement will open as a PDF in a new window. If it does not, make sure you have disabled pop-up blockers for this website in your internet browser.

From this same screen you can also use the filter icon to view a different date range of paystatements:



Click on Paycheck Details to **view the details behind any pay statement** (rate of pay, hours paid, accrued time used, etc.)