

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:

AND UMass/PostDoctoral Health
Insurance Enrollment form
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 (www.umass.edu/humres/commonly-referenced-laws-and-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
- MA Earned Sick Time & MA Paid Family and Medical Leave notices
- 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

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

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Signature

Date

Printed Name

Employing Department

Personal Data Sheet

General Employee Information

Name: _____ Date of Birth: _____
 First Middle Last Suffix MM/DD/YYYY

Gender: Female Male

Highest Level of Education Completed:

- Less than High School Grad Some College (undergrad) Some Graduate School
 High School Grad/Equivalent Associate's Degree (2 Yr. College) Master's Degree
 Technical School Bachelor'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

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

Primary Emergency Contact _____

Secondary Emergency Contact (optional) _____

Name : _____
(first name, last name)

Name : _____
(first name, last name)

Relationship to you: _____

Relationship to you: _____

Address: Same address as employee

Address: Same address as employee

Telephone number: Same phone 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

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
Print home address.....

Social Security no.
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.

Date..... Signed

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.

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.**

2022

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents	If your 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 and enter the total here	3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$

Step 5: Sign Here

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

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

▶ **Date**

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
	University of Massachusetts Amherst 181 President's Dr, 325 Whitmore, 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 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 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, 2023.

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

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

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

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

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

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

Specific Instructions

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

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

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

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



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

Step 3. 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 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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



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

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

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
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
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
c Add the amounts from lines 2a and 2b and enter the result on line 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.
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)

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



- 1 Enter an estimate of your 2022 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
2 Enter: { \$25,900 if you're married filing jointly or qualifying widow(er), \$19,400 if you're head of household, \$12,950 if you're single or married filing separately }
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-"
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
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$110	\$850	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,770	\$1,870
\$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
\$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
\$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
\$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
\$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
\$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
\$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
\$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
\$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
\$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
\$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
\$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
\$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
\$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
\$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
\$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
\$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	\$400	\$930	\$1,020	\$1,020	\$1,250	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970	\$2,040	\$2,040
\$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
\$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
\$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
\$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
\$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
\$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
\$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
\$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
\$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
\$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
\$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
\$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
\$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
\$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	\$760	\$910	\$1,020	\$1,020	\$1,020	\$1,190	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040
\$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
\$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
\$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
\$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
\$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
\$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
\$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
\$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
\$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
\$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
\$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
\$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

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

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

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

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

Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State ZIP Code
Date of Birth <i>(mm/dd/yyyy)</i>	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date <i>(mm/dd/yyyy)</i>
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date <i>(mm/dd/yyyy)</i>	
Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>	
Address <i>(Street Number and Name)</i>		City or Town	State ZIP Code

STOP *Employer Completes Next Page* STOP



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

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

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name <i>(Family Name)</i>	First Name <i>(Given Name)</i>	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date <i>(if any) (mm/dd/yyyy)</i>		Expiration Date <i>(if any) (mm/dd/yyyy)</i>		Expiration Date <i>(if any) (mm/dd/yyyy)</i>
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date <i>(if any) (mm/dd/yyyy)</i>				
Document Title				
Issuing Authority				
Document Number				
Expiration Date <i>(if any) (mm/dd/yyyy)</i>				

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

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

Signature of Employer or Authorized Representative	Today's Date <i>(mm/dd/yyyy)</i>	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name University of Massachusetts Amherst	
Employer's Business or Organization Address <i>(Street Number and Name)</i> 181 Presidents Drive, 325 Whitmore Administration Building	City or Town Amherst	State MA	ZIP Code 01003

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

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

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

Document Title	Document Number	Expiration Date <i>(if any) (mm/dd/yyyy)</i>
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date <i>(mm/dd/yyyy)</i>	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

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) <input type="checkbox"/> Start Direct Deposit <input type="checkbox"/> Change* (add/delete a bank, increase/decrease fixed amount or select new balance acct.)				
Bank Name _____	Routing #: _____ Acct#: _____	<input type="checkbox"/> Checking or <input type="checkbox"/> Savings	<input type="checkbox"/> Full Deposit or <input type="checkbox"/> Fixed Amount: \$ _____	<input type="checkbox"/> 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#: _____	<input type="checkbox"/> Checking or <input type="checkbox"/> Savings	<input type="checkbox"/> Full Deposit or <input type="checkbox"/> Fixed Amount: \$ _____	<input type="checkbox"/> Balance Account Deposit any balance of net pay to this acct.
Bank Name _____	Routing #: _____ Acct#: _____	<input type="checkbox"/> Checking or <input type="checkbox"/> Savings	<input type="checkbox"/> Full Deposit or <input type="checkbox"/> Fixed Amount: \$ _____	<input type="checkbox"/> Balance Account Deposit any balance of net pay to this acct.
Bank Name _____	Routing #: _____ Acct#: _____	<input type="checkbox"/> Checking or <input type="checkbox"/> Savings	<input type="checkbox"/> Full Deposit or <input type="checkbox"/> Fixed Amount: \$ _____	<input type="checkbox"/> 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: _____

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.

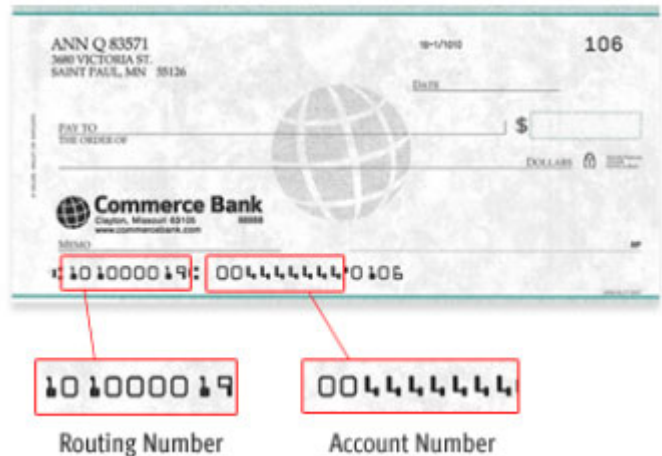
Deposit Options:

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 05/31/2023

Name: _____

Date: _____

Employee ID: _____
(if applicable) or last 4 of SSN

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, 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?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

- Yes, I Have A Disability, Or Have A History/Record Of Having A Disability
No, I Don't Have A Disability, Or A History/Record Of Having A Disability
- I Don't Wish 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, 2022) 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, 2021	Twice monthly premium eff. July 1, 2022	Supporting documentation required
Employee only	\$51.24	\$52.46	
Employee and Child/ren	\$92.01	\$94.21	Proof of relationship for each covered child, eg certificate of birth or adoption, is required.
Employee and Spouse/Domestic Partner (eff July 2021):	\$127.64	\$130.70	Proof of Marriage / Domestic Partnership Agreement is required.
Employee, Spouse/Domestic Partner (eff July 2021) and Child/ren	\$219.65	\$224.94	Proof of Marriage / Domestic Partnership Agreement and proof of relationship for each covered child, eg certificate of birth or adoption, are required.

**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

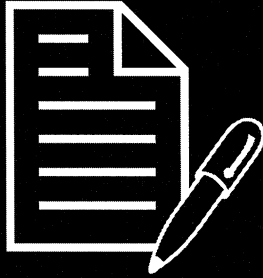
Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to 1-617-246-7531

1. To Be Filled Out by Your Employer			
Company Name University of Massachusetts Amherst		Current Medical Group #: 2357680	Medical Group #, Transferring To:
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 <input type="checkbox"/> ADD <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE Three digit termination code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TRANSFER		Remarks: (i.e., qualifying event for a new add, change to family or other instruction) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change to Family <input type="checkbox"/> New Hire <input type="checkbox"/> Add Spouse <input type="checkbox"/> COBRA <input type="checkbox"/> Add Dependent <input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter Required) <input type="checkbox"/> Other: _____	
2. Yourself (Member 1)			
What products? <input type="checkbox"/> Access Blue <input type="checkbox"/> Blue Medicare Rx (Part D) <input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Network Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> Dental Blue <input type="checkbox"/> Managed Blue for Seniors <input checked="" type="checkbox"/> PPO <input type="checkbox"/> Blue Choice New England <input type="checkbox"/> HMO Blue <input type="checkbox"/> Medex (Group) <input type="checkbox"/> Saver Blue		Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Membership Type (Dental) <input checked="" type="checkbox"/> Individual <input type="checkbox"/> 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 <input type="checkbox"/> / N <input type="checkbox"/>	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 <input type="checkbox"/> / N <input type="checkbox"/>
Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/>	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY Medicare # <input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date
3. Member 2 Please Check One: <input type="checkbox"/> Spouse <input type="checkbox"/> Divorced Spouse (court ordered) Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental			
First Name	M.I.	Last Name	Sex Date of Birth
Social Security # (REQUIRED) ¹	Phone ()	Other Insurance? ² Y <input type="checkbox"/> / N <input type="checkbox"/>	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 <input type="checkbox"/> / N <input type="checkbox"/>
Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/>	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY Medicare # <input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD 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 <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/>	Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> 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 <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/>	Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> 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 <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/>	Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental
Please check if you are using separate forms for additional dependent children <input type="checkbox"/>		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.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

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,SM or Blue Choice New EnglandSM: 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 BlueSM 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

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	Code #	Reason for Canceling
041	<ul style="list-style-type: none"> • Changing to other health plan • Voluntary termination • COBRA cancellation (under 18 months or nonpayment) 	061	<ul style="list-style-type: none"> • Left employment • COBRA ending
042	<ul style="list-style-type: none"> • 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. 	063	<ul style="list-style-type: none"> • Transfer
043	<ul style="list-style-type: none"> • Medicare (age < 65) 	064	<ul style="list-style-type: none"> • Cancellation as of original effective date
		070	<ul style="list-style-type: none"> • Deceased
		071	<ul style="list-style-type: none"> • Moved out of state (out of HMO service area)
		076	<ul style="list-style-type: none"> • 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.

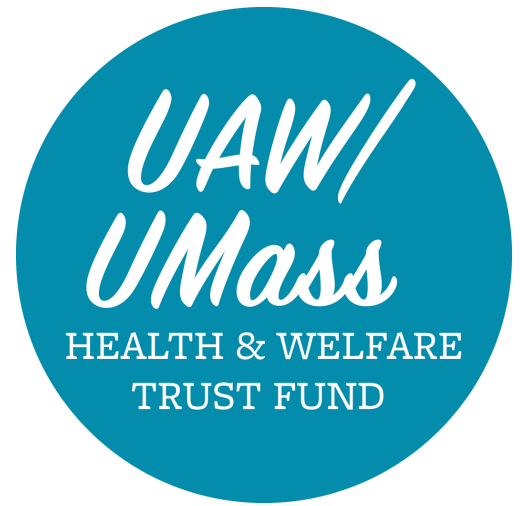
New Employee Informational Session

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
Thursday, September 15, 2022	10:30am-11:30am	Campus Center room 803
Thursday, October 13, 2022	10:30am-11:30am	Campus Center room 903
Thursday, November 17, 2022	10:30am-11:30am	Campus Center room 803
Thursday, December 15, 2022	10:30am-11:30am	Campus Center room 903
Thursday, January 12, 2023	10:30am-11:30am	Campus Center room 803
Thursday, February 16, 2023	10:30am-11:30am	Campus Center room 803
Thursday, March 16, 2023	10:30am-11:30am	Campus Center room 803
Thursday, April 13, 2023	10:30am-11:30am	Campus Center room 803
Thursday, May 11, 2023	10:30am-11:30am	Campus Center room 803
Thursday, June 8, 2023	10:30am-11:30am	Campus Center room 803
Thursday, July 6, 2023	10:30am-11:30am	Campus Center room 803
Thursday August 17, 2023	10:30am-11:30am	Campus Center room 803

2022-23

POSTDOC EMPLOYEE BENEFITS



Postdoc employees are beneficiaries of the Health & Welfare Trust Fund, a labor/mgmt fund providing dental & vision insurance, among other benefits. These plans are separate from your health plan and enrollment is not automatic. Apply for benefits at hwtrust.geouaw.org 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 as the employee
- Only \$10/month for single+1 plans and \$20/month for family plans
- 100% coverage for exams, x-rays and up to 4 cleanings per year
- \$2250 dental plan year maximum
- Coverage available for fluoride treatments, athletic mouth guards for children under 19 and teeth whitening (see plan description) **New!**
- Vision exam is just a \$10 copay
- \$150 contact benefit and \$175 frame benefit **New!**
- Nationwide network of providers
- Diabetic Eye Care Services **New!**

Reimbursements

- \$60K fund available to support families with childcare, after school, tutoring and summer camp costs

Extras!

- Free MetLife prepaid legal plan
- Free Basic \$10K Life Insurance Policy
- Optional prepaid rock climbing or massage therapy memberships (first come first served)
- Free access to the Calm app
- Free subscription to Daily Burn
- Up to \$250 in Outschool class fees for families



scan for more info

Benefits Fair: August 31, 11 am-3 pm
Student Union Ballroom

apply at hwtrust.geouaw.org

more info: uawumasstrustfund.org

OBRA Information Guide

S A V E M O N E Y A N D R E T I R E T O M O R R O W

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

All mandatory contributions to the SMART Plan will be invested in 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 objectives, risks, fees and expenses of the annuity and/or the investment options. Contact us for a prospectus, a summary prospectus and disclosure document, as available, containing this information. Read them carefully before investing.

Administrative Fee

There is a fee of \$14.10 per OBRA account, per annum, charged monthly. Fees are used to pay for administrative, recordkeeping, communication and investment education expenses.

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 at **877-457-1900** and say "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 an annual statement in January of each year showing 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 Plan administrator advised of your current address.

To update your address, call the SMART Plan Service Center at **877-457-1900** or visit www.mass-smart.com. Once you log into 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 70½.
- 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.

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 ordinary income tax.

Securities offered or distributed through GWFS Equities, Inc., Member FINRA/SIPC and a subsidiary of Great-West Life & Annuity Insurance Company.

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98966-02-03-FLY-386-1812 (20794)-OBGRAPH AM679190-1218

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 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 at **877-457-1900** and say “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 one below or on Form SSA-1945 available on the Social Security Administration website here: www.socialsecurity.gov/form1945/SSA-1945.pdf.

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



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.

University of Massachusetts Payroll Schedule

From	To	Paydate
07/18/21	07/31/21	08/06/21
08/01/21	08/14/21	08/20/21
08/15/21	08/28/21	09/03/21
08/29/21	09/11/21	09/17/21
09/12/21	09/25/21	10/01/21
09/26/21	10/09/21	10/15/21
10/10/21	10/23/21	10/29/21
10/24/21	11/06/21	11/12/21
11/07/21	11/20/21	11/26/21
11/21/21	12/04/21	12/10/21
12/05/21	12/18/21	12/24/21
12/19/21	01/01/22	01/07/22
01/02/22	01/15/22	01/21/22
01/16/22	01/29/22	02/04/22
01/30/22	02/12/22	02/18/22
02/13/22	02/26/22	03/04/22
02/27/22	03/12/22	03/18/22
03/13/22	03/26/22	04/01/22
03/27/22	04/09/22	04/15/22
04/10/22	04/23/22	04/29/22
04/24/22	05/07/22	05/13/22
05/08/22	05/21/22	05/27/22
05/22/22	06/04/22	06/10/22
06/05/22	06/18/22	06/24/22
06/19/22	07/02/22	07/08/22
07/03/22	07/16/22	07/22/22
07/17/22	07/30/22	08/05/22
07/31/22	08/13/22	08/19/22

University of Massachusetts Amherst HR Direct Access Your Pay Statement Online

Please note – you must enroll in two-step multi-factor authentication (www.umass.edu/it/authentication) and disable your pop-up blockers for these instructions to work. Please consult the University’s Information Technology helpdesk (A109 Lederle Graduate Research Center/ telephone: 545-9400) for help enrolling in two-step authentication or if you do not know your NetID and/or password.

In a web browser, navigate to www.umass.edu/humres and click on “HR Direct Login”

University of Massachusetts Amherst

Visit Apply Give

HR Direct Resources For Work Life Events HR Library

Human Resources

Employment Benefits Compensation Payroll HR Personnel Processing Labor Relations Training and Support Contact

Bringing Arts into the Community, and Creating Community through the Arts

Welcome to the UMass Amherst Office of Human Resources!
We are a team of HR professionals dedicated to providing quality service to both employees and campus departments. Please reach out with any questions you may have – we are here to serve!

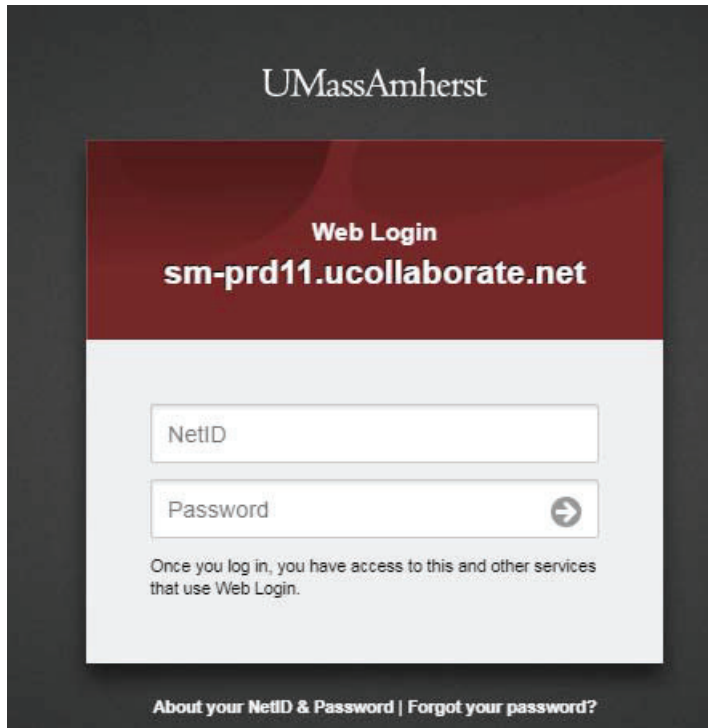
PageUp Login

HR Direct Login

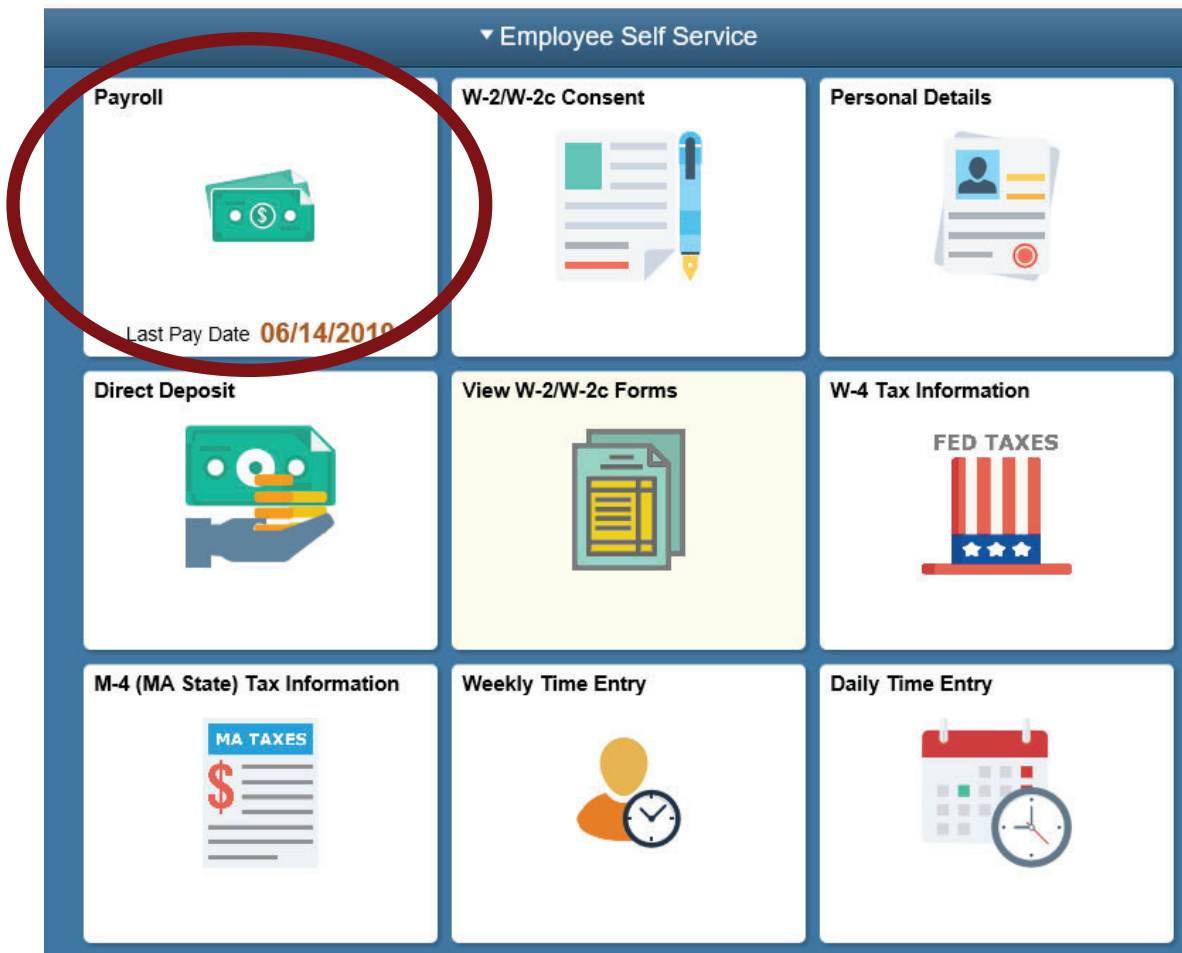
Executive Search

University of Massachusetts Amherst HR Direct Access Your Pay Statement Online

Login using your University NetID & password (your SPIRE ID & password).

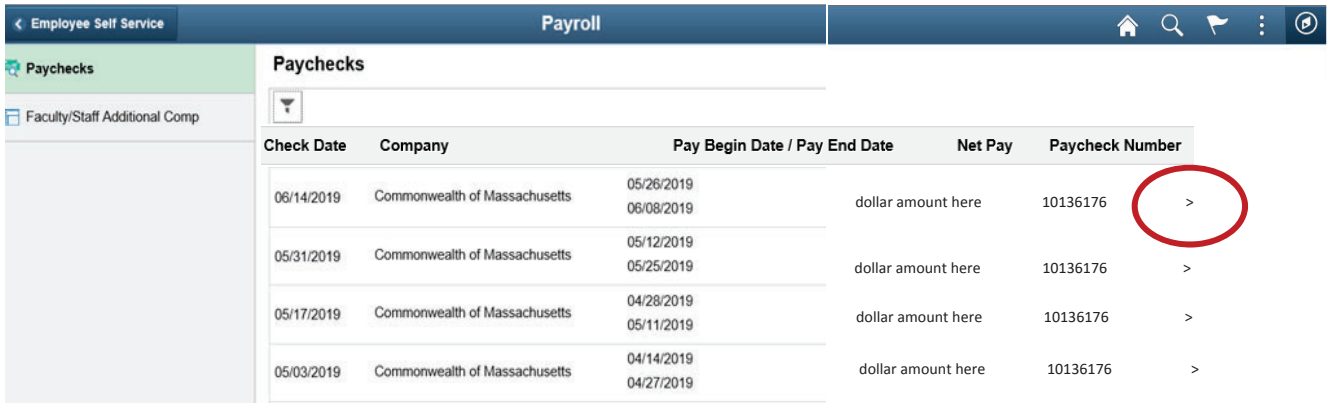


From the Employee Self Service Homepage select Pay to access your pay statements:



University of Massachusetts Amherst HR Direct Access Your Pay Statement Online

A list of paychecks will appear on screen. Click on the arrow to the right of the paycheck you wish to view:



Check Date	Company	Pay Begin Date / Pay End Date	Net Pay	Paycheck Number	
06/14/2019	Commonwealth of Massachusetts	05/26/2019 06/08/2019	dollar amount here	10136176	>
05/31/2019	Commonwealth of Massachusetts	05/12/2019 05/25/2019	dollar amount here	10136176	>
05/17/2019	Commonwealth of Massachusetts	04/28/2019 05/11/2019	dollar amount here	10136176	>
05/03/2019	Commonwealth of Massachusetts	04/14/2019 04/27/2019	dollar amount here	10136176	>

Your bi-weekly paystatement will appear as a PDF in a new window.

EARNED SICK TIME

Notice of Employee Rights

Beginning July 1, 2015, Massachusetts employees have the right to earn and take sick leave from work.

WHO QUALIFIES?

All employees in Massachusetts can earn sick time.

This includes full-time, part-time, temporary, and seasonal employees.

HOW IS IT EARNED?

- Employees earn 1 hour of sick time for every 30 hours they work.
- Employees can earn and use up to **40 hours per year** if they work enough hours.
- Employees with unused earned sick time at the end of the year can **rollover up to 40 hours**.
- Employees **begin earning** sick time on their first day of work and **may begin using** earned sick time 90 days after starting work.

WILL IT BE PAID?

- If an employer has 11 or more employees, sick time must be paid.
- For employers with 10 or fewer employees, sick time may be unpaid.
- Paid sick time must be paid on the same schedule and at the same rate as regular wages.

WHEN CAN IT BE USED?

- An employee can use sick time when the employee or the employee's child, spouse, parent, or parent of a spouse is sick, has a medical appointment, or to address the effects of domestic violence.
- The smallest amount of sick time an employee can take is one hour.
- Sick time cannot be used as an excuse to be late for work without advance notice of a proper use.
- Use of sick time for other purposes is not allowed and may result in an employee being disciplined.

CAN AN EMPLOYER HAVE A DIFFERENT POLICY?

Yes. An employer can have their own sick leave or paid time off policy, so long as employees can use at least the same amount of time, for the same reasons, and with the same job-protections as under the Earned Sick Time Law.

RETALIATION

- Employees using earned sick time cannot be fired or otherwise retaliated against for exercising or attempting to exercise rights under the law.
- Examples of retaliation include: denying use or delaying payment of earned sick time, firing an employee, taking away work hours, or giving the employee undesirable assignments.

NOTICE & VERIFICATION

- Employees must **notify** their employer before they use sick time, except in an emergency.
- Employers may require employees to **use a reasonable notification system** the employer creates.
- If an employee is out of work for 3 consecutive days **OR** uses sick time within 2 weeks of leaving their job, an employer may require documentation from a medical provider.

DO YOU HAVE QUESTIONS?

Call the Fair Labor Division at 617-727-3465 ○ E-Mail us at EarnedSickTime@state.ma.us

Visit www.mass.gov/ago/earnedsicktime



Commonwealth of Massachusetts
Office of the Attorney General

The Attorney General enforces the Earned Sick Time Law and regulations.

It is unlawful to violate any provision of the Earned Sick Time Law.

Violations of any provision of the Earned Sick time law, M.G.L. c. 149, § 148C, or these regulations, 940 CMR 33.00 shall be subject to paragraphs (1), (2), (4), (6) and (7) of subsection (b) of M.G.L. c. 149, §27C(b) and to §150.

This notice is intended to inform.

Full text of the law and regulations are available at www.mass.gov/ago/earnedsicktime.



**NOTICE AND ACKNOWLEDGEMENT
PAID FAMILY AND MEDICAL LEAVE LAW
MGL c. 175M**

In 2018, Massachusetts signed into law a statute that provides paid family and medical leave (PFML) benefits to public and private workers. That law requires covered employers to provide employees with notice of the benefits and the employer/employee contributions for the Paid Family Medical Leave program. The University of Massachusetts is providing you with this notice in order to comply with this requirement. [Options and instructions for how to acknowledge this notice are located at the bottom of this document.](#)

Explanation of Benefits

- **Beginning January 1, 2021,**
 - employees may be entitled to up to 12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child, or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces.
 - employees may be entitled to up to 20 weeks of paid medical leave in a benefit year if they have a serious health condition that incapacitates them from work.
 - employees may be entitled to up to 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member's military service.

- **Beginning July 1, 2021,**
 - employees may be entitled to up to 12 weeks of paid family leave in a benefit year to care for a family member with a serious health condition.

Employees may be eligible for up to 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year. An employee's weekly benefit amount will be based on the employee's earnings, with a percentage of wages up to a maximum benefit of \$850 per week.

Leave taken under M.G.L. c. 175M shall run concurrently with leave taken under other applicable state and federal leave laws, including but not limited to, the Commonwealth's Parental Leave Act (section 105D of M.G.L. c. 149), the federal Family and Medical Leave Act of 1993 (29 U.S.C. 2601 et seq.), as amended, when the leave is for a qualified reason under those acts.

In some instances, paid leave provided under a collective bargaining agreement or employer policy and paid at the same or higher rate than paid leave available under this law may count against the allotment of leave benefits available under this law.

Employer/Employee Contributions to the DFML Family and Employment Security Trust Fund

- On October 1, 2019, contributions to the Department of Family and Medical Leave (DFML) Employment Security Trust Fund will begin. An employer will be responsible for sending contributions to the DFML for all employees.
- Currently, the total contribution amount is 00.75% of wages. Of that 00.75% total contribution amount, there is a split: 17.5% is a family leave contribution and 82.5% is a medical leave contribution.
- Under the law, employers are permitted to deduct from employees' wages up to 40% of the medical leave contribution and up to 100% of the family leave contribution.
- As an employee of the University of Massachusetts, the Default Employee Share from your earnings is as follows:
 - 40% of the Medical Leave Contribution
 - 100% of the Family Leave Contribution

Your employer will contribute:

- 60% of the Medical Leave Contribution
- 0% of the Family Leave Contribution

Job Protection, Continuation of Health Insurance and No Retaliation

- **Job Protection:** Generally, an employee who has taken family or medical leave under the law must be restored to the employee's previous position or to an equivalent position, with the same status, pay, employment benefits, length-of-service credit and seniority as of the date of leave.
- **Continuation of Health Insurance:** The employer must continue to provide for and contribute to the employee's employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if the employee had continued working continuously for the duration of such leave.
- **No Retaliation:** It is unlawful for any employer to discriminate or retaliate against an employee for exercising any right to which such employee is entitled under the paid family and medical leave law. An employee or former employee who is discriminated or retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court.

How to File a Claim

- Employees must file claims for paid family and medical leave benefits with the DFML using the Department's forms. Forms and claim instructions will be available on the Department's website www.mass.gov/DFML before January 2021.
- Employees are required to provide at least 30 days' notice to their employer of the anticipated starting date of Paid Family Medical Leave, the anticipated length of the leave and the expected date of return. An employee who is unable to provide 30 days' notice due to circumstances beyond his or her control is required to provide notice as soon as practicable.

Contact Information

The Massachusetts Department of Family and Medical Leave

Charles F. Hurley Building
19 Staniford Street, 1st Floor Boston, MA 02114
(617) 626-6565
MassPFML@mass.gov

For more detailed information, please consult the Department's website: www.mass.gov/DFML.

For the purposes of this notification your employer is:

Commonwealth of Massachusetts
1 Ashburton Place Room 901
Boston, MA 02108
Employer ID# 04-6002284

Options and Instructions for Acknowledgement

You have three options for acknowledging receipt of this Notice:

1. Select the link to HR Direct that is embedded in the email that you received or log onto HR Direct and (insert instructions).
2. Print the portion of this document entitled "PFML Notice Acknowledgement Form", sign it, and mail it to the UMass Presidents Office, Human Resources Office, 333 South Street, Suite 400, Shrewsbury, MA 01545.
3. Print the portion of this document entitled "PFML Notice of Acknowledgement Form" and have it hand delivered to any of the locations listed below. You can also pick up a printed copy of the regulations and the acknowledgement form at these locations.

Drop-off Locations

Main Human Resources Office
325 Whitmore Building - 181 Presidents Drive

Auxiliary Enterprises Human Resources Office
918 Campus Center - 1 Campus Center Way

Physical Plant Human Resources Office
360 Campus Center Way Room 214