University of Massachusetts Amherst Checklist for New, GIC-Eligible Employees

Mandatory forms for payroll purposes:
- Personal Data Sheet
- State and Federal Tax Forms
  If you are an international employee you will receive an e-mail regarding the University's Glacier international tax information program.
- Statement of Conditional Employment
- I-9 Confirmation of Identity & Eligibility to work in the United States
- Statement Concerning Your Employment in a Job Not Covered by Social Security
- Direct Deposit Form

I have received, read, understood and acknowledge my responsibility to conduct myself consistent with University and Commonwealth policies, including but not limited to those attached:

- Principles of Employee Conduct and Policy Against Intolerance
- Sexual Harassment Policy & Procedures
- Your Responsibilities as a Public Employee
- Drug Free Workplace Policy
- Fraudulent Financial Activities Policy
- Information on health insurance availability through the Commonwealth Connector (ACA)
- Statement on Bullying
- Pedestrian Crosswalk Policy
- Summary of the Conflict of Interest Law for State Employees
- Smoke Free Policy
- Export Control Policy & corresponding employee obligations
- MA Right to Know Laws
- Notification of MA Ethics Commission on-line training requirement
- FICA/Medicare Deduction Memorandum
- Family Medical Leave Act (FMLA) and MA Pregnant Workers Fairness Act notices

I hereby acknowledge that:
- I have read and understood the attached materials.
- Once I have received my first pay statement from the University of Massachusetts Amherst, I must log onto the HR Direct system (from www.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 Intro 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 ___________________________
### Personal Data Sheet

#### General Employee Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Middle</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Male</td>
</tr>
</tbody>
</table>

#### Highest Level of Education Completed:

- [ ] Less than High School Grad
- [ ] High School Grad/Equivalent
- [ ] Technical School
- [ ] Some College (undergrad)
- [ ] Associate’s Degree (2 Yr. College)
- [ ] Bachelor’s Degree
- [ ] Some Graduate School
- [ ] Master’s Degree
- [ ] Ph.D.
- [ ] Professional Degree (e.g. MD, JD, DDS)

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

<table>
<thead>
<tr>
<th>School Name</th>
<th>Major</th>
<th>Degree or Certificate</th>
<th>Year Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Personal Information

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Married</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address: (if different)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**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

**Voluntary disclosure/self identification of Military Status:** Please answer both questions:

1) If you are a veteran and were discharged from active service within the last three (3) years, please provide your date of discharge: _______________________

2) Check all that apply:
   - [ ] Disabled Veteran
   - [ ] Armed Forces Service Medal Veteran
   - [ ] Vietnam Era Veteran
   - [ ] Other Protected Veteran
Citizenship Status:
- U.S. Native
- Naturalized
- Resident Alien
- Perm. Resident Card Holder
- Non-Resident Alien

If you are an international employee you will receive an e-mail regarding the University's Glacier international tax information program.

<table>
<thead>
<tr>
<th>Citizenship Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Native</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Primary Emergency Contact</th>
<th>Secondary Emergency Contact (optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (first name - last name)</td>
<td>Name (first name - last name)</td>
</tr>
<tr>
<td>Relationship to employee</td>
<td>Relationship to employee</td>
</tr>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>City, State, Postal Code</td>
<td>City, State, Postal Code</td>
</tr>
<tr>
<td>Telephone number</td>
<td>Telephone number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to employee</th>
<th>Same address as employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Same address as employee</td>
</tr>
<tr>
<td>City, State, Postal Code</td>
<td>Same telephone # as employee</td>
</tr>
<tr>
<td>Telephone number</td>
<td>Same telephone # as employee</td>
</tr>
</tbody>
</table>

Disability: defined, for these purposes, as a person who: 1) has a physical or mental impairment which substantially limits one or more of such person’s major life activities. 2) has a record of such impairment, or 3) is regarded as having such impairment affects employability.  

Yes ☐  No ☐

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 place restrictions on the 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.

Employee Signature ___________________________ Date Signed ____________
Form W-4 (2018)

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

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

Exemption from withholding. You may claim exemption from withholding for 2018 if both of the following apply.
• For 2017 you had a right to a refund of all federal income tax withheld because you had no tax liability, and
• For 2018 you expect a refund of all federal income tax withheld because you expect to have no tax liability.

If you’re exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions
If you aren’t exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you’re having withheld compares to your projected total tax for 2018. If you use the calculator, you don’t need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you’re married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Employee’s Withholding Allowance Certificate

Form W-4
Department of the Treasury Internal Revenue Service

2018

W-4

Employee’s Withholding Allowance Certificate

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

1 Your first name and middle initial

2 Last name

3 Home address (number and street or rural route)

3 City or town, state, and ZIP code

3 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.

4 Total number of allowances you’re claiming (from the applicable worksheet on the following pages)

4 Additional amount, if any, you want withheld from each paycheck

4 I claim exemption from withholding for 2018, and I certify that I meet both of the following conditions for exemption.

4 Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and

4 This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

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

Employee’s signature

This form is not valid unless you sign it.

Date

8 Employer’s name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)

9 First date of employment

10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 4.

Cat. No. 10220Q
your wages and other income, including income earned by a spouse, during the year.

**Line G. Other credits.** You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

**Deductions, Adjustments, and Additional Income Worksheet**

Complete this worksheet to determine if you’re able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You’re not required to complete this worksheet or reduce your withholding if you don’t wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at www.irs.gov/W4App. If you use the calculator, you don’t need to complete any of the worksheets for Form W-4.

**Two-Earners/Multiple Jobs Worksheet**

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don’t complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you’re entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero (“0-”) on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at www.irs.gov/W4App to make your withholding more accurate.

**Tip:** If you have a working spouse and your incomes are similar, you can check the “Married, but withhold at higher Single rate” box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the “Married, but withhold at higher Single rate” box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

**Instructions for Employer**

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

**New hire reporting.** Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn’t previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to www.acf.hhs.gov/programs/css/employers.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

**Box 8.** Enter the employer’s name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

**Box 9.** If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee’s first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer’s service for at least 60 days, enter the rehire date.

**Box 10.** Enter the employer’s employer identification number (EIN).
### Personal Allowances Worksheet (Keep for your records.)

<table>
<thead>
<tr>
<th></th>
<th>A Enter “1” for yourself</th>
<th>B Enter “1” if you will file as married filing jointly</th>
<th>C Enter “1” if you will file as head of household</th>
<th>D Enter “1” if:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>You’re single, or married filing separately, and have only one job; or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>You’re married filing jointly, have only one job, and your spouse doesn’t work; or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Your wages from a second job or your spouse’s wages (or the total of both) are $1,500 or less.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>E Child tax credit. See Pub. 972, Child Tax Credit, for more information.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If your total income will be less than $69,801 ($101,401 if married filing jointly), enter “4” for each eligible child.</td>
</tr>
<tr>
<td></td>
<td>If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter “2” for each eligible child.</td>
</tr>
<tr>
<td></td>
<td>If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter “1” for each eligible child.</td>
</tr>
<tr>
<td></td>
<td>If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter “-0-”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>F Credit for other dependents.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If your total income will be less than $69,801 ($101,401 if married filing jointly), enter “1” for each eligible dependent.</td>
</tr>
<tr>
<td></td>
<td>If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter “1” for every two dependents (for example, “-0-” for one dependent, “1” if you have two or three dependents, and “2” if you have four dependents).</td>
</tr>
<tr>
<td></td>
<td>If your total income will be higher than $175,550 ($339,001 if married filing jointly), enter “-0-”</td>
</tr>
</tbody>
</table>

|   | G Other credits. If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. |

<table>
<thead>
<tr>
<th></th>
<th>H Add lines A through G and enter the total here.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For accuracy, complete all worksheets that apply.</td>
</tr>
<tr>
<td></td>
<td>If you plan to itemize or claim adjustments to income and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the Deductions, Adjustments, and Additional Income Worksheet below.</td>
</tr>
<tr>
<td></td>
<td>If you have more than one job at a time or are married filing jointly and you and your spouse both work, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the Two-Earners/Multiple Jobs Worksheet on page 4 to avoid having too little tax withheld.</td>
</tr>
<tr>
<td></td>
<td>If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 above.</td>
</tr>
</tbody>
</table>

### Deductions, Adjustments, and Additional Income Worksheet

**Note:** Use this worksheet only if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

<table>
<thead>
<tr>
<th></th>
<th>1 Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 Enter:</td>
</tr>
<tr>
<td></td>
<td>$24,000 if you’re married filing jointly or qualifying widow(er)</td>
</tr>
<tr>
<td></td>
<td>$18,000 if you’re head of household</td>
</tr>
<tr>
<td></td>
<td>$12,000 if you’re single or married filing separately</td>
</tr>
<tr>
<td></td>
<td>3 Subtract line 2 from line 1. If zero or less, enter “-0-”</td>
</tr>
<tr>
<td></td>
<td>4 Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items).</td>
</tr>
<tr>
<td></td>
<td>5 Add lines 3 and 4 and enter the total</td>
</tr>
<tr>
<td></td>
<td>6 Enter an estimate of your 2018 nonwage income (such as dividends or interest)</td>
</tr>
<tr>
<td></td>
<td>7 Subtract line 6 from line 5. If zero, enter “-0-”. If less than zero, enter the amount in parentheses</td>
</tr>
<tr>
<td></td>
<td>8 Divide the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction</td>
</tr>
<tr>
<td></td>
<td>9 Enter the number from the Personal Allowances Worksheet, line H above.</td>
</tr>
<tr>
<td></td>
<td>10 Add lines 8 and 9 and enter the total. If zero or less, enter “-0-”. If you plan to use the Two-Earners/Multiple Jobs Worksheet, also enter this total on line 1, page 4. Otherwise, stop here and enter this total on Form W-4, line 5, page 1.</td>
</tr>
</tbody>
</table>
### Two-Earners/Multiple Jobs Worksheet

**Note:** Use this worksheet only if the instructions under line H from the Personal Allowances Worksheet direct you here.

1. Enter the number from the Personal Allowances Worksheet, line H, page 3 (or, if you used the Deductions, Adjustments, and Additional Income Worksheet on page 3, the number from line 10 of that worksheet) ................................................................. 1

2. Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However, if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don’t enter more than “3” ................................................................. 2

3. If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. Do not use the rest of this worksheet ....................................................... 3

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

4. Enter the number from line 2 of this worksheet ................................. 4

5. Enter the number from line 1 of this worksheet ................................. 5

6. Subtract line 5 from line 4 ................................. 6

7. Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here ................................. 7 $ 

8. Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed ................................. 8 $ 

9. Divide line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck ................................. 9 $ 

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Table 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Married Filing Jointly</strong></td>
<td><strong>All Others</strong></td>
</tr>
<tr>
<td>If wages from LOWEST paying job are—</td>
<td>Enter on line 2 above</td>
</tr>
<tr>
<td>$0 - $5,000</td>
<td>0</td>
</tr>
<tr>
<td>5,001 - 9,500</td>
<td>1</td>
</tr>
<tr>
<td>9,501 - 19,000</td>
<td>2</td>
</tr>
<tr>
<td>19,001 - 26,500</td>
<td>3</td>
</tr>
<tr>
<td>26,501 - 37,000</td>
<td>4</td>
</tr>
<tr>
<td>37,001 - 43,500</td>
<td>5</td>
</tr>
<tr>
<td>43,501 - 55,000</td>
<td>6</td>
</tr>
<tr>
<td>55,001 - 60,000</td>
<td>7</td>
</tr>
<tr>
<td>60,001 - 70,000</td>
<td>8</td>
</tr>
<tr>
<td>70,001 - 75,000</td>
<td>9</td>
</tr>
<tr>
<td>75,001 - 85,000</td>
<td>10</td>
</tr>
<tr>
<td>85,001 - 95,000</td>
<td>11</td>
</tr>
<tr>
<td>95,001 - 130,000</td>
<td>12</td>
</tr>
<tr>
<td>130,001 - 150,000</td>
<td>13</td>
</tr>
<tr>
<td>150,001 - 160,000</td>
<td>14</td>
</tr>
<tr>
<td>160,001 - 170,000</td>
<td>15</td>
</tr>
<tr>
<td>170,001 - 180,000</td>
<td>16</td>
</tr>
<tr>
<td>180,001 - 190,000</td>
<td>17</td>
</tr>
<tr>
<td>190,001 - 200,000</td>
<td>18</td>
</tr>
<tr>
<td>200,001 and over</td>
<td>19</td>
</tr>
</tbody>
</table>

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

You aren’t required to provide the information requested on a form that’s 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.
MASSACHUSETTS EMPLOYEE’S WITHHOLDING EXEMPTION CERTIFICATE

Print full name ....................................................... Social Security no. .......................................
Print home address .................................................. City....................... State ............... Zip ................

Employee:
File this form or Form W-4 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 .............................................................................

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. If you claim more than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. 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.

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 withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a wife or husband, write “4” in line 2. Using “4” is the 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.

IF THE ALLOWABLE MASSACHUSETTS WITHHOLDING EXEMPTIONS ARE THE SAME AS YOU ARE CLAIMING FOR U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.
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
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.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Last Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>Employee's E-mail Address</th>
<th>Employee's Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

1. A citizen of the United States
2. A noncitizen national of the United States (See instructions)
3. A lawful permanent resident (Alien Registration Number/USCIS Number):
4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy):

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number:
2. Form I-94 Admission Number:
3. Foreign Passport Number:

<table>
<thead>
<tr>
<th>Country of Issuance:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Signature of Employee

Today's Date (mm/dd/yyyy)

Preparer and/or Translator Certification (check one):

1. I did not use a preparer or translator.
2. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator

Today's Date (mm/dd/yyyy)

Employer Completes Next Page
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.")

<table>
<thead>
<tr>
<th>Employee Info from Section 1</th>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>M.I.</th>
<th>Citizenship/Immigration Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**List A**

- Document Title
- Issuing Authority
- Document Number
- Expiration Date (if any)(mm/dd/yyyy)

**List B**

- Document Title
- Issuing Authority
- Document Number
- Expiration Date (if any)(mm/dd/yyyy)

**List C**

- Document Title
- Issuing Authority
- Document Number
- Expiration Date (if any)(mm/dd/yyyy)

**Additional Information**

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

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

Signature of Employer or Authorized Representative ____________________________

Today's Date (mm/dd/yyyy) ____________________________

Title of Employer or Authorized Representative ____________________________

Last Name of Employer or Authorized Representative ____________________________

First Name of Employer or Authorized Representative ____________________________

Employer’s Business or Organization Name ____________________________

181 President's Drive, 325 Whitmore Administration Building, Amherst, MA 01003

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

A. New Name (if applicable)

- Last Name (Family Name) ____________________________
- First Name (Given Name) ____________________________
- Middle Initial ____________________________
- Date (mm/dd/yyyy) ____________________________

B. Date of Rehire (if applicable)

- Date (mm/dd/yyyy) ____________________________

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

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

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

Signature of Employer or Authorized Representative ____________________________

Today's Date (mm/dd/yyyy) ____________________________

Name of Employer or Authorized Representative ____________________________
LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

<table>
<thead>
<tr>
<th>LIST A</th>
<th>LIST B</th>
<th>LIST C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Documents that Establish Both Identity and Employment Authorization</strong></td>
<td><strong>Documents that Establish Identity</strong></td>
<td><strong>Documents that Establish Employment Authorization</strong></td>
</tr>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>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</td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>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</td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter's registration card</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>5. U.S. Military card or draft record</td>
<td>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</td>
</tr>
<tr>
<td>a. Foreign passport; and</td>
<td>6. Military dependent's ID card</td>
<td>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</td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td>4. Native American tribal document</td>
</tr>
<tr>
<td>(1) The same name as the passport; and</td>
<td>8. Native American tribal document</td>
<td>5. U.S. Citizen ID Card (Form I-197)</td>
</tr>
<tr>
<td>(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.</td>
<td>9. Driver's license issued by a Canadian government authority</td>
<td>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
</tr>
<tr>
<td>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</td>
<td><strong>For persons under age 18 who are unable to present a document listed above:</strong></td>
<td>7. Employment authorization document issued by the Department of Homeland Security</td>
</tr>
<tr>
<td></td>
<td>10. School record or report card</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Clinic, doctor, or hospital record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Day-care or nursery school record</td>
<td></td>
</tr>
</tbody>
</table>

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

Refer to the instructions for more information about acceptable receipts.
Direct Deposit Authorization Form

University of Massachusetts – Amherst

Please note: direct deposit is mandatory.

Name
Phone
Email

Action Requested (Check One)
☐ Start Direct Deposit
☐ Stop Direct Deposit
☐ Change (add/delete a bank, increase/decrease fixed amount or select new balance account)

* A change replaces the direct deposit authorization currently on file. Fill in every row of bank information to show how your check should be deposited.

Bank Name
Routing #
Acct# (9 digits)
Checking or Savings
Full Deposit or Fixed Amount

☐ Balance Account
Deposit any balance of net pay to this account

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

Bank Name
Routing #
Acct# (9 digits)
Checking or Savings
Full Deposit or Fixed Amount

☐ Balance Account
Deposit any balance of net pay to this account

Bank Name
Routing #
Acct# (9 digits)
Checking or Savings
Full Deposit or Fixed Amount

☐ Balance Account
Deposit any balance of net pay to this account

Bank Name
Routing #
Acct# (9 digits)
Checking or Savings
Full Deposit or Fixed Amount

☐ Balance Account
Deposit any balance of net pay to this account

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

I understand that 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 issue to 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 a (revoked by my written request; or b) immediately following my termination from employment with the University; or c) 120 days after my last paycheck was issued.

I understand I must immediately notify the Payroll Office before I close any/all account(s) listed above while this authorization is in effect.

Employee Signature ____________________________ Today’s Date ____________________________

A voided check is not required, but is encouraged, for each new checking account entered above.

Bring or send the completed Authorization form with attached voided check(s) to:
Human Resources, 3rd floor, Whitmore Administration Building
Questions? Call the Payroll Office, (413) 545-3761 or 545-0391
How to Fill Out the Direct Deposit Form

Action Requested
1. Check one box to indicate the action you are requesting:
   - [ ] Start - for new enrollments only to start Direct Deposit. Allow up to one (1) pay period for new direct deposits to take effect.
   - [ ] Stop - to stop direct deposit of paycheck to all accounts. Your request to stop deposit must be received by Human Resources at least seven (7) days before the next payday.
   - [ ] Change - to add or delete a bank, increase or decrease a fixed amount, and/or change the Balance Account. Allow at least one (1) pay cycle for the change to take effect. A change replaces the direct deposit authorization currently on file. Fill in every row of bank information to show how your check should now be deposited.

Employee Information
2. Name — Enter your name in the order of: Last Name, First Name, Middle Initial
3. HR ID — If you are a new employee and have never been paid, leave this space blank. All others, enter the last 5 digits of your HR employee ID # (see upper left corner of your pay statement.)
4. SSN — Enter the last four digits of your social security number ONLY if you do not have an EmployeeID number.
5. Phone & E-mail — Enter your daytime phone number and email address. HR uses this information to contact you in the event there is a question about your direct deposit.

Deposit Options
The entire net pay amount must be directly deposited. Partial direct deposits are not allowed. There are two deposit options available:
   - send 100% of your net pay to one Checking or Savings account.
   - assign a fixed dollar amount to go to as many as four (4) different banks. One bank must also be selected as the Balance Account to take any leftover net pay.

Account Information
6. Bank Name — enter the name of your bank, credit union or financial institution.
7. Routing # — enter the 9-digit transit routing number that identifies your bank (see example below).
8. Account # — enter your bank account number (see below). Only one account per bank is allowed for direct deposit. If you want your pay distributed to different accounts within the same bank, you must make arrangements with the bank to have this done for you.
9. Checking or Savings — Check one box.
10. Full Deposit — Check this box if all your net pay will be directly deposited to one bank.
    - or
    - Fixed Amount $ - If depositing to more than one account, fill in the dollar amount you want to deposit in each account.
11. Balance Account — If your pay is going to more than one place you must check one bank your "Balance Account." Any money left after the fixed amounts are deposited will go into the Balance Account.
Forms that need to be completed

- **GIC Enrollment/Change Form (Form 1)**
  - Health Insurance (if choosing the family plan, please provide divorce or marriage certificates and birth or adoption certificate(s) for your dependent(s))
  - Basic and/or Optional Life Insurance
  - Long Term Disability Insurance

- **GIC Life Insurance Beneficiary Form-319**
  - Only need to fill out if signing up for Basic and/or Optional Life Insurance

- **Dependent age 19 to 26 Enrollment/Change Form**
  - Only need to fill out if you have dependent(s) on your health insurance that are age 19 to 26

- **Flexible Benefit Plan Enrollment Form**
  - Only need to fill out if you want the Health Care Spending Account or the Dependent Care Assistance Program.

- **State Employee Acknowledgement Form GIC Eligible Employees**

- **Statement Concerning your Employment in a Job not Covered by Social Security**

- **State Board of Retirement New Member Enrollment Form**
  - Do not sign the back of this page until you are at 325 Whitmore so that we may be your witness.
  - **OR** if you are in MSP, PSU unit A, IBPO or Non-unit (exempt) unions you must choose between the State Employees’ Retirement System (MSERS) and ORP
  - **Optional Retirement Program** Only MSP, PSU unit A, IBPO and Non-unit (exempt) are eligible and you will have received an ORP Enrollment Kit. Refer to pink sheet in binder. There is 180 day enrollment period. If undecided, may choose MSERS initially. Enrollment in ORP is irrevocable.

- **Dental Insurance**
  - MSP, USA/MTA, or NON-UNIT: Dental enrollment form is included in your dental book in the back of your binder. (if choosing the family plan, please provide divorce or marriage certificates and birth or adoption certificate(s) for your dependent(s))
  - PSU/MTA Units A & B, AFSCME, NEPBA and IBPO: You will receive your dental information by mail from your unions.

*Once all these forms above are completed please bring them to 325 Whitmore Building Monday-Friday 8:30 am – 5pm. (except for the 3rd Weds of every month when we open at 10:45 am)*
**GIC ENROLLMENT/CHANGE FORM (FORM-1)**

**Health, Basic Life, Optional Life, and Long Term Disability Insurance**

### INSURED INFORMATION

<table>
<thead>
<tr>
<th>Insured Information</th>
<th>GIC ID (usually Soc. Sec. #)</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Dept. ID # or Agency/Division #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M/F</td>
<td></td>
<td>UMS</td>
</tr>
</tbody>
</table>

- **Name** – Last Name
- **Address** – Street
- **City** – City
- **State** – State
- **Zip** – Zip

**Contact Information**

- **Home or Cell Phone**
- **Work Phone**
- **Email**
- **Country** (if not USA)

### Employment Information

- **Bargaining Unit/Union Name**
- **HR/CMS or UMASS Employee ID #**
- **Full-time**
- **Part-time**
- **Date of Hire**

### Select all that apply:

- **New Enrollment**
- **Annual Enrollment**
- **Address Change**
- **Adding Dependent(s)**
- **Address Change**
- **Decline GIC Health Insurance**
- **Decline All GIC Coverage**

**Qualifying Status Change**

- **Marriage**
- **Birth/Adoption**
- **Divorce/Legal Separation**
- **Change in Dependent**
- **Eligibility Status**
- **Gain of Other Coverage**

**Date of Event**

- **/ / /**

### HEALTH, BASIC LIFE, OPTIONAL LIFE AND LTD

<table>
<thead>
<tr>
<th>Basic Life Only</th>
<th>Long Term Disability (LTD)</th>
<th>Basic Life and Health</th>
<th>Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Harvard Pilgrim Independence (POS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Harvard Pilgrim Primary Choice (HMO)</td>
</tr>
</tbody>
</table>

**Salary Effective Date**

- **/ / /**

<table>
<thead>
<tr>
<th>Optional Life</th>
<th>Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Harvard Pilgrim Independence (POS)</td>
</tr>
<tr>
<td></td>
<td>Harvard Pilgrim Primary Choice (HMO)</td>
</tr>
</tbody>
</table>

**Enrollment/Change:**

- **Automatic Increase – select multiple of salary**
  - 1x
  - 2x
  - 3x
  - 4x
  - 5x
  - 6x
  - 7x
  - 8x

**Fixed Amount – Amount $**

### SPOUSE/DEPENDENT INFORMATION

<table>
<thead>
<tr>
<th>For Changes Only</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>SSN (REQUIRED)</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add</td>
<td></td>
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<td></td>
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<td>M/F</td>
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<td>Drop</td>
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<td>M/F</td>
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</table>

**FOR FORMER SPOUSE INFORMATION**

- **Are you remarried?**
  - Yes
  - No

- **Date of your remarriage:**
  - / /

- **Has your former spouse remarried?**
  - Yes
  - No

- **Date of former spouse’s remarriage:**
  - / /

**Authorization**

- **I have read the instructions on the reverse side of this form and authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected. I understand that due to IRS regulations, my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/ birth of a child, death of a dependent, and involuntary loss of other coverage). I understand that the GIC must receive any required documentation for health insurance changes within 60 days of the event. Family status change documentation for optional life enrollment and changes must be received by the GIC within 31 days of the qualifying event.**

**Signature of Applicant:**

- ____________________________  ____________________________

**Signature of Authorized Official:**

- ____________________________  ____________________________

**For GIC Use Only**

- **Entered**
- **Verified**
- **Political Subdivision**

(See over for Form-1 instructions)
State employees and retirees who have a qualified status change

- **Qualifying Status Change for Health Insurance:** State employees actively at work who have the following qualifying status changes during the year may enroll in or increase their optional life insurance coverage without any medical review in an amount not to exceed four times their salary: marriage, birth/adoption, divorce and death of a spouse. Proof of the qualifying event and the completed form must be received by the GIC within 31 days of the qualifying event. You must already have basic life insurance for this option. Forms received after 31 days are subject to proof of good health.

- **Qualifying Status Change for Health Insurance:** State employees and retirees who have a qualified status change during the year can enroll in GIC health insurance or change from individual to family coverage or family to individual with proof of the family status change. Documentation of the event and the completed form must be received at the GIC within 60 days of the qualifying event. Forms and documentation received after 60 days are returned and you may re-apply during Annual Enrollment.

- **Return from FMLA or Military Leave:** If you voluntarily canceled GIC health insurance coverage at the beginning of your FMLA or military leave of absence, you can re-enroll in GIC basic life and health insurance coverage upon your return from leave. Optional Life and Long Term Disability are subject to evidence of insurability unless you are returning from a military leave. The enrollment form must be received at the GIC within 60 days of the return to work. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.

### Deadlines and Required Documentation

- **Required Documentation**: To add a spouse or dependent to coverage, documentation is required. Refer to dependent information section below for details.

- **New Hire**: Completed paperwork and required documentation must be received by your GIC Coordinator no later than your 10th calendar day of regular, benefit eligible employment. If you miss the deadline, you must wait until the next Annual Enrollment period to enroll in GIC basic life and health insurance benefits.

- **Annual Enrollment**: Completed paperwork and required documentation must be received by your GIC Coordinator (active employees) or the GIC (retirees and survivors) by the end of the Annual Enrollment period.

- **Qualifying Family Status Change for Optional Life**: State employees actively at work who have the following qualifying family status changes during the year may enroll in or increase their optional life insurance coverage without any medical review in an amount not to exceed four times their salary: marriage, birth/adoption, divorce and death of a spouse. Proof of the qualifying event and the completed form must be received by the GIC within 31 days of the qualifying event. You must already have basic life insurance for this option. Forms received after 31 days are subject to proof of good health.

- **Qualifying Status Change for Health Insurance**: State employees and retirees who have a qualified status change during the year can enroll in GIC health insurance or change from individual to family coverage or family to individual with proof of the family status change. Documentation of the event and the completed form must be received at the GIC within 60 days of the qualifying event. Forms and documentation received after 60 days are returned and you may re-apply during Annual Enrollment.

- **Return from FMLA or Military Leave**: If you voluntarily canceled GIC health insurance coverage at the beginning of your FMLA or military leave of absence, you can re-enroll in GIC basic life and health insurance coverage upon your return from leave. Optional Life and Long Term Disability are subject to evidence of insurability unless you are returning from a military leave. The enrollment form must be received at the GIC within 60 days of the return to work. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.

### Work Hours and Eligibility

Active state employees must work at least 18.75 hours in a 37.5-hour workweek or 20 hours in a 40-hour workweek and must contribute to your Employer's public sector retirement system. For GIC purposes, OBRA is not such a retirement system. For additional eligibility details, refer to the GIC’s Regulations: mass.gov/gic-regulations.

### Long Term Disability

New state employees can enroll within 10 days of hire in Long Term Disability without providing evidence of good health. Current active state employees can apply at any time, but are subject to proof of good health.

### Optional Life Insurance

New state employees can enroll within 10 days of hire in Optional Life Insurance for a coverage amount of up to eight times your salary without the need for any medical review. Current active state employees can apply at any time, but must have basic life insurance and are subject to proof of good health. If you select an amount of Optional Life Insurance that is a multiple of your salary of two to eight times, up to $1.5 million maximum, you will be enrolled in the Automatic Increase; your Optional Life Insurance coverage will increase automatically after an increase in your salary. If you elect to change from a fixed amount (where your coverage does not increase as your salary increases) to Automatic Increase, you will be subject to proof of good health.

### Dependent Information and Required Documentation

In order to enroll your eligible spouse, former spouse and/or dependents in GIC health insurance, you must enter their information in the spouse/dependent box and provide a copy of a marriage certificate, birth certificate or hospital announcement letter (newborns only), separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. If covering a former spouse, also complete the former spouse information section. Failure to provide required documentation with this enrollment/change form will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must do so during Annual Enrollment or within 60 days of a qualifying event. Under federal health care reform, Social Security Numbers must be provided for each spouse/dependent to be covered under the health plan. For a newborn only, the Social Security Number can be provided at a later date. Please indicate the exact date of birth for each dependent. To cover a dependent age 19 to 26, you must also provide a completed Dependent Age 19 to 26 Enrollment and Change Form.

### Form and Documentation Submission

Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

- **Active employees**: Return completed form and documentation to your GIC Coordinator.

- **Retirees**: Return completed form to the GIC, P.O. Box 8747, Boston, MA 02114

*(See over for Form-1)*
GIC LIFE INSURANCE BENEFICIARY FORM-319

For one to three beneficiaries

<table>
<thead>
<tr>
<th>Insured GIC ID (Usually Soc. Sec. No.):</th>
<th>Agency/Division</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UMS/0147</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Insured Name: First</th>
<th>M.I.</th>
<th>Last</th>
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<tr>
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<table>
<thead>
<tr>
<th>Street Address</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Country (if not USA)</th>
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**YOU MUST READ INSTRUCTIONS ON BACK BEFORE COMPLETING FORM – PRINT CLEARLY IN CAPITAL LETTERS**

### BENEFICIARY #1

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Relationship</th>
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<tbody>
<tr>
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<td></td>
<td></td>
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<td>□ Child</td>
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<td></td>
<td>□ Brother/Sister</td>
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<td></td>
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<td></td>
<td>□ Other, specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Q Same as Insured</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Country (if not U.S.A.)</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Phone Number (Optional)</th>
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</tbody>
</table>

% OF PROCEEDS (Do Not Put $ Amount)

### BENEFICIARY #2

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Relationship</th>
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<tbody>
<tr>
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<td>□ Brother/Sister</td>
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<td>□ Other, specify:</td>
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</tbody>
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<table>
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<tr>
<th>Street Address</th>
<th>Q Same as Insured</th>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Country (if not U.S.A.)</th>
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<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Phone Number (Optional)</th>
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% OF PROCEEDS (Do Not Put $ Amount)

### BENEFICIARY #3

<table>
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<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Relationship</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>□ Parent</td>
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<td>□ Child</td>
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<td>□ Brother/Sister</td>
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<td>□ Other, specify:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Q Same as Insured</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Country (if not U.S.A.)</th>
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<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Phone Number (Optional)</th>
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</table>

% OF PROCEEDS (Do Not Put $ Amount)

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I hereby make the above designation of beneficiary revoking any and all previous beneficiary nominations and make the above nomination of beneficiary with respect to all insurance provided now or at any time in the future under the group insurance policies. I still reserve the privilege of making other and future changes subject to the policy provisions.

If more than one beneficiary is designated, settlement will be made in equal shares to each of the designated beneficiary(ies) that survive me, unless otherwise provided herein. If no designated beneficiary(ies) survive me, settlement will be made as provided in the policy in the following order: to the spouse, then to the children, then to the parents, then to the siblings, then to the estate.

---

**Signature of Insured**

**Date**

Please make a copy of this completed form and file with your important records.

For GIC Use Only

Entered

Verified

Please return form to: Group Insurance Commission, P.O. Box 8747, Boston, MA 02114

(See over for Form-319 instructions)
GIC LIFE INSURANCE BENEFICIARY FORM-319 INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS AND EXAMPLES CAREFULLY BEFORE COMPLETING THIS FORM.

1. Please print all beneficiary information clearly in capital letters on the lines provided, indicating your beneficiary’s name, relationship, Social Security number, date of birth, address and the percentage of proceeds to be paid to each beneficiary. Incomplete forms will be returned. Refer to the samples illustrated to the right to assist you in the completion of your form.

2. If you do not provide a percentage of proceeds for your beneficiaries, the proceeds will be divided equally among all listed beneficiaries. If you provide a percentage for some but not all of the listed beneficiaries, your form will be returned to you to complete. DO NOT PUT A DOLLAR AMOUNT IN the “% of Proceeds” BOX.

3. Use this form to designate up to three beneficiaries. If you wish to list more than three beneficiaries, an estate or trust, DO NOT use this form. Instead, you must obtain a GIC Life Insurance Beneficiary Form G-500 from your GIC Coordinator and use that form to list all your beneficiaries. If you are a retiree and need a G-500, please call 617.727.2310.

4. If you list beneficiaries who have the same last name as you, DO NOT write their last name. Instead, simply mark an “X” in the “Same as Insured” box for each beneficiary who has the same last name as yours.

5. If you list beneficiaries who live at the same address as you, DO NOT write their address. Instead, simply mark an “X” in the “Same as Insured” box for each beneficiary who lives at your address.

6. Please sign and date the form clearly, in ink, where indicated. Keep a copy of the completed form with your important papers.

7. Please return this completed form to the Group Insurance Commission, P.O. Box 8747, Boston, MA 02114.

8. The effective date of an enrollee’s life insurance beneficiary designation is the date that the GIC receives the completed beneficiary form.

(See over for Beneficiary Form-319)
DEPENDENT AGE 19 TO 26 ENROLLMENT/CHANGE FORM – FEDERAL HEALTH CARE REFORM (ACA)

Use this form to enroll your dependent age 19 to 26 for the first time or to report your dependent’s age 19 to 26 status change. Upon receipt of a complete application, the GIC will determine coverage eligibility and effective date. For new insureds, coverage for the dependent age 19 to 26 will begin on the new insured’s effective date. Dependents of existing GIC enrollees who are already over age 19 must have a qualifying event to enroll during the year or may apply during the GIC’s Annual Enrollment. Incomplete applications will be returned. PLEASE USE ONE FORM FOR EACH DEPENDENT AGE 19 TO 26.

I am applying for coverage or reporting a status change for my dependent age 19 to 26. The GIC may require proof of relationship for the dependent you plan to cover and will contact you for any documents, if necessary.

<table>
<thead>
<tr>
<th>Name of Insured</th>
<th>Social Security #</th>
<th>Telephone #</th>
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<tbody>
<tr>
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</table>

Address

<table>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
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</table>

Section A – Enroll Your Dependent

A) ENROLLMENT DEPENDENT AGE 19 TO 26  Use this section to enroll your dependent

<table>
<thead>
<tr>
<th>Name of Dependent Age 19 - 26</th>
<th>Social Security #</th>
<th>Dependent’s Date of Birth</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Relationship to Insured</th>
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</table>

Check here if your dependent is a full-time student attending an accredited institution outside your health plan’s service area and provide school name and address below: (Check with your health plan for benefits available to full-time students that are attending school outside the service area.)

<table>
<thead>
<tr>
<th>Name of School</th>
<th>School Address</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

(That is outside health plan’s service area)

You must contact the GIC when your dependent is no longer a full-time student to continue coverage to age 26.

B) CHANGE OF DEPENDENT’S AGE 19 TO 26 STATUS  Use this section to report dependent address and full-time student status changes

<table>
<thead>
<tr>
<th>Name of Dependent Age 19 - 26</th>
<th>Social Security #</th>
<th>Dependent’s Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Relationship to Insured</th>
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<tbody>
<tr>
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</tbody>
</table>

Dependent Address Change

<table>
<thead>
<tr>
<th>New Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Dependent is no longer a full-time student as of ____________________ . (Date)

Signature Required  Please sign and date below

Full-time student and non-student adult children age 19-26 may reside outside of your health plan’s service area but will be subject to the plan’s coverage rules. Be sure to review your plan’s out of service area coverage and consider whether you should change to a plan providing greater geographical coverage for your dependent. Under the pains and penalties of perjury, I attest that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies and financial consequences, at the GIC’s discretion.

Signature of Insured _______________________________  Date ____________________

Return to: Group Insurance Commission, PO Box 8747, Boston, MA 02114

GIC USE ONLY  APPROVED _______ Effective Date _________  Expiration Date _________  DENIED _______
GROUP INSURANCE COMMISSION
FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

PLAN YEAR: JULY 1, 2018 TO JUNE 30, 2019
2 ½ MONTH GRACE PERIOD: JULY 1 – SEPTEMBER 15, 2019
CLAIM FILING DEADLINE: OCTOBER 15, 2019

EMPLOYEE: Fill out Sections A through E. Turn this form into your Benefits Coordinator.

A. Employee Information – Please Print Clearly!

Name: ___________________________ Social Security Number (Required): _______________________
Address: ___________________________ Daytime Phone: ___________________________
City: _______________________________ State: ___________ Zip Code: _______________________
Employee ID#: ______________________ Date of Birth: _______________ Agency Name: UMass Amherst

E-mail (Required):

B. Flexible Benefit Plan Pre-tax Elections

1. Health Care Spending Account (HCSA): Eligible health expenses include medical, dental, vision and hearing expenses incurred by my dependents or myself during the Plan Year for “the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.” See IRS Publication 502 for more information.

   Your Contribution Per Pay Period X # of Pay Periods = $ Total HCSA Election

   Election allowed per Plan Year
   $250 minimum / $2,650 maximum

2. Dependent Care Assistance Program (DCAP) Eligible dependent care expenses must be work-related and incurred to allow me and, if applicable, my spouse to be gainfully employed. Qualifying dependents include children under age 13 or older dependents who are not capable of self-care. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes. A maximum of $5000.00 can be elected per calendar year per household. See IRS Publication 503 for more information.

   Your Contribution Per Pay Period X # of Pay Periods = $ Total DCAP Election

   Election allowed per Plan Year
   $192.30/Biweekly pay period, not to exceed $5000.00. ($96.15/biweekly if married and filing separately)

C. ASIFlex Card HCSA participants will automatically receive two debit cards. A $5.00 fee will be assessed for each additional/replacement card set and billed directly to your HCSA. Please indicate the number of additional cards set you would like to request below. (You will automatically get 2 cards to start). Please note that cards are ordered in multiples of 2. (Example: 2, 4, 6, 8, etc.)

   Additional Cards Requested: _________

   REQUIRED: You must indicate the medical plan in which you have enrolled. Please check the appropriate box. If not enrolled in a GIC plan, check the last box.

   Fallon Health Direct Care HMO
   Fallon Health Select Care HMO
   Harvard Pilgrim Independence Plan POS
   Harvard Pilgrim Primary Choice Plan HMO
   Health New England HMO
   NHP Care (Neighborhood Health Plan)
   Tufts Health Plan Navigator POS
   Tufts Health Plan Spirit EPO(HMO-Type)
   Unicare State Indemnity Plan Basic with CIC
   Unicare State Indemnity Plan/Community Choice PPO-Type
   Unicare State Indemnity Plan/Plus PPO-Type
   Not enrolled in any plan listed

D. Direct Deposit Authorization Claim payments can be sent directly to a bank account of your choice, and you can be notified by email/text alert each time a payment is issued.

   Bank Name: ___________________________ (See #1 on sample)

   Routing Number - 9 digits (See #2 on sample): ___________________________

   Account Number (See #3 on sample): ___________________________

   Cell Phone: ___________________________ Mobile Carrier: ___________________________

E. Signatures By signing below, I agree to the following Terms and Conditions stated on the opposite side of this form.

   Employee Signature (Required): ___________________________ Date: ______________

   Required: The section below must be completed, in full, by agency Payroll/Benefits Coordinator

   Benefit Effective Date: DCAP: __ / __ / __ HCSA: __ / __ / __
   Division Code (ex: ABC1234) UMS/0147
   Agency Coordinator: Beth Ives
   E-mail Address: bives@admin.umass.edu
   Phone #: 413.545.6115

   Reason for Enrollment: Open Enrollment New Hire Qualifying Status Change:

   COORDINATORS: Be sure form is legible and complete. Fax or Upload completed form to ASIFlex, not the GIC

Rev. 1/2018
**Enrollment Form Instructions**

**Section A**  
**Employee Information** - Please print your name and complete address clearly. Your phone number and e-mail address will be used only to communicate with you with regard to this plan. It will not be distributed to any other organization or used for marketing purposes in any way. Statements of your account balance and activity will be sent via e-mail/text alert whenever possible. Please understand that this is an employee account and due to federal and state laws we cannot release detailed information to anyone other than the participant (employee). Please contact our office for further information or you can sign a HIPAA release to allow others to act on your behalf and obtain information.

**Section B**  
**Flexible Benefit Pre-Tax Elections**

1. **Health Care Spending Account (HCSA)** - Carefully consider how much money you would like to set aside each pay period during the Plan Year to pay for your family’s eligible out-of-pocket medical expenses. Make sure you read your Summary Plan Description and/or the Health Care brochure to fully understand how the plan works.

2. **Dependent Care Assistance Program (DCAP)** - Carefully consider how much money you would like to set aside each pay period during the Plan Year to cover the expenses you will incur to care for your eligible dependents while you and your spouse (if applicable) are gainfully employed. *Qualifying dependents are children under age 13 or older dependents not capable of self-care.* Make sure you read your Participant Handbook to fully understand how the plan works.

**Section C**  
**ASIFlex Card** - You may order an additional set of cards for other eligible dependents if desired. A fee of $5.00 per additional set will be assessed to your HCSA for each set of cards. Cards are reloaded over plan years, so if you already have debit card from a prior plan year, it will be loaded with your election funds. You will not receive new cards unless requested.

**Section D**  
**Direct Deposit Authorization** - If you would like your reimbursements sent directly to your checking or savings account via Direct Deposit, fill out this section and attach a voided check (for checking) or deposit slip (for savings). Payment Confirmations are sent via email/text alert and will show current transaction information, as well as, available funds in the account.

**Section E**  
**Signatures** - After you have completely filled out this form and carefully read the following Terms and Conditions please sign and date then return the enrollment form to your benefits office. Employers must review the elections and sign that the employee meets the eligibility requirements.

---

**Flexible Benefit Plan Terms and Conditions**

I UNDERSTAND THAT:

- By participating in the Flexible Benefit Plan, my employer will deduct pre-tax from my pay check: $2.50 per month from the first paycheck of each month and my election amount equally divided by the number of pay periods within the plan year.
- I cannot change this election during the Plan Year unless I have a qualifying change in status as described in the Plan.
- I must make all of my elections carefully and conservatively. Expenses paid under the HCSA or DCAP cannot be reimbursed from any other source and I will not seek reimbursement from any other source.
- Expenses must be incurred during the Plan Year or the Grace Period. The Grace Period is a 2 ½ month period following the end of the Plan Year during which I may continue to incur expenses for the prior plan year. (September 15)
- All FY18 claims must be submitted by the claim filing deadline, called a run-out period, which ends October 15. The IRS imposes a strict “use-it-or-lose-it” rule, which means money left in a pre-tax account at the plan year end is forfeited.
- Qualifying expenses are those incurred by me, or by my legal dependents.
- HCSA expenses can be reimbursed up to the plan year election, less prior reimbursements. DCAP expenses can be reimbursed up to the year-to-date deposits, less prior reimbursements.
- The ASIFlex Card can be used only for qualifying health care expenses as defined by IRS guidelines. The IRS requires me to keep documentation of all my card transaction expenses and submit documentation to the administrator upon request. If I do not provide the requested documentation as required, IRS regulations require that the card be temporarily deactivated. Claims submitted will be offset by any outstanding card transaction amount. Misuse of the card may result in permanent revocation and repayment of ineligible expenses.
- If I have not selected to be reimbursed by Direct Deposit, I am accepting to receive reimbursement check by mail to my address on file. I understand that reimbursements will accumulate until a minimum of $25.00 is met. A reimbursement check will not be issued for an amount below $25.00; unless the plan year has ended.
- I understand additional details are outlined in the Participant Handbook available at asiflex.com/gic.
**Important Information Regarding Enrollment and Changes**

**Administrative Fee**
The cost to administer this program is paid for by each employee on a before tax basis. The monthly administrative fee is $2.50 for any account participation - for Health Care Flexible Spending Account (HCSA) alone, Dependent Care (DCAP) alone or one fee for HCSA/DCAP combined.

**Eligibility and Annual Maximum and Minimum for HCSA and DCAP**
HCSA: Active state employees who are eligible for GIC benefits. Enrollment must be elected within 10 days from your date of hire. The waiting period is the same as for other GIC life and health benefits; coverage effective the first of the month following 60 days or 2 calendar months. Minimum $250; Maximum $2,650.

DCAP: Active state employees, eligible for GIC benefits, who work at least 18.75 hours per 37.5 hour work week or 20 hours per 40 hour work week. You are eligible on the first day of employment. Enrollment forms must be submitted to your Payroll Coordinator within 10 days from your date of hire. Maximum $5,000 at beginning of plan year, $192.30 per biweekly pay period mid-year ($2,500 if married filing separately).

**Change in Status**
Elections may be changed during open enrollment if you experience a qualifying “change in status” as defined in the Plan. A change needs to be consistent and corresponds with the qualifying event. Only the following events will be considered a valid change in status under Internal Revenue Service rules.

- Change in legal marital status
- Change in number of dependents
- Change in employment status that changes your eligibility for the program
- Change in work schedule, which changes your eligibility requirements for the program
- Dependent satisfies or ceases to satisfy eligibility requirements
- Judgment decree or order pertaining to child or spouse

If you would like to terminate your elections as a result of a valid change in status, enter a zero dollar amount in the HCSA/DCAP section(s) of the enrollment form. Payroll Coordinators must obtain the appropriate supporting documentation of a Change in Status, such as a copy of the marriage or birth certificate. Please see the Participant Handbook for additional information and information regarding Leaves of Absence and Leaving State Service. Forms must be submitted within 60 days of the qualifying event.

**Signature and Form Submission**
The employee and Payroll Coordinator must sign this form. All forms must be submitted to the Benefits/Payroll Office at your work site. The Benefits Coordinator must send the original form to ASIFlex. Please do not send completed forms to the GIC.

**Eligible Expenses under a Dependent Care Assistance Plan**
Eligible expenses under a Dependent Care Assistance Plan are defined as those that are “work-related” as defined in the regulations and enable the participant and the participant’s spouse to work or to look for work, and are incurred for the protection and well-being of the dependent.

Dependents must be under the age of 13 or, if older, not capable of self-care. Qualifying providers and expenses include:

- Child Care centers that care for six or more children and that meet the IRS’ definition of a qualified day care center.
- Caregivers for a disabled spouse or dependent who lives with the participant and is not capable of self-care.
- Babysitters for work-related expenses
- Before school or after school care
- Day Camp (not overnight camps)
- Household expenses provided that a portion of such expenses are incurred to ensure a qualifying dependent’s well-being and protection.

Note: Please see IRS Publication 503 additional information. In compliance with the IRS guidelines, the service provider cannot be an individual for whom a personal tax exemption may be claimed. In addition, a child of the participant or spouse cannot be under the age of 19.

**Ineligible Expenses under a Dependent Care Assistance Plan**

- Expenses for services not yet provided, even if you must pay in advance
- Babysitting for social events, or services that are not “work-related” as defined by the IRS
- Educational or tuition expenses (kindergarten, first-grade or higher)
- Overnight camp
- Expenses incurred while you are not working or looking for work

Note: If you are divorced, only expenses incurred by the custodial parent may be considered.

**Eligible Expenses under a Health Care Spending Account**
Eligible expenses under a HCSA are defined as those that are medically necessary, prescribed by a licensed practitioner and are not reimbursed under another program. Eligible expenses are listed in the Participant Handbook available on the GIC’s web site, www.mass.gov/gic/fsa. Don’t forget that expenses such as insurance premiums may be deductible on Schedule A tax return, but not eligible for reimbursement through a HCSA. Some examples of eligible expenses are: acupuncture, ambulance, artificial limbs, contact lenses, health plan deductibles, dental expenses, health and RX co-pays, hearing aids, vision expenses, over-the-counter health care products, and more. Additional information is also located at www.asiflex.com/gic.

**Ineligible Expenses under a Health Care Spending Account**

- Expenses for services not yet provided, even if you must pay in advance
- Expenses paid under any other source (such as another insurance plan)
- Cosmetic treatments, medications or surgery (such as teeth whitening, face lifts, hair transplants, etc.)
- Expenses for general health and well-being (such as fitness programs, exercise equipment, health club memberships, etc.)
- Insurance premiums
- Expenses that are not properly substantiated.
State Employee Acknowledgement Form
For GIC Eligible Employees

You are responsible for familiarizing yourself with your benefit options and making your elections within 10 days of the date of hire:

- Basic Life Insurance
- Basic Life & Health Insurance
- Summary of Benefits and Coverage (www.mass.gov/gic/sbc)
- Optional Life Insurance
- Long Term Disability (LTD)
- Dental/Vision (if eligible) – this plan does not apply to UMass Employees
- Health Care Spending Account (HCSA)
- Dependent Care Assistance Program (DCAP)

Your signature is required on this form before your agency can process your benefit elections. Please sign, date and return this form to your GIC Coordinator after you have reviewed the Benefit Decision Guide.

I hereby acknowledge that I have reviewed the most recent GIC Benefit Decision Guide and understand my benefit options before I made my benefit elections. I understand that if I enroll in GIC basic life or basic life and health insurance, my premiums will be deducted on a pretax basis unless I elect post tax benefits.

Name: ____________________________________

(Please print)

Signature: __________________________________

Date: _________________________________

Employee: Return this signed form to your GIC Coordinator with your benefit elections.
GIC Coordinator: Give employee a copy of this form and retain original signed form in employee’s personnel file. Do not send to the GIC.
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: ________________

Form SSA-1945 (01-2013)  Destroy Prior Editions
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
SECTION A  To be filled out by employee *(Please print or type, except for signature).*

<table>
<thead>
<tr>
<th>Name ___________________________</th>
<th>Maiden Name ________________________</th>
<th>S.S.N. ____________________________</th>
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</thead>
<tbody>
<tr>
<td>Street Address ____________________</td>
<td>D.O.B. <strong><strong><strong>/</strong></strong><em>/</em></strong>___</td>
<td>Sex □ M □ F</td>
</tr>
<tr>
<td>City ____________________________</td>
<td>State ____</td>
<td>Zip Code ____________</td>
</tr>
</tbody>
</table>

Marital Status

☐ Married  ☐ Single  ☐ Widowed  ☐ Divorced

Spouse D.O.B. ______/_____/______  Number of Children

Are you a Veteran?

☐ Yes  ☐ No

Position __________________________

Start Date _________________________

Agency or Department University of Massachusetts Amherst

Agency Phone # (_____ ) ____________

**A COPY OF A MILITARY DISCHARGE MAY BE REQUESTED**

The retirement law establishes specific periods of active service, which may qualify you for certain Veteran benefits.

---

Past membership history with any other contributory retirement system in Massachusetts.

<table>
<thead>
<tr>
<th>RETIREMENT SYSTEM</th>
<th>FROM</th>
<th>TO</th>
<th>WAS REFUND TAKEN?</th>
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<tbody>
<tr>
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<td></td>
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<td>□ YES □ NO</td>
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<td>□ YES □ NO</td>
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</table>

Are you currently or have you ever received a retirement allowance from another public retirement system?  □ YES  □ NO

---

Statement and Signature By Member

I certify the above information to be true and correct to the best of my knowledge and hereby accept membership in the Massachusetts State Retirement System. This statement is signed under penalties of perjury.

(Date) ____________________________  (Signature) ____________________________

(continues on reverse) Please return completed form (Section A—questions 1–5) to: State Board of Retirement, One Winter Street, 8th Floor, Boston, MA 02108-1607 Section B—question 6 (on reverse) to be completed by the Agency.
**SECTION A (Continued)**

**Beneficiary Information**

Beneficiary or beneficiaries nominated will receive in the proportion designated any sum due at your death. The right to change any nominated beneficiary is reserved by the member. A Beneficiary with corrections or erasures is not acceptable.

**GIVE COMPLETE NAME AND ADDRESS OF EACH BENEFICIARY**

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<thead>
<tr>
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<th>Designation:</th>
<th>Proportion:*</th>
<th>Date of Birth:</th>
<th>Relationship:</th>
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**SECTION B To be completed by the Agency:**

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<tr>
<th>POSITION</th>
<th>DEDUCTION</th>
<th>SERVICE STATUS</th>
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</tr>
<tr>
<td>Date of First Deduction</td>
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</table>

| University of Massachusetts Amherst UMS 0147 |
|---------------------------------------------|---------------------------------------------|
| (Agency Name and Payroll Number) (Authorized Signature) |