



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 05/31/2027

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code	
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number		
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.			Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
			☐ 1. A citizen of the United States				
			☐ 2. A noncitizen national of the United States (See Instructions.)				
			☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)				
			☐ 4. An alien authorized to work until (exp. date, if any)				
			If you check Item Number 4., enter one of these:				
			USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee			Today's Date (mm/dd/yyyy)				

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

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

Document Title 1	List A	OR	List B	AND	List C
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
☐ Check here if you used an alternative procedure authorized by DHS to examine documents.					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

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

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



**Supplement A,
Preparer and/or Translator Certification for Section 1**

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

**USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027**

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle Initial (if any) from Section 1.
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)		Middle Initial (if any)
Address (Street Number and Name)	City or Town	State	ZIP Code

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		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)		Middle Initial (if any)
Address (Street Number and Name)	City or Town	State	ZIP Code

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		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)		Middle Initial (if any)
Address (Street Number and Name)	City or Town	State	ZIP Code

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		Date (mm/dd/yyyy)	
Last Name (Family Name)	First Name (Given Name)		Middle Initial (if any)
Address (Street Number and Name)	City or Town	State	ZIP Code



**Supplement B,
Reverification and Rehire (formerly Section 3)**

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

**USCIS
Form I-9
Supplement B**
OMB No. 1615-0047
Expires 05/31/2027

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle Initial (if any) from Section 1.
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (if applicable) Date (mm/dd/yyyy)	New Name (if applicable) Last Name (Family Name)	First Name (Given Name)	Middle Initial
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Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
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Additional Information (Initial and date each notation.)

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

Date of Rehire (if applicable) Date (mm/dd/yyyy)	New Name (if applicable) Last Name (Family Name)	First Name (Given Name)	Middle Initial
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Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
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Additional Information (Initial and date each notation.)

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

Date of Rehire (if applicable) Date (mm/dd/yyyy)	New Name (if applicable) Last Name (Family Name)	First Name (Given Name)	Middle Initial
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Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
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Additional Information (Initial and date each notation.)

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

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

2026**Step 1:****Enter
Personal
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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

Step 2:**Multiple Jobs
or Spouse
Works**

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

Do only one of the following.

- (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; or
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate ☐

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

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

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 . . . ☐		
Step 5:	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
Sign Here	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

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

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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

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



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

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

Step 4.

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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

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

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

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

- 1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3 1 \$ _____

- 2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a 2a \$ _____
 - b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b 2b \$ _____
 - c Add the amounts from lines 2a and 2b and enter the result on line 2c 2c \$ _____

- 3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3 _____

- 4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) 4 \$ _____

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

See the instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.		
a Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000	1a	\$ _____
b Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	1b	\$ _____
c Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000	1c	\$ _____
2 Add lines 1a, 1b, and 1c. Enter the result here	2	\$ _____
3 Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):		
a Enter \$6,000 if you are age 65 or older before the end of the year	3a	\$ _____
b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	3b	\$ _____
4 Add lines 3a and 3b. Enter the result here	4	\$ _____
5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	5	\$ _____
6 Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:		
a Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income	6a	\$ _____
b State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)	6b	\$ _____
c Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	6c	\$ _____
d Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income	6d	\$ _____
e Other itemized deductions. Enter the amount for other itemized deductions	6e	\$ _____
7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	7	\$ _____
8 Limitation on itemized deductions.		
a Enter your total income	8a	\$ _____
b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	8b	\$ _____
9 Enter: { • \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,800 if you're single or head of household • \$384,350 if you're married filing separately }	9	\$ _____
10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10	\$ _____
11 Standard deduction.		
Enter: { • \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately }	11	\$ _____
12 Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)	12	\$ _____
13 Add lines 11 and 12. Enter the result here	13	\$ _____
14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14	\$ _____
15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	15	\$ _____

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary														
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000	\$120,000 - 130,000	\$130,000 - 140,000	\$140,000 - 150,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,220	2,220	2,220	2,220
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,420	3,420	3,420	3,420	3,420
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	3,990	3,990	3,990	3,990	3,990	3,990
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,190	4,190	4,190	4,190	4,190	4,190	4,190
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360	4,360
\$80,000 - 89,999	1,020	2,220	3,420	4,240	5,440	6,610	6,610	6,610	6,610	6,610	6,610	6,610	6,610	6,610	6,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560	17,810	19,110	20,460
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240	19,440	20,640	21,840
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580	19,780	20,980	22,180
\$320,000 - 394,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580	19,780	20,980	22,180
\$395,000 - 524,999	2,720	5,920	9,360	12,260	14,760	17,260	19,530	21,830	24,130	26,430	28,730	31,030	33,330	35,630	37,930
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,980	36,480	38,980	41,480

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary														
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000	\$120,000 - 130,000	\$130,000 - 140,000	\$140,000 - 150,000
\$0 - 9,999	\$0	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,830	3,830	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,030	5,030	5,030	5,030	5,030	5,030
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,030	6,030	6,030	6,030	6,030	6,030	6,030
\$40,000 - 49,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950	9,150	9,350	9,550
\$50,000 - 59,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300	10,500	10,700	10,900
\$60,000 - 69,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700	10,900	11,100	11,300
\$70,000 - 79,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,790	10,990	11,190	11,390	11,590	11,790
\$80,000 - 89,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,400	10,600	10,800	11,000	11,200	11,400	11,600	11,800
\$90,000 - 99,999	2,040	4,200	5,600	6,800	8,150	9,150	10,150	10,350	10,550	10,750	10,950	11,150	11,350	11,550	11,750
\$100,000 - 124,999	2,040	4,200	5,600	6,150	7,150	8,150	9,150	9,350	9,550	9,750	9,950	10,150	10,350	10,550	10,750
\$125,000 - 149,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340	24,640	25,940	27,240
\$150,000 - 174,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,230	25,530	26,830	28,130
\$175,000 - 199,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,230	25,530	26,830	28,130
\$200,000 - 249,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,230	25,530	26,830	28,130
\$250,000 - 449,999	3,140	6,800	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,600	28,100	29,600	31,100
\$450,000 and over	3,140	6,800	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,600	28,100	29,600	31,100

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary														
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000	\$120,000 - 130,000	\$130,000 - 140,000	\$140,000 - 150,000
\$0 - 9,999	\$0	\$280	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,220	2,220	2,220	2,220	2,220	2,220	2,220	2,220
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	2,980	2,980	2,980	2,980	2,980	2,980	2,980	2,980	2,980
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,180	3,180	3,180	3,180	3,180	3,180	3,180	3,180	3,180	3,180
\$40,000 - 49,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,640	8,640	9,640	10,640	11,640	12,640	13,640	14,640
\$50,000 - 59,999	1,020	2,610	4,370	5,570	6,840	7,750	8,950	10,150	11,350	12,550	13,750	14,950	16,150	17,350	18,550
\$60,000 - 69,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	14,410	15,610	16,810	18,010	19,210	20,410
\$70,000 - 79,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,900	16,100	17,300	18,500	19,700	20,900
\$80,000 - 89,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	13,870	15,070	16,270	17,470	18,670	19,870	21,070
\$90,000 - 99,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	13,870	15,070	16,270	17,470	18,670	19,870	21,070
\$100,000 - 124,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,580	20,580	22,580	24,580	26,580	28,580	30,580
\$125,000 - 149,999	2,720	5,920	8,660	10,960	13,270	15,570	17,870	20,170	22,470	24,770	27,070	29,370	31,670	33,970	36,270
\$150,000 - 199,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,910	28,210	30,510	32,810	35,110	37,410
\$200,000 - 449,999	3,140	6,840	10,110	12,610	15,360	17,880	20,380	22,880	25,380	27,880	30,380	32,880	35,380	37,880	40,380
\$450,000 and over	3,140	6,840	10,110	12,610	15,360	17,880	20,380	22,880	25,380	27,880	30,380	32,880	35,380	37,880	40,380



MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name _____ SSN _____

Employee's Residence _____

Number and Street _____ City or Town _____ State _____ Zip Code _____

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION			
Marital Status	Personal Exemption Allowed		Amount Claimed
EMPLOYEE:			
1. Single	Enter \$6,000 as exemption ▶		\$
2. Marital Status (Check One)	(a)	Spouse NOT employed: Enter \$12,000 ▶	\$
	(b)	Spouse IS employed: Enter that part of \$12,000 claimed by you in multiples of \$500. See instructions 2(b) below. ▶	\$
3. Head of Family	Enter \$9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d) below ▶		\$
EMPLOYER: Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	4. Dependents Number Claimed 	You may claim \$1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim \$1,500 for each dependent excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by \$1,500. Enter amount claimed...▶	
	5. Age and blindness	• Age 65 or older Husband Wife Single • Blind Husband Wife Single Multiply the number of blocks checked by \$1,500. Enter the amount claimed ▶ * Note: No exemption allowed for age or blindness for dependents.	
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5...▶		\$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer ▶		\$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write "Exempt" on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim...▶		

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____

Date: _____

INSTRUCTIONS

1. The personal exemptions allowed:

- | | | | |
|-----------------------------------|----------|---------------------|---------|
| (a) Single individuals | \$6,000 | (d) Dependents | \$1,500 |
| (b) Married individuals (Jointly) | \$12,000 | (e) Age 65 and Over | \$1,500 |
| (c) Head of family | \$9,500 | (f) Blindness | \$1,500 |

2. Claiming personal exemptions:

(a) Single individuals enter \$6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of \$12,000.

If the spouse is not employed, enter \$12,000 on Line 2(a). If the spouse is employed, the exemption of \$12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of \$500. For example, the taxpayer may claim \$6,500 and the spouse claims \$5,500; or the taxpayer may claim \$8,000 and the spouse claims \$4,000. The total claimed by the taxpayer and spouse may not exceed \$12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter \$9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of \$1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but

should not include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the age of 65 before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both are blind. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by \$1,500 and enter amount of exemption claimed.

3. Total Exemption Claimed:

Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION.

6. IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENEFIT OF EXEMPTION.

To comply with the Military Spouse Residency Relief Act (PL 111-97) signed on November 11, 2009.



Employee Emergency Contact Form

Name: _____

Department: _____ Date: _____

Work Telephone: _____ Cellular Telephone: _____

Email: _____

Primary Emergency Contact

Contact Name: _____

Relationship to Contact: _____

Telephone: _____

Email: _____

Secondary Emergency Contact

Contact Name: _____

Relationship to Contact: _____

Telephone: _____

Email: _____

Mississippi Delta Community College does not discriminate on the basis of age, race, color, national origin, religion, sex, sexual orientation, gender identity or expression, physical or mental disability, pregnancy, or veteran status in its educational programs and activities or in its employment practices. The following person has been designated to handle inquiries regarding the non-discrimination policies: Waunita Roberts Jones, Executive Director of Human Resources, Stauffer-Wood Administration Building, Suite 144, Office 145, P. O. Box 668, Moorhead, MS 38761, 662-246-6309; EOC@msdelta.edu.

Mississippi New Hire Reporting Form

Mail completed form to: Mississippi State Directory of New Hires
PO Box 437
Norwell, MA 02061



Or fax completed form to: 1-800-937-8668

Effective October 1, 1997, all Mississippi employers (or independent contractors) are required to report certain information about personnel who have been newly hired, rehired, or have returned to work. **Reports must be made within 15 calendar days from date of hire.** Employers must either (1) complete this form, or (2) submit a copy of the worker's IRS W-4 form with the "other information section" completed on this form, or (3) submit the information by magnetic tape or floppy diskette. *To submit new hire reports electronically, call 1-800-241-1330 to obtain information.*

Below, please complete all employer information

EMPLOYER INFORMATION

*Federal Employer Identification Number (FEIN):

6	4
---	---

 -

6	0	0	1	1	0	1
---	---	---	---	---	---	---

(Please the same FEIN for which listed employee(s) quarterly wages will be reported under)

State Employer Identification Number (SEIN):

6	9
---	---

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0	6	5	0	6	2	0
---	---	---	---	---	---	---

*Employer Name: Mississippi Delta Community College DBA: _____

*Address: Human Resources
P.O Box 668

(Please indicate the address where the Income Withholding Order will be sent)

*City: Moorhead *State: MS *Zip Code: 38761 +4: 0668

Contact Name: Waunita Roberts-Jones Phone: (662) 246-6241

Email: wroberts@msdelta.edu

Below, please complete one entry for each new employee

EMPLOYEE INFORMATION

*Social Security Number:

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 -

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 Gender (circle one): Male Female

*First Name: _____ Middle: _____

*Last Name: _____

*Employee Address: _____

*City: _____ *State: _____ *Zip Code: _____ +4: _____

Date of Birth: ____/____/____ *Date of Hire: ____/____/____ State of Hire _____

Employee Salary: _____ Payment Frequency (circle one): Weekly Bi-weekly Monthly Annually

Is this employee eligible for medical insurance (circle one)? Yes No

For information please visit our website at www.ms-newhire.com or call us toll-free at 1-800-241-1330



Direct Deposit Agreement Form Authorization Agreement

I hereby authorize **Mississippi Delta Community College** to initiate automatic deposits to my account at the financial institution named below. I also authorize **Mississippi Delta Community College** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Mississippi Delta Community College** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I also understand that it is my responsibility to make sure that Human Resources has a valid mailing address on file to ensure delivery of my first payroll check, which will be mailed if account information is not received in time to implement direct deposit. Every check thereafter, will be deposited into my account.

This agreement will remain in effect until **Mississippi Delta Community College** receives a written notice of change from me or my financial institution, or until I submit a new direct deposit form to Human Resources.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ ☐ Checking ☐ Savings
% or \$ _____ Amount

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ ☐ Checking ☐ Savings
% or \$ _____ Amount

Signature

Authorized Signature: _____ Date: _____

Employee Name (Print): _____ ID #: *

* Leave ID # blank if you are a new employee.

☐ NEW ACCOUNT

☐ ADD ACCOUNT

☐ CHANGE ACCOUNT

☐ CHANGE % or \$ AMOUNT

PLEASE ATTACH A VOIDED CHECK OR OFFICIAL DOCUMENTATION FROM YOUR BANK AND RETURN THIS FORM TO HUMAN RESOURCES; DIRECT DEPOSITS WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.



MISSISSIPPI DELTA

Americans with Disabilities Act (ADA) Accommodations Request Form

Mississippi Delta Community College is committed to equal employment opportunity and affirmative action for the disabled. As a government contractor, the Mississippi Community College Board Executive Office is subject to the Americans with Disabilities Act of 1990 (ADA), and therefore must comply with governmental recordkeeping, reporting, and other requirements.

A disable person is defined as:

1. An individual who has a physical or mental impairment that substantially limits a major life activity;
2. An individual who has a record of a substantially limiting impairment; and
3. An individual who is regarded as having substantially limiting impairment.

Those who believe themselves covered by the Act and who wish to benefit under Mississippi Delta Community College's Affirmative Action Plan are asked to identify themselves. All information will be considered confidential except (1) supervisors may be informed regarding work restrictions or accommodations; (2) emergency response workers may be informed for first aid purposes; (3) governmental officials investigating compliance of the Act will be informed. Choosing not to provide this information will not result in adverse treatment or disciplinary action.

☐ ADA information is not applicable.

Signature _____

Date _____

☐ I choose not to provide ADA status information.

Signature _____

Date _____

DATE: _____

NAME: _____

SEX: M F (Circle One)

MDCC EMPLOYEE ID #: _____

BIRTH DATE: _____

POSITION TITLE: _____

DEPARTMENT/OFFICE: _____

BRIEFLY DESCRIBE YOUR DISABILITY:

Please describe any reasonable accommodations that you request Mississippi Delta Community College to make to enable you to perform your job in a proper and safe manner.

DRUG FREE ENVIRONMENT POLICY

Mississippi Delta Community College has adopted and implemented a program to prevent the unlawful possession, use, or distribution of illicit drugs and alcohol by its students and employees on school premises as part of its activities in compliance with the Drug-Free Schools and Communities Acts of 1989 Public Law 101-226.

Mississippi Delta Community College is committed to maintaining a drug-free environment in conformity with state and federal laws as set forth in the Uniform Controlled Substances Law of the State of Mississippi.

Illicit drugs are defined in Section 202 of the Controlled Substance Act; and the Mississippi Uniform Controlled Substance Law, Mississippi Code supplement (1989). Alcoholic beverages are defined in Sections 41-29-139, 141, 61-1-37, 81, 97-29-7 of the Mississippi Code Annotated for 1972 (1989 Supplement).

As specified in Section 41-29-142, 41-29-139, 61-1-81, 97-29-47 of the Mississippi Code Supplement, legal sanctions are applied to the following actions: possession of alcohol on college property; public drunk on college property; utilization of false ID to obtain alcohol; driving under the influence of alcohol; possession of illicit drugs, sale of illicit drugs near schools; possession of paraphernalia; and sale of paraphernalia. Sanctions range from fines of \$25 to \$1 million and jail sentences of 30 days in the county jail to 30 years in the state penitentiary.

Mississippi Delta Community College strictly prohibits the unlawful possession, use, or distribution of illicit drugs including drug paraphernalia, and alcohol on campus and during any college sponsored activities.

Employees who are guilty of violating the above stated policy can expect to face disciplinary action, which may include:

- a) Suspension as an employee from the college.
- b) Referral to law enforcement agency.
- c) Termination from employment.
- d) Any other disciplinary action deemed appropriate by the college president or the Board of Trustees.

Employee Signature

Date

EMPLOYEE ACKNOWLEDGEMENT

Mississippi Delta Community College provides qualified, competent administrators, faculty, and staff members who are committed to fulfilling the goals of the institution.

Definitions:

- ***"Contractual" employee*** – a full-time administrator, faculty, or staff member who is under written contract. A written contract establishes the terms and conditions of employment.
- An ***"at will"*** employee (non-contractual full time or part time) serves "at will" of the President. This means that either the college or the employee may terminate the employment relationship at any time, with or without notice and with or without cause.

Probation:

All faculty and staff members are considered to be hired for a probationary period for the first employment period. Probation also applies when an employee takes a new position. During the course of the probationary period, the employee's performance will be evaluated by his/her supervisor(s); and the appropriate administrator will recommend to the President whether or not a faculty/staff member's employment should be renewed or discontinued.

- Non-contractual employee's probationary period is one year from his or her effective date of employment.
- Contractual employee's probationary period is anywhere between 9 months to 12 months.

Signature

Date

**MISS. CODE ANN. §25-1-113
EMPLOYEE CERTIFICATION AND AUTHORIZATION STATEMENT**

NOTICE

Section 25-1-113, Mississippi Code of 1972, as amended, prohibits the hiring for public employment of individuals who have been convicted of or pled guilty to the unlawful taking or misappropriation of public funds effective July 1, 2013. Effective July 1, 2014, the State cannot continue to employ a person who has been convicted or pled guilty to the unlawful misappropriation of public funds. Specifically, Section 25-1-113, has been amended to read as follows:

The State and any county, municipality, or any other political subdivision may not employ or continue to employ a person who has been convicted or pled guilty in any court of this state, another state, or in federal court of any felony in which public funds were unlawfully taken, obtained or misappropriated in the abuse or misuse of the person's office or employment or money coming into the person's hands by virtue of the person's office or employment.

EMPLOYEE CERTIFICATION AND AUTHORIZATION

I have been notified that as an employee of the State of Mississippi I cannot have been convicted of or pled guilty in any court of this state, another state, or in federal court of any felony in which public funds were unlawfully taken, obtained or misappropriated in the abuse or misuse of my office or employment or money coming into my hands by virtue of my office or employment. I understand that any conviction of embezzlement will disqualify me from employment with the State of Mississippi and result in my termination.

I swear or affirm that I have never been convicted or pled guilty in any court of this state, another state, or in federal court of any felony in which public funds were unlawfully taken, obtained or misappropriated by the abuse or misuse of any office or employment or money coming into my hands by virtue of my office or employment.

I hereby authorize the Mississippi Community College Board to conduct a background check of my criminal history at any time as a condition of and/or subsequent to my employment. I understand and acknowledge that I may revoke my permission for such background check. In such case, no background check investigation will be done and my employment may be terminated. I further understand and acknowledge that should the criminal background check occur and it establishes that I have been convicted or pled guilty to misuse of public funds in violation of Section 25-1-113, my employment will terminate and I will have no recourse against the Mississippi Community College Board. In addition, I agree to hold harmless and indemnify Mississippi Community College Board, its members and employees, for any loss due to my employment being found to be in violation of Section 25-1-113.

Signature of Employee

Date

Employee's Name - Printed

Date of Birth

Social Security Number

Signature of Witness

Date

Name of Witness - Printed



Membership Application

Form 1 – Revised 02/11/2026

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Member Information – ☐ Attach a copy of the member's Social Security card.

First Name: _____ MI: _____ Last Name: _____ Gender: ☐ M ☐ F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date mm/dd/ccyy: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: _____ Other Phone: _____

Have you previously served on active duty in the U.S. Armed Forces? If yes, ☐ attach a legible Form(s) DD214 ☐ Yes ☐ No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? ☐ Yes ☐ No

2 Retirement Plan – Plans are governmental plans qualified under Section 401(a) of the Internal Revenue Code. Select applicable plan.

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

3 Family Information – Use additional Membership Applications if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B, Beneficiary Designation, to officially designate any and all beneficiaries.

Marital Status – Select one. Add date for last three. ☐ Single ☐ Married ☐ Divorced ☐ Widowed Effective Date mm/dd/ccyy: _____

Spouse's Full Name	Social Security No.	Birth Date mm/dd/ccyy	Wedding Date mm/dd/ccyy	Gender
_____	_____	_____	_____	☐ M ☐ F

Dependent Child's Full Name – Up to age 19, or 23 if unmarried and a full-time student	Social Security No.	Birth Date mm/dd/ccyy	Relationship	Gender
_____	_____	_____	_____	☐ M ☐ F
_____	_____	_____	_____	☐ M ☐ F
_____	_____	_____	_____	☐ M ☐ F
_____	_____	_____	_____	☐ M ☐ F

4 Member Certification – I certify that the above information is true and correct. Furthermore, I understand that if I became a member of PERS on or after March 1, 2026, I have been automatically enrolled in a hybrid retirement plan, which consists of a defined benefit and defined contribution components administered by PERS and a contracted third-party administrator.

Member's Signature: _____ Date mm/dd/ccyy: _____

5 Employer Certification – This section must be completed by an authorized employer representative, not the member.

Member's Position Held/Job Title: _____ Member's Hire Date for Position mm/dd/ccyy: _____

Member's Status: Elected Official: ☐ Yes ☐ No Fee Paid Official: ☐ Yes ☐ No Public Safety Employee: ☐ Yes ☐ No

Employer Name: Mississippi Delta Community College PERS Employer No.: 0620

Employer Representative's Name: Waunita Roberts-Jones Employer Representative's Title: Executive Director of Human Resources

Employer Representative's Phone: (662) 246-6241 Fax: (662) 246-9632 E-Mail: wroberts@msdelta.edu

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, Eligibility of Part-time Employees for State Retirement Annuity Service Credit, and PERS Board of Trustees Regulation 36, Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS). I understand that, if the employee named in Section 1 became a member of PERS on or after March 1, 2026, I am required to report employee information, as well as contributions as defined in state statute to both PERS and the contracted third-party administrator. Mandatory employer contributions must be reported to PERS.

Employer Representative's Signature: _____ Date mm/dd/ccyy: _____

Public Employees' Retirement System of Mississippi

429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, fax www.pers.ms.gov

Reset Form

Print



Beneficiary Designation

Form 1B - Revised 08/30/2022

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ ☐ Member ☐ Retiree
Social Security No.: _____ Birth Date mm/dd/ccyy: _____ Gender: ☐ M ☐ F

2 Retirement Plan - Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. Select applicable plan.

- ☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)
☐ Supplemental Legislative Retirement Plan (SLRP)

3 Beneficiary Information - Use additional Form 1B, Beneficiary Designation, to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary beneficiaries must equal 100 percent, and total secondary beneficiaries must equal 100 percent. Secondary beneficiaries will only receive payment if all listed primary beneficiaries are deceased.

Beneficiary Name	Social Security No.	Birth Date mm/dd/ccyy	Relationship	Beneficiary Percentage P=Primary, S=Secondary Use whole numbers	Gender
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F
_____	_____	_____	_____	☐ P ☐ S _____ %	☐ M ☐ F

4 Member/Retiree Certification - Check applicable acknowledgement then sign. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

- ☐ Member - I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).
- ☐ Retiree - I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date mm/dd/ccyy: _____

5 Employer Certification - This section must be completed by an authorized employer representative, not the member. Only complete for active members.

Employer Name: **Mississippi Delta Community College** Employer No.: **0620 000**
Employer Representative's Name: **Waunita Roberts-Jones** Employer Representative's Title: **Executive Director of Human Resources**
Employer Representative's Phone: **(662) 246-6241** Fax: **(662) 246-6392** E-Mail: **wroberts@msdelta**

Employer Representative's Signature: _____ Date mm/dd/ccyy: _____



Non-Covered Employment Acknowledgment Form 4A – Revised 06/14/2023

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Employee Status

First Name: _____ MI: _____ Last Name: _____ Gender: ☐ M ☐ F

Is employee currently receiving PERS service retirement benefits? Choose yes or no and follow related instructions.

- ☐ Yes – Do not complete form. Instead, complete PERS Form 4B, Reemployment of PERS Retiree Certification/Acknowledgement.
☐ No – Continue to next question.

Is employee currently employed with a PERS-covered employer other than the employer to be listed in Section 4? Choose yes or no and follow related instructions.

- ☐ Yes – Choose type of employee for the employer to be listed in Section 4 and follow related instructions.
☐ Temporary or Intermittent Part-Time Employee – Continue to Section 2.
☐ Eligible Part-Time Employee (meeting eligibility requirements listed in Section 105 of PERS Board of Trustees Regulation 36 as it relates to dual employment) – Do not complete this form. Instead, complete PERS Form 1, Membership Application.
☐ No – Continue to Section 2.

2 Employee Information

Social Security No.: _____ Birth Date mm/dd/yyyy: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

3 Employee Acknowledgment

I hereby acknowledge that I am not receiving service retirement benefits from PERS and that my employment does not meet the eligibility requirements of PERS Board of Trustees Regulation 26, *Eligibility of Part-time Employees for State Retirement Annuity Service Credit*, and PERS Board of Trustees Regulation 36, *Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS)*, and that I, therefore, am not eligible for coverage for this employment under the provisions of PERS. **CAUTION** If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

Employee's Signature: _____ Date mm/dd/yyyy: _____

4 Employer Certification – This section must be completed by an authorized employer representative, not the employee.

Employee's Position Held/Job Title: _____

Employee's Hire Date mm/dd/yyyy: _____ Employee's Termination Date mm/dd/yyyy: _____

Employer Name: _____ Employer No.: _____ - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

As employer representative, I understand that wages earned and paid to the above-named individual during this period of employment will not be subject to withholding for state retirement. I further understand that any person who makes a false statement or shall falsify or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution. With that understanding, I certify that the above information is true and correct and that employment in this position does not meet the eligibility requirements of PERS Board of Trustees Regulation 26, *Eligibility of Part-time Employees for State Retirement Annuity Service Credit*, and PERS Board of Trustees Regulation 36, *Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS)*.

Employer Representative's Signature: _____ Date mm/dd/yyyy: _____



Reemployment of PERS Service Retiree Certification/Acknowledgement

Form 4B - Revised 02/07/2023

Please print or type in black ink. A Form 4B, Reemployment of PERS Service Retiree Certification/Acknowledgement, should be submitted each fiscal year (July 1 - June 30) of reemployment. See Regulation 34, Reemployment after Retirement, for rules governing reemployment. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Retiree Information

First Name: _____ MI: _____ Last Name: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Social Security No.: _____ E-Mail: _____
Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work
Position/Agency from which Retired: _____ Retirement Date mm/dd/yyyy: _____

2 Annual Retiree Acknowledgement and Election - Please check one.

I hereby acknowledge that I have read, understand, and agree to comply with the provisions for reemployment as outlined in PERS Board Regulation 34, Reemployment after Retirement, which stipulates that I must be retired at least 90 days or I forfeit my retirement benefit. With that understanding, I make the following annual election in accordance with Miss. Code Ann. § 25-11-127 (1972, as amended):

A. ☐ I hereby elect to be employed by a covered employer for a period of time not to exceed one-half of the normal working days or hours for the full-time equivalent position during the state fiscal year indicated in Section 3, and I will receive no more than one-half of the salary in effect for the position at the time of employment. The full-time annual salary authorized for this position is \$ _____ and I will earn no more than \$ _____ during the state fiscal year indicated in Section 3.

B. ☐ I hereby elect to earn an annual salary that will not exceed 25 percent of the final average compensation used in calculating my service retirement allowance. My final average compensation at retirement was \$ _____ and I will earn no more than \$ _____ from all PERS-covered employers during the state fiscal year indicated below.

Retiree's Signature: _____ Date mm/dd/yyyy: _____

3 Employer Certification - This section should be completed by an authorized employer representative, not the retiree.

I hereby certify that the above-named individual, who is a service retiree receiving benefits from PERS, is employed in the below-named position in accordance with the reemployment provisions as authorized in Miss Code Ann. § 25-11-127 (1972 as amended) and in accordance with the provisions of PERS Regulation 34, Reemployment after Retirement. I understand that wages earned and paid to the above-named individual during this period of employment will be reported in accordance with reporting requirements prescribed by PERS and the applicable employer contributions on the wages actually paid must be submitted. I further understand that any person who makes a false statement or shall falsify or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution, and with that understanding, I certify that the election above provides the facts upon which the employment is being made, and the information below is true and correct.

Retiree's Position/Job Title: _____ Fiscal Year of Reemployment (July 1 - June 30): _____

Retiree Employed through Third Party: ☐ No ☐ Yes Name of Third Party: _____

Employer Name: _____ Employer No.: _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

Employer Representative's Signature: _____ Date mm/dd/yyyy: _____

**STATE OF MISSISSIPPI
STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
APPLICATION FOR COVERAGE**

PLEASE PRINT		Employer Name	
Section A: Enrollee Information (all fields are required)			
Social Security Number	First Name	MI	Last Name
Home Address		City	State ZIP
Primary Telephone Number	Secondary Telephone Number	Personal Email Address	
Marital Status ☐ Single ☐ Married	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement
Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? ☐ No (Horizon) ☐ Yes (Legacy)			
If yes, please list your most recent (pre-1/1/06) employer and dates of employment: _____			
If married, is your spouse a Plan participant? ☐ Yes ☐ No If yes, Spouse Name and SSN: _____			

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

☐ I hereby apply to **ADD, CONTINUE AND/OR CHANGE COVERAGE** for myself and/or my dependents named on this Application for Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the Plan Document. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

☐ I hereby **WAIVE COVERAGE** in the State and School Employees' Health Insurance Plan. I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.

Enrollee Signature: _____ Date: _____

Section C: Coverage

Enrollee Type: ☐ Employee - Legacy ☐ Employee - Horizon ☐ Retiree ☐ COBRA ☐ Surviving Spouse	Coverage Type: ☐ Enrollee Only ☐ Enrollee + Spouse ☐ Enrollee + Child ☐ Enrollee + Children ☐ Enrollee + Spouse & Child(ren)	Coverage Option: (Choose Only One) ☐ Select ☐ Base (HIGH DEDUCTIBLE)	Do you have Medicare? ☐ Yes ☐ No Medicare Number: _____ "A" Effective Date: _____ "B" Effective Date: _____ Reason for Entitlement: ☐ Age ☐ ESRD ☐ Disability
Are you a tobacco user? ☐ Yes ☐ No If yes, are you interested in participating in the Plan's free cessation program? ☐ Yes ☐ No			

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? ☐ Yes ☐ No If yes, please provide the following:

Name of Individual Covered:	1. _____	2. _____	3. _____	4. _____
Policyholder's Name:	_____	_____	_____	_____
Policyholder's Date of Birth:	_____	_____	_____	_____
Policyholder's Insurance Effective Date:	_____	_____	_____	_____
Policy Number:	_____	_____	_____	_____
Policyholder's Employment Status:	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐
Insurance Company Name address & phone #:	_____	_____	_____	_____
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:
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Section E: Dependents

Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security Number	Date of Birth (mm/dd/yyyy)	Address (if different from Enrollee)	Current Status
1.	☐ Spouse ☐ Male ☐ Female				☐ Employed? ☐ Yes ☐ No
2.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
3.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
4.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? ☐ Yes ☐ No
 If yes, please provide the following:

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Section F: Change Information

☐ Add Enrollee: ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of Coverage due to Divorce ☐ Other: _____ Requested Effective Date: _____		
☐ Add Dependent(s): ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Other: _____ (List all dependents in Section E.) Qualifying Event/ Effective Date: _____		
☐ Change Coverage: ☐ Base Coverage ☐ Select Coverage		
☐ Drop Dependent(s): ☐ Divorce ☐ Deceased ☐ Other: _____ Provide information below for dependents to be dropped:		
Name	Social Security Number	Requested Termination Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
☐ Other Changes (Explain): _____		

FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER: _____ New Legacy Employee, Requested Effective Date: _____ New Horizon Employee, Requested Effective Date: _____ Retiree, Requested Effective Date: _____ COBRA, Requested Effective Date: _____ Surviving Spouse, Requested Effective Date: _____ Change(s), Requested Effective Date: _____	ENTERED BY: _____ DATE: _____ VERIFIED BY: _____ DATE: _____
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Print

STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN ENROLLMENT/CHANGE REQUEST FORM

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.
Policy 33683-G

SECTION A: Employee/Employer Information

Employee/Retiree Last Name:	First Name:	MI:	Social Security Number:	Birthdate: (MM/DD/YYYY):
Employee/Retiree Home Address:			Email Address:	Home Phone:
				Alternate Phone:
Employer Name:				Employer Phone:
Employer Address:				

SECTION B: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)

ACTIVE FULL-TIME EMPLOYEE: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of \$30,000 and a maximum of \$100,000. The employee and employer each pay 50 percent of the monthly premium.

- ☐ **New Employee** – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.
- ☐ **Late Enrollee Applicant** – Applications made after initial 31 days of employment will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life. (Employee must also complete the Minnesota Life GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form.)

Date of Employment: _____

- ☐ **RETIRED EMPLOYEE:** Life benefit amounts are limited to \$5,000, \$10,000 or \$20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

Date of Retirement: _____ COVERAGE AMOUNT REQUESTED: ☐ \$5,000 ☐ \$10,000 ☐ \$20,000

- ☐ **DISABLED EMPLOYEE:** Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months. (Employee must also complete the Minnesota Life NOTICE OF DISABILITY and ATTENDING PHYSICIAN'S STATEMENT forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

NOTE: You cannot designate your life insurance beneficiary on this form. To designate your life insurance beneficiary, please follow the instructions below:

1. Log in to your myBlue site, <https://myblue.bcbsms.com>, and click on the My Benefits tab.
2. Scroll down to the Life Benefits section below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on the site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through the myBlue portal.

If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the policy.

If you do not have Internet access, contact Minnesota Life toll free at **877-348-9217** to request a paper beneficiary designation form.

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone
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SECTION D: Authorization and Certification

I am applying for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Insurance Company, Group Policy #33683-G, and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee/Retiree Signature (Required)

Date

SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)

☐ **Waiver of Coverage** – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

☐ **Cancellation of Coverage** – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.

Employee/Retiree Signature

Date

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT <http://KnowYourBenefits.dfa.ms.gov/> OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	GROUP NUMBER:	INFORMATION VERIFIED: (INITIAL AND DATE)

MISSISSIPPI DELTA COMMUNITY COLLEGE

INFORMATION NETWORK RESOURCES POLICIES & PROCEDURES

I. INTRODUCTION AND PURPOSE

The purpose of the MDCC Information Network is to support the overall educational mission of the college, in accordance with college policies. Access to the network and its resources is a privilege. Network users must respect the rights of others and the integrity of the components of the network.

This policy governs the use of all computers, computer-based networks, and related hardware and software at Mississippi Delta Community College. Under federal statutes and the sections of the Mississippi code that regulates the use of these resources, the college is required to ensure that this equipment and software are used properly, and for the purpose for which state funds were expended. The intent of this policy is to allow maximum freedom of use consistent with state and federal law, college policy and a productive work environment.

II. SCOPE

This policy applies to all college faculty, staff, administrators, students, and members of the community who use the College network resources. It covers all computing hardware that is connected to the network, including microcomputers, printers, etc. It also includes all network infrastructure: data wiring and fiber optic cable, routers, switches, hubs, servers, data connectors, and all other associated hardware and materials.

The following types of software are covered under this policy: operating systems, network software, compilers, and all instructional and application software defined as "supported by the college".

The following categories of data systems are included: the administrative and student information system and data that have been collected or generated by the college. Not covered is software or data that the college does not support, even though such may be stored on college hardware and/or used by individual departments.

III. GENERAL STATEMENTS

- A. Training – Training is provided for administration, faculty and staff as new hardware, software and services are made available. Prior to receiving access to the network, each employee must demonstrate a satisfactory level of proficiency in certain areas such as proper use of passwords, how to access the Internet, e-mail, administrative software, and other application software. Administration, faculty, and staff are encouraged to attend workshops and classes at off-site locations provided sufficient funds are available in the departmental budgets.

Training will be made available to the employee at the time of employment.

- B. Network Access --** Network access is controlled by passwords, and the level of access granted is determined by a user's job-related or educational requirements.
1. **Username and Passwords --** Users will be assigned a username and password which should not be disclosed. Usernames will follow a naming convention developed by the Office of Information Technology. Passwords must be at least eight positions in length. The *recommended* length is eight to twelve positions. Passwords *must* contain an upper-case character, a lower-case character and *must* contain at least one number, and *may not* contain spaces. The password should not contain the user's account name or parts of the user's full name. Users will be required to change passwords periodically. The password cannot be the same as the last four used passwords. Requests for new usernames and passwords should be submitted and approved using the User Access Request Form. Requests for usernames and passwords to be deleted from the computer system when an employee is terminated should be submitted and approved using the College's Employee Departure Form.
 2. **Accounts --** Network accounts for employees are managed by the Office of Information Technology staff. Requests for establishment or modification of employee accounts must be approved at the Dean/Director level or above. Specific access granted to an employee account is subject to approval by the appropriate Dean/Director with the guidance of the Director of Information Technology. Removal of an account occurs when the owner is no longer an employee of the college, or when disciplinary action is indicated. It is the responsibility of the employee's supervisor to notify Information Technology staff within 24 hours of an account holder's separation from service. Student accounts and public accounts must be requested and maintained by the appropriate department under the supervision of Information Technology staff.
- C. Ethical Use --** The network is for official college use only and must not be used for personal business, profit-making ventures, political activities, or to harass or offend anyone. Some employees will be given access to the student information systems and/or other administrative systems. The confidentiality of these records is governed by the federal Family Education Rights and Privacy Act of 1974 (a.k.a. Buckley Amendment, FERPA). All information is confidential, and students have a right to expect that their scholastic records are being properly supervised and maintained. Requests for disclosure of this information must be approved by the appropriate administrative officer.
- D. Security --** All information is property of Mississippi Delta Community College and use or distribution is prohibited without approval of the appropriate department. Information should be protected against unauthorized access and/or destruction. A backup copy of administrative information is made daily. It is recommended that each user make a backup copy of information on individual personal computers frequently. A disaster recovery plan is maintained by the Office of Information Technology. Users should not leave a terminal/computer unattended while signed on. A secure off-site facility will be provided for storage of backups, user documentation, copies of disaster plan, and critical forms. The college attempts to protect the network from intrusion from within and without. All suspected attempts to violate network security must be reported to the Director of Information Technology as soon as possible. If it is determined that a breach in network security has compromised sensitive information, the President of the college may request the aid of law enforcement to handle the investigation. The Office of Information

Technology will periodically check for, and follow up on, security violations.

- E. **Disaster Recovery Plan** – The Office of Information Technology maintains a Disaster Recovery Plan. All programs, files, folders, configuration, and security information are saved on a daily basis. **Backup of individual personal computers is the responsibility of the individual user.**
- F. **Software Supported by the College** – Software standards will be established and distributed by the Office of Information Technology. Only approved software will be supported and maintained. The support and maintenance of other software will be the responsibility of the user. Computer software should be properly registered to obtain updates and protect warranties or other legal rights.
- G. **Computer Hardware** – Computer hardware should not be relocated or have components added or removed without coordination with the Office of Information Technology.
- H. **User requests** – All requests for services which fall within the realm of the Office of Information Technology (telephones, e-mail, hardware, software, programming, network services and support, Internet access) should be submitted by the appropriate supervisor using the Trackit System. The request will be directed to the proper Office of Information Technology personnel for resolution.
- I. **Web Site** – The college will operate a web site for the purposes of recruiting and disseminating college information. This service will be operated and maintained by the Webmaster. All requests concerning this area should be directed to the Webmaster.
- J. **Access to the Internet** - The college provides Internet access through the college network to all employees having a network account. Student Internet access is through the individual instructional departmental laboratories, learning centers, and computer classrooms. Community access is through the learning centers and open labs as approved by the college. Internet access is intended only for official college business. The college discourages personal use of the Internet through the college network, especially during the normal business hours. The college does not condone access to sites which contain pornography and other sexually explicit material. The use of the Internet for political purposes, illegal activity, profit-making ventures, or the harassment of individuals or organizations is considered a violation of college policy. Users should be aware that our system logs all Internet sites which are accessed through the network. This information will be monitored on a regular basis through normal network maintenance and to investigate abuse of the resource.
- K. **E-Mail** – An e-mail account is provided for each employee who has a network account. As with Internet access, e-mail is intended only for official college business and not for illegal activity, personal profit-making ventures, political purposes, or to harass any person or organization. E-mail is, by definition, public, and is subject to review by college officials without prior notification. Users are responsible for maintaining their e-mail accounts and removing old messages.
- L. **Agreement** – Every employee who uses the network is required to read and sign the "Information Network Resources Use Agreement".

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
EFFECTIVE JANUARY 1, 2026

Legacy - Initially hired before 1/1/2006
 Horizon - Initially hired on or after 1/1/2006

	LEGACY EMPLOYEES			
	BASE		SELECT	
	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
ACTIVE EMPLOYEE				
Employee*	\$513	\$0	\$533	\$20
Employee + Spouse	\$1,074	\$561	\$1,173	\$660
Employee + Spouse & Child(ren)	\$1,367	\$854	\$1,467	\$954
Employee + Child	\$659	\$146	\$759	\$246
Employee + Children	\$886	\$373	\$983	\$470

	HORIZON EMPLOYEES			
	BASE		SELECT	
	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	\$513	\$0	\$566	\$53
Employee + Spouse	\$1,074	\$561	\$1,205	\$692
Employee + Spouse & Child(ren)	\$1,367	\$854	\$1,499	\$986
Employee + Child	\$659	\$146	\$790	\$277
Employee + Children	\$886	\$373	\$1,015	\$502

*The State pays 100% of the employee's premium for Base Coverage. Active employees enrolling in Select Coverage must pay a portion of the employee premium.

	LEGACY RETIREES	
	BASE	SELECT
RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE		
Retiree	\$590	\$614
Retiree + Spouse (Non-Medicare)	\$1,235	\$1,349
Retiree + Spouse & Child(ren) (Non-Medicare)	\$1,571	\$1,686
Retiree + Child	\$758	\$839
Retiree + Children	\$1,017	\$1,063
Retiree + Spouse (Medicare)	N/A	\$864
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$1,089
RETIRED EMPLOYEE - MEDICARE ELIGIBLE		
Retiree	N/A	\$250
Retiree + Spouse (Non-Medicare)	N/A	\$985
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	\$1322
Retiree + Child	N/A	\$474
Retiree + Children	N/A	\$699
Retiree + Spouse (Medicare)	N/A	\$500
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$725

	HORIZON RETIREES	
	BASE	SELECT
Retiree	\$941	\$975
Retiree + Spouse	\$1,887	\$2,010
Retiree + Spouse & Child(ren)	\$2,109	\$2,234
Retiree + Child	\$1,109	\$1,200
Retiree + Children	\$1,368	\$1,425
Retiree + Spouse (Medicare)	N/A	\$1,225
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$1,450
Retiree	N/A	\$250
Retiree + Spouse	N/A	\$1285
Retiree + Spouse & Child(ren)	N/A	\$1509
Retiree + Child	N/A	\$474
Retiree + Children	N/A	\$699
Retiree + Spouse (Medicare)	N/A	\$500
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$725

	LEGACY	
	BASE	SELECT
COBRA		
Participant	\$522	\$545
Participant + Spouse	\$1,095	\$1,197
Participant + Spouse & Child(ren)	\$1,394	\$1,496
Participant + Child	\$672	\$774
Participant + Children	\$903	\$1,003
COBRA DISABILITY EXTENSION		
Participant	\$769	\$801
Participant + Spouse	\$1,611	\$1,760
Participant + Spouse & Child(ren)	\$2,051	\$2,201
Participant + Child	\$988	\$1,138
Participant + Children	\$1,329	\$1,476

	HORIZON	
	BASE	SELECT
Participant	\$522	\$577
Participant + Spouse	\$1,095	\$1,229
Participant + Spouse & Child(ren)	\$1,394	\$1,529
Participant + Child	\$672	\$806
Participant + Children	\$903	\$1,036
Participant	\$769	\$849
Participant + Spouse	\$1,611	\$1,808
Participant + Spouse & Child(ren)	\$2,051	\$2,249
Participant + Child	\$988	\$1,186
Participant + Children	\$1,329	\$1,524

MISSISSIPPI DELTA COMMUNITY COLLEGE INFORMATION NETWORK RESOURCES EMPLOYEE USE AGREEMENT

I hereby agree to use professional judgment with regard to use of the college network resources. Specifically, I *will* *not*:

1. use the college network or any device connected to the college network for any purpose other than official college business. I will not use the network for illegal purposes, profit-making activities, political activities, or to harass anyone or any organization.
2. access sites which contain pornography and other sexually explicit material.
3. reveal my system password to anyone, or make it possible for anyone to access it by posting it or by the careless handling of it.
4. access, view, alter or attempt to access, view or alter college information except that which is permitted by my password, and only then in the performance of my job.
5. allow or assist any unauthorized individual to access, view or alter college information, or share such information with them except as authorized by appropriate authority.
6. connect any electronic device to, remove any electronic device from, or alter any electronic device which is connected to the college network without the expressed permission of the Director of Information Technology.
7. relocate or disturb any of the network infrastructure (including wiring, hubs, switches, connectors, etc.) without the expressed permission of the Director of Information Technology.
8. move a college network device (microcomputer, printer, etc.) from its assigned location without notifying Computer & Information Services and completing an Inventory Deletion/Relocation Form obtained from the Business Office.
9. share knowledge of the college network infrastructure with anyone except an authorized college employee.
10. load any file which has not been scanned for viruses to a networked computer.
11. install any software on a computer without the approval of the Director of Information Technology, and will not duplicate copyrighted or licensed software or other materials unless specifically permitted to do so by author or publisher agreement.
12. store on college media (disks, tape, etc.) any materials which violate sexual harassment or civil rights policy.

I understand my responsibility with respect to ensuring appropriate security, confidentiality, and use of the college network. I also understand that the college is not responsible for any consequences or legal actions that may result because of my misuse of the college network resources. I have read and do understand the above conditions. I realize that failure to comply with any of the above conditions can result in disciplinary action against me as described in the college's Policies and Procedures Manual.

Signed _____

Date _____

Print Name _____

MISSISSIPPI DELTA COMMUNITY COLLEGE

Office of Information Technology

✉ it@msdelta.edu ☎ 662.246.6330 📠 Fax: 662.246.6431

USER ACCESS REQUEST FORM

This request must be preceded by the signed and dated Information Network Resources Use Agreement.

Date: _____

Personal eMail address: _____

Please clearly print the following information—

Full Name: _____

Preferred First Name: _____

Last 4 digits of Social Security #: _____ Date of Birth: _____

Title: _____

☐ Full-time ☐ Part-time

Department: _____

D#: _____ (N/A will provide)

For Office of Information Technology use only

Received Signed Employee Use Agreement? ☐ Yes ☐ No

Employee ID #: _____ User Name: _____

Email Address: _____

☐ Setup Active Directory/Network account – Done by: _____

☐ Setup Email account – Done by: _____

☐ Notified Supervisor of Employee – Done by: _____

☐ Sent Welcome Email – Done by: _____

☐ Sent FERPA Email – Done by: _____

☐ Sent Policies & Procedures Email – Done by: _____

MISSISSIPPI DELTA COMMUNITY COLLEGE

Assigning Registration Time Tickets in MyBanner (SSB)

1. Log in to the **MyDelta Portal**.
2. Click the **MyBanner** link.
3. Click on **Faculty and Advisors** menu item OR the **Faculty Services** tab.
4. Scroll to the bottom of the page and click on **Registration Time Ticket**.
5. If a term has not been previously selected, click on the down arrow to select the term then click
6. **Submit**.
7. If a student has not been previously selected, select a student ID by either entering the student's Banner ID OR entering the student's last name, first name and then click **Submit**.
8. If searching for a student by name, click on the down arrow next to the name then click on
9. the name from the list (NOTE: DO NOT JUST SELECT THE FIRST NAME DISPLAYED - it may not be the student you are searching for).
10. After the student name has been selected, verify the information, and then click **Submit**.
11. Click on **Registration Time Ticket** again and the student's ID, name and major will display.
12. To assign a time ticket, click on the down arrow next to **Select Group**.
13. Click on the group based on the major or other instructions you received on assigning time ticket groups for this term.
14. Click on **Assign this Group**.
15. Verify that the correct group was assigned to this student.
16. To change the time ticket group click on down arrow next to **Select Group**, select the new group, click on **Submit**.
17. To remove a student from a group so they will not be able to register in SSB, click on **Remove**
18. **Time Ticket Group** at the top of the screen.
19. 17. To proceed with another student click **Student ID Selection** in brackets at the bottom of the screen and repeat the steps for selecting a student and assigning a group as listed above
20. 18. When finished click on **Exit** at top of screen.

MISSISSIPPI DELTA COMMUNITY COLLEGE

ATTENDANCE MODULE INTEGRATED WITH BANNER

Please review the following detailed explanation of the Attendance roll integration with Banner.

- LDA = Last Date of Attendance
- When a student registers for a class on the web (SSB/MyBanner), "RW" status code is assigned. When a student is registered directly in Banner (INB) for a class, "RE" status code is assigned. These codes are displayed on the Attendance roll under the Reg column. When a student is dropped from a class the status code will be changed as follows:
 - The registration status code for any student marked as a no show will be changed to "DD" and the first day of class is used as the status date. Any student marked as CIs WD whose LDA is within the refund period (two weeks) will also be changed to "DD". The student will be removed from the Detail and Summary Class List in SSB/MyBanner but will remain on the Attendance roll. The student will receive a 100% refund for the class.
 - After the refund period, the registration status code for a student marked as CIs WD will be changed to "DC" and the LDA (last date of attendance) will be used as the status date. A "W" grade will be automatically assigned. The student will not receive a refund for the class.
 - The registration status code for a student marked as Exc Abs will also be changed to "DC" and the LDA will be used as the status date. An "F" grade will automatically be assigned, but may be changed to "W" using the Final Grade option on the Faculty Services tab in SSB/MyBanner using established.
 - If a student is readmitted (reinstated) to a class, the "DC" status code will be changed back to "RE". The LDA and grade will also be removed.
 - If a student is withdrawn from school (ALL classes) in Banner, "WS" enrollment status code is assigned to the student term record in Banner. If all classes have been recorded as no shows or dropped within the refund period "WD" is assigned to the student term record.
- Currently VCC class withdrawals are processed directly in Banner (INB).
- **ATTENDANCE REMINDERS:**
 - All attendance (absences, class withdrawals, no shows) should be up-to-date and complete prior to entering final grades!
 - Please do not wait to assign a W grade at grade entry time! If a student has "cut out" or withdrawn, you should go through the proper steps in the attendance module to record that prior to grade entry time! If you do give a W grade at grade entry time, you MUST enter an LDA!
 - When finished with marking absences for the class, be sure to click on Save Audit Roll or you will lose attendance entered. ****NOTE: You MUST save attendance before changing weeks. For example, if you enter attendance for Weeks 1-4, and want to then record attendance for Weeks 5-8, you must save Weeks 1-4 before proceeding to the Weeks 5-8 screen.***
- The information in the Attendance roll will be updated in Banner each afternoon (5:00 pm).
- The information for a dropped class will only be updated in Banner once. If LDA has been entered incorrectly, the Final Grade option on the Faculty Services tab may be used to make a correction. A correct LDA is essential for financial aid and state board auditing purposes.

Contact The Office of Information Technology if you have technical issues.

Recording Attendance

- Click on **MyBanner** link from the MDCC web site at www.msdelta.edu
- Click on **MyBanner Log In**.
- Click on **Enter Secure Area** on the initial Self Service Banner (SSB/MyBanner) page.
- Enter your User ID (Banner ID or SSN) and your PIN (Password).
- Click on **Log In**.
- Click on **Faculty and Advisors** menu item OR the **Faculty Services** tab.
- Scroll to the bottom of the page and click on **Attendance Roll Form**.
- Click on the **down arrow** next to the Class(es) heading, then click on a class to enter attendance.
- Click on the Week in the semester for which attendance is to be entered (Weeks 1-4, 5-8, etc.), if not already selected.
- To mark a student absent, click on the box under the correct class meeting (NOTE: hovering over box will display date).
- After clicking once an "A" will be inserted in the box.
- To remove an absence, click on "A" and it will be removed.
- If the box is blank, it is assumed that the student was present.
- Continue marking students absent.
- **IMPORTANT!** When finished with marking absences for the class, be sure to click on **Save Audit Roll** or you will lose attendance entered. **NOTE: You MUST save attendance before changing weeks. For example, if you enter attendance for Weeks 1-4, and want to then record attendance for Weeks 5-8, you must save Weeks 1-4 before proceeding to the Weeks 5-8 screen.*
- Your initials and date of birth will be automatically saved in the database indicating you certify the attendance entered.

Recording No Shows

- When instructed to record no shows for the semester, click on the down arrow under the Status column for the student.
- Click on **No Show**.
- Boxes will be grayed out and will be automatically marked as absences for the remainder of the semester when saved.
- When finished marking no shows click on **Save Audit Roll**.
- When transferred to Banner, the Reg status will be changed to "DD" and the first day of class is used as the status date. The student will be removed from the Detail and Summary Class List in Banner but will remain on the Attendance roll. The student will receive a 100% refund for the class.

Recording Class withdrawals

- Click on the down arrow under the Status column for the student.
- To officially withdraw a student from class, click on the **Cls WD** in the list.
- Click on the down arrow next to the date box under Cls WD, and select the LDA from the list.
- Boxes after the LDA will be grayed out and will be automatically marked as absences for the remainder of the semester when saved.
- When finished, click on **Save Audit Roll**.
- When transferred to Banner and the LDA is after the refund period, the Reg status will be changed to "DC" and the LDA will be used as the status date. A "W" grade will be automatically assigned. The students will not receive a refund.
- If the LDA is within the refund period, "DD" will be assigned. The student will be removed from the Detail and Summary Class List in Banner but will remain on the Attendance roll. The student will receive a 100% refund for the class.

Recording Excessive Absences (Cut Outs)

- Click on the down arrow under the Status column for the student.
- To officially withdraw a student from class due to excessive absences, click on **Exc Abs** in the list.
- Click on the down arrow next to the date box under Exc Abs, and select the LDA from the list.
- Boxes after the LDA will be grayed out and will be automatically marked as absences for the remainder of the semester when saved.
- When finished click on **Save Audit Roll**.
- When transferred to Banner and the LDA is after the refund period, the Reg status will be changed to "DC" and the LDA will be used as the status date. An "F" grade will automatically be assigned, but may be changed to "W" on the Final Grade option under the Faculty Services tab using established grading policies.
- If the LDA is within the refund period, "DD" will be assigned. The student will be removed from the Detail and Summary Class List in Banner, but will remain on the Attendance roll. The student will receive a 100% refund for the class.

Readmitting (Reinstate) a student

- Click on the down arrow under the Status column for the student to be readmitted to class.
- Click on **Readmit**.
- Students LDA will be removed and all absences will be retained.
- Click on absences from date readmitted to end of semester (through Week 17 - 18) to remove absences.
- When finished, click on **Save Audit Roll**.
- When transferred to Banner, the Reg status will be changed back to "RE". The LDA and "W" grade will also be removed.

MISSISSIPPI DELTA COMMUNITY COLLEGE

BANNER – Final Grade Entry

MDCC does not record mid-term grades

- **IMPORTANT!** All attendance records should be updated before proceeding with final grades!

*****Please do not wait to assign a W grade at grade entry time! If a student has "cut out" or withdrawn, you should go through the proper steps in the attendance module to record that prior to grade entry time!***

- Click on **MyBanner** link from the MDCC web site at www.msdelta.edu
- Click on **MyBanner Log In**.
- Click on **Enter Secure Area** on the initial Self Service Banner (SSB/MyBanner) page.
- Enter your User ID (Banner ID or SSN) and your PIN (Password).
- Click on **Log In**.
- Click on **Faculty and Advisors** menu item OR the **Faculty Services** tab.
- Click on **Final Grades**.
- If a term has not been previously selected, click on the down arrow to select the term then click **Submit**.
- Click on the down arrow to select the CRN for class, and then click **Submit**.
- Click on the down arrow under the grade column and select a grade.
 - **NOTE:** For class withdrawals leave the grade as "W". For excessive absences the grade may be left as "F" or changed to "W" based on school policy.
 - **NOTE:** Instructors **cannot** enter an "I" grade in MyBanner. If you need to assign an "I" grade, please contact the Office of Instruction at 662.246.6317. If an "I" grade for incomplete is assigned, please remember that according to college policy, the "I" grade will be changed to "F" within one year if you do not submit a change of grade form to the Office of Admissions before the incomplete extension date.
- **Last Attend Date should be blank for students completing the class.** If a student has a class withdrawal or excessive absences, check the last attend date and correct if necessary. The date should be entered in MM/DD/YYYY format (include the slashes).
 - **NOTE:** Students that show "**non-gradable**" in the final grade column should **NOT** have a date in the LDA field. If there is a date in that field, grades for other students **will not** post.
 - **NOTE:** If you give a "W" grade, a LDA **MUST** be entered. Also, if an "F" grade was assigned to a cut-out, a LDA **MUST** be entered. An **EARNED** "F" grade should **NOT** have an LDA.
- Also – there seems to be some confusion about this -- "Last Attend Date should be blank for students **completing** the class with a grade." You only enter an LDA if the student cut out or withdrew from the class. The date should be entered in MM/DD/YYYY format (include the slashes)." To explain – According to policy, at some point in the semester, you have the option to give a student a W or F grade if a student cuts out or withdraws from your class. **If you decide to give an F grade, you still must put an LDA because the student either cut out or withdrew & did not complete the class.** The key word in the statement above is "**completing**". If a student cuts out or withdraws from your class, this is not considered completing the course with a grade, although you may choose to give an F grade.

ALL CUT OUTS & CLASS WITHDRAWALS MUST HAVE EITHER A W OR F GRADE AND MUST HAVE AN LDA!

- Leave Attend Hours blank.
- A reminder message will display at the bottom of the page that you have **20 minutes** to finish entering grades for this class.
- When finished entering all grades, click **Submit**. A message will be displayed at the top of the screen indicating the changes were successfully saved or error messages will inform you of any errors.
- If the Rolled column contains an N you may update the grade. When all grades for the term have been received, they will be rolled (updated) in history and any grade changes will need to be made by the Admissions office.
- To enter grades for another class click on CRN selection at the bottom of the screen, select the CRN for the class, select **Final Grades**, and then repeat steps above.
- Verify that all grades have been entered correctly.
- Click on Exit when finished.

Mississippi Delta Community College

Frequently Asked Questions

Employees and students *must* know how to log on to the MyDelta portal, Email, MyBanner, and Canvas (students & faculty) and should be checking them frequently.

Detailed instructions for use of MyDelta Portal, etc. can be found on the Office of Information Technology section of the MDCC website -- <http://www.msdelta.edu/information-technology/>

Student problems or questions related to admission status, grades, or transcripts?

- Contact the **Office of Admissions & Records** at 662.246.6306 or email admissions@msdelta.edu

Student problems or questions about Financial Aid?

- Contact the **Office of Financial Aid** at 662.246.6263 or 662.246.6310

Student problems or questions about student accounts, financial aid refunds?

- Contact the **Office of Business Services** at 662.246.6312.

Student or Employee problems or questions concerning online classes or Canvas?

- Contact the **Office of eLearning** at 662.246.6319 or email vccd1c@msdelta.edu

Student or Employee problems or questions concerning MyDelta Portal, Banner, Argos, MyBanner or Email?

- Contact **Office of Information Technology** at 662.246.6330 or by emailing it@msdelta.edu

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: MISSISSIPPI DELTA COMMUNITY COLLEGE	Group Plan Number: 00491714	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment ☐ Add Employee/Dependents ☐ Drop/Refuse Coverage ☐ Information Change		

Class: ALL ELIGIBLE EMPLOYEES ELECTING VOLUNTARY LONG TERM DISABILITY AMOUNT \$500 - \$2100 OR WAIVING VOLUNT	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer)
--	-----------------	----------------------	---

About You: First, MI, Last Name: _____	Employer Provided Identification: _____	Social Security Number _____-_____-_____ Your Social Security Number must be provided if enrolling for Life Coverage, Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address _____	City _____	State _____	Zip _____
Gender: ☐ M ☐ F Date of Birth (mm-dd-yy): ____-____-____			
Phone (indicate primary): ☐ Home (____) ____-____ ☐ Work (____) ____-____ ☐ Mobile (____) ____-____			
Email Address (indicate primary) ☐ Home _____ ☐ Work _____			
Are you married or do you have a partner? ☐ Yes ☐ No Date of marriage/union: ____-____-____ Do you have children or other dependents? ☐ Yes ☐ No Placement date of adopted child: ____-____-____			

About Your Job: Job Title: _____		
Work Status: ☐ Active ☐ Retired ☐ Cobra/State Continuation Hours worked per week: _____	Date of full time hire: ____-____-____	Annual Salary: \$ _____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner").	Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy) ____-____-____	
Child/Dependent 1:	☐ Add ☐ Drop	Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy) ____-____-____
			Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 2:	☐ Add ☐ Drop	Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy) ____-____-____
			Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

CEF2021

Questions? Call the Guardian Helpline (888) 600-1600

www.guardianlife.com

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DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Child/Dependent 3:	☐ Add ☐ Drop	Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy) ____-____-____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 4:	☐ Add ☐ Drop	Gender ☐ M ☐ F	Date of Birth (mm-dd-yyyy) ____-____-____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

Drop Coverage: ☐ Drop Employee ☐ Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____-____-____ ☐ Termination of Employment ☐ Retirement Last Day Worked: ____-____-____ ☐ Other Event: _____ Date of Event: ____-____-____	Coverage Being Dropped: ☐ Dental ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Vision ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Voluntary Life ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Critical Illness ☐ Accident ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Hospital Indemnity ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Long Term Disability ☐ Short Term Disability
Loss Of Other Coverage: I and/or my dependents were previously covered under Loss of coverage was due to: ☐ Termination of Employment: ____-____-____ ☐ Divorce/Separation ____-____-____ ☐ Death of Spouse ____-____-____ ☐ Termination/Expiration of Coverage ____-____-____ Coverage Lost ☐ Dental ☐ Vision	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: ☐ Covered under another insurance plan ☐ Other _____ (additional information may be required)

Dental Coverage: You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
PPO	☐ \$33.87	☐ \$73.39	☐ \$82.16	☐ \$120.13

☐ I do not want Dental Coverage because (Check all that apply):

- ☐ I am covered under another Dental plan
- ☐ My spouse is covered under another Dental plan
- ☐ My dependents are covered under another Dental plan

Vision Coverage: You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature - Designer	☐ \$9.84	☐ \$15.49	☐ \$16.83	☐ \$24.58

☐ I do not want this Vision coverage because (Check all that apply):

- ☐ I am covered under another Vision plan
- ☐ My spouse is covered under another Vision plan
- ☐ My dependents are covered under another Vision plan

LIFE INSURANCE *continued***Voluntary Term Life Coverage:** You must be enrolled to cover your dependents. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Employee**Policy Amount** *Check one box only*

☐ \$10,000	☐ \$20,000	☐ \$30,000	☐ \$40,000	☐ \$50,000	☐ \$60,000
☐ \$70,000	☐ \$80,000	☐ \$90,000	☐ \$100,000	☐ \$110,000	☐ \$120,000
☐ \$130,000	☐ \$140,000	☐ \$150,000*	☐ \$160,000	☐ \$170,000	☐ \$180,000
☐ \$190,000	☐ \$200,000	☐ \$210,000	☐ \$220,000	☐ \$230,000	☐ \$240,000
☐ \$250,000**	☐ \$260,000	☐ \$270,000	☐ \$280,000	☐ \$290,000	☐ \$300,000
☐ \$310,000	☐ \$320,000	☐ \$330,000	☐ \$340,000	☐ \$350,000	☐ \$360,000
☐ \$370,000	☐ \$380,000	☐ \$390,000	☐ \$400,000	☐ \$410,000	☐ \$420,000
☐ \$430,000	☐ \$440,000	☐ \$450,000	☐ \$460,000	☐ \$470,000	☐ \$480,000
☐ \$490,000	☐ \$500,000				

Guarantee issue up to: Employee Less than age 65 \$150,000*, 65-69 \$50,000, 70+ \$10,000. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected. Additional Amount: per employee \$100,000**. The Additional amount is available for ages Less than age 65. An Evidence of Insurability form must be completed if any amount above the Guarantee Issue Amount plus Additional Amount is elected.

☐ I do not want this coverage**Add Voluntary Life for Spouse****Policy Amount**

☐ \$5,000	☐ \$10,000	☐ \$15,000	☐ \$20,000	☐ \$25,000	☐ \$30,000
☐ \$35,000	☐ \$40,000	☐ \$45,000	☐ \$50,000*	☐ \$55,000	☐ \$60,000
☐ \$65,000	☐ \$70,000	☐ \$75,000**	☐ \$80,000	☐ \$85,000	☐ \$90,000
☐ \$95,000	☐ \$100,000	☐ \$105,000	☐ \$110,000	☐ \$115,000	☐ \$120,000
☐ \$125,000	☐ \$130,000	☐ \$135,000	☐ \$140,000	☐ \$145,000	☐ \$150,000
☐ \$155,000	☐ \$160,000	☐ \$165,000	☐ \$170,000	☐ \$175,000	☐ \$180,000
☐ \$185,000	☐ \$190,000	☐ \$195,000	☐ \$200,000	☐ \$205,000	☐ \$210,000
☐ \$215,000	☐ \$220,000	☐ \$225,000	☐ \$230,000	☐ \$235,000	☐ \$240,000
☐ \$245,000	☐ \$250,000				

Guarantee issue up to: Spouse Less than age 65 \$50,000*, 65-69 \$10,000, 70+ \$0. Additional Amount: Spouse \$25,000**. The Additional amount is available for ages Less than age 65

*The amount may not be more than 50% of the employee amount for Voluntary Life.

☐ I do not want this coverage**Add Voluntary Life for Dependent/Child(ren)****Policy Amount**

☐ \$1,000	☐ \$2,000	☐ \$3,000	☐ \$4,000	☐ \$5,000	☐ \$6,000
☐ \$7,000	☐ \$8,000	☐ \$9,000	☐ \$10,000*		

*Guarantee Issue Amount

*The amount may not be more than 50% of the employee amount for Voluntary Life.

☐ I do not want this coverage**Important Notes:**

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

LIFE INSURANCE *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

(If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.)

Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ - _____ %

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

Name: _____ Social Security Number: _____ - _____ - _____ %

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) - If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Please contact your employer for any record of or changes to your beneficiary information.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ☐ Yes ☐ No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____ - _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Short-Term Disability (STD) Coverage:

The amount of STD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you.

Weekly Benefit

- ☐ \$100.00
- ☐ \$150.00
- ☐ \$200.00
- ☐ \$250.00
- ☐ \$300.00
- ☐ \$350.00
- ☐ \$400.00
- ☐ \$450.00
- ☐ \$500.00
- ☐ \$550.00

Weekly Benefit

- ☐ \$600.00
- ☐ \$650.00
- ☐ \$700.00
- ☐ \$750.00
- ☐ \$800.00
- ☐ \$850.00
- ☐ \$900.00
- ☐ \$1,000.00
- ☐ \$1,250.00
- ☐ \$1,500.00

This amount may not exceed 60% of your weekly salary.

☐ I do not want this coverage.

Long-Term Disability (LTD) Coverage:

The amount of LTD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you.

Monthly Benefit

- ☐ \$500.00
☐ \$700.00
☐ \$1,000.00
☐ \$1,400.00
☐ \$1,500.00
☐ \$1,700.00
☐ \$1,800.00
☐ \$1,900.00
☐ \$2,000.00
☐ \$2,100.00

This amount may not exceed 60% of your monthly salary.

☐ I do not want this coverage.

Critical Illness Coverage:

Benefit reductions apply. Please see plan administrator.

Employee

Insurance Amount: ☐ \$1,000

☐ I do not want this coverage.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

(If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records)

Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

Please contact your employer for any record of or changes to your beneficiary information

Spouse and dependent child(ren) - If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ☐ Yes ☐ No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN if a corporate entity): _____ - _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Accident Coverage

You must be enrolled to cover your dependents.

Your Monthly premium

Employee Only

EE & Spouse

EE &
Dependant/Child(ren)EE, Spouse &
Dependant/Child(ren)☐ \$17.94☐ \$29.46☐ \$30.31☐ \$41.83☐ I do not want this coverage.**Hospital Indemnity Coverage**

You must be enrolled to cover your dependents.

Check only one box.

Your Monthly premium

Employee Only

EE & Spouse

EE & Child(ren)

EE, Spouse & Child(ren)

<\$0 ☐ \$18.41☐ \$35.12☐ \$30.26☐ \$46.97\$0-\$9 ☐ \$25.18☐ \$50.36☐ \$37.03☐ \$62.21\$10-\$19 ☐ \$38.49☐ \$74.18☐ \$48.34☐ \$88.03\$20-\$29 ☐ \$47.02☐ \$97.35☐ \$58.87☐ \$109.20☐ I do not want this coverage. ☐ I do not want this coverage. ☐ I do not want this coverage. ☐ I do not want this coverage.

Applicants over the age of 69 are not eligible to enroll in the Hospital Indemnity coverage.

Health History

Complete the following question(s) if you are enrolling for one or more of the following benefits listed below and you are electing an amount above coverage that is Guaranteed Issue. NOTE: Additional information may be required.

Voluntary Life

In the last 6 months have you or any of your dependents received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to Acquired Immune Deficiency Disorder (AIDS); or any other Chronic Condition?

☐ Yes, I have. ☐ No, I haven't. ☐ Yes, my spouse has. ☐ No, my spouse hasn't. ☐ Yes, my dependent child(ren) have. ☐ No, my dependent child(ren) haven't.

An Evidence of Insurability form must be completed for any person with a "Yes" answer to the question(s) above.

Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- An employee's decision to elect Vision and/or Hospital Indemnity not elect Vision and/or Hospital Indemnity must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in Vision and/or Hospital Indemnity coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- HOSPITAL INDEMNITY ONLY: This is a limited plan of Hospital Indemnity insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.
- LIFE ONLY: I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Guardian Group Plan Number: 00491714

Please print employee name:

- I consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

SIGNATURE OF EMPLOYEE X _____

DATE _____

Enrollment EN 00491714, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

Oregon: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material thereto, may be committing a fraudulent act, and may be subject to civil penalties or denial of insurance benefits.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.