Full-Time Administrative New Hire Packet



(Academic Year 2023-24)

FULL TIME ADMINISTRATIVE NEW HIRE PACKET CHECKLIST

- COMPLETE ALL FORMS IN THE PACKET (EXCEPT ORP FORMS IF CHOOSING TRS)
- ATTACH VOIDED CHECK FOR DIRECT DEPOSIT AND CLEARLY STATE WHERE YOUR FIRST CHECK NEEDS TO BE SENT (DIRECT DEPOSIT IS FOR 2ND CHECK)
- ATTACH PROPER I-9 BACKUP DOCUMENTATION
- COMPLETE THE EEO TRAINING AND SUBMIT CERTIFICATE WITH PACKET
- MAKE CHOICES FOR YOUR INSURANCE ELECTIONS FOR ERS (WE WILL DISCUSS THEM AT YOUR ORIENTATION)
- SEND ORDER (if applicable) TO YOUR HIGHER LEARNING INSTITUTION FOR OFFICIAL TRANSCRIPTS SENT TO LAURIE.KINCANNON@CISCO.EDU
- CALL LAURIE @ 254-442-5121 TO SCHEDULE YOUR ORIENTATION

These items are mandatory to complete your hiring process. Please forward the entire completed packet to Human Resources. Without all the documentation, your onboard date will be delayed.



Title:	
Last Name:	
First Name:	
Social Security #	
Address:	
City,State,Zip:	
Home Phone:	
Cell Phone:	
FT/PT Full Time Part Time Primary Location Cisco Abilene	
	nave Direct Deposit: ail my 1 st paycheck to the following address:

Highest Degree Earned:
Ethnicity:
Job Title: Faculty Position (If applicable):
Division:
Hire Date:
Emergency Contact Person:
Relationship to Emergency Contact:
Emergency Contact Address:
Emergency Contact City, State, Zip:
Emergency Contact Cell/Home Phone:
Emergency Contact Work Phone:
Personal Phone Available to Students: Yes No
Emergency Contact Home Email:
Employee Signature:Date:



BIOGRAPHIC REPORT

NAME:			
ADDRESS:			
Street	City	State	Zip
Telephone Number:			
Social Security Number:			
Highest Degree or Certificate:			
Institution of Highest Degree:			
Area of Specialization:			
Date of Birth:			
Total Teaching Experience:			
Date of Employment:			
Job Title:			
Teaching Experience at Cisco College:			
Teaching Experience other than Cisco Co	ollege:		
Ethnic origin – Please check only one:			
American-Indian/Alaskan Native			
Asian			
Black			
Hispanic			
White			
Other		Date:	

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.

OMB No. 1545-0074

Department of the T			rm W-4 to your employer.	ne		<u> </u>			
Internal Revenue Se		irst name and middle initial	g is subject to review by the IF Last name	15.	/b) 6	Social security number			
Step 1:	(a) 1	1st hame and middle milia	Lastrianie		(b) 3	ocial security number			
Enter					Does	your name match the			
Personal					name	on your social security			
Information	City o	r town, state, and ZIP code				If not, to ensure you get for your earnings,			
		,,				ct SSA at 800-772-1213 to www.ssa.gov.			
	(c)	Single or Married filing separately			J 01 90	10 WW.00d.gov.			
	(0)	Married filing jointly or Qualifying surviving s	pouse						
		Head of household (Check only if you're unmar		of keeping up a home for yo	ourself a	nd a qualifying individual.)			
		4 ONLY if they apply to you; otherwism withholding, other details, and privac		2 for more information	n on e	each step, who can			
Step 2:		Complete this step if you (1) hold mor also works. The correct amount of wit							
Multiple Job or Spouse	S		amerang depende on meening	o carriou ironii aii or ti	.000 jo	20.			
Works		Do only one of the following. (a) Reserved for future use.							
WOIKS		` '	on mage 2 and enter the real	It in Ctan 4(a) balauu					
		(b) Use the Multiple Jobs Worksheet	· -			ada a da la Tida			
		(c) If there are only two jobs total, you option is generally more accurate higher paying job. Otherwise, (b) is	than (b) if pay at the lower pa						
		TIP: If you have self-employment inco	ome, see page 2.						
		4(b) on Form W-4 for only ONE of the you complete Steps 3–4(b) on the Form			s. (Yo	ur withholding will			
Step 3:		If your total income will be \$200,000 c	or less (\$400,000 or less if ma	arried filing jointly):					
Claim		Multiply the number of qualifying o	children under age 17 by \$2,0	00 \$	_				
Dependent and Other		Multiply the number of other depe	-						
Credits		Add the amounts above for qualifying this the amount of any other credits.	3	\$					
Step 4		(a) Other income (not from jobs).	If you want tax withheld f	or other income you	ı l				
(optional):		expect this year that won't have w	•						
Other		This may include interest, dividend	ds, and retirement income .		4(a	1) \$			
Adjustments	s	(b) Deductions. If you expect to claim	deductions other than the st	andard deduction and	1				
		want to reduce your withholding, u							
		the result here			4(b) \$			
		(c) Extra withholding. Enter any addi	tional tax vou want withheld e	each pav period	4(c	s) \$			
		,	,			71,			
Step 5: Sign Here	Unde	er penalties of perjury, I declare that this certi	ificate, to the best of my knowled	dge and belief, is true, c	orrect,	and complete.			
11010	Em	ployee's signature (This form is not va	ılid unless you sign it.)	Da	ite				
Employers	Fmnl	oyer's name and address		First date of	Fmplo	yer identification			
Only	p	Cisco College		1		er (EIN)			
Jy		e	Y 76437		-	751164343			
		101 College Heights, Cisco, T	Λ /043/		,	51104545			

Form W-4 (2023)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 and you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your selfemployment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

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.

Page 2

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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

Form W-4 (2023)

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.

1	Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3	1	\$
2	Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.		
	a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a	2a	\$
	b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b	2b	\$
	c Add the amounts from lines 2a and 2b and enter the result on line 2c	2c	\$
3	Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc	3	
4	Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)	4	\$
	Step 4(b) – Deductions Worksheet (Keep for your records.)		
1	Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income	1	\$
2	Enter: • \$27,700 if you're married filing jointly or a qualifying surviving spouse • \$20,800 if you're head of household • \$13,850 if you're single or married filing separately	2	\$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	3	\$
4	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	4	\$
5	Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4	5	\$

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

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

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

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

Form W-4 (2023) Page **4**

Married Filing Jointly or Qualifying Surviving Spouse											. ago <u>-</u>	
Higher Paying Job				Lowe	er Paying	Job Annua	al Taxable	Wage & \$	Salary			
Annual Taxable Wage & Salary	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999 \$280,000 - 299,999	2,040 2,040	4,440 4,440	6,760 6,760	8,160 8,160	9,560 9,560	10,780 10,780	11,980 11,980	13,180 13,180	14,380 14,380	15,580 15,870	16,780 17,870	18,140 19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250
4,	-,	, ,,,,,,				d Filing S				1 ==,===	1 22,222	1,
Higher Paying Job Lower Paying Job Annual Taxable Wage & Salary												
Annual Taxable	\$0 -	\$10,000 -	\$20,000 -	\$30,000 -	\$40,000 -	\$50,000 -	\$60,000 -	\$70,000 -	\$80,000 -	\$90,000 -	\$100,000 -	\$110,000 -
Wage & Salary	9,999	19,999	29,999	39,999	49,999	59,999	69,999	79,999	89,999	99,999	109,999	120,000
\$0 - 9,999	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999 \$125,000 - 149,999	2,040 2,040	3,970 3,970	5,300 5,300	6,500 6,500	7,700 7,700	8,900 9,610	9,110	9,610 11,610	10,610 12,610	11,610 13,610	12,610 14,900	13,430 16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 174,939 \$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330
					Head of	Househo	old					
Higher Paying Job				Lowe	er Paying	Job Annua	al Taxable	Wage & S	1			
Annual Taxable Wage & Salary	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999 \$150,000 - 174,999	2,040	4,440 4,440	6,070 6,070	7,430 7,980	8,630 9,980	9,980	11,980 13,980	13,980 15,980	15,190 17,420	16,190 18,720	17,270	18,530 21,280
\$175,000 - 174,999 \$175,000 - 199,999	2,040	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	20,020 22,770	21,280
\$200,000 - 249,999	2,190	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,720	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,090	26,230
\$450,000 = 443,939 \$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600
+ 100,000 and 0vol	3,170	0,040	5,770	12,700	1 ,000	.,,,,,			_ ==,100			



Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No. 1615-0047 Expires 10/31/2022

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

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

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Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment , but not before accepting a job offer.)										
Last Name (Family Name) First Name (Given	Name)		Middle Initial	Other L	Other Last Names Used (if any)					
Address (Street Number and Name) Apt. Num	nber Cit	ty or Town			State	ZIP Code				
Date of Birth (mm/dd/yyyy) U.S. Social Security Number	Employee's	E-mail Addro	ess	Er	mployee's T	Felephone Number				
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.										
I attest, under penalty of perjury, that I am (check one o	f the follo	owing boxe	es):							
1. A citizen of the United States										
2. A noncitizen national of the United States (See instructions)										
3. A lawful permanent resident (Alien Registration Number/U	JSCIS Num	nber):								
4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): Some aliens may write "N/A" in the expiration date field. (See instructions)										
Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number. QR Code - Section 1 Do Not Write In This Space 1. Alien Registration Number/USCIS Number:										
OR 2. Form I-94 Admission Number:										
OR			_							
3. Foreign Passport Number:			_							
Country of Issuance:			_							
Signature of Employee			Today's Date	e (mm/dd/	′уууу)					
Preparer and/or Translator Certification (chec I did not use a preparer or translator. A preparer(s) and/	,	or(s) assisted	the employee in	completin	g Section 1					
(Fields below must be completed and signed when prepared				-		· · · · · · · · · · · · · · · · · · ·				
I attest, under penalty of perjury, that I have assisted in knowledge the information is true and correct.	the comp	oletion of S	ection 1 of thi							
Signature of Preparer or Translator				Today's D	ate (mm/de	d/yyyy)				
Last Name (Family Name)		First Name	e (Given Name)							
Address (Street Number and Name) City or Town State ZIP Code										

STOP

Employer Completes Next Page

STOP

Form I-9 10/21/2019 Page 1 of 3



Employment Eligibility Verification Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No. 1615-0047 Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

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

of Acceptable Documents.")	1 -													
Employee Info from Section 1	Last Nam	ie (Far	mily Name)			lame (Given I	Name)	M	I.I. C	Citizens	ship/Immigration Status			
List A Identity and Employment Autl	norization	OR	R	List Iden			AND	ID List C Employment Authorizati						
Document Title			Document Ti	tle			!	Documen						
Issuing Authority			Issuing Author	ority				Issuing A	uthority	У				
Document Number			Document N	umber				Documen	t Numl	ber				
Expiration Date (if any) (mm/dd/yy)	yy)		Expiration Da	ate (if any) (/mm/dd/	<i>(yyyy</i>)		Expiratior	n Date	(if any) (mm/dd/yyyy)			
Document Title		\neg \vdash												
Issuing Authority			Additional	Informatio	n						ode - Sections 2 & 3 t Write In This Space			
Document Number														
Expiration Date (if any) (mm/dd/yy)	yy)													
Document Title														
Issuing Authority														
Document Number														
Expiration Date (if any) (mm/dd/yyy	yy)													
Certification: I attest, under per (2) the above-listed document(semployee is authorized to work	s) appear c in the U	to be	genuine an States.	d to relate		employee n	amed	, and (3)	to the	e best	of my knowledge the			
The employee's first day of e	mploym	ent (n	nm/dd/yyyy):		(Se	e ins	truction	s for e	exem	ptions)			
Signature of Employer or Authorize	ed Represe	entativ	е	Today's Da	te (mm/	'dd/yyyy)	Title of	of Employer or Authorized Representative HR Director						
Last Name of Employer or Authorized	Representa	tive	First Name of I	Employer or a	Authorize	<u> </u>					or Organization Name			
Employer's Business or Organization	on Address	s (Stre	eet Number an	nd Name)	City or	· Town			State	е	ZIP Code 76437			
Section 3. Reverification	and Pak	niros	(To be some	nleted and	leianos	d hy ampley	or or o	authoriza	d ran	recent	tative)			
A. New Name (if applicable)	and Ker	63	(10 De COIII)	oreteu ariu	signet	a by employ		Date of I						
Last Name (Family Name)	F	First N	ame <i>(Given N</i>	lame)		Middle Initial		ate (mm/		` ''	<i>modulicy</i>			
C. If the employee's previous grant continuing employment authorization					provide	the informat	ion for	the docu	ment o	r recei	pt that establishes			
Document Title				Docume	Document Number					Expiration Date (if any) (mm/dd/yyyy)				
I attest, under penalty of perjur the employee presented docun														
Signature of Employer or Authorize	ed Represe	entativ	e Today's	Date (mm/c	dd/yyyy)	Name o	f Empl	oyer or A	uthoriz	ed Re	presentative			

LISTS OF ACCEPTABLE DOCUMENTS All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

Form I-9 10/21/2019 Page 3 of 3

Texas Employer New Hire Reporting Form



Submit within 20 calendar days of new employee's first day of work to:

Central File Maintenance P.O. Box 12048 Austin, TX 78711-2048

Phone: 1-800-850-6442 FAX: 1-800-732-5015 Online: www.employer.oag.texas.gov To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

Α	В	C

1 2 3

Eı	nplo	yer	Infor	mati	on																				
1.					umber I that a _l			arterly v	vage re	eports.			2	2. Stat	e Emp	oloyer	ID Nu	mber ((Optio	nal):					
3.	Emplo	oyer N	lame:																						
4.	Emplo	oyer A	Addres	s (Plea	ase ind	dicate	the a	ddress	wher	e the	ncome	e With	holdir	ng Ord	ers sh	ould l	oe sen	t):							
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]										
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11	. Emp	loyer	Telep	hone (Option	nal):	I				_		12. l	Emplo	yer F	AX (O	ptional):		1				_	
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Ei	mplo	vee	Info	rmati	on																				
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18	. Emp	loyee	Last I	Name:		ı		ı	I	1	1	1	1	ı		1	1	1	1		I		ı	1	
19	. Emp	loyee	Home	Addr	ess:		1		Г		1							1	1	1	Г				
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29	. Sala	ry Fre Houi			eck Or Weekly			Option iweekl		Se	mi-Mo	nthly		Mont	hly		Annua	lly							

REV 05/23 ENHR RPT FORM

INSTRUCTIONS FOR COMPLETING THE TEXAS EMPLOYER NEW HIRE REPORTING FORM

The purpose of the Texas New Hire Reporting Form is to allow employers to fulfill new hire reporting requirements. You may enter your employer information and photocopy a supply and then enter employee information on the copies.

REPORTING OF NEW HIRES IS REQUIRED:

All required items (numbers 1, 3, 4, 5, 6, 7, 14, 15, 16, 17, 18, 19, 20, 21, 22) on this form must be completed.

- Box 1: Federal Employer ID Number (FEIN). Provide the 9-digit employer identification number that the federal government assigns to the employer. This is the same number used for federal tax reporting. Please use the same FEIN that appears on quarterly wage reports.
- Box 2: State Employer ID Number (Optional). Identification number assigned to the employer by the Texas Workforce Commission.
- **Box 3: Employer Name.** The employer name as listed on the employee's W4 form. Please do not provide more than one employer name (for example, "ABC, Inc DBA. John Doe Paint and Body Shop" is not correct).
- **Box 4: Employer Address.** Please indicate the address where the Income Withholding Orders should be sent. Do not provide more than one address (for example, P.O. Box 123, 1313 Mockingbird Lane is not correct).
- Box 8: Employer Province/Region (if foreign). Provide this information if the employer address is not in the United States.
- Box 9: Employer Country (if foreign). Provide the two letter country abbreviation if the employer address is not in the United States.
- Box 10: Postal Code (if foreign). Provide the postal code if the employer address is not in the United States.
- Box 13: New Hire Contact Person (Optional). Providing the name of a contact staff person will facilitate communication between the employer and the Texas Employer New Hire Reporting Program.
- Box 15: Date of Hire. List the date in month, day and year order. Use four digits for the year (for example, 2001). This should be the first day that services are performed for wages by an individual. If you are reporting a rehire (where a new W-4 is prepared) use the return date, not the original date of hire.
- Box 23: Employee Province/Region (if foreign). Provide this information if the employee does not reside in the United States.
- Box 24: Employee Country (if foreign). Provide the two letter country abbreviation if the employee address is not in the United States.
- Box 25: Postal Code (if foreign). Provide the postal code if the employee address is not in the United States.
- Box 26: State Where Employee was Hired. Use the abbreviation recognized by the U.S. Postal Service for the state in which the employee was hired.
- Box 27: Employee DOB (Date of Birth) (Optional). List the date in month, day and year order. Use four digits for the year (for example, 1985).
- Box 28: Employee Salary (Optional). Enter employee's exact wages in dollars and cents. This should correspond to the salary pay frequency indicated in Box 29.
- **Box 29: Salary (Check One ONLY) (Optional).** Check the appropriate box relating to the employee's salary pay frequency. Check "Biweekly" if the salary is based on 26 pay periods. Check "Semi-monthly" if the salary is based on 24 pay periods. Check "Annually" if salary payment is a one-time distribution.

SUBMISSION OF NEW HIRE REPORTS. The Texas Employer New Hire Reporting Program offers a variety of methods that employers can use to submit new hire reports. For further information on which method may be best for you, call 1-800-850-6442. Employers are encouraged to keep photocopies or electronic records of all reports submitted. When the form is completed, send it to the Texas Employer New Hire Reporting Program using one of the following means:

- FAX: 1-800-732-5015
- U.S. Mail:

Central File Maintenance P.O. Box 12048 Austin, TX 78711-2048

- Telephone Submissions: 1-800-850-6442
- Internet Submissions: www.employer.oag.texas.gov

Employers must provide all of the required information within 20 calendar days of the employee's first day of work to be in compliance. State law provides a penalty of \$25 for each employee an employer knowingly fails to report, and a penalty of \$500 for conspiring with an employee to 1) fail to file a report or 2) submit a false or incomplete report.

REV 05/23 ENHR RPT FORM



Shaded Area for Payroll Use Only										
Received										
Prenoted	Deposited									

Date: _____

DIRECT DEPOSIT AUTHORIZATION FORM

	Last Name	First Name	MI
SSN:			
Payroll Type	: Semi-Monthy [☐ Monthly	
net pa	y automatically to my	nd the financial institution account(s) each payday, anade in error to my account	nd to initiate adjustments, if
	_	r Savings: I authorize you ncial institution listed below	to change my direct deposit w.
STOP	: I authorize you to s	stop the direct deposit of m	y net paycheck.
Institution Na	me		% of net check or \$
Account Type	e:Checking	Savings Account Num	ıber:
Bank Routing	/Transit Number:		
<u>A V</u> (DIDED CHECK M	<u>IUST BE PROVIDED I</u>	N THE SPACE BELOW
·:000000	0000: 12345	7890 0101	
ting/Transit N	umber - Account Num 9-digit your checking es the number. where	nber - This is Check Number	er - The financial institution scans the electronically in order for it to appear or statement.

DIRECT DEPOSIT INFORMATION

- 1. The payroll deposit authorized by the employee' signature on the Direct Deposit Authorization form is accomplished by a process known as electronic funds transfer. It is covered by a number of Federal regulations designed to safeguard the integrity of the employee's account
- 2. The funds deposited should be available to the employee for withdrawal by all regular means on the morning of the scheduled payday.
- 3. The electronic funds transfer system requires an additional step known as prenotification. This is a procedure whereby account numbers must be verified by the receiving financial institution before we will transmit direct deposit data to them. Therefore new authorizations, changes, or cancellations should be in the Payroll Department one month prior to the month the authorization, change or cancellation is to take effect. If the authorization cannot be processed, Payroll will notify the employee, who will continue to receive a payroll check until the authorization can be processed.
- 4. The pre-notification process also dictates that if a change in the financial institution or account number is made, the employee must be removed from direct deposit for a minimum of one pay period before the change will take effect. For the payday(s) the employee will receive a payroll check(s).
- 5. Cisco College assumes no responsibility to issue a payroll check to any employee whose direct deposit could not be processed due to his/her account being closed, or any other reason, until the receiving financial institution has either refunded or guaranteed refund of such deposit to the College.

RETURN COMPLETED FORM TO:

Cisco College Human Resources Office 101 College Heights Cisco, TX 76437

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

Employee Name	Employee ID#
Employer Name CISCO COLLEGE	Employer ID#
may receive a pension based on earnings from this jo Security based on either your own work or the wor pension may affect the amount of the Social Securi	ocial Security. When you retire, or if you become disabled, you ob. If you do, and you are also entitled to a benefit from Social rk of your husband or wife, or former husband or wife, your ty benefit you receive. Your Medicare benefits, however, will re are two ways your Social Security benefit amount may be
modified formula when you are also entitled to a per a result, you will receive a lower Social Security bene example, if you are age 62 in 2005, the maximum methis provision is \$313.50. This amount is updated an	cial Security retirement or disability benefit is figured using a usion from a job where you did not pay Social Security tax. As efit than if you were not entitled to a pension from this job. For nonthly reduction in your Social Security benefit as a result of unually. This provision reduces, but does not totally eliminate nation, please refer to Social Security Publication, "Windfall
become entitled will be offset if you also receive a	ny Social Security spouse or widow(er) benefit to which you a Federal, State or local government pension based on work offset reduces the amount of your Social Security spouse or our pension.
two-thirds of that amount, \$400, is used to offset yeligible for a \$500 widow(er) benefit, you will recei Even if your pension is high enough to totally offset	based on earnings that are not covered under Social Security, your Social Security spouse or widow(er) benefit. If you are twe \$100 per month from Social Security (\$500 - \$400=\$100), your spouse or widow(er) Social Security benefit, you are still nation, please refer to Social Security Publication, "Government
	ion, including information about exceptions to each provision, also call toll free 1-800-772-1213, or for the deaf or hard of ontact your local Social Security office.
·	nat contains information about the possible effects of the nent Pension Offset Provision on my potential future Social
Signature of Employee	Date

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

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

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

Employers must:

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

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

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/form1945. Paper copies can be requested by email at oplm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.



Cisco College Policy Manual

I verify that I will read the Cisco College Policy Manual The reference is located on the Cisco College Website at:

https://www.cisco.edu/for-faculty-staff

Signature of Employee

Date



OATH OF OFFICE

In the name and by the authority of

STATE OF TEXAS

[,	do solemnly swear	(or affirm), that
(Employee Name) I will faithfully execute the duties of the office of the State of Texas, and will to the best of Constitution and laws of the United States and (or affirm), that I have not directly nor indirectly nor promised any public office or employment confirmation thereof. So help me God.	of(Job Title - including subject from ability preserve, protect of this State; and I furthermory paid, offered, or promised to	et if teaching) t, and defend the re solemnly swear pay, contributed,
	Signature	
	Sworn to and Subscribedday of	

Information Technology Acceptable Use

SECTION ONE - PURPOSE

A. To remain competitive, better serve and provide our employees with the best tools to do their work, *Cisco College* makes available access to one or more forms of electronic media and services, which may include computers, e-mail, databases, software, telephones, voicemail, fax machines, external electronic bulletin boards, wire services, online services, intranet, Internet and the World Wide Web.

B. Cisco College encourages the use of these media and associated services because they can make communication more efficient and effective and because they are valuable sources of information. However, everyone connected with the college should remember that electronic media and services provided by the college are college property and their purpose is to facilitate and support school business. All computer users have the responsibility to use these resources in a professional, ethical, and lawful manner.

C. To help all employees make responsible decisions, the following guidelines have been established for using information resources. No policy can lay down rules to cover every possible situation. Instead, it is designed to express *Cisco College* philosophy and set forth general principles when using electronic media and services.

SECTION TWO - PROHIBITED COMMUNICATIONS

Electronic media cannot be used for knowingly transmitting, retrieving, or storing any communication that is:

- Discriminatory or harassing;
- Derogatory to any individual or group;
- Obscene, sexually explicit or pornographic;
- Defamatory or threatening;
- In violation of any license governing the use of software; or
- Engaged in for any purpose that is illegal or contrary to Cisco College's policy or business interests.
- For product advertisement or political lobbying.

SECTION THREE - PERSONAL USE

The computers, electronic media and services provided to employees by *Cisco College* are primarily for work related purposes. Limited, occasional, or incidental use of electronic media (sending or receiving) for personal purposes is understandable and acceptable, and all such use should be done in a manner that does not negatively affect the systems' use for their intended purposes, the employee's job performance or the college budgets. Employees are expected to demonstrate a sense of responsibility and not abuse this privilege. See section four for additional information.

SECTION FOUR - ACCESS TO EMPLOYEE COMMUNICATIONS

A. Generally, electronic information created and/or communicated by an employee using e-mail, word processing, utility programs, spreadsheets, voicemail, telephones, Internet and bulletin board system access, and similar electronic media is not reviewed by the college. However, the following conditions should be noted:

Cisco College does routinely gather logs for most electronic activities and monitor communications directly, e.g., sites accessed, upload/download content, and time at which transfers are made, for the following purposes:

- Cost analysis;
- Resource allocation;
- Optimum technical management of information resources; and
- Detecting patterns of use that indicate users are violating college policies or engaging in illegal activity.

B. Cisco College reserves the right, at its discretion, to review any employee's electronic files and messages to the extent necessary to ensure electronic media and services are being used in compliance with the law, this policy and other college policies.

C. Employees should not assume electronic communications are completely private. Accordingly, if they have sensitive information to transmit, they should use other means.

SECTION FIVE - SOFTWARE

To prevent computer viruses from being transmitted through the school's computer system, unauthorized downloading of any unauthorized software is strictly prohibited. Only software registered through *Cisco College* may be downloaded. Employees should contact the Helpdesk if they have any questions.

SECTION SIX - SECURITY/APPROPRIATE USE

A. Access to Information Technology Resources is granted according to role based needs by appropriate administrators.

- B. Employees must respect the confidentiality of other individuals' electronic communications. Except in cases in which explicit authorization has been granted by school administration, employees are prohibited from engaging in, or attempting to engage in:
 - Monitoring or intercepting the files or electronic communications of other employees or third parties;
 - Hacking or obtaining access to systems or accounts they are not authorized to use;
 - Using other people's log-ins or passwords; and
 - Breaching, testing, or monitoring computer or network security measures.
- C. No e-mail or other electronic communications can be sent that attempt to hide the identity of the sender or represent the sender as someone else.
- D. Electronic media and services should not be used in a manner that is likely to cause network congestion or significantly hamper the ability of other people to access and use the system.
- E. Anyone obtaining electronic access to other companies' or individuals' materials must respect all copyrights and cannot copy, retrieve, modify or forward copyrighted materials except as permitted by the copyright owner. Respect for the intellectual work of others has traditionally been essential to the mission of colleges and universities. We do not tolerate plagiarism, and we do not condone unauthorized copying of software, including programs, applications, databases and code.

SECTION SEVEN - PARTICIPATION IN ONLINE FORUMS

A. Employees should remember that any messages or information sent on school-provided facilities to one or more individuals via an electronic network—for example, Internet mailing lists, bulletin boards, and online services—are statements identifiable and attributable to *Cisco College*.

B. Cisco College recognizes that participation in some forums might be important to the performance of an employees job functions and/or professional responsibilities.

SECTION EIGHT - FEDERAL COPYRIGHT LAWS

Copyright infringement is the act of exercising, without permission or legal authority, one or more of the exclusive rights granted to the copyright owner under section 106 of the Copyright Act (Title 17 of the United States Code). These rights include the right to reproduce or distribute a copyrighted work. In the file-sharing context, downloading or uploading substantial parts of a copyrighted work without authority constitutes an infringement.

Penalties for copyright infringement include civil and criminal penalties. In general, anyone found liable for civil copyright infringement may be ordered to pay either actual damages or "statutory" damages affixed at not less than \$750 and not more than \$30,000 per work infringed. For "willful" infringement, a court may award up to \$150,000 per work infringed. A court can, in its discretion, also assess costs and attorneys' fees. For details, see Title 17, United States Code, Sections 504, 505.

Willful copyright infringement can also result in criminal penalties, including imprisonment of up to five years
and fines of up to \$250,000 per offense. For more information, please see the Web site of the U.S. Copyright
Office at www.copyright.gov, especially their FAQ's at www.copyright.gov/help/faq.
SECTION NINE - VIOLATIONS
Any employee who abuses the privilege of their access to e-mail or the Internet in violation of this policy will be

subject to corrective action, including possible termination, legal action, an	d criminal liability.
Employee Name	Date



TRS28 (09-16)

1000 Red River Street Austin, TX 78701-2698 (800) 223-8778 www.trs.texas.gov

Section 1 - Member	Information			
Name			Social Security Nu	ımber
Address			_ ,	
Street Ad	dress or Box Number	City	State	Zip Code
Phone Number			Date of Birth	
To be completed if y	our refund will be sent to a fo	reign address:		
If you answered no t	e not a U.S. citizen, are you a o both questions above, see p onal information regarding rec	age 1 of the <i>Informati</i>	J.S.? Yes on Sheet for ORP E	☑ No ☑ No lection and/or Refund
Section 2 - Prior O	ptional Retirement Program	Election Information	า	
Have you previously	elected the Optional Retirem	ent Program in lieu of	TRS? Yes	No
If yes, institution nan	ne	dates	of employment	**************************************
If yes, you are not el	igible to elect ORP a second t	time.		
Section 3 - Membe	r Election			
Code, in lieu of mem not be eligible for me employed by the Tex electing ORP, I forfe	pate in the Optional Retiremenbership in the Teacher Retire embership in TRS unless I ceases public school system othe it all accrued rights to benefits election. I am entitled only to vocable.	ment System of Texas ase to be employed by r than in an institution s from TRS, if any, inc	s (TRS). I understand an institution of high of higher education. Ituding benefits base	d that by this election I will her education and become I further understand that by ed on TRS service credit
Section 4 - Refund	Election (select one)			
Refund	the taxable amount of m amount is greater than \$2	y refund will be withhe 200.00). See page 2 o	eld for federal income f the <i>Information Sh</i>	me. I understand that 20% of e taxes (provided the eet for ORP Election and/or it a U.S. citizen or resident
Direct Rollov	I elect to have all or a po eligible retirement plan. I er option is selected. A Refu to TRS.	understand that TRS	will provide me with	
No Refund		n my TRS service cre	dit accrued prior to i	nd that I forfeit all accrued my election to participate in n apply for a refund at a



TRS28 (09-16)

1000 Red River Street Austin, TX 78701-2698 (800) 223-8778 www.trs.texas.gov

Name	Social Security Number				
Section 5 – Paym	ent Method for Portion Not Being Rolled ()ver			
Direct Deposit	I elect to have the portion of my refund being paid directly to me sent electronically to the financial institution listed below.				
Name of F	nancial Institution	 	 		
Account T	rpe (must select one) Checking	Savi	ngs		
Bank Rout	ng Number				
Account N	umber				
	ring declaration MUST be completed if yo yment be transferred or forwarded outside of			eposit.	
No	Yes If yes, to what country?	-			
	Percentage to be transferred		%		
Check	I elect to have the portion of my refund paper treasury warrant.	paid directly to	o me sent to	my mailing add	ress as a
Section 6 - Mem	ber Certification and Signature				
Special Tax Notice consider my decis	I have received a copy of the <i>Information S</i> Regarding Your Rollover Options Under TR on of whether to elect a direct rollover of m ade an election to roll over my refund and I nged.	RS, and that I ny distribution	have 30 day of accumulate	s from receipt ted contribution	of the notice to s. I understand
Signature of Member of	Retiree Date				
STATE OF	C	OUNTY OF			
On			_ acknowledg	ed this docume	nt before me
(date)	(printed name of person whose signa	iture appears above)	_		
a notary public.					
				(SEAL)	

Be sure to include your name and Social Security Number on all 3 pages.



TRS28 (09-16)

1000 Red River Street Austin, TX 78701-2698 (800) 223-8778 www.trs.texas.gov

Name	Social Security Number
Section 7 - Employer Certification	
This is to certify that the above named ind Retirement Program in lieu of membership in	ividual is eligible and has elected to participate in the Optiona the Teacher Retirement System of Texas.
Name of Institution of Higher Education	
TRS Reporting Entity Number	
Effective Date of Election	
Date First Eligible to Elect ORP	
ORP Eligibility Notification Date	
Report Month/Year for Final Deposit to TRS	
Printed Name of Reporting Official	
Title of Reporting Official	
Signature of Reporting Official	
Date	



Information Sheet for Optional Retirement

1000 Red River Street Austin, TX 78701-2698 (800) 223-8778 www.trs.texas.gov TRS28IN (09-16)

Optional Retirement Program (ORP) Election

- The election of ORP in lieu of membership in the Teacher Retirement System of Texas (TRS) is irrevocable.
- If you established membership in TRS prior to your election to participate in ORP, your membership in TRS is terminated by your election to participate in ORP.
- All accrued rights to benefits from TRS, if any, are forfeited upon the election of ORP. This includes
 any benefits associated with TRS service credit you accrued prior to your election to participate in
 ORP, such as service or disability retirement benefits.
- Only one Election to Participate in Optional Retirement Program and/or Refund form (TRS 28) should be filed with TRS for ORP election purposes, as you may elect ORP only once in lieu of participation in TRS. However, if you elect not to withdraw your TRS accumulated contributions at the time you elect to participate in ORP, you may submit a second TRS 28 only for purposes of requesting a refund.
- The election to participate in ORP in lieu of membership in TRS must be made within 90 days of the date you become eligible to participate in ORP.

Refund Election

A person who is a participant in ORP may withdraw their accumulated contributions from TRS; however, you are not required to withdraw your accumulated contributions at the time the election is made. To apply for a refund at a later date, you must submit a second TRS 28. Please note that your account will not accrue interest after your election to participate in ORP.

Federal Income Tax Implications

Refunded amounts that represent tax sheltered contributions are subject to a mandatory 20 percent federal income tax withholding unless you elect to roll over all eligible amounts to another eligible retirement plan. The amount withheld may not be sufficient to cover your income tax liability for the refund. A 10 percent early withdrawal penalty assessed by the Internal Revenue Service (IRS) may also be applicable. All or a portion of your refund that is eligible for rollover may be rolled over. For more information regarding amounts in your TRS account that are eligible for rollover and types of retirement plans that are eligible to receive rolled over amounts, see the *Special Tax Notice Regarding Your Rollover Options Under the Teacher Retirement System of Texas*.

If you are a non-U.S. citizen and a non-resident alien, TRS is required to withhold 30 percent for federal income tax unless you qualify for benefits under a U.S. tax treaty. If so, you must notify TRS of your eligibility for reduced withholding or exemption from withholding and provide TRS with a completed IRS Form W-8BEN (Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding) and any other required documentation. The W8-BEN can be obtained on the IRS' website, www.irs.gov, or from TRS upon request. TRS recommends that you submit the completed Form W-8BEN with your TRS 28 in order to expedite the processing of your refund.

It is your responsibility to submit the proper tax returns to the IRS and to pay any additional taxes or penalties that may be due. TRS encourages you to contact your professional tax advisor for specific advice on how this distribution may affect your taxes.

TRS TEACHER RETIREMENT SYSTEM OF TEXAS

Information Sheet for Optional Retirement

TRS28IN (09-16)

1000 Red River Street Austin, TX 78701-2698 (512) 542-6400 (800) 223-8778 www.trs.texas.gov

Additional Information about Rollovers

If you elect either a full or partial rollover, TRS will make the treasury warrant for the rollover payable to the trustee of the eligible retirement plan named on the *Refund Rollover Election form* (TRS 6A). **TRS will mail** the treasury warrant for the rollover to the address listed on your TRS 28. You are responsible for forwarding the treasury warrant to the plan receiving the rollover in order to complete the rollover.

If the amount you elect to roll over is less than the total amount in your account at the time of distribution, TRS will pay any balance to you through a second payment, which will be payable to you and issued as either a direct deposit or paper treasury warrant.

If the amount you elect to roll over is less than your account total, TRS will roll over your tax sheltered funds first, then your non-tax sheltered funds to reach the total dollar amount you chose to roll over. If the amount you wish to roll over is less than your tax sheltered amount, TRS will pay you the remaining tax sheltered amount minus 20% for federal income tax withholding, plus any non-tax sheltered amount in your account.

Roth IRAs: A rollover to a Roth IRA results in a taxable distribution in the year in which it is paid by TRS. If you choose to rollover to a Roth IRA, you must complete Section 3 of the TRS 6A regarding your withholding preference. TRS recommends that you consult with a professional tax advisor about whether the tax sheltered amount of your refund is subject to the 10% additional tax on early distributions described in the *Special Tax Notice Regarding Your Rollover Options Under the Teacher Retirement System of Texas*.

Foreign Trusts: A direct rollover may be made to a foreign trust that is part of a stock bonus, pension, or profit sharing plan established outside the U.S., if the receiving foreign trust would qualify for exemption from tax under Internal Revenue Code (IRC) §§ 401(a) and 501(a), except for the fact that it is a trust created or organized outside the U.S. To claim this exemption, in addition to any other information required by TRS, the distributee must furnish a written statement by an authorized official of the foreign trust stating that the foreign trust is a trust described under IRC § 402(d). TRS will not make a transfer to a foreign trust without this statement.

Tax Statements Sent by TRS

Tax statements (Form 1099-R) are required to be mailed to your address on record no later than January 31 of the year following a refund. Form 1099-R includes the total amount of the lump sum distribution, any portion that is taxable income for the year paid, and the amount of income tax withheld. This information is also provided to the IRS as required by federal law. If you are a non-U.S. citizen and non-resident alien, TRS will report your distribution on a Form 1042-S instead of on a Form 1099-R.

If you elect to roll over all or a part of your refund, you will receive a separate Form 1099-R regarding the rollover amount. Tax statements are mailed to the same address used for refunds. You must notify TRS in writing if your address changes after you receive your refund. TRS must receive your notification prior to December 10 of the year in which you received your refund in order to ensure that the form will be sent to the correct address.



TRS28 (09-16)

1000 Red River Street Austin, TX 78701-2698 (800) 223-8778 www.trs.texas.gov

Instructions

If you are electing ORP participation and requesting a refund of your TRS accumulated contributions:

- 1. Read the Special Tax Notice Regarding Your Rollover Options Under The Teacher Retirement System of Texas.
- 2. Complete the *Election to Participate in Optional Retirement Program and/or Refund form* (TRS 28) in its entirety.
- Section 4 Refund Election. You must select one of the three options: Refund, Direct Rollover, or No Refund.
- 4. Section 5 Payment Method for Portion Not Being Rolled Over. You may select either Direct Deposit or a paper treasury warrant. If you select Direct Deposit, be sure to include your financial institution name, account type, bank routing number, account number, and complete the declaration.
- 5. Sign the form in the presence of a notary public in Section 6 Member Certification and Signature.
- 6. Have your employer complete Section 7 Employer Certification.
- 7. Send the completed form to TRS.

If you previously elected ORP participation but you did not withdraw your TRS accumulated contributions at the time you elected ORP and you are now applying for a refund of your TRS accumulated contributions:

- 1. Read the Special Tax Notice Regarding Your Rollover Options Under The Teacher Retirement System of Texas.
- 2. Complete Section 1 Member Information on the *Election to Participate in Optional Retirement Program and/or Refund form* (TRS 28).
- 3. Do Not Complete Section 2 Prior Optional Retirement Program Election Information.
- 4. Do Not Complete Section 3 Member Election.
- 5. Complete Section 4 Refund Election. You must select one of the three options: Refund, Direct Rollover, or No Refund.
- 6. Complete Section 5 Payment Method for Portion Not Being Rolled Over. You may select either Direct Deposit or Check. If you select Direct Deposit, be sure to include your financial institution name, account type, bank routing number, account number, and complete the declaration.
- 7. Sign the form in the presence of a notary public in Section 6 Member Certification and Signature.
- 8. Do not have your employer complete Section 7 Employer Certification.
- 9. Send the completed form to TRS.

Important Information

The form must be signed in front of a notary. If your name on the TRS 28 is different than the one shown on TRS records, you must send TRS a copy of the court order or marriage license documenting your name change. If your attorney-in-fact signs the request, a copy of the power of attorney must be submitted for review.

Please note that in some cases, TRS will issue your refund payment as a paper treasury warrant even when you have selected direct deposit. This may occur if the direct deposit information was not completed in its entirety. In addition, if you elect direct deposit and indicate that 100% of the refund will be transferred out of the United States, you will not be able to receive your refund through direct deposit and TRS will issue your refund payment as a paper treasury warrant mailed to the address listed on your TRS 28 form.

If you would like to roll over all or a portion of your accumulated contributions that are eligible for rollover, a *Refund Rollover Election form* (TRS 6A) must be submitted to our office. You must complete and sign the form TRS 6A indicating the amount that you wish to roll over. The representative of the retirement plan (plan administrator or trustee) accepting the rollover must also sign the form certifying that the plan is eligible to receive the funds being rolled over from your TRS account. Refer to the *Special Tax Notice Regarding Your Rollover Options Under the Teacher Retirement System of Texas* included with the *Requesting a Refund* packet for additional information as you consider whether to roll over your refund.

Cisco College Optional Retirement/Tax Sheltered Annuities Approved Program Carriers

Contact Information

New Accounts:

➤ VALIC
Representative:
https://www.valic.com
682-557-9384

 Lincoln Financial Group Representative:
 https://www.lfg.com
 www.elsvisionwealth.com
 (469) 271-1318

VOYA Financial Services (formerly ING/Aetna)
 Representative: Zera Harris
 www.voya.com
 (972) 225-1524

> ISC Group, Inc.

Representative: Frank Wilson

www.iscgroup.com (940) 781-6053 cell

WORKERS' COMPENSATION NOTICE 6

NOTICE TO EMPLOYEES CONCERNING **WORKERS' COMPENSATION IN TEXAS**

COVERAGE: [Name of employer] Cisco College compensation insurance coverage from [name of commercial insurance company] Claims Administrative Services . In the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation which occur on or after that date will be handled by [name of commercial insurance company] Claims Administrative Services . An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION Notice 6 (01/13)

Rule 110.101(e)(1)

DISCRIMINATION



EQUAL EMPLOYMENT OPPORTUNITY IS ... The Law In Texas

The law prohibits employers, employment agencies and labor unions from denying equal employment opportunities in

- hiring
- promotion
- discharge
- pay
- fringe benefits
- membership
- training
- other aspects of employment

because of race, color, national origin, religion, sex, age, or disability. The Sex Protected Class includes Sexual Harassment, Gender Stereotyping, Pregnancy Discrimination, Gender Identity, and Sexual Orientation.

IGUALIDAD DE OPORTUNIDADES EN EL EMPLEO ES ... La Lev en Texas

La ley prohíbe a los empleadores, agencias de empleo y sindicatos de negar la igualidad de oportunidades de empleo en

- ocupar
- ascensos
- desocupar
- · pago, beneficios
- membrecia
- entrenamiento
- otros aspectos del empleo

por causa de raza, color, nacionalidad, religion, sexo, edad, o incapacidad. La clase protegida por sexo incluye acoso sexual, estereotipos de género, discriminación por embarazo, identidad de género y orientación sexual.

If you believe you have been discriminated against, contact the Texas Workforce Commission, Civil Rights Division

Si usted cree que ha sido discriminado, comuníquese con la Comisión Laboral de Texas, División de Derechos Civiles

Website: www.twc.texas.gov/jobseekers/how-submit-employment-discrimination-complaint Email: EEOintake@twc.texas.gov

101 E. 15th Street, RM. 154; Austin, TX 78778 (512) 463-2642

Toll Free (within Texas) 1-888-452-4778 TTY (512) 371-7473

Equal Opportunity Employer

Program Igualdad de Oportunidad de Empleo / Progra

NOTIFICATION OF THE OMBUDSMAN PROGRAM

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-393-6432.

More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

What Is An Ombudsman? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has completed a comprehensive training program designed specifically to assist you with your dispute.

> An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation.

Once a proceeding is scheduled an Ombudsman can:

- · Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- · Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

Figure 28 TAC §276.5(c) – September 2022



Aviso Para Los Empleados Sobre La Asistencia Disponible En El Sistema De Compensación Para Trabajadores Por Parte De La Oficina De Asesoría Pública Para El Empleado Lesionado

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel –OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con su reclamación en el sistema de compensación para trabajadores. Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: 1-866-393-6432.

Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

Programa de Ombudsman

¿Qué es un Ombudsman? Un Ombudsman es un empleado de OIEC que le puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte del Ombudsman es gratuita.

Cada Ombudsman ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa. Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation, por su nombre en inglés).

Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- · Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- · Ayudarlo a usted con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.



Título 28 del Código Administrativo de Texas §276.5(c) – Septiembre de 2022



WORKERS' COMPENSATION INSURANCE

I have read and understood the Workers' Compensation Insurance information provided with my new hire packet which includes:

- ➤ Notice to new employees
- ➤ Notice to new employees concerning workers' compensation insurance in the State of Texas
- ➤ Notification of the Ombudsman Program

Employee's Printed Name:	
Signature of Employees:	
Date Signed:	
Employer's Representative:	
Employer's Representative.	

CONTINUATION COVERAGE NOTIFICATION (COBRA)

On April 7, 1986, a federal law was enacted (Public Law 99-272, commonly called "COBRA"). This law requires the State of Texas to offer employees and dependents covered under the Texas Employees Group Benefits Program (GBP) the opportunity to temporarily extend their health and/or dental coverage at the group rates. Continuation coverage is available only when certain qualifying events cause coverage under the GBP to end. Coverage under COBRA is limited to the health and/or dental coverage in effect at the time of the qualifying event.

Note: If eligible for optional coverages as a retiree, this document is only applicable to health.

WHO MAY CONTINUE COVERAGE

If you are an employee covered under the GBP, you and/or your covered dependents have the right to elect up to 18 months of continuation coverage if your GBP coverage ended due to:

- Termination of employment for reasons other than gross misconduct (including retirement with less than 10 years of service credit with the Employees Retirement System of Texas (ERS), Teacher Retirement System (TRS) of Texas or an Optional Retirement Program (ORP)
- Loss of GBP eligibility due to expiration of coverage following leave without pay
- Loss of GBP eligibility due to reduction of hours

If you are a dependent covered by an employee under the GBP, you have the right to elect up to 36 months of continuation coverage if your GBP coverage ended due to loss of dependent status, including such qualifying events as:

- Death of the employee
- Divorce of the employee and covered spouse
- A dependent child who marries or attains age 25
- An other than natural child who moves out of the employee's household

If you are a former employee's dependent continuing GBP coverage under COBRA as a result of the former employee's termination of employment, expiration of coverage following leave without pay or loss of GBP eligibility due to reduction of hours, you have the right to extend your coverage for a total continuation period of up to 36 months if a secondary qualifying event occurs and you lose dependent status under the rules of the GBP provided you were covered as a dependent at the time of the initial qualifying event. A COBRA participant's newborn child or newly adopted child acquired on or after the initial qualifying event who is added to the existing COBRA coverage will also have a right to extend their coverage. Secondary qualifying events which occur during the initial 18 months of continuation coverage that entitles covered dependents to the additional continuation period are:

- Death of the former employee
- Divorce of the former employee and covered spouse
- A dependent child who marries or attains age 25
- An other than natural child who moves out of the employee's household
- The former employee begins receiving Medicare benefits.

ELECTION PERIOD

For employees and dependents eligible for continuation coverage

The ERS will provide you with a COBRA Election Form and COBRA Notification following the termination of your coverage. You and/or your dependents must formally elect continuation coverage on the form provided and submit the appropriate premium payment within 105 days of the date coverage terminated or the date of notice, whichever is later. Failure to do so will result in the forfeiture of your continuation coverage. Each covered participant has the right to elect continuation coverage independently. You and your dependents will not have coverage after the date coverage terminated until you formally elect continuation coverage and pay all premiums due retroactive to the first day of the month following the date coverage terminated.

For dependents whose coverage terminates due to loss of dependent status

The member or the covered dependent has the responsibility to notify one of the following of a divorce or when a covered dependent loses dependent status. Notification must occur within 60 days of the qualifying event date.

- Active employee your agency or institution Benefits Coordinator
- Retiree or current COBRA participant the Employees Retirement System of Texas (ERS)

COB Notice (R 09/2003) Page 1 of 4

Upon notification the ERS will provide a form for the dependent to complete and forward to the ERS with the appropriate premium within 105 days of the date of notice on the form or the date coverage terminated, whichever is later. If the Benefits Coordinator or the ERS is not notified within 60 days, continuation coverage will be forfeited.

Adding newly acquired dependents during the election period

Newly acquired dependents may be added to the COBRA continuation coverage provided the ERS is notified in writing within 30 days of the date the individual first became an eligible dependent. This rule also applies during the 105-day election period. Example: An employee terminated employment on July 20 and acquired an eligible dependent on August 5. To add the new dependent to the COBRA continuation coverage, the request must be postmarked on or before September 4 even though the 30-day notification deadline occurs before the end of the 105-day election period.

COST OF CONTINUATION COVERAGE

Persons electing continuation coverage must pay the full premium plus an additional 2% administrative fee. The first premium payment is due within 105 days from the date of the COBRA qualifying event or the date of notice, whichever is later. If you will receive an annuity from ERS, your monthly premium will be automatically deducted from your monthly annuity payment. To ensure that no break in coverage occurs, the first premium payment must include all premiums due retroactive to the first day of the month following the date coverage terminated. Subsequent monthly payments are due on the first of each coverage month and must be postmarked by the U. S. Postal Service within 30 days of the due date. If your payment is late, your coverage will be automatically cancelled retroactive to the last day of the month in which a full payment was received and was not considered delinquent.

LENGTH OF CONTINUATION COVERAGE

Your continuation coverage may be cancelled for any of the following reasons:

- The required premium for your continuation coverage is not received within the required time period, regardless of the circumstances.
- You enroll in another group health plan on or after the COBRA coverage effective date unless the other group health plan subjects you to a pre-existing condition limitation or exclusion. If you enroll in another group health plan, your COBRA coverage will end when the new group health plan covers you and does not limit or exclude coverage for pre-existing conditions in accordance with Public Law 104-191 (Health Insurance Portability and Accountability Act of 1996).
- You begin receiving Medicare benefits on or after the COBRA coverage effective date.
- The GBP ceases to provide coverage to any employee/retiree.
- You extend coverage due to a disability and the Social Security Administration (SSA) makes a final determination that the disability no longer exists.
- You submit a written request to cancel coverage. Cancellations will be made effective the last day of the month in which the U. S. Postal Service postmarks your request. Therefore, you must make the full premium payment for the month in which you are mailing the cancellation request.

IMPORTANT: Cancelled continuation coverage cannot be reinstated.

Special provision for covered individuals who are determined to be disabled by the SSA

An 18-month continuation coverage period may be extended to a possible maximum of 29 months if a qualified beneficiary is determined to be disabled under Title II or XVI of the Social Security Act at any time prior to or during the first 60 days of COBRA continuation coverage. The disabled individual may be any qualified beneficiary whose coverage was continued under COBRA due to termination of employment, expiration of coverage following leave without pay or due to reduction of hours. To be eligible for the extension, the ERS must be notified by submitting a copy of the SSA Notice of Award letter during the initial 18 months of COBRA continuation coverage. Coverage will be extended for an additional 11 months or until Medicare entitlement begins, whichever occurs first. The premium for the additional months of coverage will be equal to 150% of the current cost of coverage in the GBP. A covered individual who may be eligible for the coverage extension period due to a disability must contact the local SSA office to begin the determination process.

Conversion to an individual policy

Within thirty (30) days after the date your COBRA continuation coverage expires, you may enroll in an individual conversion health plan and or dental plan. Please contact your health and/or dental plan for specific information.

Questions about COBRA continuation coverage should be direct to the Customer Benefits Division of the Employees Retirement System at (512) 867-7711 or toll free (877) 275-4377 (outside the Austin calling area only)

COB Notice (R 09/2003) Page 2 of 4

Information for Participants Continuing Their Coverage

We have prepared some of the most commonly asked questions regarding COBRA continuation coverage. These are general questions only. For more specific information, please contact the Customer Benefits Division of the Employees Retirement System (ERS) directly at (512) 867-7711 or toll-free (877) 275-4377 (outside the Austin calling area). Our mailing address is P. O. Box 13207, Austin, Texas 78711-3207.

What is COBRA?

COBRA is an acronym for "Consolidated Omnibus Budget Reconciliation Act of 1985." COBRA requires employers to offer continuation of group health and/or dental benefits for a specified time to individuals who would otherwise lose coverage due to certain qualifying events.

What is a Qualified Beneficiary?

An individual who is entitled to COBRA continuation coverage due to being covered under a group health and/or dental plan on the day the qualifying event causes loss of coverage (e.g., termination of employment, divorce from the covered employee, etc.). This also includes a COBRA participant's newborn child or newly adopted child acquired who is added to the coverage on or after the initial qualifying event.

How long can a Qualified Beneficiary keep COBRA coverage?

If a qualifying event is due to termination of employment, loss of coverage following leave without pay or reduction in hours, a qualified beneficiary is entitled to a maximum of 18 months of continuation coverage. All other qualifying events entitle a qualified beneficiary up to 36 months of coverage. An 18-month continuation period may be extended to 36 months if a secondary qualifying event occurs during the initial 18-month continuation coverage period (e.g., divorce, death or loss of dependent status). A qualified beneficiary is never entitled to more than 36 months of continuation coverage.

How long can a disabled individual remain on COBRA?

A qualified beneficiary who is determined to be disabled by the SSA under Title II or XVI before or at any time during the first 60 days of COBRA coverage may be eligible to extend coverage from 18 to a possible maximum of 29 months. The ERS must receive a copy of the SSA Notice of Award letter prior to the end of the original 18-month continuation coverage period.

How much are the premiums?

Premiums for 18-month and 36-month qualifying events are calculated at 102% of the current group rate. The premium for disability participants who extend their coverage beyond the initial 18 months of coverage will be calculated at 150% of the current group rate. Premiums are recalculated every year; if the rates change, the new plan year premium amount will be effective beginning September 1. You will be sent a new payment notice for the new plan year, after September 1. Premium amounts for other levels of coverage may be obtained by contacting the ERS or visiting the ERS website at www.ers.state.tx.us.

When are the premiums due?

The initial COBRA premium payment will be due within 105 days of the date coverage terminated or the date of notice whichever is later. If you will receive an annuity from ERS, your monthly premium will be automatically deducted from your monthly annuity payment. Subsequent premiums are due on the first day of the coverage month. Your monthly premium payment must be postmarked within thirty (30) days of the due date or coverage will be automatically cancelled retroactive to the last day of the month in which a full premium payment was received and was not considered delinquent. For example, your June premium payment is due on June 1, and will be considered late if it is postmarked after June 30. If the June premium payment is late, coverage would be terminated May 31.

Will the ERS notify me if a premium payment is not received?

It is the participant's responsibility to determine if a premium payment is due. If your coverage is cancelled, you will be notified at that time. Cancelled COBRA coverage may not be reinstated.

For what reasons can COBRA coverage be cancelled by the ERS?

COBRA coverage may be cancelled prior to the end of the continuation coverage expiration date if:

- A timely premium payment is not received.
- The GBP ceases to provide coverage to any employee/retiree.

COB Notice (R 09/2003) Page 3 of 4

- The participant becomes covered under another group health and/or dental plan on or after the COBRA coverage effective date unless the participant is subject to a pre-existing condition limitation or exclusion in the other group health plan. COBRA coverage will end when the new group health plan coverage begins and there is no limitation or exclusion for pre-existing conditions in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- The participant begins receiving Medicare benefits on or after the COBRA coverage effective date.
- The participant extends coverage due to a disability and later begins receiving Medicare benefits or the SSA makes a final determination that the disability no longer exists.
- A written request is received from the participant requesting cancellation of coverage. Coverage cancellations will be made effective the last day of the month in which the U. S. Postal Service postmarks the request. A full premium payment must be submitted for the month in which a request for cancellation is submitted.

IMPORTANT: Cancelled COBRA coverage may not be reinstated

What if I become covered under another group health plan or begin receiving Medicare benefits?

You are responsible for notifying the ERS in writing when you enroll in another group health and/or dental plan or begin receiving Medicare benefits. The right to continue COBRA coverage terminates when an individual becomes covered on or after the COBRA effective date by another group health plan that does not limit or exclude coverage for pre-existing conditions OR if you begin receiving Medicare benefits. Your COBRA coverage will be cancelled retroactive to the last day of the month prior to the month in which you first became covered under the other group health and/or dental plan or began receiving Medicare benefits.

Under HIPAA, a group health plan's pre-existing condition exclusion period will be reduced month for month by the individual's preceding period of "creditable coverage" under another health plan. The continuous coverage period in another health plan is considered "creditable coverage" provided there has been no lapse in coverage of more than 63 days. COBRA continuation coverage may be terminated if a COBRA participant becomes covered by a new group health plan with a pre-existing condition exclusion clause that is satisfied by the "creditable coverage" provision. The HIPAA rules limiting the applicability of exclusions in most employers' health plans for pre-existing conditions became effective in plan years beginning on or after July 1, 1997.

If a participant becomes covered by another group health plan that limits or excludes coverage for pre-existing conditions on or after the COBRA effective date, COBRA coverage will not be terminated until the expiration of the pre-existing conditions exclusion period. In order to continue COBRA coverage you will be required to provide the following items regarding the other group health plan: documentation of the pre-existing conditions limitation provision, documentation of the effective date of coverage for each person that is covered by the other group health plan and documentation (e.g. medical or prescription billings) indicating that services were provided during the pre-existing period for each person that is covered by the other group health plan. COBRA coverage will be cancelled on the last day of the month in which the pre-existing condition exclusion period expires.

What if I return to employment with a GBP participating agency or higher education institution?

If you return to employment with a GBP participating agency or higher education institution while your COBRA coverage is in effect, your COBRA coverage will extend through the end of your rehire month. The full COBRA premium for the month during which you became covered as an active employee or as a dependent of an active employee will be due. This will not result in a break in coverage. However, if the full premium is not received, COBRA coverage will be retroactively cancelled and you will be subject to the 90-day waiting period.

May I change my health and/or dental carrier or make changes to my COBRA coverage?

COBRA coverage will continue with your current health and/or dental carrier. If you are enrolled in a Health Maintenance Organization (HMO) and move out of the service area where there is no other HMO available, you will be automatically enrolled in HealthSelect. You may decrease your level of coverage by submitting a written request to the ERS. The decrease in coverage will be effective the first day of the month following the postmarked date of your request. Newly acquired dependents may be added if you notify the ERS in writing within thirty (30) days of the qualifying life event. (For example, if you were married on July 1, to add your new spouse, your request must be postmarked on or before July 31). Other eligible dependents may be added and eligible changes may be made during the annual Summer Enrollment Period or through the Evidence of Insurability (EOI) process.

Can COBRA coverage be converted to an individual policy?

COBRA coverage may be converted to an individual policy if you apply for conversion within thirty (30) days after the date your COBRA coverage expires or is cancelled, provided your premium payments are current. We will notify you forty-five (45) days before the expiration date. Please contact your health and/or dental carrier for specific information about conversion.

COB Notice (R 09/2003) Page 4 of 4



COBRA

This is to certify that I have received a CONTINUATION COVERAGE NOTIFICATION (COBRA) FORM.

Signature of Employee
Signature of Employee
Date

THE EMPLOYEES RETIREMENT SYSTEM OF TEXAS SUMMARY NOTICE OF PRIVACY PRACTICES

The Employees Retirement System of Texas ("ERS") administers the Texas Employees Group Benefits Program, including your health plan, pursuant to Texas law. THIS NOTICE DESCRIBES HOW ERS MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO YOUR OWN INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA") PRIVACY RULE. PLEASE REVIEW THIS NOTICE CAREFULLY.

Uses and disclosures of health information:

ERS and/or a third-party administrator under contract with ERS may use health information about you on behalf of your health plan to authorize treatment, to pay for treatment, and for other allowable health care purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods.

By law, ERS may use or disclose identifiable health information about you without your authorization for several reasons, including, subject to certain requirements, for public health purposes, for auditing purposes, for research studies, and for emergencies. ERS provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, ERS will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. ERS cannot use or disclose your genetic information for underwriting purposes. ERS may change its policies at any time. When ERS makes a significant change in its policies, ERS will change its notice and post the new notice on the ERS website at www.ers.state.tx.us. Our full notice is available

For more information about our privacy practices, contact the ERS Privacy Officer. ERS originally adopted its Notice of Privacy Practices and HIPAA Privacy Policies and Procedures Document April 14, 2003, and subsequently revised them effective February 17, 2010, and September 23, 2013.

Individual rights:

In most cases, you have the right to look at or get a paper or electronic copy of health information about you that ERS uses to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. For all authorized or by law requests made by others, the requestor will be charged for production of medical records per ERS' schedule of charges. You also have the right to receive a list of instances when we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that ERS correct the existing information or add the missing information. You have the right to request that ERS restrict the use and disclosure of your health information above what is required by law. If ERS accepts your request for restricted use and disclosure then ERS must abide by the request and may only reverse its position after you have been appropriately notified. You have the right to request an alternative means of communications with ERS. You are not required to explain why you want the alternative means of communication.

Complaints:

If you are concerned that ERS has violated your privacy rights, or you disagree with a decision ERS has made about access to your records, you may contact the ERS Privacy Officer. You also may send a written complaint to the U.S. Department of Health and Human Services. The ERS Privacy Officer can provide you with the appropriate address upon request.

Our Legal duty:

ERS is required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this Notice, and obtain your acknowledgement of receipt of this Notice.

Detailed Notice of Privacy Practices:

For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Office of the Privacy Officer or by visiting ERS' web site at www.ers.state.tx.us. If you have any questions or complaints, please contact the ERS Privacy Officer by calling (512) 867-7711 or toll-free (877) 275-4377 or by writing to ERS Privacy Officer, The Employees Retirement System of Texas, P.O. Box 13207, Austin, TX 78711-3207.

Cignoture	Data	



EEO Training Acknowledgment

I have received notification from Human Resources of the requirement to complete EEO Training as a new employee of Cisco College. I understand that prior to employment, I must complete the training, print a certificate, and provide a copy of the completion certificate to the Human Resources Office. I understand that I will have to re-certify this training every two years, if still employed with Cisco College. I also understand that the link to take the course may be accessed by me as indicated below:

- Go to the Cisco College website (www.cisco.edu).
 - Select "Faculty & Staff"
 - Select "Current Employee"
 - Under "Forms and Information"
 - "Equal Employment Opportunity (EEO) Training

training.	raining instructions to assist me in completing the
Name	Date



EEO Training Instructions

All Cisco College employees (full-time/part-time) are required by law to complete the Equal Employment Opportunity Training upon initial employment and every two years thereafter. An updated Computer Based Training (CBT) has been made available to us by the Texas Workforce Commission. Please be prompt about completing this required training. Upon completion please send a copy of your certificate or score to the HR Office. Your EEO training completion date is tracked in your Payroll System Record, and a copy is filed in your personnel file.

You will be reminded via email four weeks prior to your 2-year completion date so you will have sufficient time to take the course again and submit your new Completion Certificate by the 2-year mark from your previous training.

To Take the EEO Training:

- 1. Go to the Cisco College website (www.cisco.edu).
 - Select "Faculty & Staff"
 - Select "Current Employee"
 - Under "Forms and Information"
 - "Equal Employment Opportunity (EEO) Training
- 2. Login Information is as follows:
 - You will be prompted to enter your information
 - This will take you directly into the course
- 3. You can stop the course to go back to finish it at a later date. However, you cannot start the course over again or change previously completed answers. The course will simply pick up at the point you stopped.
- 4. When you are prompted at the end of the course to enter your "Agency Code," you should enter "Cisco College & Your name," (EX: Cisco College -Jane Doe). This information will be used for your completion certificate. Select "Print Certificate." Once printed, then select "Finish." AND SEND AN EMAIL TO YOURSELF WITH THE SCORE. HR MUST HAVE A COPY OF YOUR CERTIFICATE OR SCORE IN ORDER TO GIVE YOU CREDIT FOR COMPLETING THE COURSE.

EEO Training Updated

Sec. 21.010. EMPLOYMENT DISCRIMINATION TRAINING FOR STATE EMPLOYEES. (a) Each state agency shall provide to employees of the agency an employment discrimination training program that complies with this section.

- (b) The training program must provide the employee with information regarding the agency's policies and procedures relating to employment discrimination, including employment discrimination involving sexual harassment.
- (c) Each employee of a state agency shall attend the training program required by this section not later than the 30th day after the date the employee is hired by the agency and shall attend supplemental training every two years.
- (d) The commission shall develop materials for use by state agencies in providing employment discrimination training as required by this section.
- (e) Each state agency shall require an employee of the agency who attends a training program required by this section to sign a statement verifying the employee's attendance at the training program. The agency shall file the statement in the employee's personnel file.



Acknowledgement of Official Transcripts Requirement

As a newly-hired employee with Cisco College, I understand that it is *my responsibility* to order and have official transcripts sent directly to the following address:

Director of Human Resources 101 College Heights Cisco, Texas 76437

humanresources@cisco.edu

This is a SACS requirement and necessary to maintain our credentialing. I further understand that Human Resources office must receive and have on file official transcripts for *all my degrees* prior to the date of my hire.

Signed	Date



Veteran Status

The following request for information is used for reporting purposes and to obtain information for the Veteran Workforce Summary Report. The Veteran Workforce Summary Report compiles and analyzes information on the hiring and employment of veterans by Texas state agencies and institutions of higher education, including public community and junior colleges.

Disabled Veteran

I am a Veteran

Date_____

I am not a Veteran

Employee Signature _____

			
	reteran was killed while eran (who has not rem	☐ YES ☐ YES	□ NO

The next section of pages are your ERS benefit selection forms. Please fill in ONLY demographic information and hold until you are scheduled with Human Resources for the New Employee Orientation to review benefit selections. If you are covering any dependent children, please complete a certification form for <u>each</u> child.

New Hire Orientations are held on the **Cisco Campus** with the Director of Human

Resources. Please call **254-442-5121** to schedule your meeting. Come prepared with all your paperwork and questions.

Welcome to Cisco College.

ERS® EMPLOYEES RETIREMENT

BENEFITS ELECTION FORM

You may complete your benefits election either by:

- Using your online account at www.ers.texas.gov, or
- Sending this completed form to your benefits coordinator or HHS Employee Service Center for employees at HHS Enterprise agencies

Information provided to ERS is maintained for managing your benefits.

If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify your benefits coordinator or HHS Employee Service Center.

SECTION A: EMPLOYEE DATA (To be completed by employee.)

Social Security Number/National ID (SSN)	Employee ID	First Active Duty Date			
Employee Name: First, MI, Last	Eligibility County	Mailin	g Address	☐ Check if new	
City	State	ZIP Code		Phone Number	
			☐ Home ☐ Cell		
Email Address		Gend	er	Date of Birth	
		□м	□F		
Agency Name	Dept ID/Agency Number	Employee	Class	Insurance Pay Rate	
Employee SSN/National ID Correction	Employee Name Char	nge or Correcti	on	Date of Birth Correction	
Please provide this information, as it could affer • Were you covered as a dependent under the Tex				vour hire? □ Yes □ No	
If yes, please provide the Social Security number					
• Are you a University of Texas (UT) or Texas A&M University (TAMU) employee or dependent transferring to this GBP-participating agency or institution without a break in health coverage? Yes No Date coverage ends If yes, please provide proof of no break in coverage to your benefits coordinator. If you are a Health and Human Services (HHS) Enterprise employee, provide the proof to HHS Employee Service Center.					
• Are you recently rehired with the same state agency within 90 days of leaving active military duty? ☐ Yes ☐ No If yes, please provide your military release date:					
, , p					
SECTION B: ACTION (Mark appropriate cho	ice.)	y Status Change	HIR □] New Hire	
SECTION B: ACTION (Mark appropriate cho DTA □ FTE to PTE/PTE to FTE OR Retiree RTW	ice.) //Retiree LTW FSC □ Family	y Status Change on LOA REH	HIR □	☑ New Hire RFL ☐ Return from Leave	
BECTION B: ACTION (Mark appropriate cho DTA	ice.) //Retiree LTW FSC □ Family ange RED □ Reduction while	on LOA REH	Rehire	RFL □ Return from Leave	

SECTION D: BENEFITS OPTIONS (Mark appropriate choices.)

SSN	Em	ployee	Name: First,	MI, Last						
Health Coverage		wit	thin 31 days o	ired employees may elo f hire/rehire without enr m hire/rehire date				age.)	/ date o	
Health	Dental*		Vision	Optional Term Life Insurance**		luntary .D&D*		— ∖ Depende m Life lı ance**	ent nsur-	Short-term Disability**
 □ Waive □ HealthSelect of Texas® □ Consumer Directed HealthSelectSM □ Enroll/Add/Drop Dependent (See Section E) □ Waive + Opt-Out Credit* (By checking Waive + Opt Out Credit, you also certify that you have comparable coverage. See page 3 for 	□ Waive □ State of Texas Dental Choice Plan SM □ DeltaCare® USA DHMO □ Enroll/Add/Drop Dependent (See Section E		Vaive State of Texas /ision sM Enroll/ Add/Drop Dependent See Section E)	☐ Waive ☐ Enroll Elect coverage level ☐ OL1 Election 1 ☐ OL2 Election 2 ☐ OL3 Election 3 ☐ OL4 Election 4 Decrease Level to ☐ OL1 Election 1 ☐ OL2 Election 2 ☐ OL3 Election 3	☐ Yo \$ Amor \$200	ou Only ou + Fam ount up to 0,000 in ments o	□ E Dro (See	Vaive Enroll/Add p Depend e Section	d/ dent <i>E</i>)	□ Waive □ Enroll Long-term Disability** □ Waive □ Enroll
important information.) *A monthly credit of up to \$60 (o	enrollee or due to	o a qua	alifying life ev	h care, dependent care ent, you must comple	te the	TexFle	x Enroll			
**To add this coverage will requi www.ers.texas.gov, or contact	re evidence of insurab	oility (EC	I). Initiate the E	OI process online by sign				ount at		
Employee Tobacco-User Ce times in the last three months e-cigarettes / vaping products ☐ Yes ☐ No	? This includes but									
SECTION E: DEPENDENT Dependent Tobacco-user Ce any type of tobacco product five chewing tobacco, snuff, dip, and	rtification: If your dive or more times in	dependo the las	ents are enroll t three months	ed in a GBP health pla						
	ent's Name MI, Last)	Gender	Date of Birth (mm-dd-yyyy)	Dependent SSN (Required for 12 months or o	older)	Health	Dental	Vision	Dep. Li	fe Tobacco User
□ Sp □ D □ S □ O		□ M □ F				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
□Sp □D □S □O		□ M □ F				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
□Sp □D □S □O		□ M □ F				Yes No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
□Sp□D □S□O		□ M □ F				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
□Sp□D □S□O		□ M □ F				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
* Relationship Code: Sp – Sp foster child, or ward child. If you are adding a child, you m ERS. For dependents newly en	ust complete a Depo	endent	Child Certificat	ion form (ERS GI 1.081) availa	able at v	vww.ers	atexas.g	ov or by	/ calling
Did your dependent have GBP coverage under ERS through another member within the last 31 days? Yes No f yes, please provide the Social Security number under which your dependent was covered: s this dependent a new addition to your household because of this event? Please check one only: Adoption Acquisition of other than natural child Birth Not newly acquired Marriage								_		

SSN Employee Name: First, MI, Last
I authorize payroll deductions for the elections indicated on this Benefits Election Form. I understand that my insurance coverage may be cancelled if I do not pay the required amounts due, either by payroll deduction or personal payment. I understand that all insurance premiums are deducted on a pre-tax basis, except Dependent Life, and Disability. I authorize any provider to release any information on persons covered when needed to verify eligibility or to process an insurance claim/complaint. I understand that insurance participation rule and enrollment and benefits information are available from my benefits coordinator/HHS Employee Service Center or ERS. I understand that double coverage for dependents is not allowed for health, vision and dental coverage in the Texas Employees Group Benefit Program (GBP). I understand that state law does not permit me to receive more than one state insurance contribution as either an employee, retiree, or dependent. I certify that I am familiar with the requirements for enrolling myself and/or dependent(s) in the GBP based on a new/post hire change or a qualifying life event (QLE). I further certify that my QLE is valid, correct, and allowable under the GBP. I understand that I may be asked to show documentation to support my QLE and will be required to submit documentation for any newly enrolled dependents, proving their eligibility. I also understand that if I knowingly provide any materially incorrect, incomplete, untrue information, I may be permanently expelled from the GBP and/or subject to criminal prosecution.
Notice about Insurance: Funding for health and other insurance benefits for participants in the GBP is subject to change based on available state funding. The Texas Legislature determines the level of funding for such benefits and has no continuing obligation to provide funding for those benefits beyond each fiscal year.
Tobacco-User Certification: I certify my understanding and agreement to the following: "Tobacco product" is defined as all types of tobacco, including but not limited to, cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, and dip; and all electronic cigarettes and vaping products and a "tobacco user" is a participant who has used a tobacco product or tobacco products five or more times during the preceding three months. If I (or any of my covered dependents): 1) have used tobacco products as a tobacco user; or 2) start using tobacco products without notifying ERS, I will be subject to monetary penalties and may be terminated from participation in the GBP. Also, failure to notify ERS may constitute fraud. Under the penalties of perjury, the above information is true and correct. Providing or entering false information may disqualify me from continued coverage in the GBP. If I intentionally misrepresent material facts or engage in fraud, my coverage may be rescinded retroactively to the date of the misrepresentation or fraudulent act. In that event, I will receive thirty days notice before my coverage is rescinded. Further, if I or any of my covered dependents start using tobacco products without notifying ERS, I will be subject to monetary penalties and such failure to notify ERS may constitute fraud.
If you certified yourself or any of your dependents as a tobacco user, you may be able to participate in Choose to Quit, an alternative to the tobacco-user premium, if it is right for your health status and complies with your doctor's recommendations. For more information about th program, visit, www.ers.texas.gov/Employees/Health/Tobacco_Policy.
If you previously certified yourself or any of your dependents as a tobacco user, and you or they have stopped using tobacco for three consecutive months, you must complete the Tobacco-User Certification Form (ERS 2.933) available at https://ers.texas.gov/PDFs/FormsTobacco_User_Certification_ERS2933.pdf, or change the certification using your online account at www.ers.texas.gov.
If you selected "Waive + Opt-Out Credit": I certify that I do not want the health plan coverage offered to me as an eligible participant. I am waiving my health plan coverage and certify that I have other health plan coverage with substantially equivalent coverage to the basic health plan. I understand waiving my state health insurance will cancel my prescription drug coverage and \$5,000 Basic Term Life policy. I will receive a credit of up to \$60 (or \$30 for part-time participants) that will be applied only toward the cost of eligible optional coverage in which I am enrolled (dental, vision and/or Voluntary Accidental Death and Dismemberment (AD&D)). The credit is in place of the state contribution for basic health coverage. Due to federal legislation Medicare members cannot receive the Opt-Out Credit. I am able to view the Health Insurance Opt-Out Credit applied toward my eligible optional coverage premium by signing into my online account at www.ers.texas.gov.
I understand that if I am currently in a waived status, I must have a QLE or wait until Summer Enrollment to enroll in medical or optional coverage offered to eligible participants.

If you are a Health and Human Services (HHS) Enterprise employee, return this form to HHS Employee Service Center.

Employee's Signature _____ Date Signed (mm-dd-yyyy) ___

Keep a copy of this form for your files and return the original to your benefits coordinator.



Information provided to the Employees Retirement System of Texas (ERS) is maintained for managing your benefits.

If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

Complete a congrate form for each dependent child to be covered

DEPENDENT CHILD CERTIFICATION

Note: If you certify online, you do not need to complete this form, unless requested due to a dependent eligibility audit. You may certify your dependent either by:

- · Using your online account at www.ers.texas.gov, or
- · Active employees: may send this completed form to your benefits coordinator or HHS Employee Service Center, or
- Other members: may send this completed form to:

Employees Retirement System of Texas Customer Benefits P.O. Box 13207 Austin, TX 78711-3207 (866) 399-6908 Toll-free

Date Signed (mm-dd-yyyy)

	Social Security Number (S	SN)	Empl	oyee ID
Agency Name			Dept ID/Agend	cy Number
Legal Name of Child: First, MI, I	Last Child's S	ocial Se for 12 m	curity Number conths or older)	Child's Birth Date mm/dd/yyyy
FION B: DEPENDENT CHILD CATEGOR				
_ 1. I certify this child is my:	year Al vator. - 3. I certify: • this chi not clai year be year Al • will be for ever for ever - OR - - 4. I certify this eligible for ledigible for l	med on r cause th ND claimed on ty year the child is r cenefits in the to good not good e: Good nder item ces that r I this year ss you wi	ny federal income to e child was born in on my federal income child is enrolled. The child is enrolled. The elated to me by block the Texas Employed cause and I have do cause provided because means that you so a so a so above because quired you to take to the child was not certificated.	the current calendar ne tax this year and od or marriage and is ees Group Benefits read and understand flow. Definition of ou cannot certify use of unexpected parental responsibility fy the child for good hild as your dependen
mber Comment – Only complete this b	ox if you choose Option 4.			

Signature of Employee/Retiree



TOBACCO USE CERTIFICATION FORM

Send this completed form to:
Employees Retirement System of Texas
P.O. Box 13207
Austin, Texas 78711-3207
or Fax: (512) 867-7438

Information provided to ERS is maintained for managing your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify your benefits coordinator or ERS.

You must certify your status as a tobacco-user or non-user as well as the status of any of your dependents enrolled in a Texas Employees
Group Benefits Program (GBP) health insurance plan, even if you and your covered dependents don't use tobacco.
For more information, visit www.ers.texas.gov/Employees/Health/Tobacco_Policy/

Tobacco Use Certification (effective the first of the month following the date this form is received by ERS).

Name	Relationship to Employee	Tobacco Use
		□ Yes □ No
		□ Yes □ No
		☐ Yes ☐ No
		□ Yes □ No
		□ Yes □ No

You must certify your understanding and agreement to the following:

- "Tobacco Product" is defined as all types of tobacco, including but not limited to, cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes/vaping products and a "Tobacco-User" is a person who has used any Tobacco Products five or more times within the past three consecutive months.
- If I (or any of my covered dependents): 1) have used Tobacco Products as a tobacco-user; or 2) start using tobacco products without notifying ERS, I will be subject to monetary penalties and may be terminated from participation in the GBP. Also, failure to notify ERS will constitute fraud.
- Under the penalties of perjury, the above information is true and correct. Providing or entering false information may
 disqualify me from continued coverage in the GBP. If I intentionally misrepresent material facts or engage in fraud, my
 coverage may be rescinded retroactively to the date of the misrepresentation or fraudulent act. In that event, I will receive
 thirty days notice before my coverage is rescinded. Further, if I or any of my covered dependents start using tobacco
 products without notifying ERS, I will be subject to monetary penalties and such failure to notify ERS will constitute fraud.

Member Name __	Last four digits of Social Securit	y Number
Signature	Date _	

You will pay \$30, \$60 or \$90 each month in addition to any GBP health insurance premiums you are paying, depending on how many tobacco users you cover.

Tobacco User(s)	Monthly fee
You only	\$30
Spouse only	\$30
Child* only	\$30
You + spouse	\$60
You + child*	\$60
Spouse + child*	\$60
You + spouse + child* (Family)	\$90

*Note: The charge for a child is the same regardless of how many children in the household use tobacco.

If you are a tobacco-user, you may be able to participate in an alternative to the tobacco-user premium, if it is right for your health status and complies with your doctor's recommendations. Please visit www.ers.texas.gov/Employees/Health/Tobacco_Policy/ for more information.



EMPLOYEES RETIREMENT SYSTEM OF TEXAS TEXFLEX ENROLLMENT/CHANGE FORM

After completing this form, please send it to your Benefits Coordinator either via fax or e-mail:

- 866-245-3659
- hhsservicecenter.bef@ngahrhosting.com

Information provided to ERS is maintained for managing your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

Employee Name:	SSN ERS Emplo	ovee ID
p 1,3 1 1		
Type of employee: ☐ 12-month		
SECTION B: ACTION AND REASON CODE (C		
FSC ☐ Family Status Change ☐ HIR New Hire ☐ RED ☐ Reduction while on LOA RFL ☐ Return f	<u> </u>	ence
Enter a reason code and event date if you checked t See the Family Status Change (FSC) Reference Cha		
Reason Code:	Event Date: (mm-dd-yyyy)	
	UNT (Fill out only one of the three options in this section, if a	,
minimum annual pledge of \$180 and a maximum and your employment or qualifying life event. You will reco	nual pledge of \$2,700 per tax year. Enrollment/change must be madeive a TexFlex debit card, at no cost, to pay for eligible expenses. The cost is the cost of the	de within 31 days of here is no annual
OPTION 1: NEW ENROLLMENT (Complete or	nly if New Hire/Rehire or Family Status Change.)	
I	want my monthly deduction to be (not to exceed \$225 per month):	\$.00
1	x	
	Annual pledge:	\$ 0 .00
OPTION 2: INCREASE PLEDGE AMOUNT (Co	omplete only if increasing pledge amount due to a Family Sta	atus Change.)
	Current annual pledge amount:	\$.00
	Increase my annual pledge amount to:	\$.00
OPTION 3: REDUCTION (Complete only if redu	ucing pledge amount due to a Family Status Change.)	
	Increase my annual pledge amount to:	
	Reduce my annual pledge amount to:	\$.00
	CCOUNT (Fill out only one of the three options in this sectio	
and a maximum annual pledge of \$5,000 or the lesser must be made within 31 days of your employment or expenses. There is no annual administrative fee for the enrolled in this account.	child or adult dependent care expenses. Program has a minimum aller of your spouse's or your annual income that is below \$5,000. En qualifying life event. The TexFlex debit card is not available to pay he TexFlex dependent care account. Note: If you do not check this	rollment/change for dependent care
OPTION 1: NEW ENROLLMENT (Complete or	nly if New Hire/Rehire or Family Status Change.)	
	want my monthly deduction to be (not to exceed \$416 per month):	\$.00
1	Number of months left in the plan year (September 1 – August 31):	х
	Annual pledge:	\$ 0 .00
OPTION 2: INCREASE PLEDGE AMOUNT (Co	omplete only if increasing pledge amount due to a Family St	atus Change.)
	Current annual pledge amount:	\$.00
	Increase my annual pledge amount to:	\$.00
OPTION 3: REDUCTION (Complete only if redu	ucing pledge amount due to a Family Status Change.)	
	Current annual pledge amount:	
	Reduce my annual pledge amount to:	\$.00

Page 1 of 3 ERS FB 9.20 (R 3/2020)

qualifying life event. You will receive a TexFlex debit card, at no cost, to pay for dental and vision expenses. There is no fee for the TexFlex LFSA. Note: If you do not check this box, you will not be enrolled in this account.		
OPTION 1: NEW ENROLLMENT (Complete only if New Hire/Rehire or Family Status Change.)		
I want my monthly deduction to be (not to exceed \$225 per month):	\$.00
Number of months left in the plan year (September 1 – August 31):	x	
Annual pledge:	<u> </u>	.00
OPTION 2: INCREASE PLEDGE AMOUNT (Complete only if increasing pledge amount due to a Family Sta	atus Change.)	
Current annual pledge amount:	\$.00
Increase my annual pledge amount to:	\$.00
OPTION 3: REDUCTION (Complete only if reducing pledge amount due to a Family Status Change.)		
Current annual pledge amount:	\$.00
Reduce my annual pledge amount to:	\$.00
Authorization: I understand my TexFlex health care, dependent care, and/or limited flexible spending account enrollment plan year, unless I have a qualifying life event, terminate employment or retire. I authorize payroll deductio listed on this form.		
I understand I have until August 31 to incur health care expenses for the plan year and can carry over a mi \$500 of my TexFlex health care account balance to the next plan year. Any amount over \$500 will be forfei		up to
I understand I have until August 31 to incur eligible dental or vision expenses for the plan year and can car of \$25, up to \$500 of my TexFlex limited flexible spending account balance to the next plan year. Any amount forfeited.	•	
I understand I have until November 15 to incur dependent care expenses for the plan year. The carryover i TexFlex dependent care account.	is not allowed f	or the
I must file all eligible claims for reimbursement by December 31 of the associated plan year.		
I understand that TexFlex account eligibility, enrollment and benefits information is available from my employwww.ers.texas.gov. I certify that I have read and agree to all of the conditions and participation rules for t	•	

Date:

Sign:_

SECTION E: TEXFLEX LIMITED FLEXIBLE SPENDING ACCOUNT (Fill out only one of the three options in this section, if applicable.)

Enrollment in the TexFlex limited flexible spending account (LFSA) is only applicable if you are enrolled in Consumer Directed HealthSelectSM

TexFlex LFSA – for eligible dental and vision out-of-pocket costs excluding healthcare costs. Program has a minimum annual pledge of



TEXAS EMPLOYEES GROUP BENEFITS PROGRAM (GBP) SUPPLEMENTAL INFORMATION FORM FOR EMPLOYEES

Information provided to Employees Retirement System of Texas (ERS) is maintained for managing your benefits.

Please mail the completed form to your health plan carrier.

SIGN, DATE AND MAIL THIS FORM TO YOUR HEALTH PLAN.

 \square No

New Employee? ☐ Yes ☐ No	Employee Name:	First, MI, L	.ast	Birthdate Last four digit (mm-dd-yyyy) Social Security N							
2100 2110				(mm aa	9999/	XXX-		ucy .	101111001		
	Mailing Address			(City		Stat	e ZI	P Code	Eligibility	County
3											
SECTION B: OTHER	R INSURANCE DATA	\									
Please check type of coverage:	□ Employer Group	Health	□ Emplo	oyer Group	Dental		Individ	lual H	ealth	□ Individua	al Dental
Name of Po	blicyholder	ID numbe	B ⁴	rthdate n-dd-yyyy)	Ge	ender			Re	elationship	
					□М		F	□ Se	elf 🗆	Spouse	□ Child
Name and Add Insurance Comp		Group or	Policy	Effective [Date	1	/		Le	evel of Cove	rage
mourance comp	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Will Cove		itinue				You Only	
						الممسا	Data			You/Spouse	
				If No, Expected Cancel Date				☐ You/Child(ren)☐ You/Family			
SECTION C: MEDIC	ARE COVERAGE IN	FORMATI	ON								
Name of Medic	are Beneficiary	Medicare	Part A (I	Hospital) Ef	fective D	ate	Med	dicare	No. (Fr	om Medicar	e Card)
		/	<i></i>		(e						
			/ / Part B	Medical) Ef —	rective D	ate					
050510N D DD1144		051 507	510NL /5		ism s T				., -		`
SECTION D: PRIMA Name of your Healt		IN SELECT	ION (for	HealthSele	ects™ of I	exas	and C	ommı	inity Firs	t participants	5)
	ect of Texas or Commu	ınity First He	ealth Plar	ns, select yo	ur primar	y care	physi	cian (F	PCP) fror	n the plan's p	rovider
directory. Attach an ac	dditional sheet if neces	sary.					. ,				
Patient's Name: First, MI, Last	Social Security Number (SSN)		Birthda (mm-dd-y		PCP Name: rst, MI, Las			PCP Ac	ddress	NPI or PCP No.	Existing Patient?
Employee		□ M □ F									□ Yes □ No
Spouse		□М									□ Yes
		□F									□ No
Child		□ M □ F									□ Yes □ No
Child		□ M □ F									□ Yes
Child		□ M □ F									☐ Yes
Child											□ Yes

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Over

 \Box F

SECTION E: OTHER COVERED DEPENDENT NOT LIVING IN THE HOUSEHOLD

□ Dependent Lives Out-of-Area□ Dependent Lives in Different	Dependent Name: First, MI, Last			Security No (SSN)	Birthdate (mm-dd-yyyy)	
Network or Service Area						
Mailing Ad	dress City		State	ZIP Code		County
Participant's Signature				Date Signe	d (mm-do	d-yyyy)

GENERAL INSTRUCTIONS

This GBP Supplemental Information Form is NOT an enrollment form. Enrollment forms are submitted to ERS and coverage is reported to the selected health plan. This form will facilitate the receipt of your health care identification card once your enrollment form has successfully been processed by ERS and your coverage reported to the selected health plan.

This GBP Supplemental Information Form must be completed, signed and dated by you when:

1) enrolling in any GBP health plan, 2) adding a dependent to your current health coverage, or 3) making an eligible health plan change (for example, at Summer Enrollment).

SECTION A: EMPLOYEE DATA

Complete this section and specify your mailing address, ZIP Code, and Eligibility County. Indicate if you are a new employee.

SECTION B: OTHER INSURANCE DATA

Complete this section if you or any member of your family are covered by other health or dental coverage. If more space is needed, please attach a separate sheet.

SECTION C: MEDICARE COVERAGE INFORMATION

Complete this section if you or any member of your family are covered under Medicare Part A and/or Part B. If more space is needed, please attach a separate sheet.

SECTION D: PRIMARY CARE PHYSICIAN SELECTION

Complete this section if you are enrolling in a GBP health plan requiring a PCP selection prior to receiving services. Refer to the provider directories at **www.ers.texas.gov** when completing this section.

- 1. Write the name of your chosen health plan.
- 2. Write the full name and provider code of your chosen PCP for yourself and each covered dependent, even if you are selecting the same physician for all covered persons.
- 3. Indicate if you are an existing patient or not (Y/N).

If you need assistance in completing this section, contact your health plan.

SECTION E: OTHER DEPENDENT INFORMATION

- 1. Complete this section if you are enrolling in HealthSelect (In-Area) and your eligible dependent lives out-of-area or in another HealthSelect network area.
- 2. Complete this section if you are enrolling in an HMO and your eligible dependent lives in another Texas service area of the selected HMO.

HEALTH PLAN ADDRESSES AND TELEPHONE NUMBERS:

HMO: Scott & White KelseyCare powered by **Community First** HealthSelectSM of Texas Health Plans, Inc. **Health Plan Community Health Choice** BlueCross BlueShield 2636 South Loop West, (877) 698-7032 1206 West Campus Drive (800) 252-8039 (210) 358-6262 Temple, TX 76508 Suite 900 Mail Supplemental Temple: (800) 321-7947 Houston, TX 77054 Mail Supplemental **Information Forms to:** Georgetown: (800) 758-3012 (713) 295-6792; **Information Forms to:** 4002 Loop 322 Waco (254) 756-8000 toll-free (844) 515-4877 Community First Abilene, TX 79602-7330 12238 Silicon Drive, Suite 100 San Antonio, TX 78249



TEXAS EMPLOYEES GROUP BENEFITS PROGRAM (GBP) DEPENDENT ELIGIBILITY CHART

Make sure your dependents are eligible for insurance and that you have the appropriate documentation to show eligibility before you enroll them in any coverage. For example, if you add a common law spouse, you must have a government-issued Declaration of Informal Marriage dated prior to enrolling the spouse AND a current federal tax return. You are required to provide the documentation to Alight Solutions (formerly Aon Hewitt) to enroll a new dependent. For newborn children, age three months or younger, a hospital-issued birth certificate will be accepted in place of a government-issued birth certificate.

Dependent of the Participant (employee, retiree or other individual enrolled in program as recognized by Texas law)	Eligibility	Examples of Supporting Documents (required)
Spouse	Spouse as recognized by law	Government-issued marriage Certificate AND Current federal tax return OR Proof of joint ownership** issued within last six months OR Government-issued marriage certificate only (if married in the last 12 months)
Common Law Spouse	Spouse as recognized by law	 Declaration of Informal Marriage with the county courthouse AND Current federal tax return OR Proof of joint ownership** issued within last six months
Biological Child*	Natural born child	Government-issued birth certificate
Adopted Child*	Child is eligible at time of placement.	 Adoption certificate OR Adoption Placement Agreement AND Petition for adoption
Stepchild*	Child is not required to live in participant's household.	Government-issued marriage certificate OR Declaration of Informal Marriage with the county courthouse AND Government-issued birth certificate AND Current federal tax return OR Proof of joint ownership** issued within last six months
Child of Managing Conservator	Child is identified in the managing conservatorship granted to the participant.	Managing conservatorship court document signed by a judge
Foster Child*	Child must not have other governmental insurance.	Placement order AND Affidavit of foster child
Legal Ward Child*	Child is under the protection or in the custody of the participant.	Court order signed by a judge appointing participant as the child's guardian (documentation of legal custody) AND Government-issued birth certificate
Other Child*	Child is related to participant by blood or marriage, and was claimed as dependent on participant's federal income tax return for previous tax year, and will continue to be claimed on participant's federal income tax return for every calendar year the child is covered. A child who is acquired or born in the current calendar year will be claimed and continued to be claimed on participant's federal income tax return for every calendar year the child is covered.	Government-issued birth certificate OR Government-issued marriage license to prove family relationship AND Current federal tax return OR Affidavit of Good Cause

^{*}Child must be under age 26 for health insurance, and can be married or unmarried. Child must be under age 26 and unmarried for dental, vision, and Dependent Term Life Insurance. Disabled dependent children age 26 and over may be eligible for insurance. For more information visit the ERS website.

^{**}See Documentation Requirements for examples of Joint Ownership documents. False information could lead to expulsion from the GBP and/or criminal prosecution.

New Employees:

• May elect health coverage at time of hire; however, this coverage will be effective when you have satisfied your waiting period.

Employees making changes to their benefits options during the plan year:

- Use this form to indicate only the changes you want to make.
- Complete this form on or within 31 days after your qualifying life event (QLE) (birth, marriage, etc.).
- Using the chart below, identify a reason code (required in Section C) when changing insurance coverage.

Below are examples of qualifying life events; other similar circumstances may also represent a qualifying life event. Remember, rules will determine if you can enroll in or make the insurance changes you want. You may either enter your changes using your online account at www.ers.texas.gov or send this form to your benefits coordinator.

If you are a Health and Human Services System employee, you may send this form to HHS Employee Service Center. If you do not make changes within 31 days, you may not be eligible to make the changes you want.

Family Status Change Reference Chart

	Participant gets married	MAR				
mployee Marital Status Change	Participant gets a divorce or an annulment	DIV				
	Death of a spouse	DOD				
	Birth of a newborn child	BIR				
	Participant adopts, fosters, or gets court-appointed guardianship, or becomes managing conservator of a child	ADP				
	Participant gains or loses dependent(s) through death	DOD				
ependent Status Change	Dependent becomes eligible or loses eligibility for insurance coverage					
openium ciana ciang	(Example: Participant's spouse is covering their child. The child lost eligibility for the spouse's insurance because the child does not attend school.)	DEP				
	ependent is related by blood or marriage, and was previously claimed on the participant's income tax sturn, but is no longer eligible to be claimed on participants income tax return					
	Child gets married	DGM				
mulaumant Status Change	Participant/Dependent employment status change	ESC				
Employment Status Change	Dependent becomes eligible for insurance after a waiting period	DWP				
ddress Change that Changes ependent Eligibility	Dependent moves out of health or dental plan service area	DMV				
edicare/Medicaid/CHIP	Participant/Dependent gains Medicare/Medicaid/CHIP eligibility	MDG*				
ligibility Change	Participant/Dependent loses Medicare/Medicaid/CHIP eligibility	MDL*				
	Significant change in cost by day care provider	SCC				
ignificant Change in Cost/Coverage nposed byThird Party	Significant change in cost/coverage of dependent's health, vision or dental plan (excluding GBP)	SCC				
inposed by fillion fairty	HIPP approval or loss of eligibility	SCC				
	Participant gains requirement to provide coverage for child through a National Medical Support Notice (NMSN) issued by the Office of the Attorney General (OAG)	MSO				
ffice of the Attorney General (OAG)	(Example: employee receives an NMSN to provide health coverage for his child.)					
Ordered Coverage Change (Eligibility rules apply for these dependents)	NMSN issued by the Office of the Attorney General (OAG), which requires participant to provide coverage for child expires					
	(Example: employee's NMSN to provide health coverage for his child expires and the employee is no longer					

* DEPENDENT ENROLLMENT INFORMATION:

CHIPRA requires a 60-day QLE window to notify ERS if:

- 1. The dependent is not in the GBP and loses their eligibility for Medicaid or CHIP OR
- 2. The dependent is not in the GBP and they become eligible for premium assistance through Medicaid or HIPP, they have 60 days to enroll in the GBP.

DROP DEPENDENT COVERAGE INFORMATION:

In other QLE instances related to Medicaid or CHIP there is the usual 30-day window to drop dependents from the GBP.

** Employees must contact their benefits coordinator (HHS System employees contact HHS Employee Service Center) to drop dependent(s) added with a National Medical Support Notice (NMSN).

You may be asked to show proof of the QLE and will be required to submit documentation for newly enrolled dependents, proving their eligibility.

Employees Retirement System of Texas PO Box 13207 Austin, Texas 78711-3207 (877) 275-4377 (TTY:711)

DOCUMENTATION REQUIREMENTS

Make sure your dependents are eligible for insurance and that you have the appropriate documentation to show eligibility before you enroll them in any coverage. For example, if you add a common law spouse, you must have a Declaration of Informal Marriage with the county courthouse AND a current federal tax return. You are required to provide the documentation to Alight Solutions to enroll a new dependent. For newborn children, age three months or younger, a hospital-issued birth certificate will be accepted in place of a government-issued birth certificate.

Important reminders for all documents:

- DO NOT SEND ORIGINALS. Send copies only.
- Black out all Social Security numbers, monetary amounts and account numbers on all documents.
- · No documents will be returned.

Federal tax return:

- Send only the first page of your federal tax return that shows your dependents.
- A state tax return will NOT be accepted in place of a federal return.
- Black out all Social Security numbers and monetary amounts appearing on your federal tax returns. For example, black out earnings listed on your 1040.

Joint ownership document:

You must provide a mortgage statement, credit card statement, bank statement, property tax statement, residential leasing agreement or similar document that lists both parties' names as co-owners. The joint ownership may be established prior to the current year; however, the statement provided must be issued within the last six months to show that joint ownership still exists.

Proof-of-marriage document:

You must provide a government-issued marriage license or marriage certificate that includes the date of your marriage. Church-issued certificates will NOT be accepted.

Birth certificate:

You must provide a government-issued birth certificate listing parents' names.

- A <u>hospital-issued</u> birth certificate will be accepted only for a newborn child, three months of age or younger.
- Some state and county clerk offices issue the shortform certificate as a standard (lowa, New Jersey, South Carolina, among others). Please get the long form that includes the parents' names. (The long-form certificate is the same kind used to get a passport.)

Requesting vital records:

In some state and county clerk offices, it can take four to eight weeks for vital records to come in. Typically, though, they are delivered within 10 to 14 business days. Please order your documents as soon as possible to ensure receipt by the verification deadline.

Photocopying vital records:

Some state and county clerk offices will not let you copy of vital records (Florida, Pennsylvania and Wisconsin, among others). In those cases, there usually is a warning on the documents that copying is not allowed. If copying is not allowed, you should ask for the non-certified record from the office. Non-certified records usually cost less than certified records.



PLAN YEAR 2024 RATES

EMPLOYEES, RETIREES NOT ELIGIBLE FOR MEDICARE, SURVIVING DEPENDENTS AND COBRA

Sept. 1, 2023 - Aug. 31, 2024

Rates for retirees who don't get a 100% premium contribution from the state are available at https://ers.texas.gov/Retirees/Rates-for-retirees.

Full-time Employees and Retirees Not Eligible for Medicare (Same as Plan Year 2023)

	Premium*	State Pays	You Pay
HealthSelect of Texas®			
You Only	\$ 624.82	\$ 624.82	\$ 0.00
You + Spouse	1,340.82	982.82	358.00
You + Children	1,104.22	864.52	239.70
You + Family	1,820.22	1,222.52	597.70
Consumer Directed HealthS	Select ^{SM**}		
You Only	624.82	\$ 624.82	\$ 0.00
You + Spouse	1,305.02	982.82	322.20
You + Children	1,080.24	864.52	215.72
You + Family	1,760.44	1,222.52	537.92

^{*}Includes applicable premium for Basic Term Life Insurance

Part-time Employees and Retirees Not Eligible for Medicare, Graduate Students/Teaching Assistants, Post-doctoral and Adjunct Faculty[†] (Same as Plan Year 2023)

	Premium*	State Pays	You Pay	
HealthSelect of Texas®				
You Only	\$ 624.82	\$ 312.41	\$ 312.41	
You + Spouse	1,340.82	491.41	849.41	
You + Children	1,104.22	432.26	671.96	
You + Family	1,820.22	611.26	1,208.96	
Consumer Directed HealthS	Select ^{SM**}			
You Only	\$ 624.82	\$ 312.41	\$ 312.41	
You + Spouse	1,305.02	491.41	813.61	
You + Children	1,080.24	432.26	647.98	
You + Family	1,760.44	611.26	1,149.18	

^{*}Includes applicable premium for Basic Term Life Insurance

RateSheet PY24 1 5/17/2022

^{**}The "State Pays" amount includes a monthly contribution to the member's Optum Bank health savings account (HSA). Please see the Consumer Directed HealthSelect HSA Contribution table on the next page.

^{**}The "State Pays" amount includes a monthly contribution to the member's Optum Bank health savings account (HSA). Please see the Consumer Directed HealthSelect HSA Contribution table on the next page.

[†]The state does not contribute to the cost of health insurance for adjunct faculty.

Consumer Directed HealthSelectSM Health Savings Account (HSA) Contribution

(Same as Plan Year 2023)

	State Pays
You Only	\$ 45 monthly (\$540 annually)
You + Spouse	90 monthly (\$1,080 annually)
You + Children	90 monthly (\$1,080 annually)
You + Family	90 monthly (\$1,080 annually)

An HSA is a tax-free savings account for qualified health expenses.

You can receive the "State Pays" HSA contribution if you are:

- enrolled in Consumer Directed HealthSelect,
- eligible for a portion of your health premium to be paid by the state and
- not eligible for Medicare.

Medicare-enrolled Dependents of Retirees Not Eligible for Medicare

Retirees from full-time employment

Through Dec. 31, 2023

	Pı	remium	State Pays		tate Pays You Pay	
HealthSelect ^{s™} Me	dic	are Adva	ınta	ige		
Spouse Only	\$	464.66	\$	358.00	\$	106.66
Children Only		346.36		239.70		106.66
Spouse + Children		811.02		597.70		213.32

Retirees from part-time employment

Through Dec. 31, 2023

	Premium		State Pays		You Pay	
HealthSelect ^{s™} Medicare Advantage						
Spouse Only	\$	338.99	\$	179.00	\$	159.99
Children Only		279.84		119.85		159.99
Spouse + Children		618.83		298.85		319.98

NOTE: HealthSelectSM Medicare Advantage Plan PPO rates for Plan Year 2024 will be available in the fall at https://ers.texas.gov/Retirees/Rates-for-retirees.

Surviving Dependents

	HealthSelect of Texas®	Consumer Directed HealthSelect sm	HealthSelect sM Medicare Advantage (Through December 31, 2023)
Spouse Only	\$ 716.00	\$ 680.20	\$ 213.32
Children Only	479.40	455.42	213.32
Spouse + Children	1,195.40	1,135.62	426.64

COBRA

(Same as Plan Year 2023)

	HealthSelect of Texas®	Consumer Directed HealthSelect sm	
You Only	\$ 635.05	\$ 589.15	
You + Spouse	1,365.37	1,237.06	
You + Children	1,124.04	1,007.78	
You + Family	1,854.36	1,701.58	

COBRA Disability

(Same as Plan Year 2023)

	HealthSelect of Texas®	Consumer Directed HealthSelect sm
You Only	\$ 933.90	\$ 866.40
You + Spouse	2,007.90	1,819.20
You + Children	1,653.00	1,482.03
You + Family	2,727.00	2,502.33

Dental Insurance

DeltaCare [®] USA DHMO	Employee/ Retiree	COBRA	COBRA Disability	Surviving Depe	ndents
You Only	\$ 9.59	\$ 9.78	\$ 14.39	Spouse Only	\$ 9.59
You + Spouse	19.18	19.56	28.77	Spouse + Children	23.02
You + Children	23.02	23.48	34.53	Children Only	13.43
You + Family	32.59	33.24	48.89		

State of Texas Dental Choice Plan ^{sм} (Same as Plan Year 2023)	Employee/ Retiree	COBRA	COBRA Disability	Surviving Depe	ndents
You Only	\$ 28.73	\$ 29.30	\$ 43.10	Spouse Only	\$ 28.73
You + Spouse	57.46	58.61	86.19	Spouse + Children	68.95
You + Children	68.95	70.33	103.43	Children Only	40.22
You + Family	97.68	99.63	146.52		

Vision Insurance

(Same as Plan Year 2023)

State of Texas Vision ^{sм}	Employee/ Retiree	COBRA	COBRA Disability	Surviving Deper	ndents
You Only	\$ 4.61	\$ 4.70	\$ 6.92	Spouse Only	\$ 4.61
You + Spouse	9.22	9.40	13.83	Spouse + Children	9.91
You + Children	9.91	10.11	14.87	Children Only	5.30
You + Family	14.52	14.81	21.78		

Tobacco-user Premium

If you and/or a family member enrolled in medical insurance is certified as a tobacco-user, you will pay an additional tobacco-user premium of \$30, \$60 or \$90 each month, depending on how many tobacco-users or uncertified family members you cover.

Tobacco-users of Any Age and Adults age 18 and over Who Fail to Certify	Monthly Tobacco-user Premium
Member or Spouse or Children* Only	\$30
Member + Spouse or Member + Children* or Spouse + Children*	\$60
Family (Member + Spouse + Children*)	\$90

^{*}The charge for a child is the same regardless of how many children in the household use tobacco or how many covered children age 18 or over are not certified.

If you are a tobacco-user, you may be able to participate in an alternative to the tobacco-user premium, if it is right for your health status and complies with your doctor's recommendations. Please visit www.ers.texas.gov/About-ERS/Policies/Tobacco-Policy-and-Certification for more information.

Optional Term Life Insurance

(Same as Plan Year 2023)

Optional Term Life Insurance				
Age	Election 1 Annual Salary x 1	Election 2 Annual Salary x 2	Election 3* Annual Salary x 3	Election 4*† Annual Salary x 4
	Month	ly Rate per \$1,000 o	f Annual Salary	
Under 25	\$ 0.05	\$ 0.10	\$ 0.15	\$ 0.20
25 - 29	0.05	0.10	0.15	0.20
30 - 34	0.06	0.12	0.18	0.24
35 - 39	0.06	0.12	0.18	0.24
40 - 44	0.08	0.16	0.24	0.32
45 - 49	0.13	0.26	0.39	0.52
50 - 54	0.20	0.40	0.60	0.80
55 - 59	0.35	0.70	1.05	1.40
60 - 64	0.60	1.20	1.80	2.40
65 - 69	0.98	1.96	2.94	3.92
70 - 74	1.56	3.12	4.68	6.24
75 - 79	2.55	5.10	7.65	10.20
80 - 84	4.15	8.30	12.45	16.60
85 - 89	7.18	14.36	21.54	28.72
90+	11.18	22.36	33.54	44.72

After the first 31 days of employment, Elections 1 and 2 require approval through evidence of insurability (EOI).

Elections 3 and 4 always require EOI approval.

Beginning at age 70, Optional Term Life coverage is reduced to a percentage of your annual salary as follows:

Age 70-74	65%
Age 75-79	40%
Age 80-84	25%
Age 85-89	15%
Age 90+	10%
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Retiree Fixed Optional Life Insurance (\$10,000 policy)

\$24.80 per month for \$10,000

Dependent Term Life Insurance Employee: \$1.45 per month for \$5,000 (includes \$5,000 AD&D coverage) Retiree: \$3.23 per month for \$2,500

Voluntary Accidental Death & Dismemberment Insurance (AD&D)*

(Same as Plan Year 2023)

You may enroll in AD&D coverage according to the following table:

Age	Minimum Coverage	Maximum Coverage	Minimum Increments
Under 70	\$ 10,000	\$ 200,000	\$ 5,000
70-74	6,500	130,000	3,250
75-79	4,000	80,000	2,000
80-84	2,500	50,000	1,250
85-89	1,500	30,000	750
90+	1,000	20,000	500

You Only \$0.02 per \$1,000 of coverage

You + Family \$0.04 per \$1,000 of coverage

Texas Income Protection PlanSM (TIPP)*

Same as or lower than Plan Year 2023

Short-term disability	Long-term disability
\$0.24 per \$100 of monthly salary	\$0.68 per \$100 of monthly salary

^{*}Optional Term Life Insurance at Elections 3 and 4, AD&D, and short-term and long-term disability insurance are not available to retirees.
†Optional Term Life Insurance is limited to a maximum of \$400,000 or four times your annual salary, whichever is less.