Full-Time Faculty/Staff New Hire Packet

CISCO COLLEGE

(Academic Year 2023-24)

FULL TIME FACULTY AND STAFF

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.

CISCO COLLEGE

New Employee Information

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

Payroll Disbursement:

☐ I have Direct Deposit:

Mail my 1st 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: _____

CISCO COLLEGE

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 College:_____

Ethnic origin – Please check only one:

American-Indian/Alaskan Native _☐___

Asian _☐___

Black _☐___

Hispanic _☐___

White _☐___

Other _☐___ Date:_____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

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

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

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Cisco College 101 College Heights, Cisco, TX 76437		751164343

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 self-employment 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.

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.

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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$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	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	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

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$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	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	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 - 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 Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$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	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	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	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$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

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.

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 Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
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.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		HR Director

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Kincannon	Lorraine	Cisco College

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
101 College Heights	Cisco	TX	76437

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

A. New Name *(if applicable)* 76437			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

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

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

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:

A	B	C

1	2	3

Employer Information

1. Federal Employer ID Number (FEIN):
Please use the same FEIN that appears on quarterly wage reports.

7 5 1 1 6 4 3 4 3

2. State Employer ID Number (Optional):

3. Employer Name:

C I S C O C O L L E G E

4. Employer Address (Please indicate the address where the Income Withholding Orders should be sent):

1 0 1 C O L L E G E H E I G H T S

5. Employer City (if US):

C I S C O

6. State (if US):

T X

7. ZIP Code (if US):

7 6 4 3 7 –

8. Province/Region (if foreign):

9. Country (if foreign):

10. Postal Code (if foreign):

11. Employer Telephone (Optional):

2 5 4 4 4 2 5 1 2 1

12. Employer FAX (Optional):

13. New Hire Contact Person (Optional):

L A U R I E K I N C A N N O N

Employee Information

14. Social Security Number (SSN):

15. Date of Hire (MM/DD/YYYY):

16. Employee First Name:

17. Employee Middle Name:

18. Employee Last Name:

19. Employee Home Address:

20. Employee City (if US):

21. State (if US):

22. ZIP Code (if US):

–

23. Province/Region (if foreign):

24. Country (if foreign):

25. Postal Code (if foreign):

26. State Where Employee Was Hired (Optional):

27. Employee DOB (MM/DD/YYYY) (Optional):

28. Employee's Salary (Dollars and Cents) (Optional):

29. Salary Frequency (Check One ONLY) (Optional):

☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

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 " Bi-weekly" 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.

CISCO COLLEGE

Shaded Area for Payroll Use Only	
Received	
Prenoted	Deposited

DIRECT DEPOSIT AUTHORIZATION FORM

Name:_____
Last Name First Name MI

SSN:_____

Payroll Type: ☐ Semi-Monthy ☐ Monthly

_____**START**: I authorize you and the financial institution listed below to deposit my net pay automatically to my account(s) each payday, and to initiate adjustments, if necessary, for any entries made in error to my accounts.

_____**CHANGE** Checking and/or Savings: I authorize you to change my direct deposit to the account(s) at the financial institution listed below.

_____**STOP**: I authorize you to stop the direct deposit of my net paycheck.

Institution Name_____ _____% of net check **or** $_____

Account Type:_____Checking_____Savings Account Number: _____

Bank Routing /Transit Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

A VOIDED CHECK MUST BE PROVIDED IN THE SPACE BELOW

Routing/Transit Number - Routing/Transit is a 9-digit number that identifies the financial institution where your checking account is located.

Account Number - This is your checking account number.

Check Number - The financial institution scans the check number electronically in order for it to appear on your monthly statement.

Signature:_____ **Date:** _____

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 pre-notification. 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

CISCO COLLEGE

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

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

Employee Name _____ **Employee ID#** _____

Employer Name CISCO COLLEGE **Employer ID#** _____

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

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

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

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

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

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

Signature of Employee **Date**

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

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

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

OATH OF OFFICE

In the name and by the authority of

STATE OF TEXAS

I,_____do solemnly swear (or affirm), that
(Employee Name)
I will faithfully execute the duties of the office of _____
(Job Title - including subject if teaching)
Of the State of Texas, and will to the best of my ability preserve, protect, and defend the Constitution and laws of the United States and of this State; and I furthermore solemnly swear (or affirm), that I have not directly nor indirectly paid, offered, or promised to pay, contributed, nor promised any public office or employment, as a reward to secure my appointment or the confirmation thereof. So help me God.

_____
Signature

Sworn to and Subscribed before me this

_____day of_____, 20___

_____, Notary Public

_____, County, Texas

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, and criminal liability.

Employee Name

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.

Signature _____ Date _____

Election to Participate in Optional Retirement Program and/or Refund

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 Number _____

Address _____

Street Address or Box Number City State Zip Code

Phone Number _____ Date of Birth _____

To be completed if your refund will be sent to a foreign address:

Are you a U.S. citizen? ☐ Yes ☐ No

If you are not a U.S. citizen, are you a resident alien of the U.S.? ☐ Yes ☐ No

If you answered no to both questions above, see page 1 of the *Information Sheet for ORP Election and/or Refund* (TRS28IN) for additional information regarding required federal income tax withholding.

Section 2 – Prior Optional Retirement Program Election Information

Have you previously elected the Optional Retirement Program in lieu of TRS? ☐ Yes ☐ No

If yes, institution name _____ dates of employment _____

If yes, you are not eligible to elect ORP a second time.

Section 3 – Member Election

☐ I elect to participate in the Optional Retirement Program (ORP) established under Chapter 830, Texas Government Code, in lieu of membership in the Teacher Retirement System of Texas (TRS). I understand that by this election I will not be eligible for membership in TRS unless I cease to be employed by an institution of higher education and become employed by the Texas public school system other than in an institution of higher education. I further understand that by electing ORP, I forfeit all accrued rights to benefits from TRS, if any, including benefits based on TRS service credit accrued prior to this election. I am entitled only to a refund of my TRS accumulated contributions, if any. **I understand this election is irrevocable.**

Section 4 – Refund Election (select one)

☐ **Refund**	I elect to have my TRS accumulated contributions paid directly to me. I understand that 20% of the taxable amount of my refund will be withheld for federal income taxes (provided the amount is greater than $200.00). See page 2 of the *Information Sheet for ORP Election and/or Refund* (TRS28IN) for information on tax withholding if you are not a U.S. citizen or resident alien of the U.S.
☐ **Direct Rollover**	I elect to have all or a portion of my TRS accumulated contributions rolled over into an eligible retirement plan. I understand that TRS will provide me with an additional form if this option is selected. A *Refund Rollover Election* form (TRS6A) must be completed and returned to TRS.
☐ **No Refund**	I elect to leave my accumulated contributions with TRS. I understand that I forfeit all accrued rights to benefits based on my TRS service credit accrued prior to my election to participate in ORP, if any, by electing ORP in lieu of TRS. I understand that I can apply for a refund at a later date.

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

Election to Participate in Optional Retirement Program and/or Refund

TRS28 (09-16)

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

Name_____ Social Security Number _____

Section 5 – Payment Method for Portion Not Being Rolled Over

☐ **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 Financial Institution _____

Account Type (must select one) ☐ Checking ☐ Savings

Bank Routing Number | | | | | | | | | |

Account Number _____

The following declaration MUST be completed if you are requesting direct deposit.
Will this payment be transferred or forwarded outside of the United States?

☐ No ☐ Yes If yes, to what country? _____

Percentage to be transferred _____%

☐ **Check** I elect to have the portion of my refund paid directly to me sent to my mailing address as a paper treasury warrant.

Section 6 - Member Certification and Signature

I acknowledge that I have received a copy of the *Information Sheet for ORP Election and/or Refund* (TRS 28IN) and the *Special Tax Notice Regarding Your Rollover Options Under TRS*, and that I have 30 days from receipt of the notice to consider my decision of whether to elect a direct rollover of my distribution of accumulated contributions. I understand that once I have made an election to roll over my refund and TRS has issued the distribution, my rollover is irrevocable and cannot be changed.

_____ _____
Signature of Member or Retiree Date

STATE OF _____ COUNTY OF _____

On_____,_____acknowledged this document before me
(date) (printed name of person whose signature appears above)

a notary public.

_____ (SEAL)

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

Election to Participate in Optional Retirement Program and/or Refund

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 individual is eligible and has elected to participate in the Optional Retirement Program in lieu of membership in 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

TEACHER RETIREMENT SYSTEM OF TEXAS

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.

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.

Election to Participate in Optional Retirement Program and/or Refund

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.
3. 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 S*pecial 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: Landon Freeman
  https://www.valic.com
  682-557-9384

- Lincoln Financial Group
  Representative: Lawrence Smith
  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

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] Cisco College has workers' 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 insurance policy] 09/01/2023. Any injuries or occupational diseases 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.

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

La ley prohíbe a los empleadores, agencias de empleo y sindicatos de negar la igualdad 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

CISCO COLLEGE

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: _____

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)

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)

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.

- 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.

CISCO COLLEGE

COBRA

This is to certify that I have received a

CONTINUATION COVERAGE NOTIFICATION (COBRA) FORM.

_____

Signature of Employee

_____

Date

CISCO COLLEGE

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

I have also been provided a copy of the EEO Training Instructions to assist me in completing the training.

_____ _____

Name Date

CISCO COLLEGE

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.

CISCO COLLEGE

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:

Laurie Kincannon
Director of Human Resources
101 College Heights
Cisco, Texas 76437

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* within 30 days of my hire date.

The HR Office will confirm receipt of these transcripts to me via my Cisco College email address.

_____	_____
Signed	Date

CISCO COLLEGE

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.

___I am not a Veteran ___Disabled Veteran ___I am a Veteran

Are you an orphan of a veteran, if veteran was killed while on active duty? ☐ YES ☐ NO
Are you a surviving spouse of a veteran (who has not remarried)? ☐ YES ☐ NO

Employee Signature_____ Date_____

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 each 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 System of Texas

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**	**Mailing Address** ☐ **Check if new**	
City	**State**	**ZIP Code**	**Phone Number**
			☐ **Home** ☐ **Cell**
Email Address		**Gender**	**Date of Birth**
		☐ **M** ☐ **F**	
Agency Name	**Dept ID/Agency Number**	**Employee Class**	**Insurance Pay Rate**
Employee SSN/National ID Correction	**Employee Name Change or Correction**		**Date of Birth Correction**

Please provide this information, as it could affect the waiting period for your medical insurance.

- Were you covered as a dependent under the Texas Employees Group Benefits Program (GBP) at the time of your hire? ☐ Yes ☐ No
  If yes, please provide the Social Security number of the person covering you: _____
- 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: _____.

SECTION B: ACTION (Mark appropriate choice.)

DTA ☐ FTE to PTE/PTE to FTE **OR** Retiree RTW/Retiree LTW **FSC** ☐ Family Status Change **HIR** ☐ New Hire
LOA ☐ Leave of Absence **PHC** ☐ Post Hire Change **RED** ☐ Reduction while on LOA **REH** ☐ Rehire **RFL** ☐ Return from Leave

SECTION C: REASON CODE (See Family Status Change reference table on page 4 before completing.)

Complete for changes during the plan year. Reason Code: _____ Event Date: _____ (mm-dd-yyyy)

Continue to next page to complete form.

SECTION D: BENEFITS OPTIONS (Mark appropriate choices.)

SSN ______________________________ **Employee Name: First, MI, Last** ____

Health Coverage	**Optional Benefits** (Newly hired employees may elect benefits on first active duty date or within 31 days of hire/rehire without enrolling in health coverage.) Effective date, if different from hire/rehire date ____________________ (mm-dd-yyyy)					
Health	**Dental***	**Vision**	**Optional Term Life Insurance****	**Voluntary AD&D***	**Dependent Term Life Insurance****	**Short-term Disability****
☐ Waive ☐ HealthSelect of Texas® ☐ Consumer Directed HealthSelect℠ ☐ 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 important information.)*	☐ Waive ☐ State of Texas Dental Choice Plan℠ ☐ DeltaCare® USA DHMO ☐ Enroll/Add/Drop Dependent *(See Section E)*	☐ Waive ☐ State of Texas Vision℠ ☐ 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	☐ Waive ☐ You Only ☐ You + Family $__________ Amount up to $200,000 in increments of $5,000	☐ Waive ☐ Enroll/Add/ Drop Dependent *(See Section E)*	☐ Waive ☐ Enroll **Long-term Disability**** ☐ Waive ☐ Enroll
	If you want to elect a TexFlex℠ health care, dependent care, or limited-purpose account as a new enrollee or due to a qualifying life event, you must complete the TexFlex Enrollment Change Form.					

*A monthly credit of up to $60 (or $30 for part-time participants) can be applied to optional coverage (dental, vision and AD&D).

To add this coverage will require evidence of insurability (EOI). Initiate the EOI process online by signing into your online account at **www.ers.texas.gov, or contact your benefits coordinator/HHS Employee Service Center.

Employee Tobacco-User Certification: If you are enrolling in the GBP health plan, have you used any type of tobacco product five or more times in the last three months? This includes but is not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes / vaping products.
☐ Yes ☐ No

SECTION E: DEPENDENT PERSONAL DATA (and coverage choices.)

Dependent Tobacco-user Certification: If your dependents are enrolled in a GBP health plan, you must certify below if your dependent used any type of tobacco product five or more times in the last three months. This includes but is not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes/vaping products.

Dependent Relationship*	Dependent's Name (First, MI, Last)	Gender	Date of Birth (mm-dd-yyyy)	Dependent SSN (Required for 12 months or older)	Health	Dental	Vision	Dep. Life	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 – Spouse D or S - Natural or adopted daughter or son O – Other than natural or adopted child. Includes stepchild, foster child, or ward child.

If you are adding a child, you must complete a Dependent Child Certification form (ERS GI 1.081) available at **www.ers.texas.gov** or by calling ERS. For dependents newly enrolled in health coverage, you will be required to provide documentation to verify your dependents' eligibility.

Did your dependent have GBP coverage under ERS through another member within the last 31 days? ☐ Yes ☐ No

If yes, please provide the Social Security number under which your dependent was covered: ______________________________

Is 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

Continue to next page to complete form.

SECTION F: AUTHORIZATION (Carefully read the statements below before you sign and date.)

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 rules 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 Benefits 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 this 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/Forms/Tobacco_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.

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.

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

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Employees Retirement System of Texas

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

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 separate form for each dependent child to be covered.

SECTION A: PERSONAL DATA

Employee/Retiree Name: First, MI, Last	Social Security Number (SSN)	Employee ID

Agency Name	Dept ID/Agency Number

Legal Name of Child: First, MI, Last	Child's Social Security Number (Required for 12 months or older)	Child's Birth Date mm/dd/yyyy

SECTION B: DEPENDENT CHILD CATEGORY

Pick one true statement to certify dependent eligibility:

___ 1. I certify this child is my:
(check one, a. through f.)
___ a. natural child,
___ b. adopted child,
___ c. foster child,
___ d. stepchild,
___ e. court-appointed ward, or
___ f. child under managing conservator.

- OR -

___ 2. I certify:
- this child is related to me by blood or marriage **AND**
- was claimed as a dependent on my federal income tax return in the previous calendar year **AND**
- I will continue to claim this child on my federal income tax return for every year the child is enrolled.

- OR -

___ 3. I certify:
- this child is related to me by blood or marriage and was not claimed on my federal income tax return for last year because the child was born in the current calendar year **AND**
- will be claimed on my federal income tax this year and for every year the child is enrolled.

- OR -

___ 4. I certify this child is related to me by blood or marriage and is eligible for benefits in the Texas Employees Group Benefits Program due to good cause and I have read and understand the definition of good cause provided below. Definition of Good Cause: Good cause means that you cannot certify this child under items 2 or 3 above because of unexpected circumstances that required you to take parental responsibility for the child this year. You may not certify the child for good cause unless you will legally claim the child as your dependent for federal income tax purposes in this current year.

Member Comment – Only complete this box if you choose Option 4.

SECTION C: CERTIFICATION

I understand I may be asked to show documentation to support my selection. False information could lead to expulsion from the Texas Employees Group Benefits Program and/or criminal prosecution.

_____ Signature of Employee/Retiree

_____ Date Signed (mm-dd-yyyy)

ERS®
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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 Security 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

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.

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

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

Only for participants with active employee benefits.

SECTION A: EMPLOYEE DATA

Employee Name:	SSN	ERS Employee ID
Type of employee: ☐ **12-month**		

SECTION B: ACTION AND REASON CODE (Check only one box.)

FSC ☐ Family Status Change ☐ **HIR** New Hire ☐ **REH** Rehire **PHC** ☐ Post Hire Change **LOA** ☐ Leave of Absence
RED ☐ Reduction while on LOA **RFL** ☐ Return from Leave **DTA** ☐ FTE to PTE/PTE to FTE

Enter a reason code and event date if you checked the FSC box above.
See the Family Status Change (FSC) Reference Chart on page 3 before completing.

Reason Code:	Event Date: (mm-dd-yyyy)

SECTION C: TEXFLEX HEALTH CARE ACCOUNT (Fill out only one of the three options in this section, if applicable.)

☐ **TexFlex health care account** – for eligible medical, vision and dental out-of-pocket costs excluding insurance premiums. Program has a minimum annual pledge of $180 and a maximum annual pledge of $2,700 per tax year. Enrollment/change must be made within 31 days of your employment or qualifying life event. You will receive a TexFlex debit card, at no cost, to pay for eligible expenses. There is no annual administrative fee for the TexFlex health care account. **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:	$ 0 .00
OPTION 2: INCREASE PLEDGE AMOUNT (Complete only if increasing pledge amount due to a Family Status 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.)	
Increase my annual pledge amount to:	$ .00
Reduce my annual pledge amount to:	$ .00

SECTION D: TEXFLEX DEPENDENT CARE ACCOUNT (Fill out only one of the three options in this section, if applicable.)

☐ **TexFlex Dependent Care Account** – for eligible child or adult dependent care expenses. Program has a minimum annual pledge of $180 and a maximum annual pledge of $5,000 or the lesser of your spouse's or your annual income that is below $5,000. Enrollment/change must be made within 31 days of your employment or qualifying life event. The TexFlex debit card is not available to pay for dependent care expenses. There is no annual administrative fee for the TexFlex dependent care account. 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 $416 per month):	$ .00
Number of months left in the plan year (September 1 – August 31):	x
Annual pledge:	$ 0 .00
OPTION 2: INCREASE PLEDGE AMOUNT (Complete only if increasing pledge amount due to a Family Status 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

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 HealthSelect℠ ☐ **TexFlex LFSA** – for eligible dental and vision out-of-pocket costs excluding healthcare costs. Program has a minimum annual pledge of $180 and a maximum annual pledge of $2,700 per tax year. You must enroll or make any changes within 31 days of your employment or qualifying life event. You will receive a TexFlex debit card, at no cost, to pay for dental and vision expenses. There is no annual administrative 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:	$ 0	.00
OPTION 2: INCREASE PLEDGE AMOUNT (Complete only if increasing pledge amount due to a Family Status 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 is irrevocable for the plan year, unless I have a qualifying life event, terminate employment or retire. I authorize payroll deductions for the amount 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 minimum of $25, up to $500 of my TexFlex health care account balance to the next plan year. Any amount over $500 will be forfeited.

I understand I have until August 31 to incur eligible dental or vision expenses for the plan year and can carry over a minimum of $25, up to $500 of my TexFlex limited flexible spending account balance to the next plan year. Any amount over $500 will be forfeited.

I understand I have until November 15 to incur dependent care expenses for the plan year. The carryover is not allowed for the TexFlex dependent care account.

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 employer and at **www.ers.texas.gov**. I certify that I have read and agree to all of the conditions and participation rules for this program.

Sign:_____ Date:_____

ERS
Employees Retirement System of Texas

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.

SECTION A: EMPLOYEE DATA

New Employee? ☐ Yes ☐ No	Employee Name: First, MI, Last	Birthdate (mm-dd-yyyy)	Last four digits of Social Security Number	Phone Number ☐ Home ☐ Cell
			XXX-XX-	

Mailing Address	City	State	ZIP Code	Eligibility County

SECTION B: OTHER INSURANCE DATA

Please check type of coverage: ☐ Employer Group Health ☐ Employer Group Dental ☐ Individual Health ☐ Individual Dental

Name of Policyholder	ID number	Birthdate (mm-dd-yyyy)	Gender	Relationship
			☐ M ☐ F	☐ Self ☐ Spouse ☐ Child

Name and Address of Other Insurance Company, TPA, HMO	Group or Policy	Effective Date____/____/____ Will Coverage Continue ☐ Yes ☐ No If No, Expected Cancel Date ____/____/____	Level of Coverage
			☐ You Only ☐ You/Spouse ☐ You/Child(ren) ☐ You/Family

SECTION C: MEDICARE COVERAGE INFORMATION

Name of Medicare Beneficiary	Medicare Part A (Hospital) Effective Date ____/____/____ Medicare Part B (Medical) Effective Date ____/____/____	Medicare No. (From Medicare Card)

SECTION D: PRIMARY CARE PHYSICIAN SELECTION (for HealthSelect℠ of Texas and Community First participants)

Name of your Health Plan:

If you're in HealthSelect of Texas or Community First Health Plans, select your primary care physician (PCP) from the plan's provider directory. Attach an additional sheet if necessary.

Patient's Name: First, MI, Last	Social Security Number (SSN)	Gender	Birthdate (mm-dd-yyyy)	PCP Name: First, MI, Last	PCP Address	NPI or PCP No.	Existing Patient?
Employee		☐ M ☐ F					☐ Yes ☐ No
Spouse		☐ M ☐ F					☐ Yes ☐ No
Child		☐ M ☐ F					☐ Yes ☐ No
Child		☐ M ☐ F					☐ Yes ☐ No
Child		☐ M ☐ F					☐ Yes ☐ No
Child		☐ M ☐ F					☐ Yes ☐ No

SECTION E: OTHER COVERED DEPENDENT NOT LIVING IN THE HOUSEHOLD

☐ Dependent Lives Out-of-Area ☐ Dependent Lives in Different Network or Service Area	**Dependent Name: First, MI, Last**	**Social Security Number** (SSN)	**Birthdate** (mm-dd-yyyy)

Mailing Address	**City**	**State**	**ZIP Code**	**County**

Participant's Signature

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

ERS
Employees Retirement System of Texas

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

Employee Marital Status Change	Participant gets married	**MAR**
	Participant gets a divorce or an annulment	**DIV**
	Death of a spouse	**DOD**
Dependent Status Change	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**
	Dependent becomes eligible or loses eligibility for insurance coverage (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**
	Dependent is related by blood or marriage, and was previously claimed on the participant's income tax return, but is no longer eligible to be claimed on participants income tax return	**XMO**
	Child gets married	**DGM**
Employment Status Change	Participant/Dependent employment status change	**ESC**
	Dependent becomes eligible for insurance after a waiting period	**DWP**
Address Change that Changes Dependent Eligibility	Dependent moves out of health or dental plan service area	**DMV**
Medicare/Medicaid/CHIP Eligibility Change	Participant/Dependent gains Medicare/Medicaid/CHIP eligibility	**MDG***
	Participant/Dependent loses Medicare/Medicaid/CHIP eligibility	**MDL***
Significant Change in Cost/Coverage Imposed byThird Party	Significant change in cost by day care provider	**SCC**
	Significant change in cost/coverage of dependent's health, vision or dental plan (excluding GBP)	**SCC**
	HIPP approval or loss of eligibility	**SCC**
Office of the Attorney General (OAG) Ordered Coverage Change (Eligibility rules apply for these dependents)	Participant gains requirement to provide coverage for child through a National Medical Support Notice (NMSN) issued by the Office of the Attorney General (OAG) (Example: employee receives an NMSN to provide health coverage for his child.)	**MSO**
	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 required to continue coverage for the child.)	**MSD****

* 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.

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 *hospital-issued birth certificate will be accepted only for a newborn child, three months of age or younger.*
- Some state and county clerk offices issue the short-form certificate as a standard (Iowa, 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.

ERS®
Employees Retirement System of Texas

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 HealthSelect℠ **			
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

**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.

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 HealthSelect℠ **			
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

**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 HealthSelect℠ 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

	Premium	State Pays	You Pay
HealthSelect℠ Medicare Advantage			
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℠ 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: HealthSelect℠ 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℠	HealthSelect℠ 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℠
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℠
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 Dependents	
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℠ (Same as Plan Year 2023)	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
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℠	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
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.

The plans on this page are not available to surviving dependents, or those enrolled through COBRA and COBRA Disability.

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**
	Monthly Rate per $1,000 of 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%

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 Plan℠ (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.