Yakutat Community Health Center
712 Ocean Cape Rd ● PO Box 112 ● Yakutat, Alaska 99689
Phone (907) 784-3275 ● Fax (907) 784-3263 ● www.yakutathealth.org

EMPLOYEE CONTACT INFORMATION FORM

Please complete the following information to ensure we maintain a current record of contact information for you and your emergency contacts.

Job Information

Title/Position: _____

Work Phone/Extension: _____

Work Email Address: _____

Personal Information

Full Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Personal Email Address: _____

Emergency Contact Information

#1 Contact Name: _____

Contact's Address: _____

Contact Primary Phone: _____ Alternate Phone: _____

Relationship: _____

#2 Contact Name: _____

Contact's Address: _____

Contact Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Completed By: Please type name here _____ **Date:** _____

Submit Form

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**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 08/31/2019

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		YAKUTAT COMMUNITY HEALTH CENTER

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
712 Ocean Cape Road/PO Box 112	Yakutat	AK	99689

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

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(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)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
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		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

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

2021

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

▶ _____ ▶ _____

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

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 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 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, 2022.

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

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

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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

CAUTION ***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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 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 2021 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 10% of your income . . . . . 1 $

2 Enter:
- $25,100 if you're married filing jointly or qualifying widow(er)
- $18,800 if you're head of household
- $12,550 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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$190	$850	$890	$1,020	$1,020	$1,020	$1,020	$1,020	$1,100	$1,870	$1,870
$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

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	$440	$940	$1,020	$1,020	$1,410	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040	$2,040
$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

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	$820	$930	$1,020	$1,020	$1,020	$1,420	$1,870	$1,870	$1,910	$2,040	$2,040
$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

Alaska New Hire Reporting Form

Send completed form to:
MS 13 New Hire Reporting Section
CHILD SUPPORT SERVICES DIVISION
550 W 7th AVE STE 310
ANCHORAGE, AK 99501-6699

Or fax to: (907) 787-3197
Message Line: (907) 269-6685
Toll free in Alaska: 1 (877) 269-6685
For information call: (907) 269-6089

Employer Information

Contact Name	Contact Title

Submission Date (Year / Month / Date)	Contact Phone Number	Contact Fax Number	Contact Email address
	907-784-3275	907-784-3263	

Employer Federal Identification Number (FEIN)	Employer AK Department of Labor Number	Do you provide Health Insurance to your Employee?	
82-1180162	0000596167	Yes ☐	No ☐

Employer Name	Employer - Doing Business As / Also Known As
Yakutat Tribal Health Board	Yakutat Community Health Center

Employer Payroll Mailing Address	City	State	Zip Code
PO Box 112	Yakutat	AK	99689

Employer Physical Address "Same" if same as mailing address	City	State	Zip Code
421 E Ocean Cape Rd	Yakutat	AK	99689

Employee Information

Employee Social Security Number *	Employee First Name	M.I.	Employee Last Name

Employee Street Address	City	State	Zip Code

Employee Date of Hire ☒ / Rehire ☐	Year	Month	Day	Employee Date of Birth	Year	Month	Day

* You are required to provide the social security numbers of your newly hired or rehired employees pursuant to AS 25.27.075(b). The Child Support Services Division will use the social security numbers only for the purpose of establishing and enforcing child support.

Employee Social Security Number *	Employee First Name	M.I.	Employee Last Name

Employee Street Address	City	State	Zip Code

Employee Date of Hire ☐ / Rehire ☐	Year	Month	Day	Employee Date of Birth	Year	Month	Day

Employee Social Security Number *	Employee First Name	M.I.	Employee Last Name

Employee Street Address	City	State	Zip Code

Year	Month	Day	Year	Month	Day

Yakutat Community Health Center
712 Ocean Cape Rd ● PO Box 112 ● Yakutat, Alaska 99689
Phone (907) 784-3275 ● Fax (907) 784-3263 ● www.yakutathealth.org

EMPLOYEE DIRECT DEPOSIT SIGN UP FORM

Please complete form to request direct deposit into your checking or savings account.

PERSONAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

TYPE OF DEPOSIT

☐ Payroll ☐ Retirement/Annuity ☐ Savings

☐ Other: _____

ACCOUNT SELECTION
(Account to Automatically Deposit Check Into)

Financial Institution: _____

Routing Number: _____ Account Number: _____

Account Type: ☐ Checking ☐ Savings

Name on the Account: _____

I authorize the Yakutat Tlingit Tribe/Yakutat Community Health Center and KeyBank to automatically deposit my check into my account listed above. This authorization will remain in effect until I have a new authorization, or until this authorization is revoked by me in writing.

Employee Signature: _____ **Date:** _____

PLEASE PROVIDE A VOIDED CHECK OR SAVINGS DEPOSIT SLIP

Our mission is to empower our community to thrive physically, mentally and spiritually.

Our work is guided by traditional values of: Listening with respect, Working together, Responsibility and Care of Self, Inclusivity and Fairness, and Living in Peace and Harmony

INDIVIDUAL DRIVER QUESTIONNAIRE

Named Insured: Yakutat Tribal Health Board
DBA: Yakutat Community Health Center
Policy No: CPP 1222262 01

DRIVER IDENTIFICATION

Name of Driver: _____ **Date of Birth:** _____
(as shown on Driver's License)

Address _____
Street **City** **State** **Zip Code**

Driver's License #	State Where Licensed	Expiration Date	Type of License	No. of Years Licensed	No. of Years' Experience Driving: Trucks	Buses	Length of Present Employment

NUMBER OF ACCIDENTS AND MOVING TRAFFIC VIOLATIONS IN PAST 3 YEARS

No. of Accidents	No. of Violations	Date of Accident or Violation	EXPLAIN

M-804g (12/87)

I, the applicant named above, do hereby authorize the Dept. of Public Safety, Division of Financial Responsibility, and Motor Vehicle Records to furnish my driving record to Umialik Insurance Company, Umialik Insurance Company and/or Shattuck & Grummett Insurance, 9110 Mendenhall Mall Rd., #3 / 301 Seward Street, Juneau, Alaska, 99801.

Signature of Driver: _____ **Date:** _____

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AUTH0RIZATION TO RELEASE RECORDS AND INFORMATION

By applying for appointment as an Employee at Yakutat Community Health Center, I _____ hereby authorize Yakutat Community Health Center, its representatives, employees, agents and members to consult with prior associates and others who may have Information bearing on my professional competence, character, health status, ethical qualifications, and ability to work cooperatively with others.

I hereby release from liability all representatives, employees, agents and Medical Staff members of Yakutat Community Health Center, for their acts performed and statements made in connection with evaluating my credentials and qualifications.

I hereby release from liability any and all Individuals and organizations who provide Information to Yakutat Community Health Center, its representatives, employees, agents and members concerning my professional competence, ethics, character, and other qualifications for employment consideration.

I agree to Indemnify Yakutat Community Health Center, its representatives, employees, agents and Medical Staff members in the event that any false or misleading information or failure to provide complete data later exposes the Health Center to professional liability.

I authorize Yakutat Community Health Center and its employees and agents to allow Accrediting Bodies access to my credentialling file as requested and to permit Accrediting Bodies to review said file.

I declare under penalty of law, that all statements, answers, and information contained in this application are true, correct and complete to the best of my knowledge. I understand that falsification, misrepresentation or omission of any fact(s) will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application. I agree to inform Yakutat Community Health Center in writing within fifteen (15) days, of any changes in the information provided and the answers to questions on the application as a result of new information or developments subsequent to my signing of the application.

I agree that photocopies of this document will be as binding as the original and attest to the fact that the signature below Is my own.

Employee Signature: _____ **Date:** _____

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CONFIDENTIALITY STATEMENT

An employee may not; unless he/she receives specific permission from his/her immediate supervisor, disclose privileged information about personnel actions, personnel records**,** property acquisitions, the Yakutat Community Health Center's financial transactions, or policy actions in the formative stage. The Yakutat Community Health Center's financial programs that perform certain helping or treatment services to clients; as specified in the State and Federal Privacy Act, may not disclose confidential client information specified by that legislation.

I understand and agree that in the performance of my duties as an employee of the **YAKUTAT COMMUNITY HEATLH CENTER**, I must hold all information in confidence. I understand that any violation of this confidentiality statement may result in punitive action and/or dismissal from my job.

Employee Name (Print)	**Employee Signature**	**Date**

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HEALTH INFORMATION PORTABILITY AND ACCOUNTABILTY ACT (HIPAA) CONFIDENTIALITY AGREEMENT

I understand that the Yakutat Community Health Center (YCHC) and their clients have a legal responsibility to protect patient privacy. To do that, it must keep patient information confidential and safeguard the privacy and security of patient information. In addition, I understand that during the course of my employment, my accessing the site, or other work with YCHC, I may see, hear, or even touch confidential information including Protected Health Information (PHI) about the YCHC, any PHI I am privy to or pertaining to the practice that YCHC must be maintained as confidential.

Regardless of the capacity in which I work, whether I am employee, cleaning service, sales representative, building maintenance, or general work, I understand that I must sign and comply with this agreement in order to be allowed to work or access the site of YCHC. By signing this agreement, I understand and agree that:

1. For indirect contact as a vendor of PHI or ePHI, I will keep patient information confidential and never discuss with others.

As an employee or contractor that works directly with PHI or ePHI, I will disclose patient information only under the conditions set forth by our Privacy and Security Officers. Regarding other types of important information to the organization, I will keep such information confidential and will only disclose such information if it is required for the performance of my job and after receiving the permission of the Privacy Officer.

2. As an employee, contractor, or indirect access as a vendor to ePHI or PHI, I will not discuss any information either patient-related or operations-related in public areas (even if specifics such as a patient's name are not used), unless that public area is an essential place for the performance of my job. I will keep all security codes and passwords used to access the facility, equipment or computer systems, confidential at all times.

3. As an employee, contractor, or indirect access as a vendor to ePHI or PHI, I will only access or view patient information for that which is required to do my job. If I have any questions about whether access to certain information is required for me to do my job, I will immediately ask the Compliance Officer for assistance.

4. As an employee, contractor, or indirect access vendor to ePHI or PHI I will not disclose, copy, transmit, inquire, modify, or destroy patient information or other practice confidential information without permission from the Privacy Officer. This especially includes transmissions from the practice to my home.

5. As an employee, contractor, or indirect access as a vendor to ePHI or PHI, once my job with the organization is terminated or completed, I will immediately return all property. This includes (e.g., keys, documents, ID badges, etc) to the practice. Even after my job or access as a vendor is terminated, I agree to meet my obligations under this agreement.

I understand that violation of this agreement may result in disciplinary action, up to and including termination of my employment or relationship with the organization, and this may include civil and criminal legal penalties as a result of the final Privacy Rule issued by the federal government. I have read the above agreement and agree to comply with it so that I may obtain employment with the YCHC or continue to work with the YCHC.

Name (Printed)	**Title**	**Company**
Signature	**Date**	

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CONSENT TO COLLECTION OF BIOMTETRIC DATA

Your fingerprint will be collected and stored by Yakutat Community Health Center for the purpose of verifying your identity for access to the Yakutat Community Health Center payroll timekeeping system.

- Your fingerprint data will not be disclosed by the Yakutat Community Health Center without your consent.
- Your fingerprint data will be permanently deleted from all Yakutat Community Health Center systems upon your termination of employment from the Yakutat Community Health Center.

By signing below, you consent to the Yakutat Community Health Center's collection, use, and storage of your fingerprint in accordance with the requirements above.

Employee Name (Print)	**Signature**	**Date**

Office Use Only:

Number Assigned in Microix: _____ **Training Date:** _____

Employee Trained By: _____ **Trainer Signature:** _____

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DRUG FREE WORKPLACE POLICY ACKNOWLEDGEMENT

Employees may not engage in the use, distribution, dispensation, possession, or manufacture of a controlled substance, and may not be under the influence of alcoholic beverages, inhalants, intoxicants or illegal drugs, while (1) on tribal premises, (2) operating tribal equipment or vehicles, or (3) on tribal business. Employees may not report to work "under the influence" of a controlled substance used unlawfully. Employees shall not consume any alcoholic beverage in the workplace or during work hours, and may not report to work "under the influence" of alcohol. For purposes of this Policy, use, possession or being under the influence of marijuana during or near work time is prohibited both in and outside of Alaska.

Drug/Alcohol Testing. The Tribe reserves the right to require drug or alcohol testing now or in the future, as follows:

15.1.1 After an offer of employment has been made, but before a new employee actually starts working.

15.1.2 After an accident or serious injury at work.

15.1.3 With reasonable suspicion that the employee has violated this policy.

15.1.4 Random, suspicionless testing for safety-sensitive positions.

An employee shall be requested to submit to testing. Failure to cooperate or to timely report to the testing facility shall authorize discipline, up to and including termination.

Violation of this Policy. An employee who violates this policy may be terminated. Alternatively, with the written authorization of the Executive Director, the employee may be placed on leave status for a specific period, in order to provide the employee an opportunity to complete an appropriate treatment program. The employee's return to work shall be conditioned upon no further violations of this policy, and the employee may be required to participate in continuing treatment, testing, and/or a "last chance agreement" as a condition of their return.

Where the employee has been terminated under this policy, rehire may be conditioned upon the employee establishing that he or she has completed drug or alcohol treatment, and is continuing with appropriate aftercare.

This policy does not diminish, increase or otherwise change an employee's rights or responsibilities under the Yakutat Tlingit Tribe Personnel Rules or applicable collective bargaining agreement.

I have read and understand that any violation of the DRUG FREE WORKPLACE POLICY may result in dismissal.

Employee Name (Print)	**Signature**	**Date**

EXHIBIT A

CERTIFICATION OF COMMITMENT TO COMPLY WITH STANDARDS OF CONDUCT AND COMPLIANCE PROGRAM

I hereby acknowledge and certify that I have received and reviewed a copy of the Yakutat Community Health Center (YCHC) Standards of Conduct and Compliance Program and I understand that it represents a mandatory policy of YCHC.

By signing this form below, I agree to abide by these Standards of Conduct during the term of my Board membership, employment, contract, or agency or while otherwise authorized to serve on YCHC's behalf. In addition, I acknowledge that I have a duty to report any suspected or known violation of the Standards of Conduct or any YCHC policy or procedure to my supervisor or through the normal chain of command (or in the case of Board members, to the Board Chair). I acknowledge that I may also report the information directly to the Compliance Officer or any other member of senior management.

Please return this completed, signed Certification of Commitment to the Compliance Officer.

Name (Print)	Position with Yakutat Community Health Center
Signature	Date

EXHIBIT B

DISCLOSURE CONCERNING FINANCIAL OR OTHER INTERESTS THAT CREATE A POTENTIAL OR ACTUAL CONFLICT OF INTEREST

STATEMENT OF PURPOSE:

As a Board member, officer, employee, agent or volunteer of Health Center, I hereby certify that I understand that YCHC is a tax-exempt entity and must therefore strictly comply with the standards of the Internal Revenue Service (IRS). I will take reasonable measures to identify and avoid potential conflicts of interest in my relationship with YCHC and in carrying out my duties on behalf of YCHC. I will comply with YCHC's Compliance Program and its related policies and procedures, such as those polices that relate to YCHC's tax-exempt status, corporate and financial responsibility, conflicts of interest, and best business practices policies and others related to the business of YCHC.

I understand that I owe certain duties to YCHC including, but not limited to, a duty of loyalty to YCHC. I understand that one aspect of fulfilling my duties to YCHC is to avoid actual or potential conflicts of interest where my allegiance might be divided, or appear to be divided, between a position of responsibility to YCHC, and another professional, personal, business or volunteer position or responsibility.

To help avoid actual or potential conflicts of interest, I am disclosing other responsibilities and affiliations that may create or appear to create a conflict of interest with regard to my duties to YCHC and I agree to further disclose any such actual or potential conflicts of interest that may arise after I complete this form. I invite any further inquiry by YCHC that it deems appropriate.

AGREEMENT AND DISCLOSURE:

I have read YCHC's Standards of Conduct and agree to comply with its terms regarding conflicts of interest. I understand the definition of interests in the Standards of Conduct and agree to supplement this Disclosure Form in the event that additional interests arise. Further, I understand that a violation of these standards may, depending on the severity of the violation, subject me to oral admonishment, written reprimand, reassignment, demotion, suspension, and/or dismissal, in addition to legal penalties which might apply.

1. Disclosure of business relationships (*e.g.*, an actual or forthcoming compensation arrangement either by contract or employment) with: (1) YCHC; (2) an entity with which YCHC has entered (or is negotiating to enter) a transaction or arrangement; or (3) an entity that is a competitor or potential competitor of YCHC:

2. Disclosure of financial relationships (*e.g.*, a controlling ownership, investment interest, employment relationship or other relationship that a reasonable person would deem to be significant) with or a tangible personal benefits from: (1) an entity with which YCHC has entered (or is negotiating to enter) a transaction or arrangement; or (2) an entity that is a competitor or potential competitor of YCHC:

3. Disclosure of fiduciary relationships (*e.g.,* Board member or trustee) with: (1) an entity with which YCHC has entered (or is negotiating to enter) a transaction or arrangement; (2) an entity that is a competitor or potential competitor of YCHC:

4. Disclosure of personal relationships with an individual who has a business, financial or fiduciary relationship:

5. Disclosure of any supplementary income:

6. Suggested means of mitigating any of the situations identified in Items 1 through 5 above:

7. I know of no professional, business or volunteer position or responsibility, including vendor situations, that might give rise to an actual or apparent conflict of interest or otherwise impair my ability to make decisions in the best interests of YCHC (initial here): _____

8. I warrant that I am not debarred, suspended or otherwise excluded from participation in any state or federally funded programs. I agree to notify the Board and/or EHD, as applicable, if I become debarred, suspended or otherwise excluded from participating in any state or federally funded programs. (initial here): _____

Name (Print)	Position with Yakutat Community Health Center
Signature	Date

Yakutat Community Health Center
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Phone (907) 784-3275 ● Fax (907) 784-3263 ● www.yakutathealth.org

ACKNOWLEDGEMENT OF RECEIPT OF PERSONNEL POLICIES

I acknowledge that I have received a copy of the Yakutat Tlingit Tribe's Personnel Policies effective date January 1, 2018.

I understand that the 2018 Personnel Policy replaces any and all prior verbal and written communications regarding Yakutat Tlingit Tribe working conditions, policies, procedures, appeal processes, and benefits.

I have read and understand the contents of the Personnel Policy and will act in accordance with these policies and procedures as a condition of my employment with the Yakutat Community Health Center.

I understand that if I have questions or concerns at any time about the policies, I will consult my immediate supervisor, my supervisor's manager, Human Resources, or the Executive Director for clarification.

I also acknowledge that the personnel policies contain an employment-at-will provision that states:

"the Tribe is primarily funded by grants and funding is changing and uncertain, these policies cannot confer any rights or privileges to employees to remain employed by the Tribe, or to continue to receive particular employee benefits or rights for any particular period of time. All employment with the Tribe is "at-will" and of indefinite duration, subject to termination at the employee's or the Tribe's option, with or without cause"

I understand that the contents of the personnel policies are simply policies and guidelines, not a contract or implied contract with employees and the contents of the employee handbook may change at any time.

Please read the Personnel Policies carefully to understand these conditions of employment before you sign this document.

Employee Name (Print)	**Signature**	**Date**

I have read and understand that any violation of the policies and procedures of Yakutat Tlingit Tribe and/or Yakutat Community Health Center may result in dismissal.

Employee Name (Print)	**Signature**	**Date**

STATE OF ALASKA
DEPARTMENT OF PUBLIC SAFETY
REQUEST FOR CRIMINAL JUSTICE INFORMATION
From the Alaska Criminal History Record Repository

Original forms must be submitted to:

Criminal Records and Identification Bureau
5700 E. Tudor Road, Anchorage, AK 99507
Telephone: (907) 269-5767 Fax: (907) 269-5091
Include fee: $20 single copy, $5 each additional copy
Check or money order must be made payable to 'State of Alaska'

Type of information being requested **(from the record subject): (Choose ONE)**

☐ 1. Criminal Justice Information available **only to the SUBJECT**
- This report includes all criminal charges and dispositions, including any sealed record.
- If the record subject has a sealed record this box MUST be checked ☐

☐ 2. Criminal Justice Information available to **ANY PERSON for ANY PURPOSE**
- This report includes current/open criminal charges and charges that resulted in conviction, excluding sealed records.

☐ **3.** Criminal Justice Information available to an **INTERESTED PERSON**
- This report includes all criminal charges and dispositions, excluding sealed records

A check or money order payable to the State of Alaska in the amount of $20 ***must*** *accompany this request. Additional copies, if requested at the time of this request, may be obtained for an additional $5 per copy. State agencies with a Reimbursable Services Agreement (RSA) in place may fax the appropriate forms. All other requests must be submitted via U.S. Postal Service or in person.*

Subject Name: _____

Maiden/Alias name(s): _____

Mailing Address: _____

City/State/Zip: _____

Alaska Drivers License #: _____

Date of Birth:_____ Sex: ☐-Male ☐Female Soc Sec No. _____

Telephone: _____ Msg: _____

MAILING ADDRESS TO SEND REPORT:

Name: _____

Title: _____

Mailing Address: _____

City/State/Zip: _____

☐ If you would like the record faxed to you, provide a Fax Number: _____

Unsworn Falsification Statement (Your request will not be processed if you do not sign this statement.)
I certify under penalty of unsworn falsification (AS 11.56.210) that the information I am supplying on and with this form is true and correct.

_____

Record Subject's Signature **Date**

Criminal Records and Identification Bureau Use Only	
☐ Fee Payment Type _____	☐ Report Sent to Subject _____
☐ Fee Waiver/Authorization _____	☐ Report Sent to Requester _____
☐ OCA Number _____	☐ R&I Staff initials _____

Authority:

AS 11.56.210 - Unsworn Falsification

AS 12.62.160 – Release and Use of Criminal Justice Information; fees

AS 12.62.900 – Definitions

13 AAC 68 Article 4 – Dissemination of Criminal Justice Information

13 AAC 68.905 – Definitions

DPS Form 11/15/03

Revised 2/24/04

Revised 4/20/04

Revised 11/15/04

Revised 1/13/05

Revised 6/13/05

YAKUTAT COMMUNITY HEALTH CENTER
GOOD HIRE BACKGROUND CHECK AUTHORIZATION
CONFIDENTIAL

Print Name:

_____

(First) (Middle) (Last) (Maiden)

Former Name(s) and Dates Used:

_____

_____

Current Address Since: _____

(Street) (City) (State/Zip) (Mo/Yr)

Previous Address From: _____

(Street) (City) (State/Zip) (Mo/Yr)

Previous Address From: _____

(Street) (City) (State/Zip) (Mo/Yr)

Date of Birth: _____ Social Security Number: _____

Telephone Number: _____ Email: _____

The information contained in this application is correct to the best of my knowledge. I hereby authorize Yakutat Community Health Center and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records. I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Yakutat Community Health Center or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicant's personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: _____ Date: _____

Yakutat Community Health Center
712 Ocean Cape Rd • PO Box 112 • Yakutat, Alaska 99689
Phone (907) 784-3275 • Fax (907) 784-3263 • www.yakutathealth.org

Name: _____ Social Security #: _____

DECLARATION FOR EMPLOYMENT
INDIAN CHILD PROTECTION ACT (PL 101-630)
BACKGROUND INFORMATION

Section 408 of the Indian Child Protection and Family Violence Prevention Act of 1990 Public Law 101-630 requires an investigation of the character of each individual who is employed, or is being considered for employment, in a position with duties and responsibilities that involve regular contact with or control over Indian Children.

Section 231 of the Crime Control Act of 1990 Public Law 101-647 requires those employment applications for childcare positions have applicants sign a receipt of notice that a criminal record check will be conducted. The check shall include a search of the criminal history repositories of all states that an employee or prospective employee lists as current and former residences in an employment application.

I certify that my response to these questions is under Federal penalty of perjury, which is punishable by fine or imprisonment, and that I have received notice that a National Criminal Check will be conducted. I understand my right to obtain a copy of any criminal history made available to Yakutat Community Health Center and my right to challenge the accuracy and completeness of any information obtained in the report.

PLEASE ANSWER BOTH QUESTIONS COMPLETELY

1. **Have you ever been arrested for or charged with a crime involving a child?** ☐ **Yes** ☐ **No**

If "YES", provide the date, explanation of the violation, disposition of the arrest or charge, place of occurrence, and the name and address of the police department or court involved.

2. **Have you ever been found guilty of, or entered a plea of no contest (nolo contendere), or guilty to, any felonious offense or any of two (2) or more misdemeanors offences under Federal, State, or Tribal Law involving crimes of violence; sexual assault, molestation, exploitation, contact or prostitution; crimes against persons; or offenses committed against children?** ☐ **Yes** ☐ **No**

If "YES", provide the date, explanation of the violation, disposition of the arrest or charge, place of occurrence, and the name and address of the police department or court involved.

Applicants Signature: _____ Date: _____

Yakutat Community Health Center
Immunization Verification Review

Name: _____ **DOB:** _____

		Date Reviewed	Complete
Tdap (10 yr) Date of vaccine _____/_____/_____	Vac Declination Date: _____/ _____/ _____/		
MMR VACCINATIONS **OR** 1 st Vaccination _____/_____/_____ 2 nd Vaccination _____/_____/____	**MMR TITERS** Date of Measles titer _____/_____/____ □ Immune □ Not immune		
VARICELLA VACCINATIONS **OR** 1 st Vaccination _____/_____/_____ 2 nd Vaccination _____/_____/____	**VARICELLA TITER** Date of Varicella titer _____/_____/_____ □ Immune □ Not immune Verbal History of illness: (circle) YES NO Vac Declination Date: _____/ _____/ _____/		
HEPATITIS B VACCINATIONS (Vaccination dates AND Titer Required) 1st Dose _____/_____/_____ 2nd Dose _____/_____/_____ 3rd Dose _____/_____/_____ 4th Dose _____/_____/_____ 5th Dose _____/_____/_____ 6th Dose _____/_____/_____	**HEPATITIS B TITER** Titer Date _____/_____/_____ Titer Result (circle) Positive Negative Titer Date _____/_____/_____ Titer Result (circle) Positive Negative		
TUBERCULOSIS (Required annually) PPD #1 _____/_____/_____ Result (circle) (mm) Negative Positive PPD #2 _____/_____/_____ Result (circle) (mm) Negative Positive	If History of positive PPD or Quantiferon, date of most recent chest x- ray_____/_____/_____ Result (Circle) Negative Positive. BCG History?: (circle) YES NO Please submit copy of report.		
Influenza Date of vaccine _____/_____/_____ Date of vaccine _____/_____/_____ Vac Declination Date: ___/ ____/____/			

Verified by: Date:

YAKUTAT COMMUNITY HEALTH CENTER

Vaccine Declination

I understand that due to my occupational exposure to potentially infectious materials I am at risk of acquiring the following infectious diseases for which there are vaccines: hepatitis B (HBV), influenza, measles, and varicella. I have been given the opportunity to be vaccinated for these infections at no cost to myself. I understand that by declining the vaccine(s) I place myself, my family, and the community at increased risk of acquiring these serious diseases. If I choose to be vaccinated in the future, the vaccines will be provided.

Please sign below for each of the vaccines that you are declining. This declination will remain in effect unless if it specifically revoked.

I decline the influenza vaccine. I understand that by declining the influenza vaccine I will be required to wear a mask at all times in the clinic from mid-October until the first of May.

____

Employee Name (printed) Employee Signature Date

- -

I decline to obtain the varicella vaccine.

____

Employee Name (printed) Employee Signature Date

- -

I decline to obtain the Td and/or the Tdap vaccine.

____

Employee Name (printed) Employee Signature Date

YTT GOVERNMENTAL
401(K) PLAN

Online Retirement Plan Account Access

You are now eligible to participate in your company's retirement plan. Once enrolled, you are able to access your retirement plan account via the plan's retirement plan website as follows:

Internet Access:	**www.yourplanaccess.net/nwps/**
Initial User ID:	**Your SSN (no dashes)**
Initial Password:	**Last four digits of your SSN**
Drop Down Box:	**Select "Participant" in the third drop down box**

After you login for the first time, we encourage you to change your User ID and Password by clicking on the gear icon located at the top right of the webpage and then selecting "Password Change" from the menu. We also recommend that you click on "Personal Info" from the same menu to set up an Alternate Verification Question which can be used to retrieve your Password, should you forget it. For your own protection, keep your Password confidential. Do not disclose it to anyone.

You can use the Website to accomplish the tasks below.

- Change your User ID and/or Password
- View your account balance
- View personal information and update your email address
- View investment fund price and performance information
- View your personal returns
- View or change your future savings investment elections
- Schedule automatic recurring rebalance transfers
- View information about the plan
- Download forms
- View or download your transaction history

Transactions that are entered by the stock market close, generally 1:00 pm, will be processed the same day. Transactions entered after the stock market close will be processed the next business day.

If you have questions regarding the website or the plan, please contact the Participant Call Center at 888-700-0808, Monday through Friday, from 7:00am to 5:00pm (PST). If you have questions regarding your eligibility or benefits, please contact your Human Resources representative at your company.

YTT GOVERNMENTAL 401(K) PLAN

Website Instructions

Web Address: www.yourplanaccess.net/nwps/

System Login

To sign onto your account, enter your User ID, Password and select "Participant" for the role. The first time you enter the site, your User ID will be your Social Security Number and your Password will be the last four digits of your Social Security Number. You can change your User ID and Password after you first sign in to the system ***by clicking on gear icon in the top right of the website*** then choosing "Password Change" from the menu.

Inside the System

Once you've successfully logged in, you will notice that information is organized by menu choices on the bar at the top. You will be first linked to the summary page, where you can confirm personal information and review a summary of your account balances. After clicking on one of the menu options a sub menu will be displayed offering more pages to access. A few highlights are:

- **Dashboard.** This page displays your Account Balance, Contribution Rate (if your plan supports this feature), My Portfolio, and Recent Activity.
- **Manage Account.** This is where you can make changes to how your future contributions will be invested, change how your current balance is invested and change your deferral contribution rate (if your plan supports them). You can also view your transaction history and a history of any changes you made on the web.
- **Retirement Readiness.** Calculators to see how your retirement planning is doing.
- **Performance.** Click here to see the performance of the plan's investment options. Click on any of the options to be linked to the Morningstar ® information page for that option (if available). You can also review a personal rate of return.
- **Reports found under Forms & Reports.** Elect to receive your quarterly statement by regular mail or elect to make it viewable only on the website. This is also where you can view investment advisor reports and create statements on demand.
- **Reports found under Forms/Reports/Tools.** This will link you to a library of the plan forms that you may need, such as distribution forms and beneficiary designation forms.
- **Forms found under Forms/Reports/Tools.** This will link you to a library of the plan forms that you may need, such as distribution forms and beneficiary designation forms.
- **Personal Info.** On the top right of the website select the gear icon to review your personal settings.

The website is updated every day to reflect any activity and earnings in your account. We urge you, for security purposes, to change your User ID and Password the first time you sign on to the system.

YTT Governmental 401(k) Plan 2018

QUALIFIED DEFAULT INVESTMENT ALTERNATIVE NOTICE

Participants in the YTT Governmental 401(k) Plan (the "Plan") are entitled to direct the investment of funds in their accounts. In the Trustee's experience, participants rarely fail to make an investment choice with respect to elective or matching contributions because they make the choice at the same time they file their deferral elections. Nonetheless, there may be a time when a participant fails to make an investment choice. It is also the Trustee's experience that some participants fail to make an investment election with respect to profit sharing contributions that might be made by their employer. Therefore, the Trustees have adopted default investments for the investment of contributions for participants who don't give investment directions. The default account for contributions is the Vanguard LifeStrategy Moderate Growth Fund, a fund that seeks to provide conservation of capital, current income and long-term growth of capital and income. Amounts defaulted will remain in the default fund until the participant directs that they be invested in another fund or funds. This notice describes the default fund which is intended to constitute a qualified default investment alternative or "QDIA" within the meaning of section 404(c)(5) the Employee Retirement Security Act of 1974, as amended.

Default Investment
Vanguard LifeStrategy Moderate Growth Fund (VSMGX).

Investment Objective:
The Vanguard LifeStrategy Moderate Growth Fund seeks to provide conservation of capital, current income and long-term growth of capital and income by investing in stocks, bonds and other fixed-income securities. This model takes a balanced approach and is managed as if it constituted the complete investment program of the prudent investor.

Risk and Return Characteristics:
The Vanguard LifeStrategy Moderate Growth Fund has risk and return characteristics that would generally provide more risk and return potential than a bond, money market, or stable value investment. However, it is considered more conservative with less long-term return potential than an all-stock fund, due to the balance of stocks and bonds in the model.

Fees and expenses:
Expenses for the Moderate Model are the weighted average expense of the underlying fund investments. The current average is 0.14% annually.

If you would like to direct the investment of amounts defaulted to the QDIA fund to other investment alternatives available under the Plan, you may do so at any time through the Plan's recordkeeping web site at www.yourplanaccess.net/nwps/. Or you may direct your questions to the Administrative Committee's representative at the end of this Notice. They will provide you the necessary forms and requirements to make your own investment decisions. Since you are responsible for your own investment decisions, we encourage you to review the available funds and select the fund(s) that best suit your personal situation.

All fees incident to your investment choices will be borne by your account. There is no additional fee to invest in the default fund. In addition, there are no fees or expenses for moving your investments from the QDIA to other alternatives. If you are satisfied with the QDIA investment option, you do not have to do anything at this time.

The Plan intends to comply with Internal Revenue Code Section 404(c). As a result, the Plan's fiduciaries will not be liable for losses that are the direct result of investment instructions given by a participant or beneficiary. Assets that are invested in the QDIA are treated the same as if you directed your own investments.

To learn more about the Plan's investment funds and procedures for changing how your Plan account is invested you can review the investment information on the website at www.yourplanaccess.net/nwps/. If you have any questions about how the Plan works or your rights and obligations under the Plan, or if you would like a copy of the Plan's Summary Plan Description or other Plan documents, please contact Martha Indreland at Yakutat Tlingit Tribe, PO Box 418, Yakutat, AK 99689, 907-784-3238 x 103.

YTT Governmental 401k Plan

Savings Rate Election

Step 1: Enter Your Information and Authorization

Name:_____ SSN:_____

You must complete either Step 2a or 2b, and then Step 3.

Step 2a: Contribution Election

I DO WANT TO PARTICIPATE: I elect to contribute to the Plan according to my elections below. If I am not yet eligible, contributions will begin being deducted on the first payroll after the start date below and after I have met the Plan's eligibility requirements. Amounts will be deducted from my pay and contributed to the plan as follows.

I understand that the sum of my Pre-Tax 401(k) and Roth 401(k) contributions may not exceed $18,500 for the calendar year 2018, plus if I am age 50 by 12/31/2018 I am eligible to contribute an additional $6,000. I also understand that the total of all contributions to the plan may not exceed 100% of eligible compensation. I am also aware that the amounts designated below may be reduced by the Plan Administrator to comply with IRS regulations.

Election/Contribution Type	Applies To	Elections	Effective/Start Date
☐ Pre-Tax 401(k)	Each Pay Period	$_____ or _____ % (1% to 100%)	_____
☐ Roth 401(k)	Each Pay Period	$_____ or _____ % (1% to 100%)	_____

Step 2b: Non-Participation/Suspension

_____ Initial Here

I DO NOT WANT TO PARTICIPATE: I do not wish to contribute to the Plan at this time or I am suspending my contributions. I understand that I may reconsider my decision at a future date.

Step 3:Your Authorization

I hereby authorize deductions from my pay for any contributions required by my elections. I confirm the above elections and understand the terms of the Plan (as stated in the Summary Plan Description that I have received) Further, I understand that if I have not provided Investment Elections, my future deposits will be invested in the Vanguard LifeStrategy Moderate Growth Inv. I understand that I may reconsider my decision at any future date.

Your Signature _____ **Date** _____

DISCLOSURE STATEMENT: You must notify Human Resources within 15 days of receipt of your quarterly statement in which this transaction has occurred, if during that period there is an error in your directive change indicated above. Your Employer and NWPS will not be liable for any loss to your account, if not contacted within the 15-day period stated above.

Please return completed forms to Human Resources

_____ Plan Administrator Approval Signature

_____ Plan Administrator Approval Date

YTT Governmental 401k Plan

Investment Election Form

Step 1: Enter Your Information

Name:_____ SSN:_____

Step 2: Select Your Investment Style (for all future deposits)

☐ I want to invest based on my anticipated retirement date. (go to step 3a and then to step 4)

☐ I want to create my own mix of investments using the Plan's options (go to step 3b and then to step 4)

Step 3a: Choose Your Investment Strategy Based on Anticipated Retirement Date. (for all future deposits)

Select a *single* option from the list below by placing a check mark (✓) in the box next to the selection of your choice. Once you've made your selection, go straight to Step 4.

☐ Vanguard Target Retirement 2020
☐ Vanguard Target Retirement 2025
☐ Vanguard Target Retirement 2030
☐ Vanguard Target Retirement 2035
☐ Vanguard Target Retirement 2040
☐ Vanguard Target Retirement 2045
☐ Vanguard Target Retirement 2050
☐ Vanguard Target Retirement 2055
☐ Vanguard Target Retirement 2060
☐ Vanguard Target Retirement Income

Step 3b: Select Your Own Investment Strategy (for all future deposits – Must total 100%)

You should only complete this section if you have a higher level of financial expertise, are comfortable making investment decisions and you are willing to commit the time and effort necessary to manage your investments. Enter the percentage you want to invest in each option below, making certain that the total is equal to 100%.

Target Date Funds / Retirement Date

_____ % Vanguard Target Retirement 2020
_____ % Vanguard Target Retirement 2025
_____ % Vanguard Target Retirement 2030
_____ % Vanguard Target Retirement 2035
_____ % Vanguard Target Retirement 2040
_____ % Vanguard Target Retirement 2045
_____ % Vanguard Target Retirement 2050
_____ % Vanguard Target Retirement 2055
_____ % Vanguard Target Retirement 2060
_____ % Vanguard Target Retirement Income

Individual Investment Options

_____ % Morley Stable Value
_____ % Vanguard LifeStrategy Consv Growth
_____ % Vanguard LifeStrategy Growth Inv
_____ % Vanguard LifeStrategy Income Inv
_____ % Vanguard LifeStrategy Moderate Gr Inv

100 % **Total**

Step 4: Authorization

By my signature below, I authorize the elections made above. I also understand that if I do not provide Investment Elections, my future deposits will be invested in the Vanguard LifeStrategy Moderate Growth Inv.

Your Signature _____ **Date** _____

Please return completed forms to Human Resources

_____ Plan Administrator Approval Signature

_____ Plan Administrator Approval Date

YTT Governmental 401k Plan

Designation of Beneficiary

Step 1: Enter Your Information and Authorization

Name:_____ SSN:_____

Marital Status: (check one)
☐ Married / ☐ Single / ☐ Separated

Is there a Domestic Relations Order Pending?
(check one:) ☐ Yes / ☐ No

Step 2: Enter Your Acknowledgements/Authorizations

By my signature below:

- I understand that I have the right to change or revoke the primary beneficiary designation with the approval of my spouse (if married) subject to receipt by the Plan Administrator of my written designation prior to my death.
- I understand that I may change or revoke my contingent beneficiary designation at any time subject to receipt by the Plan Administrator.
- I understand that if I am married, I must designate my spouse as my only primary beneficiary unless my spouse consents in writing in Step 4. If I am single and marry at a later date, I understand that my spouse will automatically become my only primary beneficiary. I understand that if I do not want my spouse to be my only primary beneficiary, I and my spouse may designate a different primary beneficiary.
- I hereby authorize the Plan Administrator to provide for payment of any Death Benefits as directed by the Plan if my primary and contingent beneficiaries fail to survive me.
- I understand that my Beneficiary Designation shall become effective without further notice upon receipt by the Plan Administrator and is made subject to all of the terms and conditions of the Plan.
- I hereby revoke any prior designation and do hereby direct that, upon my death, any benefit payable with respect to my account under the Plan shall be paid to the **primary beneficiary** named in Step 3. If I should die and no primary beneficiary is alive to receive any benefit payable from the Plan, I hereby direct that such benefit shall be paid to the **contingent beneficiary** named in Step 3.
- I understand that it is my responsibility to complete this form and that I cannot rely on my will, prenuptial agreement, separation agreement, property settlement agreement or court order to specify who will inherit my account, because the Plan does not use any of these documents to distribute death benefits.
- I understand that it is important to review how I have designated my Beneficiary Designation periodically – particularly when my life situation changes (e.g., by marriage, divorce, the birth or adoption of a child, or the death of a beneficiary).
- I understand that if I do not designate a beneficiary before the date of my death, my entire account will be distributed according to the terms of the Plan.
- I understand that if my children are my beneficiaries, and they are minors: (1) the Plan generally will not transfer money directly to a minor and a court will have to appoint a trustee or guardian to receive the money; and (2) I should consider choosing a trustee (person or institution) now, and naming my children's trust as my beneficiary.
- I understand that I should consult with a tax advisor before naming a trust as a beneficiary, to be sure that the selection is appropriate and within the IRS Guidelines.
- I understand that all death benefit payments will be disbursed proportionally from all accounts in the plan and that any outstanding plan loans (if applicable) at the time of my death will become taxable income to my estate and not to my beneficiary.

Participant Signature _____ **Date** _____

Note: Be certain to fill out and return both pages, as the entire form must be completed.

YTT Governmental 401k Plan

Designation of Beneficiary

Step 3: Designate Your Beneficiary(ies)

By my signature below, I hereby designate the following beneficiary(ies) for my Plan benefits:

a: Primary Beneficiary(ies)

Name(s) and Contact Information	Relationship	Birth Date	Social Security Number	Share (Must total 100%)

b: Contingent Beneficiary(ies)

Name(s) and Contact Information	Relationship	Birth Date	Social Security Number	Share (Must total 100%)

(Attach additional sheets of paper if more space is required. Each category must total 100%.)

Participant Signature _____ **Date** _____

Step 4: Spousal Consent *(***Only required if married/separated, and spouse is not sole primary beneficiary***)*

I hereby acknowledge that my spouse has designated a Primary Beneficiary in place of me. I understand that by consenting to this designation, I am foregoing both present and future rights to these benefits if my spouse dies. I further understand my consent is irrevocable unless my spouse revokes the Primary Beneficiary designation on this form. By my signature below, I approve the designation made.

NOTARIZATION OF SPOUSE'S SIGNATURE:

_____

Spouse's Signature

STATE OF _____)

COUNTY OF _____)

On this _____ day of _____, 20_____, before me, the undersigned Notary Public, personally appeared known to me to be the person whose signature is subscribed as the spouse to the foregoing Beneficiary Election document, who acknowledged that he/she executed the same for the purposes herein contained.

WITNESS my hand and official seal.

_____

Notary Public

My Commission Expires: _____

Please return completed forms to Human Resources for Approval

_____ _____

Plan Administrator Approval Signature | Plan Administrator Approval Date

Note: Be certain to fill out and return both pages, as the entire form must be completed.

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

Please print clearly and mark carefully.

Employer Name: **YAKUTAT TLINGIT TRIBE**	Group Plan Number: **00487293**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment ☐ Re-Enrollment ☐ Add Employee/Dependents ☐ Drop/Refuse Coverage ☐ Information Change ☐ Increase Amount ☐ Family Status Change

Class:_____ Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

First, MI, Last Name:

Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address	City	State	Zip

Gender: ☐ M ☐ F Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) -

Email Address:

Are you married or do you have a spouse? ☐ Yes ☐ No
Do you have children or other dependents? ☐ Yes ☐ No

Date of marriage/union: ____-____-_____
Placement date of adopted child: ____-____-_____

About Your Job:

Hours worked per week: _____ Job Title:

Work Status:
☐ Active ☐ Retired ☐ Cobra/State Continuation

Date of full time hire: _____ - _____ - _____

Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Mar 26, 2020

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

Drop Coverage:

☐ Drop Employee ☐ Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

☐ Termination of Employment ☐ Retirement

Last Day Worked: _____-_____-_____

☐ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

☐ Dental ☐ Employee ☐ Spouse ☐ Child(ren)

☐ Vision ☐ Employee ☐ Spouse ☐ Child(ren)

☐ Basic Life

Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

☐ Termination of Employment: _____-_____-_____

☐ Divorce _____-_____-_____

☐ Death of Spouse _____-_____-_____

☐ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ☐ Dental ☐ Vision

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

☐ Covered under another insurance plan

☐ Other _____

(additional information may be required)

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

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
PPO	☐	☐	☐	☐

☐ I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

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

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

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature	☐	☐	☐	☐

☐ I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

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

Basic Life Coverage:

Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only
☑ 150% of your annual salary to a maximum of $100,000

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

Primary Beneficiaries:

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

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

Phone: ( ) - **Relationship to Employee:**_____

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

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

Phone: ( ) - **Relationship to Employee:**_____

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

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

Phone: ( ) - **Relationship to Employee:**_____

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

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $_____

Important Notes:

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

Signature

An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.

If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

I hereby apply for the group benefit(s) that I have chosen above.

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

I attest that the information provided above is true and correct to the best of my knowledge.

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Fraud Warning Statements

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

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

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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

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

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

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

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

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

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

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

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

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

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

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

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

FEHB
Federal Employees
Health Benefits Program

Form Approved:
OMB No. 3206-0160

Health Benefits Election Form

Part A - Enrollee and Family Member Information *(for additional family members use a separate sheet and attach)*

1. Enrollee name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mm/dd/yyyy)*
4. Sex ☐ M ☐ F
5. Are you married? ☐ Yes ☐ No
6. Home mailing address *(including ZIP Code)*
7. If you are covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
8. Medicare Beneficiary Identifier
9. Are you covered by insurance other than Medicare? ☐ Yes, indicate in item 10 below. ☐ No
10. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*
11. Email address
12. Preferred telephone number
13. Name of family member *(last, first, middle initial)*
14. Social Security Number
15. Date of birth *(mm/dd/yyyy)*
16. Sex ☐ M ☐ F
17. Relationship code
18. Address *(if different from enrollee)*
19. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
20. Medicare Beneficiary Identifier
21. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 22 below. ☐ No
22. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*
23. Email address *(if applicable, enter email address of your spouse or adult child)*
24. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
25. Name of family member *(last, first, middle initial)*
26. Social Security Number
27. Date of birth *(mm/dd/yyyy)*
28. Sex ☐ M ☐ F
29. Relationship code
30. Address *(if different from enrollee)*
31. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
32. Medicare Beneficiary Identifier
33. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 34 below. ☐ No
34. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*
35. Email address *(if applicable, enter email address of your spouse or adult child)*
36. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*
37. Name of family member *(last, first, middle initial)*
38. Social Security Number
39. Date of birth *(mm/dd/yyyy)*
40. Sex ☐ M ☐ F
41. Relationship code
42. Address *(if different from enrollee)*
43. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D
44. Medicare Beneficiary Identifier
45. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 46 below. ☐ No
46. Indicate the type(s) of other insurance
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*
47. Email address *(if applicable, enter email address of your spouse or adult child)*
48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

(Continued on the reverse)

Enrollee name: _____ Date of birth: _____

Part B - FEHB Plan You Are Currently Enrolled In ***(if applicable)***

1. Plan name
2. Enrollment code

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name
2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel ***(see page 6)***

1. Event code
2. Date of event

Part E - Election NOT to Enroll ***(Employees Only)***

☐ I do NOT want to enroll in the FEHB Program.

My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

☐ I CANCEL my enrollment.

My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension of FEHB ***(Annuitants/Former Spouses Only)***

☐ I SUSPEND my enrollment.

My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

Part H - Signature

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mm/dd/yyyy)*

Part I -To be completed by agency or retirement system

REMARKS

1. Date received *(mm/dd/yyyy)*
2. Effective date of action *(mm/dd/yyyy)*
3. Personnel telephone number ( )
4. Name and address of agency or retirement system
5. Authorizing official *(please print)*
6. Signature of authorized agency official
7. Payroll office number
8. Payroll office contact *(please print)*
9. Payroll telephone number ( )

Submit