NEW FULL-TIME HIRE PACKET CHECKLIST (rev 1/17)

Name: _____ **Job Title:** _____

Office/Section: _____ **Hire Date:** _____

Select the appropriate Appointment Type:

Full-Time Classified Appt with Benefits (check one):	☐ Probational	☐ Permanent	
Special Appointment (call HR for explanation of benefits):	☐ Unclassified Appointment	☐ Classified Job Appointment	
Part-Time Appointment (No benefits, no leave, no paid holidays, no retirement):	☐ Classified Restricted Appointment	☐ Seasonal or WAE Wage	☐ Student

SECTION 1: NEW HIRE FORMS AND DOCUMENTS (to be completed by new hire)

Upon notification of a satisfactory drug test result and an effective date of hire, please complete Section 1 of this checklist, and present it (along with the required documents) to your supervisor on your first day of work.

A. When reporting for your first day of work, you are REQUIRED to present the following documents:

- ☐ Form I-9 Documents to prove citizenship and work authorization (if not presented at time of job offer);
- ☐ Social Security Card
- ☐ Valid Driver's License or State-issued ID
- ☐ Voided Check for Direct Deposit to Checking Account
- ☐ Copy of DD-214 (if you are a veteran)
- ☐ Work Permit and Intention to Employ a Minor (required for employees under age 18)
- ☐ Probational Status Acknowledgement Statement (if forfeiting permanent status upon transferring from another agency)
- ☐ Official College Transcript(s)
- ☐ Selective Service Registration Card (males age 18-25)
- ☐ License or certification (if required)
- ☐ Law Enforcement Contract Agreement (for non-POST certified Park Ranger employees only)
- ☐ Form Affordable Health Care Act (ACA) "Options for Health Care Coverage" and ACA Acknowledgement.

B. The following forms should be completed prior to your first day of work:

- ☐ Personal Data Form
- ☐ Prior State Service Questionnaire
- ☐ L-4 State Withholding Exemption Certificate
- ☐ W-4 Federal Withholding Allowance Certificate
- ☐ Direct Deposit Enrollment Authorization – Main Bank (if your direct deposit will be sent to a savings account rather than a checking account, your bank MUST complete the form)
- ☐ Direct Deposit Enrollment Authorization – Secondary Bank (if applicable)
- ☐ Authorization and Driving History Form
- ☐ Employee Identification Badge/Access Card Enrollment Form

NEW FULL-TIME HIRE PACKET CHECKLIST (rev 1/17)

- ☐ Statement of Agreement or Understanding RE: Compensation for Overtime Work (only applicable for leave-earning positions)
- ☐ Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security (not applicable for students/wage employees)

SECTION 2: CONDITIONS OF EMPLOYMENT (to be completed by supervisor)

This section must be completed by the supervisor to ensure that the new hire has met all of the conditions of his/her employment before proceeding to Section 3. If any of the answers below are "No," the supervisor must check with HR to determine the appropriate course of action.

A. The following conditions of this new hire's employment have been met, to include:

• Conditional Offer of Employment is completed, approved, and discussed with employee	☐ Yes	☐ No
• Drug Testing results have been obtained from HR and employee notified	☐ Yes	☐ No
• Reference Checks have been completed by supervisor	☐ Yes	☐ No
• Criminal Background Check completed by HR (if necessary)	☐ Yes	☐ No
• Work Permit and Intention to Employ a Minor completed (required for employees under age 18)	☐ Yes	☐ No

SECTION 3: FORMS/DOCUMENT REVIEW (to be completed by supervisor)

This section should be completed by the supervisor to ensure that the employee has completed his/her new hire paperwork appropriately.

The forms and documents as listed in Section 1 above have been reviewed for completeness, and any areas of deficiency or omission have been corrected. ☐ Yes ☐ No

SECTION 4: INTRODUCTION (to be completed by supervisor with employee)

*This section must be completed by the supervisor as an introduction to OLG/DCRT, as well as overall State employment. This introduction must be provided to **ALL employees**, regardless of Appointment Type.*

A. The following introductory materials have been provided to and/or completed with the new employee, to include:

- ☐ State Employment: Advantages and Responsibilities (Handout)
- ☐ Appointment Affidavit (SF-13)
- ☐ Employee Work Schedule Form
- ☐ Louisiana Employees Online (LEO) System – Instruction Brochure (Handout)

SECTION 5: BENEFITS (to be completed by supervisor with employee)

*This section should only be completed for those **employees that are eligible for benefits** (as determined by their Appointment Type noted above). If the employee is not eligible for benefits, please write "N/A" next to this section and proceed to Section 6 below.*

A. The following GENERAL BENEFITS INFORMATION has been provided to the new employee:

NEW FULL-TIME HIRE PACKET CHECKLIST (rev 1/17)

☐ Regular, full-time employees (classified and unclassified) are eligible for State retirement and insurance. Most part-time, temporary employees are not eligible for benefits. Some exceptions may apply but must be confirmed by the Human Resources Division prior to enrollment. New employees who are eligible must enroll in the State's retirement plan immediately; however, they have 30 days from the hire date (or 121st consecutive day for temporary employees working 30 or more hours per week) to enroll in the State's Group Insurance and Flexible Benefits Plan. Additional forms are required if dental and life insurance are desired. All insurance applications submitted after 30 days are considered "late enrollments." After the 30 days, enrollment in the Flexible Benefits Plan is not available again until Annual Enrollment.

B. The following GENERAL BENEFITS HANDOUTS have been provided to the new employee:

☐ Some of the Benefits of Working in Louisiana State Government
☐ List of benefit providers' web sites and customer service numbers

C. The following RETIREMENT forms and/or information has been discussed with the new employee:

☐ Is the employee a member of another State retirement system? ☐ Yes ☐ No
☐ Has employee retired from LASERS, Teachers' Retirement, or another State retirement system? ☐ Yes ☐ No
☐ LASERS Benefits Handbook (available at www.lasersonline.org)
☐ LASERS Membership and Optional Membership Registration (Form 1-01)
*Note: Participation in LASERS is mandatory before age 55. Newly-hired employees over 55 years of age **must** contact the Human Resources Division if they are interested in other retirement plan options. If age 55 and over and eligible for Deferred Compensation or Social Security in lieu of LASERS, the employee is required by law to be enrolled in LASERS until proof of 40 quarters in Social Security (SSA-7005) is submitted by the employee to the Human Resources Division.*
☐ Membership Registration from other retirement system, if applicable (obtain from HR)
☐ LASERS Reemployment of Retiree (Form 10-2), if applicable

D. The following benefits forms for OFFICE OF GROUP BENEFITS (OGB) coverage have been provided to the new employee:

Health Insurance:

☐ Benefit rates and plan information may be found at www.info.groupbenefits.org. The "Health Plans" link provides further information on the plans available in specific areas of the State and rates applicable to those plans.
☐ Office of Group Benefits Enrollment/Change Form (GB-01) **– due within 30 days of hire date**
Note: If employee is electing not to enroll in health insurance, please have him/her mark "No coverage" under the Level of Medical Coverage Selected section and sign the "Waiver of Coverage" section on page 2.

Life Insurance (underwritten by Prudential):

☐ Office of Group Benefits Enrollment/Change Form (GB-01) **– due within 30 days of hire date**
Note: If employee is electing not to enroll in life insurance, please have him/her mark "No Coverage Employee/Dependent" under the Life Insurance section and sign the "Waiver of Coverage" section on page 2.

NEW FULL-TIME HIRE PACKET CHECKLIST (rev 1/17)

Flexible Benefits Plan:

☐ Flexible Spending Accounts Enrollment Form (available upon request)

SECTION 6: OPTIONAL BENEFITS (to be completed by supervisor with employee)
*The miscellaneous, optional benefits noted below are available to **ALL employees**, regardless of Appointment Type.*

A. The following miscellaneous, optional benefits have been made available to the new employee:

☐ Supplemental insurance policies available through private vendors
Note: These companies are approved for payroll deduction. Policies offered include term-life insurance; whole life insurance; dental; cancer; intensive care; disability; etc. More information can be obtained from www.doa.la.gov/media/ur5cgn2o/stwide_ven_prod_listing_jan2022rev11-8-21.pdf
☐ LaChip health insurance for children (fees dependent on eligibility)
☐ START Savings Plan (for college expenses)
☐ Deferred Compensation (tax-deferred savings 457 retirement plan)
☐ LA Capitol Credit Union

****
****

ORIENTATION ACKNOWLEDGEMENT:

I, _____, have been informed of all the items listed on this New Hire Orientation Checklist and have been afforded an opportunity to ask questions. If I have any further questions for which my supervisor was unable to provide guidance, I understand that I am to contact the Human Resources Division at (225) 342-0880.

_____ _____
Employee's Signature ***Date***

_____ _____
Supervisor's Signature ***Date***

***** PLEASE RETURN COMPLETED CHECKLIST TO THE HUMAN RESOURCES DIVISION WITH ALL REQUIRED FORMS/DOCUMENTS WITHIN TWO (2) DAYS OF HIRE. *****

DCRT HUMAN RESOURCES POLICIES ACKNOWLEDGEMENT FORM

Name: _____ **Job Title:** _____

Office/Section: _____ **Hire Date:** _____

NOTE:

- New employees **must** read the DCRT/ Human Resources policies during the OnBoarding process.
- Active employees, please refer to Channel Z for the DCRT/Human Resources policies: **Channel Z/Employee Information/Human Resources/Policies**

SECTION 1: HUMAN RESOURCES POLICY

DCRT/HR policies to be initialed after reading: Please initial each box below to acknowledge that you have read and understand each of the DCRT HR Policies.

	PPM# 3	Violence-Free Workplace		PPM#19	Work Hours/Schedule
	PPM#4	Sexual Harassment		PPM#30	Recoupment of Overpayments
	PPM#5	Workplace Harassment/Discrimination		PPM#39	Accident/Incident Investigations
	PPM#6	Firearms Policy		PPM#42	Attendance/Leave
	PPM#8	Ethics/Dual Employment		PPM#49	Employee Conduct
	PPM#9	Outside Employment		PPM#52	Bloodborne Pathogens
	PPM#11	Substance Abuse/Drug-Free Workplace		PPM#57	Training Policy and Requirement
	PPM#14	Transitional Return to Work			

SECTION 2: GENERAL SAFETY RULES

☐ By initialing this box, I acknowledge have read the DCRT General Safety Program, Rules & Safety Responsibilities on Channel Z. **Channel Z/E-Forms/HR Forms Webpage/Safety/General Safety Rules**
https://www.crt.state.la.us/channelz/hrforms.asp#Safety

SECTION 3: SIGN AND SEND TO HUMAN RESOURCES

Once objectives above are completed, read and sign the acknowledgement below. New employees, return form to HR in the New Hire Documentation Packet. Active employees scan entire document and email to HRfrontdesk@crt.la.gov.

DCRT HR POLICIES & GENERAL SAFETY RULES ACKNOWLEDGEMENT:

I, _____, have been informed of all the policies within DCRT and have been afforded an opportunity to ask questions. Further, I have read and understand the General Safety Rules, and understand how to obtain a copy of any or all of these policies/rules. If I have any further questions for which my supervisor was unable to provide guidance, I understand that I am to contact the Human Resources Division at (225) 342-0880.

_____ _____
Employee's Signature ***Date***

_____ _____
Supervisor's Signature ***Date***

PERSONAL DATA FORM

Revised 03/2025

Employee's Name: _____

(Print full name as it appears on your Social Security Card)

Social Security Number: _____ **Date of Birth**:_____

Gender: ____Male ____Female

Check all that apply:

Race/Ethnicity: ____American Indian or Alaska Native ____Asian ____Black or African American

____Hispanic or Latino ____Middle Eastern or North African _____White

____Native Hawaiian or Pacific Islander

Check one:

Marital Status: ____Single ____Married ____Divorced _____Not Married

---

Section 1. R.S. 44:11 is hereby amended and reenacted to read as follow:

Confidential nature of certain personnel records notwithstanding anything contained in this Chapter or any other law to the contrary, the following items in the personnel records of a public employee of any public body shall be confidential:

1. The home telephone number of the public employee where such employee has choose to have a private or unlisted home telephone number because of the nature of his occupation with such body.
2. The home telephone number of the public employee where such employee has requested that the number be confidential.
3. The home address of the public employee where such employee has requested that the address be confidential.

____**YES** ____**NO** I want my home address to be regarded as confidential in accordance with R.S. 44:11.

HOME ADDRESS: **MAILING ADDRESS:**

_____ _____

_____ _____

_____ _____

Telephone Number: _____ **Cell Phone (Optional) _____**

RESIDENCE PARISH: _____

EMERGENCY CONTACT:

_____ _____

NAME **PHONE**

_____ _____

EMPLOYEE NAME (PRINTED) **EMPLOYEE SIGNATURE & DATE**

Department of Culture, Recreation and Tourism
POLICY PROHIBITING SEXUAL HARASSMENT

ACKNOWLEDGEMENT AND CERTIFICATION

My signature hereon acknowledges that I have read PPM #4 Sexual Harassment Policy on **Channel Z/Employee Information/Human Resource/Policies**:

1) I received a copy of OLG/DCRT's Policy Prohibiting Sexual Harassment;

2) I read this Policy;

3) I understand the content of this Policy;

4) I agree to abide by the terms and provisions of this Policy;

5) I understand that compliance with this Policy is a condition of employment; and

6) I understand that disciplinary action, including the possibility of dismissal, will be imposed on those who violate the terms and provisions of this Policy.

7) I understand that I may be personally liable and responsible for reimbursing the State of Louisiana for all or a portion of any judgment or settlement if a determination is made that I have engages in sexually inappropriate workplace behavior.

_____ _____

EMPLOYEE SIGNATURE **DATE**

_____

EMPLOYEE NAME (PRINT)

SUPERVISOR CERTIFICATION

My signature hereon acknowledges that:

1) I personally discussed in detail OLG/DCRT's Policy Prohibiting Sexual Harassment with the employee identified above;

2) I answered this employee's questions regarding this Policy;

3) I confirmed this employee's completion of the online training on sexual harassment provided through CPTP; and

4) I informed the employee of the consequences of violating this Policy.

_____ _____

SUPERVISOR SIGNATURE **DATE**

_____

SUPERVISOR NAME (PRINT)

Office of the Lieutenant Governor
Department of Culture, Recreation and Tourism

NOTICE OF PERSONAL LIABILITY

SEXUAL HARASSMENT

Louisiana law requires government agencies to develop and implement policies and related training to prevent sexual harassment in the workplace. The prohibitions and requirements within these policies apply to all public servants -- employees, appointees and elected officials.

Louisiana's taxpayers have been financially burdened by judgments and settlements arising from claims of workplace sexual harassment. To reduce this impact, La. R.S. 42:351, enacted in the 2019 Regular Session (Act No. 43), declares that consideration be given to requiring that a public servant, determined to have engaged in sexually inappropriate behavior, personally reimburse all or a portion of any judgment or settlement resulting from such behavior. La. R.S. 42:353 sets forth the process and factors to be considered in making this determination, and authorizes the Attorney General to file suit against a public servant to enforce the state's right to reimbursement and indemnification.

Notice of this potential personal liability is disseminated, along with our policy prohibiting sexual harassment, to every newly hired public servant. This notice also is disseminated, on an annual basis, to the employees of this agency and every public servant in the executive branch of state government. Reference to this potential personal liability also is included in the annual CPTP training on sexual harassment available through LEO**.**

****

ACKNOWLEDGEMENT:

I, _____, have been informed of the notice of liability regarding sexual harassment and have been afforded an opportunity to ask questions. If I have any further questions for which my supervisor was unable to provide guidance, I understand that I am to contact the Human Resources Division at (225) 342-0880.

_____ _____

Employee's Signature ***Date***

STATE OF LOUISIANA
LAGOV ERP-HUMAN CAPITAL MANAGEMENT
DIRECT DEPOSIT ENROLLMENT AUTHORIZATION
MAIN BANK (PRIMARY ACCOUNT)

EMPLOYEE SSN	DEPARTMENT/OFFICE OR AGENCY
ACTION TYPE (✓ one) ☐ NEW ☐ CHANGE ☐ TERMINATE THIS OPTION	

PRIMARY ACCOUNT INFORMATION
(Main Bank)
DEPOSIT AMOUNT TO THIS ACCOUNT WILL BE EQUAL TO NET PAY LESS ANY DEPOSITS TO SECONDARY ACCOUNTS.

FINANCIAL INSTITUTION NAME	FINANCIAL INSTITUTION ROUTING (ABA) NUMBER *(Bank Key)*	
BANK ACCOUNT NUMBER	ACCOUNT NAME * (Ex: Mr. and Mrs. John Doe, John or Jane Doe, John Doe)	
ACCOUNT TYPE (✓ one) *(Bank Control Key)* ☐ **CHECKING (provide voided check or account verification) ☐ **SAVINGS (obtain account # & ABA # from financial institution)	**Account verification or completion of enrollment form by financial institution will assure the accuracy of account data: Signature from institution:_____	
	Effective Date	_____ PAYDAY
	Phone number:	

(Print full name)

I _____ authorize and request the State of Louisiana to direct my net pay check to the account at the financial institution I designated above.

It is my responsibility to notify my Employee Administration Office, as appropriate, should any changes occur to account specified. Considering all above conditions are met, this authorization remains in full effect until a written, signed notification to terminate, or another signed form (OSUP/F12A) indicating termination of this option is received from me and the State of Louisiana has had reasonable opportunity to act on the termination. However, I understand and acknowledge that I am responsible for any account information indicated on this form as well as any account information that I add or any changes that I make to my accounts through Louisiana Employees Online (LEO).

For direct deposits that are affected by the International ACH Transaction (IAT) rules check one:

☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will not** subsequently be forwarded to a foreign financial institution.

☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will** subsequently be forwarded to a foreign financial institution.

_____	_____	_____
Signature	Date	Phone number where you can be reached between 8:00 am and 4:30 pm

***Deposits can only be made to accounts that belong to you. Exceptions: Deposits can be made to the accounts of dependents or a parent/guardian when the employee is a dependent of the parent/guardian.**
****Agency requirements may vary. Contact your Employee Administration office if you have any questions.**

TO BE COMPLETED BY EMPLOYEE ADMINISTRATION OFFICE:

MAIN BANK	FINANCIAL INSTITUTION ROUTING (ABA) NO. (If not provided above)	
PERSONNEL AREA NUMBER	PERSONNEL NUMBER	EFT VALIDITY DATE

☐ **CHECK HERE IF SECONDARY ACCOUNT FORMS ARE ATTACHED**

STATE OF LOUISIANA
LAGOV ERP-HUMAN CAPITAL MANAGEMENT
DIRECT DEPOSIT ENROLLMENT AUTHORIZATION
OTHER BANK (SECONDARY ACCOUNT)

EMPLOYEE SSN	DEPARTMENT/OFFICE OR AGENCY

ACTION TYPE (✓ one)

☐ NEW ☐ TERMINATE THIS OPTION

☐ CHANGE ☐ ADD ADDITIONAL SECONDARY ACCOUNT

SECONDARY ACCOUNT INFORMATION
(Other Bank)

DEPOSIT AMOUNT TO THIS ACCOUNT WILL BE EQUAL TO THE DOLLAR AMOUNT SPECIFIED BELOW OR THE PERCENTAGE OF NET PAY SPECIFIED BELOW.

FINANCIAL INSTITUTION NAME	FINANCIAL INSTITUTION ROUTING (ABA) NUMBER *(Bank Key)*
BANK ACCOUNT NUMBER	ACCOUNT NAME * (Ex: Mr. and Mrs. John Doe, John or Jane Doe, John Doe)
ACCOUNT TYPE (✓ one) *(Bank Control Key)* ☐ **CHECKING (provide voided check or account verification) ☐ **SAVINGS (obtain account # & ABA # from financial institution)	**Account verification or completion of enrollment form by financial institution will assure the accuracy of account data: Signature from Institution: _____ Effective Date: PAYDAY Phone Number:
PERCENT OF NET TO THIS ACCOUNT	**OR** **FIXED DOLLAR AMOUNT TO THIS ACCOUNT**

(Print full name)

I _____ authorize and request the State of Louisiana to direct the percent of my net pay check or the dollar amount specified to the account at the financial institution I designated above.

It is my responsibility to notify my Employee Administration Office, as appropriate, should any changes occur to account specified. Considering all above conditions are met, this authorization remains in full effect until a written, signed notification to terminate, or another signed form (OSUP/F12B) indicating termination of this option is received from me and the State of Louisiana has had reasonable opportunity to act on the termination. However, I understand and acknowledge that I am responsible for any account information indicated on this form as well as any account information that I add or any changes that I make to my accounts through Louisiana Employees Online (LEO).

For direct deposits that are affected by the International ACH Transaction (IAT) rules check one:

☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will not** subsequently be forwarded to a foreign financial institution.

☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will** subsequently be forwarded to a foreign financial institution.

Signature	Date	Phone number where you can be reached between 8:00 am and 4:30 pm

***Deposits can only be made to accounts that belong to you. Exceptions: Deposits can be made to the accounts of dependents or a parent/guardian when the employee is a dependent of the parent/guardian.**

****Agency requirements may vary. Contact your Employee Administration office if you have any questions.**

TO BE COMPLETED BY EMPLOYEE ADMINISTRATION OFFICE:

OTHER BANK	FINANCIAL INSTITUTION ROUTING (ABA) NO. (If not provided above)	
PERSONNEL AREA NUMBER	PERSONNEL NUMBER	EFT VALIDITY DATE

☐ **CHECK HERE IF ADDITIONAL ACCOUNT FORMS ARE ATTACHED**

R-1300 (1/25)

LOUISIANA DEPARTMENT of REVENUE

Employee's Withholding Certificate (L-4)

This form must be filed with your employer.

For Questions:
Phone: (855) 307-3893
Send an email by visiting www.revenue.louisiana.gov/Contact/ContactUs.

Purpose: Complete Form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding must provide their expected tax return filing status in Block A.

- Employees must file a new certificate within 10 days if the number of their deductions decreases, except if the change is the result of the death of a spouse.
- Employees may file a new certificate any time the number of their deductions increases.
- Line 7 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willfully failing to supply information that would reduce the withholding amount.

This form must be filed with your employer. If an employee fails to complete this withholding certificate, the employer must withhold Louisiana income tax from the employee's wages without any standard deduction.

Note to Employer: Keep this certificate with your records.

Block A

- Enter "0" to claim no standard deduction and check the appropriate box under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim a standard deduction if your filing status is single or married filing separate and check the appropriate box under number 3 below if you did not claim this deduction in connection with other employment or if your spouse has not claimed a deduction.
- Enter "2" to claim a standard deduction if your filing status is married filing jointly, head of household, or qualifying surviving spouse and check the appropriate box under number 3 below.

A.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
Louisiana Department of Revenue

Employee's Withholding Certificate

1. First name and middle initial	Last name
2. Social security number	**3.** Select one: ☐ No deduction ☐ Single or married filing separately ☐ Married filing jointly, qualifying surviving spouse, or head of household
4. Home address (number and street or rural route)	
5. City / State / ZIP	
6. Total number of deductions claimed in Block A	**6.**
7. Adjustments. Enter any increase or decrease in the amount of tax to be withheld each pay period. Decreases should be indicated as a negative amount and cannot result in an amount less than zero to be withheld each pay period.	**7.**

I declare under the penalties imposed for filing false reports that the number of deductions claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date

The following is to be completed by employer.

8. Employer's name and address	**9.** Employer's state withholding account number

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

2026

Step 1: Enter Personal Information

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

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

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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

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

Future Developments

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

Purpose of Form

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

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

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

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

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4.

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

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

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

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

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

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

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

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

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

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

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

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

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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		
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		**12.** Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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

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

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

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

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

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

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

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

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

Supplement B,

Reverification and Rehire (formerly Section 3)

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Office of the Lieutenant Governor (OLG)
Department of Culture, Recreation and Tourism (DCRT)

WORK SCHEDULE FORM

The following work schedule and work hours are requested for:

Employee Name: _____

Personnel #: _____

Job Title: _____

Department/Section: _____

Requested Effective Date: _____ *(Must be beginning of a pay period)*

OPTION 1: Traditional Full-time Work Schedule

☐ Five (5) eight (8) hour workdays, Monday through Friday

Daily work schedule: _____ A.M. to _____ P.M.

Lunch *(check one)*: ☐ 30 minutes ☐ 1 hour

OPTION 2: Flexible Full-time Work Schedule

☐ Four (4) ten (10) hour workdays

Daily work schedule: _____ A.M. to _____ P.M.

Scheduled workday off (any day Monday – Friday): (Select one)

Lunch *(check one)*: ☐ 30 minutes ☐ 1 hour

☐ Four (9) hour workdays plus one (1) four (4) hour workday

Daily work schedule: _____ A.M. to _____ P.M.

Four-hour workday (any day Monday – Friday): (Select one)

Lunch *(check one)*: ☐ 30 minutes ☐ 1 hour

☐ Four (4) nine (9) hour workdays in one week of the pay period and four (4) nine (9) hour workdays plus one (1) eight (8) hour day in the other week of the pay period **(Available to Exempt employees only.)**

Nine (9) hour workday schedule:: _____ A.M. to _____ P.M.

Eight (8) hour workday schedule:: _____ A.M. to _____ P.M.

Scheduled workday off (any day Monday – Friday): (Select one)

Lunch *(check one)*: ☐ 30 minutes ☐ 1 hour

OPTION 3: Positive Time Entry (24/7)

☐ No pre-determined work schedule as provided for by Option 1 or 2 above. This option is usually reserved for part-time wage and student employees to allow for scheduling fluctuations. If a regularly-recurring work schedule is assigned, please indicate below:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

I have read and understand PPM #19, Work Hours and Work Schedules Policy. I understand that if business needs change, I may be required to change my work schedule accordingly upon immediate notice. Furthermore, if I choose a flexible work schedule, I may be compensated differently from others while traveling and when holidays fall within the workweek. I agree to these terms and conditions.

_____ _____

Employee's signature *Date*

_____ _____

Supervisor's signature *Date*

STATEMENT OF AGREEMENT OR UNDERSTANDING

Re: Compensation for Overtime Work

I, _____, understand that agencies of the State of Louisiana have the option of granting compensatory leave for overtime hours worked.

NON-EXEMPT EMPLOYEES: In cases where the Fair Labor Standards Act applies, such leave will be credited to non-exempt employees at the rate of one and one-half hour for each hour worked. For overtime hours worked during the weeks when leave is taken (with or without pay), or when holidays are observed, the agency may opt to use straight-time cash payments or hour-for-hour compensatory leave to compensate non-exempt employees, in accordance with the Rules of the Department of State Civil Service.

EXEMPT EMPLOYEES: Agencies have the option of granting no overtime compensation at all to exempt employees; but if the agency chooses to compensate exempt employees for overtime, the agency may choose to compensate such employees with compensatory leave rather than cash payment.

PAYMENT OF COMPENSATORY LEAVE UPON SEPARATION:

- NON-EXEMPT EMPLOYEES: I also understand that non-exempt employees shall be paid upon separation for any time and one-half compensatory leave earned for overtime, as required by the Fair Labor Standards Act. Other straight, hour-for-hour compensatory leave may or may not be paid upon separation in accordance with applicable Civil Service Rules. Any hour-for-hour compensatory leave that is not paid upon separation shall be cancelled.

- EXEMPT EMPLOYEES: Compensatory leave credited to exempt employees may or may not be paid upon separation in accordance with the applicable Civil Service Rules. Any such compensatory leave that is not paid shall be cancelled, in accordance with the applicable Civil Service Rules.

I have read the above and agree to accept compensatory leave as compensation for overtime work.

Printed or Typed Name:_____ _____

Signature:_____ Date:_____

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

Employee Name: _____

Employee ID#: _____

Employer Name: _____

Employer ID#: _____

Your earnings from this job are not covered under Social Security (i.e., you will not pay Social Security taxes). This means that you will not earn credits for Social Security retirement or disability benefits in this job. If you retire or become disabled, and you are eligible for a Social Security benefit based on other work, your earnings from this job will not be used to compute your Social Security benefit. In addition, we will not consider these non-covered earnings for the future potential calculation of survivor benefits based on your earnings. Your earnings from this job are subject to Medicare taxes and will count for purposes of the Medicare program. For information on how you may qualify for Social Security benefits, visit www.ssa.gov.

For More Information

Social Security publications and additional information are available at www.ssa.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778 or contact your local Social Security office.

I certify that I have received Form SSA-1945 and understand that my earnings from this job are not covered under Social Security and will not be used to determine eligibility to or the amount of my potential future Social Security Benefits.

Signature of Employee: _____

Date: _____

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

The Social Security Protection Act of 2004, Pub. L. No. 108-203, Section 419 requires State and local government employers to provide a statement to employees hired January 1, 2005, or later in a job not covered under Social Security. Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers must use to meet the requirements of the law.

While the earlier version of the SSA-1945 discussed the effect of the Windfall Elimination Provision and/or Government Pension Offset on an employee's potential future benefits, the Social Security Fairness Act (SSFA) of 2023 enacted on January 5, 2025, eliminated the reduction of Social Security benefits under the Windfall Elimination Provision and/or Government Pension Offset for individuals entitled to certain pensions from work not covered by Social Security, starting January 2024. However, this did not remove the requirement for State and local government employers to provide a statement to employees hired January 1, 2005, or later in jobs not covered under Social Security. This version of SSA-1945 explains to an employee that non-covered earnings will not be used to determine eligibility to or calculate the amount of potential future benefits.

Employers must:

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

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

A fillable, downloadable version of the SSA-1945 is available online at the Social Security website, www.ssa.gov/online/ssa-1945.pdf.

Department of Culture, Recreation and Tourism
Prior State Service Questionnaire

Employee's Name: _____ **Division/Section:** _____

Name of State Agency	Employment Status (Perm., Job Appt., Rest. Appt, Unclassified, etc.)	Employment Dates (Month, Day, Year) From TO	Full Time or Part Time	# of Hours Worked Per Week	Leave without Pay Yes or No Dates: From - To	Office Use Only Total Service Years, Months, Days

Do you have military service time? _____ If yes - Dates of Service From: _____ To: _____

Have you ever been in a Government Retirement System? If so, which one? _____

Are you currently retired from any system? If so, which one? _____

Employment information listed by me is accurate and complete to the best of my knowledge.

_____	_____	_____
Social Security	**Employee Signature**	**Date**

OFFICE USE ONLY:

Leave Balances

Sick: _____

Annual: _____

FMLA: _____

Adjusted Leave Service Date: _____

Adjusted Service Date: _____

Verified By _____

OMF 322
Revised 01/19/01

SF-13 (R 5-03)

APPOINTMENT AFFIDAVITS

IMPORTANT: Please read the following appointment affidavits. Before swearing to these affidavits, make sure you understand the fully. It is the responsibility of the employing agency to determine any change in employment status since the applicant filed the original pre-employment application.

APPOINTEE	**AGENCY /DIVISION**
PRESENT STREET ADDRESS	**PLACE OF EMPLOYMENT**
CITY/ STATE/ZIP	**DATE OF BIRTH**

A. SINCE YOU FILED THE APPLICATION RESULTING IN YOUR APPOINTMENT, HAVE YOU BEEN INDICTED OR CONVICTED OF ANY LAW VIOLATION (excludes minor traffic violations)? ☐ **YES** ☐ **NO**
IF YES, GIVE DETAILS:

DATE	**LOCATION**	**CHARGE**
DISPOSITION		

B. SINCE YOU FILED THE APPLICATION RESULTING IN YOUR APPOINTMENT, HAVE YOU RESIGNED OR BEEN DISCHARGED AS A RESULT OF MISCONDUCT? ☐ YES ☐ NO

IF YES, GIVE DETAILS:

C. DO YOU NOW HOLD OR ARE YOU A CANDIDATE FOR AN ELECTIVE PUBLIC OFFICE? ☐ YES ☐ NO

D. AS REQUIRED BY **LOUISIANA REVISED STATUE 42:52**

Do you solemnly swear (or affirm) to support the Constitution and laws of the United States and Constitution and laws of this State, and faithfully and impartially discharge and perform all of the duties incumbent upon you as a State employee according to the best of your ability and understanding? ☐ YES ☐ NO

DATE	**SIGNATURE OF APPOINTEE**	**SOCIAL SECURITY NO.**
		- -

STATE OF LOUISIANA

DRIVER AUTHORIZATION FORM

TO BE COMPLETED ANNUALLY, UPON CHANGE OF STATE OF ISSUANCE, CLASS OF LICENSE, AND/OR DRIVING RESTRICTION CHANGE

Agency: _____
Employee Name: _____ Employee Number: _____
Immediate Supervisor: _____ Driver Training Course (MM/DD/YY):_____
Drivers License Number: _____ State of Issuance: _____

AGENCY HEAD OR DESIGNEE AUTHORIZATION

By executing this document, I have reviewed the Official Driving Record and Driver Training Course dates and have confirmed the information to be current and in accordance with the ORM Loss Prevention requirements.

My signature authorizes the aforementioned employee to drive the following on state business as required (check all that apply):

_____ **STATE VEHICLE**
_____ **RENTAL VEHICLE**
_____ **PERSONAL VEHICLE**

_____ _____
AGENCY HEAD **DATE OF AUTHORIZATION**
(or designated individual)

EMPLOYEE ACKNOWLEDGEMENT/AUTHORIZATION

This is to certify that, as a condition of and if authorized to drive my personal vehicle on state business, I have and will maintain at least the minimum liability coverage as required by *LA. R.S. 32:900 (B) (2*).

I understand that the use of my vehicle on state business requires prior written authorization from my supervisor or agency head.

Further, by signing this document, I agree to notify my agency in writing should any of the following change on my license: Drivers License No., State of Issuance, Class of License or Driving Restrictions.

I authorize my agency to obtain access to my Official Driving Record (ODR) as necessary to comply with the State's Loss Prevention Program.

My signature on this document shall remain in effect until revoked by the agency or until a new form is executed.

_____ _____
EMPLOYEE SIGNATURE **DATE**

ANNUAL SUPPLEMENTAL SIGNATURE PAGE

EMPLOYEE NAME:_____

DRIVERS LICENSE NUMBER:_____

DEPARTMENT/AGENCY:_____

AGENCY HEAD OR DESIGNEE STATEMENT

By executing this document, I have reviewed the following and have confirmed the information to be current and in accordance with the ORM Loss Prevention requirements:

Official Driving Record
Drivers Training Course

Further, my signature allows the aforementioned employee to drive a state vehicle, rental vehicle or personal vehicle on state business.

_____ _____
Agency Head ***Date of Authorization***
(or designated individual)

_____ _____
Agency Head ***Date of Authorization***
(or designated individual)

_____ _____
Agency Head ***Date of Authorization***
(or designated individual)

_____ _____
Agency Head ***Date of Authorization***
(or designated individual)

_____ _____
Agency Head ***Date of Authorization***
(or designated individual)

_____ _____
Agency Head ***Date of Authorization***
(or designated individual)

_____ _____
Agency Head ***Date of Authorization***
(or designated individual)

(DUPLICATE SUPPLEMENTAL SIGNATURE PAGE AS NEEDED)

LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.[1] This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

Employee Signature:_____ Date: _____

Employer Representative Signature: _____ Date: _____

Employer Name: _____

Employee Name:_____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only):_____

Home Address: _____

Telephone Number:(____) _____

[1] Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystropy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertension	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

☐ ☐ Spinal Disc Surgery Year (approximate if unsure)_____

☐ ☐ Spinal Fusion Surgery Year (approximate if unsure)_____

☐ ☐ Amputated Foot Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Leg Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Arm Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Hand Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Knee Replacement Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Hip Replacement Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Other Joint Replacement Joint _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

Employee Signature:_____ Date: _____

Employer Representative: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) **or** any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: ______________________________ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

CONDITION: ______________________________ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

CONDITION: ______________________________ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

CONDITION: ______________________________ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

Employee Signature: ______________________________ Date: ____________________

Employer Representative: ______________________________ Date: ____________________

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐
   If "Yes," please list the restrictions: _____
   Were the restrictions: Permanent ____ Temporary ____
   Are your activities currently restricted? Yes ☐ No ☐
   What is the medical condition for which you have restrictions? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

   Please list the medical condition being treated: _____

   Doctor's Name: _____Specialty: _____

   Doctor's Address: _____

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

   Medication: _____Prescribing Doctor: _____

   Medication: _____Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐
   If you answered "YES," please provide the date for each injury and the nature of the injury:

   _____

   How long were you on compensation? _____

   Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐
   If you answered YES, please provide:

   Recommended surgery: _____

   Approximate date of recommendation: _____

   Doctor's Name: _____Specialty: _____

   Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature:_____ Date: _____

Employee Printed Name: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;

2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;

3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;

4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and

5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq*., or any other state or federal law;

6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature:_____ Date: _____

Employer Representative Printed Name: _____

Title: _____

AFFORDABLE HEALTH CARE ACT (ACA) ACKNOWLEDGEMENT

My signature hereon acknowledges that:

A) I have received a copy of the "Options for Health Care Coverage" notice;

B) I have read the notice;

C) I understand that the Health Insurance Marketplace is available at www.healthcare.gov and can be used to locate and enroll for private health insurance;

D) I may contact the Marketplace for further assistance at 1-800-318-2596;

E) If I choose to enroll in a Marketplace plan,

1. I am 100% responsible for premium costs;

2. My payments for insurance coverage through the Marketplace are made on an after-tax basis;

3. I may be eligible for a premium tax credit, which subsidizes the Marketplace insurance costs, depending on my household size, income, and whether I qualify for OGB insurance.

F) If I have questions, I may contact the Human Resources Division at (225) 342-0880.

_____ _____

Employee Signature Date

_____

Printed Name

_____

Agency Name

PLEASE RETURN
By Scan, Email or
Fax to: (225) 342-7928

By Mail to: DCRT Human Resources, P.O. Box 94361, Baton Rouge, LA 70804-9361

State of Louisiana

OFFICE OF THE LIEUTENANT GOVERNOR
DEPARTMENT OF CULTURE, RECREATION & TOURISM

Education Verification Form

Name _____ Date_____

Address _____

E-mail Address _____

Home Phone # _____ Mobile Phone # _____

Please list your **Highest Level** of education below:

EDUCATION	**Name and location of school**	**Degree Received**	**Subjects studied/Major**	**Start Date**	**Graduation Date**
High School					
College or University					
Trade, Business or Correspondence School					

Please read carefully before signing.

I attest with my signature below that I have given OLG/DCRT true and complete information on this application. No requested information has been concealed. If any information I have provided is untrue, or if I have concealed material information, I understand that this may constitute cause for the denial of employment or immediate dismissal.

Date _____ Signature _____

Office of the Lieutenant Governor (OLG)
Department of Culture, Recreation, & Tourism (DCRT)

RELATIVES DISCLOSURE FORM

In order to minimize complications associated with the employment of relatives, all applicants for employment are required to disclose family relationships to existing OLG/DCRT employees. This disclosure is necessary to preclude a violation of the Code of Governmental Ethics (R.S. 42:1119) and avoid a supervisor-subordinate relationship between immediate family members and relatives which creates a conflict of interest or the appearance of impropriety. For a full review of the ethics code regarding nepotism, please visit ethics.la.gov.

Definition of Immediate Family Members:

Your Children; Your Spouse; Your Parents; Your Brothers and Sisters, including Half-siblings; Your Children's Spouses; Your Spouse's Parents; and The Spouses of your Brothers, Sisters, and Half-siblings.

_____ To the best of my knowledge, I am not related to anyone employed by OLG/DCRT.

_____ To the best of my knowledge, I am related to the following current employee(s) of OLG/DCRT.

NAME	RELATIONSHIP	DIVISION /SECTION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I CERTIFY that the foregoing disclosure is true and correct to the best of my knowledge, information and belief, and understand that any knowing or intentional failure to disclose a family relationship existing upon my employment with OLG/DCRT or occurring during my employment with OLG/DCRT may result in disciplinary action, including the possibility of termination.

_____

Signature Date

_____

Print Name

Office of the Lieutenant Governor (OLG)
Department of Culture, Recreation and Tourism (DCRT)

OPTIONS FOR HEALTH INSURANCE COVERAGE

The Affordable Health Care Act (ACA) requires that you have health insurance coverage in order to avoid a tax penalty.

How Much Is The Tax Penalty?

The penalty (also referred to as an uninsured fee) for 2016 is 2.5% of your yearly household income or $695 per person for the year ($347.50 per child under age 18), whichever is higher. For future years, the fee is adjusted for inflation.

How Can I Avoid The Uninsured Fee?

To avoid the uninsured fee, you must have insurance that provides minimum essential coverage. If you are enrolled in any of the following, you will not have to pay the uninsured fee:

- Health plan through the Office of Group Benefits (OGB) – *see Option #1 below*
- Any Marketplace health plan – *see Option #2 below*
- Medicare
- Medicaid
- Louisiana Children's Health Insurance Program (LACHIP)
- Veterans health care programs
- TRICARE (for veterans and veteran families)
- Peace Corps Volunteer plans

As long as you have health coverage through one of the plans above, you already meet the ACA requirements and therefore do not need to take any further action.

But What If I Don't Have Insurance? What Do I Do Now?

It's time to do your homework and compare insurance options. To help you get started, below is key information you'll need to know in order to make an informed decision.

OPTION #1: Job-based health insurance

As an OLG/DCRT employee, health insurance is available to you and your family through the Office of Group Benefits (OGB) if you work 30 hours or more per week (on average).

It is important to note that if you choose one of the health plans offered through OGB:

- The cost of health insurance premiums is shared between you as the employee and OLG/DCRT as the employer.
- Your share of the premium will be "tax sheltered", meaning that the premium is deducted from your pay check *before* Federal and State income taxes are calculated. As a result, your taxes are calculated on a lower amount, which reduces the taxes you have to pay.
- OGB's health plans cover the essential health benefits required by the ACA. OGB's plans also meet the ACA's requirements for "minimum value" and "affordability."
  - Minimum value means OLG/DCRT pays 60% or more of the total costs;
  - Affordability means the cost of the plan covering you (and not any other members of your family) is less than 9.5% of your household income for the year.

Qualified employees may enroll in health insurance through OGB within 30 days of hire or if you experience an IRS-qualifying event. For more information, including a premium rates sheet and/or enrollment forms, please refer to http://www.crt.state.la.us/HR/Forms.aspx or contact the OLG/DCRT Human Resources Division at (225) 342-0880.

NOTE FOR PART-TIME EMPLOYEES: For those employees that do not qualify for OGB insurance and that do not have insurance coverage otherwise (such as through a spouse's job or a government program), you should explore your options for private insurance through the Marketplace (see right →)

OPTION #2: Health Insurance Marketplace

HealthCare.gov

Health insurance plans in the Health Insurance Marketplace are offered by private companies, and every health insurance plan covers the ACA's required essential health benefits. You'll be able to review your private insurance options based on price, benefits, quality and other features.

Run by the federal government, www.healthcare.gov offers a comparison tool, answers to frequently asked questions, and the opportunity to enroll in insurance through the Marketplace. **To contact the Marketplace for assistance, you may call 1-800-318-2596.**

It is important to note that if you choose to enroll in a qualified health plan through the Marketplace:

- You lose OLG/DCRT's contribution toward your insurance premium. Without this, you are 100% responsible for the premium costs.
- Your payments for insurance coverage through the Marketplace are made on an after-tax basis (i.e., not tax-sheltered). As a result, your taxes may be calculated on a higher amount, which increases the taxes you have to pay.
- In general, if you qualify for insurance through OGB, you are not eligible for the premium tax credit, which helps to subsidize, or reduce, Marketplace insurance costs. However, if you are not eligible for OGB coverage, you may qualify for lower monthly premiums and out-of-pocket costs for Marketplace insurance depending on your household size and income.

The yearly Open Enrollment period when you can enroll in a health insurance plan through the Marketplace is November 1 through January 31 of each year.

After open enrollment ends, you won't be able to get health coverage through the Marketplace until the next open enrollment period, unless you have a qualifying life event (such as loss of job, birth of child, etc.).

If you decide to complete an application for coverage through the Marketplace, you will be asked for the following information. This information is numbered to correspond to the Marketplace application:

3. Employer Name Office of the Lieutenant Governor (OLG) Department of Culture, Recreation and Tourism (DCRT)		**4. Employer Identification Number (EIN)** (OLG) 72-6000748 (DCRT) 72-0807104
PO BOX 94361		**6. Employer phone number** (225) 342-0880
7. City Baton Rouge	**8. State** Louisiana	**9. ZIP Code** 70804-9361
10. Who can we contact about employee health coverage at this job? Tonya Dupuy, Human Resources Specialist		
11. Phone number (if different from above) (225) 219-4331		**12. Email address** tdupuy@crt.la.gov

For assistance, please call the Human Resources Division at (225) 342-0880.

This notice is provided in accordance with the Fair Labor Standards Act (FLSA) section 18B.

STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - ENROLLMENT/CHANGE FORM (Page 1 of 2)

Agency Number	Agency Name	Primary Plan Participant/Employee Name	Date of Hire

Section 1 - Primary Plan Participant/ Employee Information

Name *First*	*M.I.*	*Last*	Social Security Number	Date of Birth

Home Phone number	Work/Alt Phone Number	Email Address* (See footnote below)	Gender ☐ Male ☐ Female

Mailing Address (Street or P.O. Box)	City	State	Zip Code	Country

Physical Address (street)	City	State	Zip Code	Country

Section 2 - Rehired Retiree

When a retiree with OGB coverage returns to benefits-eligible employment, the hiring agency must notify OGB within 30 days of reemployment and the hiring agency must begin to pay the employer portion of the Re-employed Retiree premium from the date of hire. Upon resuming retirement status, premiums will revert to the applicable retiree rates (i.e. Retiree without Medicare, Retiree with 1 Medicare, Retiree with 2 Medicare). At that time, the agency from which the retiree originally retired will resume payment of the employer portion of the premium. The employer portion of the premium will be the percentage set at the retiree's initial retirement. For example, an agency paying 19% of a retiree's premium upon retirement will pay 19% of the retiree's premium when the retiree resumes retirement. Retirees who have maintained their OGB health coverage in retirement MAY NOT waive coverage when returning to benefits-eligible employment.

AGENCY RETIRED FROM	RETIREMENT DATE (MM/DD/YYYY)

Section 3 - Enrollment Information

LEVEL OF HEALTH AND LIFE COVERAGE - FOR PLAN SELECTION SEE SECTIONS 4 AND 5

For each dependent, employee must check the box in section 3 if they wish that dependent to have health and/or life coverage. For life insurance, employee must also check the appropriate box of section 5. If adding more than 4 dependents, employee must complete, sign and submit a second GB-01 form.

☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Family

NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP	GENDER	BIRTH DATE (MM/DD/YYYY)	ADD/DELETE	SOCIAL SECURITY NUMBER	HEALTH	DEP. LIFE
SPOUSE		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES
DEPENDENT		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES
DEPENDENT		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES
DEPENDENT		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES
DEPENDENT		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES

Section 4 - Health Plan Selection - COMPLETE THE APPLICABLE SECTION BELOW. SELECT ONLY ONE HEALTH PLAN.

Active Employees and Non-Medicare Retirees

☐ Pelican HRA1000 (Administered by Blue Cross)
☐ Magnolia Local Plus (Administered by Blue Cross)
☐ Pelican HSA775* (Actives Only - Administered by Blue Cross)
$ _____monthly deduction

☐ Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐ Magnolia Open Access (Administered by Blue Cross)
☐ LSU First Option 1 (for eligible LSU Active Employees/ Non-Medicare Retirees only)

***If you select the Pelican HSA775 plan, you must complete the GB-79 form to open a Health Savings Account in your name with a minimum deposit of $200 provided. Tax implications may apply for certain members.**

Medicare Retirees

OGB Secondary Plans:

☐ Pelican HRA1000 (Administered by Blue Cross)
☐ Magnolia Local Plus (Administered by Blue Cross)
☐ Magnolia Open Access (Administered by Blue Cross)
Optional: Retiree 100
☐ Employee Only ☐ Dependent Only ☐ Employee + 1 Dependent

OGB Sponsored Medicare Advantage Plans:

☐ Peoples Health Medicare Advantage Plan
☐ Blue Advantage HMO
☐ Humana Medicare Advantage Employer HMO Plan
Via Benefits (Please call 1-855-663-4228 or visit my.ViaBenefits.com/ogb to enroll.)

☐ Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐ LSU First Option 3 (for eligible LSU Retirees only)

MEDICARE VERIFICATION	
PLAN MEMBER	**SPOUSE**
☐ No Coverage ☐ Hospital (Part A) ☐ Medical (Part B) ☐ Drugs (Part D)	☐ No Coverage ☐ Hospital (Part A) ☐ Medical (Part B) ☐ Drugs (Part D)
A COPY OF MEDICARE CARD MUST BE ATTACHED	

***Note to FSA Enrollees:** *By providing an email address, you may receive certain benefits-related correspondence through email unless you contact TASC to receive paper notices. You are responsible to provide us with your current email address and to promptly notify us of any changes to your email address by calling customer service at 1-800-272-8451.*

Agency- Continue Completing on page 2

Agency Number	Agency Name	Primary Plan Participant/Employee Name	Social Security Number

Section 5 - Life and Flexible Benefits Plan Selection

LIFE INSURANCE (check one only) OGB FLEXIBLE BENEFITS (check all that apply)

☐ **DECLINE LIFE INSURANCE COVERAGE**

BASIC	ENHANCED BASIC
☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage (Eligible Spouse $1,000 Eligible Child $500) ☐ Employee/Dependent Coverage (Eligible Spouse $2,000 Eligible Child $1,000)	☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage (Eligible Spouse $1,000 Eligible Child $500) ☐ Employee/Dependent Coverage (Eligible Spouse $2,000 Eligible Child $1,000)

BASIC PLUS SUPPLEMENTAL
☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage (Eligible Spouse $2,000 Eligible Child $1,000) ☐ Employee/Dependent Coverage (Eligible Spouse $4,000 Eligible Child $2,000)

Annual Salary _____ Date of Last Salary Increase _____ Face Life _____

FLEXIBLE BENEFITS (ACTIVE EMPLOYEES ONLY)

☐ Decline flexible spending account
☐ My agency does not participate in OGB's flexible benefits plan
☐ I do want to participate and acknowledge that I have completed the flexible spending arrangement form.

Section 6 - Acknowledge Offer and Decline Health Insurance Coverage (Active Employees Only)

ACKNOWLEDGE OFFER AND DECLINE HEALTH INSURANCE COVERAGE (ACTIVE EMPLOYEES ONLY)

☐ I have been offered health coverage for myself and my eligible dependents. I have voluntarily elected to decline the coverage as indicated below. If I choose to apply for health coverage at a later date, I understand that I may only enroll for health coverage during annual enrollment or as otherwise specified in the OGB plan document in the event I, or my eligible dependents have a Plan Recognized Qualified Life Event.

Reason for Declining Health Coverage Offer:

☐ Other Group Health Coverage (would include being covered as a dependent under an OGB plan)
☐ Other Individual Health Coverage
☐ Medicare, Medicaid, Other, Explain:
☐ I am not enrolled in any health coverage and I do not accept this offer of health coverage
☐ I do not wish to disclose

NOTE TO AGENCY REPRESENTATIVE: If the employee declines health coverage, he or she must acknowledge the offer of coverage by completing the GB-01 form. The acknowledgment must be sent to OGB and a copy retained by the agency participating employer as evidence that the employee was offered health coverage within the time-frames allowed by law and the employee subsequently declined the offer of coverage.

Section 7 - Acknowledgment and Certification

BY SIGNING THIS APPLICATION, I ACKNOWLEDGE AND CERTIFY THE FOLLOWING:

(Please check each box)

☐ I, Primary Plan Participant, acknowledge that I have provided appropriate documents to OGB to verify my eligibility and the eligibility of my covered dependent(s) and those documents are included with this application.

☐ I apply for participation or a change in my participation in the named plan(s) and agree to be bound by the plan's terms and conditions.

☐ I acknowledge and authorize deductions from my earnings or retirement check to pay for insurance for myself and my dependents, if applicable.

☐ I acknowledge and certify that the information provided on this form is true and correct I understand that if I provide false, misleading or incomplete information on this form, it may result in denial or rescission of coverage retroactive to the initial day of coverage.

☐ I accept that this acknowledgment and certification will become a part of my application for coverage and that a copy of my signature is as valid as the original.

☐ I acknowledge that any dis-enrollment from an OGB plan of benefits will result in dis-enrollment from both medical and pharmacy benefits, including, but not limited to, Medicare Part D.

Signature	Date

FOR AGENCY USE

PLAN RECOGNIZED QUALIFIED LIFE EVENT (QLE) FOR APPLICATION (REFERENCE 2023 QLE SPREADSHEET):

QLE code or qualified life event description	Qualified life event date	Add/Drop/Reinstate Coverage
		☐ Add ☐ Drop ☐ Reinstate Coverage

I, Agency Representative, certify that the documentation presented is appropriate and supports the occurrence of the OGB plan-recognized qualified life event referenced above.

If the QLE referenced above is for retirement, I further certify that the individual meets the retiree eligibility requirements set forth in OGB's rules

Signature of Agency Representative	Date
Printed Name of Agency Representative	**Date**

2025

State of Louisiana
Office of Group Benefits - Flexible Benefits Plan
Flexible Spending Arrangement Enrollment/Stop Form

*You must complete this form **each year** to participate in a tax-free Flexible Spending Arrangement. Please print.*

***Note to FSA Enrollees:** By providing an email address, you may receive certain benefits-related correspondence through email unless you contact TASC to receive paper notices. You are responsible to provide us with your current email address and to promptly notify us of any changes to your email address by calling customer service at 1-855-687-2021.*

Social Security Number	Email Address	Payroll System	Agency Number

Last Name (Print)	First Name	Middle Initial

Home Address	City	State	Zip

Home Phone	Daytime Phone	Date of Hire	Number of Pay Periods	Date of Birth	Annual Salary	Payroll Use only	
						Effective Date	**First Payroll Date**
ENROLLMENT STATUS (CHECK ONE) _____ CHANGE IN STATUS _____ ANNUAL ENROLLMENT _____ NEW HIRE							

Indicate the amount you wish to set aside via tax-free salary deduction by completing the sections below. Complete the worksheets provided in the Flexible Spending Arrangement (FSA) Handbook before deciding on the amount.

- In Box #1, indicate the dollar amount you elect to contribute for the plan year.
- In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year (9, 10, 12, 18, 24).*
- In Box #3, indicate the deduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly, to reflect rounding. By signing this form, you certify that you expect to receive the number of paychecks listed in Box #2.)
- In Box #4, indicate the annual FSA fee amount (12 months = $24.00). **
- In Box #5, indicate the FSA fee per pay period (paid biweekly is $1.00; paid monthly is $2.00). ***

*If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Type	*Dollar Amount*	*Number of Regular Payroll Checks**	*Deduction Amount per Paycheck*	*Annual FSA Fee Amount***	*FSA Fee per Pay Period****
General-Purpose Health Care FSA (GPFSA)					
For eligible medical expenses incurred by you, your family members, or both ($600 minimum contribution; $3,200 maximum contribution)					
Limited-Purpose Health Care FSA (LPFSA)					
*For eligible **dental and vision** expenses **only** incurred by you, your family members, or both\. For employees who want to participate in an FSA **and** a Health Savings Account. ($600 minimum contribution; $3,200 maximum contribution)*					
Dependent Care FSA (DCFSA)					
For eligible dependent care expenses of an eligible dependent while you work ($600 minimum contribution) *TAX FILING STATUS - CHECK ONE: _____ Married, filing separately (maximum $2,500) _____ Married, filing jointly (maximum $5,000)* *_____ Married with incapacitated spouse (maximum $5,000) _____ Single head of household (maximum $5,000) Single (maximum $2,500)*					

IMPORTANT: SALARY REDUCTION AGREEMENT

1. I hereby authorize my employer to reduce my gross salary (before federal and state income taxes are calculated) by the total deduction amount per pay period as indicated above. If applicable, I understand that this salary reduction might produce lower Social Security benefits.
2. I agree to file IRS Form 2441 regarding my Dependent Care FSA.
3. I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year (due to the IRS "use-or-lose" rule).
4. I understand that funds in one FSA cannot be used to reimburse expenses covered by another FSA.
5. I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
6. I understand that funds in any FSA can only be paid out for reimbursement of eligible expenses actually incurred during my period of coverage for the applicable plan year.
7. I understand that improper payments (ineligible expenses) may be withheld from my paycheck or reported as taxable income on my W-2.
8. I understand that the salary deduction amount will include the items specified above and will continue in effect unless I terminate employment or file an approved GB-01 form with the Human Resources office of my employer.
9. I understand and agree that my employer, the Office of Group Benefits and the Flexible Benefits Plan administrator will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year.

Employee Signature	Agency or Payroll System Name		Date Signed
Payroll Officer/Benefits Administrator	Phone Number	OGB Agency Number	Date Signed

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Health Savings Account
Enrollment and Payroll Deduction Election/Change Form

I would like to open my health savings account as follows:

Account Holder Information

First Name	M.I.	Last Name

SSN	Gender	Date of Birth (mm/dd/yyyy)
	☐ Male ☐ Female	

Email Address	Home Phone Number
	( )

Physical Street Address	City	State	Zip

Mailing Address (if different)	City	State	Zip

Agency Name	Agency Number	Deduction:
		☐ Monthly ☐ One-Time

	Deduction Amount:

Authorization and Certification

By opening a health savings account (HSA) with HealthEquity, you accept the terms of HSA enrollment and the custodial agreement. You may view the HSA custodial agreement here: http://healthequity.com/en/Site/EducationCenter/Forms.aspx by looking under Health Account Forms and Agreements. Upon enrollment, you understand, acknowledge and agree to the following:

- You are covered by a qualified high deductible health plan (HDHP).
- You are not covered by any other non-qualified health coverage, including Medicare and Tri-care.
- You do not have access to dollars in a flexible spending account (FSA) to pay for any medical expenses before the required High Deductible Health Plan deductible is met, including a spouse's FSA.
- You are not claimed as a dependent on another individual's tax return.
- Health Equity must verify your identity in order to open your HSA.
- I authorize the pre-tax reduction of my salary on a monthly basis by the amount designated below. I understand that I may change my HSA salary reduction election once a month. If an election change is entered into eEnrollment between the first and fourteenth days of the month, the effective date will be the first of the next month. If the change is entered on or after the fifteenth of the month the effective date will be the first of the second month following the entry.
- I understand that any withdrawals/distributions made from my HSA for health care expenses incurred prior to the establishment of my HSA or for other non-qualified types of expenses will be taxable and may be subject to additional penalties in accordance with IRS regulations. I further understand that it is solely my responsibility to report these withdrawals/distributions to the IRS and that I am solely responsible for any resulting taxes and penalties.

For further information regarding HSA laws, go to http://www.irs.gov/pub/irs-pdf/p969.pdf.

Printed Name	Signature	Date

OFFICE OF GROUP BENEFITS

OFFICIAL SCHEDULE OF MONTHLY PREMIUM RATES

ALL OGB-PARTICIPATING AGENCIES, EXCLUDING PARISH & CITY SCHOOL BOARDS

Rates effective January 1, 2025 (75% employer participation level)

For a complete list of premium rates at all employer participation levels please visit info.groupbenefits.org.

	Magnolia Open Access Administered by Blue Cross			Magnolia Local Administered by Blue Cross			Magnolia Local Plus Administered by Blue Cross			Pelican HSA775 Administered by Blue Cross			Pelican HRA1000 Administered by Blue Cross		
	State Share	Employee Share	Total Premium	State Share	Employee Share	Total Premium	State Share	Employee Share	Total Premium	State Share	Employee Share	Total Premium	State Share	Employee Share	Total Premium
ACTIVE EMPLOYEE															
ENROLLEE ONLY	$724.92	$241.56	$966.48	$591.04	$196.96	$788.00	$697.32	$232.40	$929.72	$252.00	$83.96	$335.96	$435.70	$145.20	$580.90
ENROLLEE + 1 (SPOUSE)	$1,268.18	$784.84	$2,053.02	$1,033.88	$639.90	$1,673.78	$1,219.86	$754.80	$1,974.66	$440.92	$272.86	$713.78	$762.16	$471.68	$1,233.84
ENROLLEE + 1 (CHILD)	$831.08	$347.76	$1,178.84	$677.54	$283.48	$961.02	$799.38	$334.46	$1,133.84	$289.00	$121.00	$410.00	$499.60	$209.12	$708.72
ENROLLEE + CHILDREN	$831.08	$347.76	$1,178.84	$677.54	$283.48	$961.02	$799.38	$334.46	$1,133.84	$289.00	$121.00	$410.00	$499.60	$209.12	$708.72
FAMILY	$1,324.28	$840.90	$2,165.18	$1,079.64	$685.66	$1,765.30	$1,273.80	$808.74	$2,082.54	$460.34	$292.28	$752.62	$795.86	$505.32	$1,301.18
RETIREE WITHOUT MEDICARE & RE-EMPLOYED RETIREE															
ENROLLEE ONLY	$1,556.64	$241.56	$1,798.20	$1,269.12	$196.96	$1,466.08	$1,502.82	$232.40	$1,735.22	N/A	N/A	N/A	$935.62	$145.20	$1,080.82
ENROLLEE + 1 (SPOUSE)	$2,390.52	$784.84	$3,175.36	$1,948.90	$639.90	$2,588.80	$2,309.12	$754.80	$3,063.92	N/A	N/A	N/A	$1,436.74	$471.68	$1,908.42
ENROLLEE + 1 (CHILD)	$1,655.20	$347.76	$2,002.96	$1,349.54	$283.48	$1,633.02	$1,598.44	$334.46	$1,932.90	N/A	N/A	N/A	$995.16	$209.12	$1,204.28
ENROLLEE + CHILDREN	$1,655.20	$347.76	$2,002.96	$1,349.54	$283.48	$1,633.02	$1,598.44	$334.46	$1,932.90	N/A	N/A	N/A	$995.16	$209.12	$1,204.28
FAMILY	$2,369.96	$789.98	$3,159.94	$1,932.20	$644.06	$2,576.26	$2,286.92	$762.32	$3,049.24	N/A	N/A	N/A	$1,424.22	$474.74	$1,898.96
RETIREE WITH 1 MEDICARE															
ENROLLEE ONLY	$438.56	$146.18	$584.74	$357.52	$119.20	$476.72	$430.56	$143.50	$574.06	N/A	N/A	N/A	$263.60	$87.88	$351.48
ENROLLEE + 1 (SPOUSE)	$1,620.46	$540.10	$2,160.56	$1,321.14	$440.34	$1,761.48	$1,573.54	$524.54	$2,098.08	N/A	N/A	N/A	$973.90	$324.60	$1,298.50
ENROLLEE + 1 (CHILD)	$759.08	$253.04	$1,012.12	$618.88	$206.28	$825.16	$740.58	$246.90	$987.48	N/A	N/A	N/A	$456.44	$152.08	$608.52
ENROLLEE + CHILDREN	$759.08	$253.04	$1,012.12	$618.88	$206.28	$825.16	$740.58	$246.90	$987.48	N/A	N/A	N/A	$456.44	$152.08	$608.52
FAMILY	$2,159.10	$719.64	$2,878.74	$1,760.28	$586.74	$2,347.02	$2,094.46	$698.14	$2,792.60	N/A	N/A	N/A	$1,297.50	$432.50	$1,730.00
RETIREE WITH 2 MEDICARE															
ENROLLEE + 1 (SPOUSE)	$788.40	$262.74	$1,051.14	$642.76	$214.22	$856.98	$771.78	$257.24	$1,029.02	N/A	N/A	N/A	$473.86	$157.90	$631.76
FAMILY	$976.08	$325.36	$1,301.44	$795.84	$265.24	$1,061.08	$955.54	$318.50	$1,274.04	N/A	N/A	N/A	$586.58	$195.54	$782.12
C.O.B.R.A.															
ENROLLEE ONLY	$0.00	$985.82	$985.82	$0.00	$803.74	$803.74	$0.00	$948.34	$948.34	$0.00	$342.70	$342.70	$0.00	$592.52	$592.52
ENROLLEE + 1 (SPOUSE)	$0.00	$2,094.06	$2,094.06	$0.00	$1,707.28	$1,707.28	$0.00	$2,014.12	$2,014.12	$0.00	$728.02	$728.02	$0.00	$1,258.50	$1,258.50
ENROLLEE + 1 (CHILD)	$0.00	$1,202.40	$1,202.40	$0.00	$980.24	$980.24	$0.00	$1,156.54	$1,156.54	$0.00	$418.20	$418.20	$0.00	$722.90	$722.90
ENROLLEE + CHILDREN	$0.00	$1,202.40	$1,202.40	$0.00	$980.24	$980.24	$0.00	$1,156.54	$1,156.54	$0.00	$418.20	$418.20	$0.00	$722.90	$722.90
FAMILY	$0.00	$2,208.46	$2,208.46	$0.00	$1,800.58	$1,800.58	$0.00	$2,124.14	$2,124.14	$0.00	$767.68	$767.68	$0.00	$1,327.18	$1,327.18
DISABILITY C.O.B.R.A.															
ENROLLEE ONLY	$0.00	$1,449.74	$1,449.74	$0.00	$1,182.00	$1,182.00	$0.00	$1,394.58	$1,394.58	$0.00	$503.96	$503.96	$0.00	$871.36	$871.36
ENROLLEE + 1 (SPOUSE)	$0.00	$3,079.52	$3,079.52	$0.00	$2,510.70	$2,510.70	$0.00	$2,962.02	$2,962.02	$0.00	$1,070.68	$1,070.68	$0.00	$1,850.76	$1,850.76
ENROLLEE + 1 (CHILD)	$0.00	$1,768.26	$1,768.26	$0.00	$1,441.54	$1,441.54	$0.00	$1,700.76	$1,700.76	$0.00	$615.00	$615.00	$0.00	$1,063.06	$1,063.06
ENROLLEE + CHILDREN	$0.00	$1,768.26	$1,768.26	$0.00	$1,441.54	$1,441.54	$0.00	$1,700.76	$1,700.76	$0.00	$615.00	$615.00	$0.00	$1,063.06	$1,063.06
FAMILY	$0.00	$3,247.80	$3,247.80	$0.00	$2,647.94	$2,647.94	$0.00	$3,123.80	$3,123.80	$0.00	$1,128.96	$1,128.96	$0.00	$1,951.76	$1,951.76

NOTE: 1) The breakdown between the State Share and the Employee Share amounts shown may not be accurate for certain school board employees due to local funding that affects agency funding, which affects agency contributions. Total Premium amounts are correct for all non-risk rated agencies.

2) The breakdown between the State Share and Employee Share amounts shown for retirees without Medicare coverage is determined based upon the requirements of LA R.S. 42:851(C)(3), which supersedes the requirements of LA R.S. 42:851(E)(1).

3) All plan members who retired on or after July 1, 1997 must have Medicare Part A and Part B to qualify for reduced premium rates.

Approved

Kathy Williams

Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information	Effective Date of Coverage (for office use only) / /		
Last Name First Name MI	Email Address	Phone Number	
Address City State Zip Code			
Your Annual Earnings $ _____	Social Security Number – –	Date of Birth (Month/Day/Year) / /	Date Employed (Month/Day/Year) / /
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Spouse Date of Birth (Month/Day/Year) / /	

Basic Term Life or Enhanced Basic Term Life

Coverage amount chosen: ☐ $5,000 ☐ $15,000 ☐ No coverage chosen

Basic Plus Supplemental Term Life With Matching Accidental Death & Dismemberment (AD&D)

Enrollment in Employee AD&D coverage is automatic when electing Basic Plus Supplemental Term Life coverage.

☐ Coverage amount chosen: $ ☐ No coverage chosen

Basic Dependent Term Life

You must be enrolled for Basic Term Life to elect Basic Dependent Term Life coverage for your dependents. Spouse coverage cannot exceed 100% of your Basic Term Life coverage amount. Child(ren) coverage cannot exceed 100% of your Basic Term Life coverage amount.

Spouse/Children ☐ No coverage chosen

☐ Coverage amount chosen: $1,000/Children $500

☐ Coverage amount chosen: Spouse $2,000/Children $1,000

Basic Plus Supplemental Dependent Term Life

You must be enrolled for Basic Plus Supplemental Term Life to elect Basic Plus Supplemental Dependent Term Life coverage for your dependents. Spouse coverage cannot exceed 100% of your Basic Plus Supplemental Term Life coverage amount. Child(ren) coverage cannot exceed 100% of your Basic Plus Supplemental Term Life coverage amount.

Spouse/Children ☐ No coverage chosen

☐ Coverage amount chosen: Spouse $2,000/Children $1,000

☐ Coverage amount chosen: Spouse $4,000/Children $2,000

You must also complete a separate beneficiary designation form. If you have any questions, please see Human Resources for details.

Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX- _____

Acceptance or Waiver of Coverage

☐ I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. To the best of my knowledge and belief, I declare the statement above is true and understand it is the basis for determining the contribution for coverage. I also understand that for coverage to become effective, I must be actively at work during the enrollment period and on the effective date of the plan. If I apply for an amount that requires evidence of insurability satisfactory to The Prudential Insurance Company of America, I must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

☐ I do not wish to enroll for any of the above optional coverages. I certify that I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish satisfactory evidence of insurability to The Prudential Insurance Company of America for myself and/or my dependents.

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

NEW YORK RESIDENTS – 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. **This warning ONLY applies to accident and disability coverage.**

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

The policy/certificate provides limited benefits. Review your certificate carefully.

Employee Signature _____ Date Signed (Month/Day/Year) _____

Acceptance of Coverage

FOR INSUREDS WHO RESIDE IN MICHIGAN OR MINNESOTA ONLY – If you wish to enroll your Spouse, and/or eligible child 18 years of age or older for Dependent Life and/or Accidental Death and Dismemberment Insurance coverage, your Spouse, and/or each of your eligible children age 18 years or older must consent to such coverage by signing and dating this consent in the appropriate space(s) below.

Coverage on your Spouse and child(ren) age 18 or older will not become effective unless and until the requisite consent is provided.

Spouse Signature _____ Date Signed (Month/Day/Year) _____

Child Signature _____ Date Signed (Month/Day/Year) _____

Child Signature _____ Date Signed (Month/Day/Year) _____

Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX- _____

Important Notices

For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia:
WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS – 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.

ALASKA RESIDENTS – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA RESIDENTS - 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.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND, AND WEST VIRGINIA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA AND TEXAS RESIDENTS - For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS - 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIDENTS - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE, TENNESSEE, VIRGINIA, WASHINGTON RESIDENTS – **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

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

Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX- _____

Important Notices

NEW HAMPSHIRE RESIDENTS - 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 RSA 638.20.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

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

OKLAHOMA RESIDENTS - 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.

OREGON RESIDENTS - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA and UTAH RESIDENTS – 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

Employees and/or Dependents may be ineligible for group insurance coverage while on active duty in the armed forces

Accelerated Death Benefit Option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill or chronically ill. You may wish to seek professional tax advice before exercising this option.

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

Basic Term Life, Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life, Long-Term Disability, Short-Term Disability Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support 1-800-842-1718. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions, which may apply. If there is a discrepancy between this document and the Booklet-Certificate/ Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. California COA #1179, NAIC#68241. Contract Series: 83500.

Beneficiary Designation - State of Louisiana

Control# 33624

Employee General Information

Last Name	First Name	Middle Initial	Social Security No.
			_____ – _____ – _____

Employee / Applicant Beneficiary Designations (to be completed by Employee/applicant or assignee, if assigned)

Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than two primary beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields. Do not name a beneficiary for Dependent Term Life Coverage; these benefits are paid to you while living. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

Basic Term Life, Enhanced Basic, Basic Plus Supplemental Term Life - Primary Beneficiary Designation

1

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

2

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Basic Term Life, Enhanced Basic, Basic Plus Supplemental Term Life - Contingent Beneficiary Designation

- Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name more than two contingent beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields.

1

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

2

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Employee Signature _____ Date (mm/dd/yyy)_____

If you have any questions, please see Human Resources for details.

Group Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, Newark, NJ 07102. Life Claims: 800-524-0542, Disability Support: 800-842-1718. This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the Group Contract will govern. Contract provisions may vary by state. Contract Series:83500. California COA # 1179 NAIC #68241

GL.2005.289 0-48836

** PENDING CONTRACT APPROVAL **

OFFICE OF GROUP BENEFITS

OFFICIAL SCHEDULE OF MONTHLY PREMIUM RATES

*BASIC AND SUPPLEMENTAL LIFE INSURANCE**

RATES EFFECTIVE JANUARY 1, 2025

Annual Earnings** From	- To	Maximum Insurance	Age Group: 35 & Younger Employee Share	Age Group: 35 & Younger Employer Share	Age Group: 35 & Younger Total Premium	Age Group: 36 - 45 Employee Share	Age Group: 36 - 45 Employer Share	Age Group: 36 - 45 Total Premium	Age Group: 46 - 50 Employee Share	Age Group: 46 - 50 Employer Share	Age Group: 46 - 50 Total Premium	Age Group: 51 - 55 Employee Share	Age Group: 51 - 55 Employer Share	Age Group: 51 - 55 Total Premium	Age Group: 56 - 60 Employee Share	Age Group: 56 - 60 Employer Share	Age Group: 56 - 60 Total Premium	Age Group: 61 - 64 Employee Share	Age Group: 61 - 64 Employer Share	Age Group: 61 - 64 Total Premium
Basic Life																				
		$5,000	$0.20	$0.20	$0.40	$0.30	$0.30	$0.60	$0.40	$0.40	$0.80	$0.60	$0.60	$1.20	$1.00	$1.00	$2.00	$1.80	$1.80	$3.60
Enhanced Basic																				
		$15,000	$0.60	$0.60	$1.20	$0.90	$0.90	$1.80	$1.20	$1.20	$2.40	$1.80	$1.80	$3.60	$3.00	$3.00	$6.00	$5.40	$5.40	$10.80
Basic & Supplemental Life																				
$2,000.01	**$2,666.66**	**$6,000**	$0.24	$0.24	$0.48	$0.36	$0.36	$0.72	$0.48	$0.48	$0.96	$0.72	$0.72	$1.44	$1.20	$1.20	$2.40	$2.16	$2.16	$4.32
$2,666.67	**$3,333.33**	**$7,000**	$0.28	$0.28	$0.56	$0.42	$0.42	$0.84	$0.56	$0.56	$1.12	$0.84	$0.84	$1.68	$1.40	$1.40	$2.80	$2.52	$2.52	$5.04
$3,333.34	**$4,000.00**	**$8,000**	$0.32	$0.32	$0.64	$0.48	$0.48	$0.96	$0.64	$0.64	$1.28	$0.96	$0.96	$1.92	$1.60	$1.60	$3.20	$2.88	$2.88	$5.76
$4,000.01	**$4,666.66**	**$9,000**	$0.36	$0.36	$0.72	$0.54	$0.54	$1.08	$0.72	$0.72	$1.44	$1.08	$1.08	$2.16	$1.80	$1.80	$3.60	$3.24	$3.24	$6.48
$4,666.67	**$5,333.33**	**$10,000**	$0.40	$0.40	$0.80	$0.60	$0.60	$1.20	$0.80	$0.80	$1.60	$1.20	$1.20	$2.40	$2.00	$2.00	$4.00	$3.60	$3.60	$7.20
$5,333.34	**$6,000.00**	**$11,000**	$0.44	$0.44	$0.88	$0.66	$0.66	$1.32	$0.88	$0.88	$1.76	$1.32	$1.32	$2.64	$2.20	$2.20	$4.40	$3.96	$3.96	$7.92
$6,000.01	**$6,666.66**	**$12,000**	$0.48	$0.48	$0.96	$0.72	$0.72	$1.44	$0.96	$0.96	$1.92	$1.44	$1.44	$2.88	$2.40	$2.40	$4.80	$4.32	$4.32	$8.64
$6,666.67	**$7,333.33**	**$13,000**	$0.52	$0.52	$1.04	$0.78	$0.78	$1.56	$1.04	$1.04	$2.08	$1.56	$1.56	$3.12	$2.60	$2.60	$5.20	$4.68	$4.68	$9.36
$7,333.34	**$8,000.00**	**$14,000**	$0.56	$0.56	$1.12	$0.84	$0.84	$1.68	$1.12	$1.12	$2.24	$1.68	$1.68	$3.36	$2.80	$2.80	$5.60	$5.04	$5.04	$10.08
$8,000.01	**$8,666.66**	**$15,000**	$0.60	$0.60	$1.20	$0.90	$0.90	$1.80	$1.20	$1.20	$2.40	$1.80	$1.80	$3.60	$3.00	$3.00	$6.00	$5.40	$5.40	$10.80
$8,666.67	**$9,333.33**	**$16,000**	$0.64	$0.64	$1.28	$0.96	$0.96	$1.92	$1.28	$1.28	$2.56	$1.92	$1.92	$3.84	$3.20	$3.20	$6.40	$5.76	$5.76	$11.52
$9,333.34	**$10,000.00**	**$17,000**	$0.68	$0.68	$1.36	$1.02	$1.02	$2.04	$1.36	$1.36	$2.72	$2.04	$2.04	$4.08	$3.40	$3.40	$6.80	$6.12	$6.12	$12.24
$10,000.01	**$10,666.66**	**$18,000**	$0.72	$0.72	$1.44	$1.08	$1.08	$2.16	$1.44	$1.44	$2.88	$2.16	$2.16	$4.32	$3.60	$3.60	$7.20	$6.48	$6.48	$12.96
$10,666.67	**$11,333.33**	**$19,000**	$0.76	$0.76	$1.52	$1.14	$1.14	$2.28	$1.52	$1.52	$3.04	$2.28	$2.28	$4.56	$3.80	$3.80	$7.60	$6.84	$6.84	$13.68
$11,333.34	**$13,333.33**	**$20,000**	$0.80	$0.80	$1.60	$1.20	$1.20	$2.40	$1.60	$1.60	$3.20	$2.40	$2.40	$4.80	$4.00	$4.00	$8.00	$7.20	$7.20	$14.40
$13,333.34	**$14,000.00**	**$21,000**	$0.84	$0.84	$1.68	$1.26	$1.26	$2.52	$1.68	$1.68	$3.36	$2.52	$2.52	$5.04	$4.20	$4.20	$8.40	$7.56	$7.56	$15.12
$14,000.01	**$14,666.66**	**$22,000**	$0.88	$0.88	$1.76	$1.32	$1.32	$2.64	$1.76	$1.76	$3.52	$2.64	$2.64	$5.28	$4.40	$4.40	$8.80	$7.92	$7.92	$15.84
$14,666.67	**$15,333.33**	**$23,000**	$0.92	$0.92	$1.84	$1.38	$1.38	$2.76	$1.84	$1.84	$3.68	$2.76	$2.76	$5.52	$4.60	$4.60	$9.20	$8.28	$8.28	$16.56
$15,333.34	**$16,000.00**	**$24,000**	$0.96	$0.96	$1.92	$1.44	$1.44	$2.88	$1.92	$1.92	$3.84	$2.88	$2.88	$5.76	$4.80	$4.80	$9.60	$8.64	$8.64	$17.28
$16,000.01	**$16,666.66**	**$25,000**	$1.00	$1.00	$2.00	$1.50	$1.50	$3.00	$2.00	$2.00	$4.00	$3.00	$3.00	$6.00	$5.00	$5.00	$10.00	$9.00	$9.00	$18.00
$16,666.67	**$17,333.33**	**$26,000**	$1.04	$1.04	$2.08	$1.56	$1.56	$3.12	$2.08	$2.08	$4.16	$3.12	$3.12	$6.24	$5.20	$5.20	$10.40	$9.36	$9.36	$18.72
$17,333.34	**$18,000.00**	**$27,000**	$1.08	$1.08	$2.16	$1.62	$1.62	$3.24	$2.16	$2.16	$4.32	$3.24	$3.24	$6.48	$5.40	$5.40	$10.80	$9.72	$9.72	$19.44
$18,000.01	**$18,666.66**	**$28,000**	$1.12	$1.12	$2.24	$1.68	$1.68	$3.36	$2.24	$2.24	$4.48	$3.36	$3.36	$6.72	$5.60	$5.60	$11.20	$10.08	$10.08	$20.16
$18,666.67	**$19,333.33**	**$29,000**	$1.16	$1.16	$2.32	$1.74	$1.74	$3.48	$2.32	$2.32	$4.64	$3.48	$3.48	$6.96	$5.80	$5.80	$11.60	$10.44	$10.44	$20.88
$19,333.34	**$20,000.00**	**$30,000**	$1.20	$1.20	$2.40	$1.80	$1.80	$3.60	$2.40	$2.40	$4.80	$3.60	$3.60	$7.20	$6.00	$6.00	$12.00	$10.80	$10.80	$21.60
$20,000.01	**$20,666.66**	**$31,000**	$1.24	$1.24	$2.48	$1.86	$1.86	$3.72	$2.48	$2.48	$4.96	$3.72	$3.72	$7.44	$6.20	$6.20	$12.40	$11.16	$11.16	$22.32
$20,666.67	**$21,333.33**	**$32,000**	$1.28	$1.28	$2.56	$1.92	$1.92	$3.84	$2.56	$2.56	$5.12	$3.84	$3.84	$7.68	$6.40	$6.40	$12.80	$11.52	$11.52	$23.04
$21,333.34	**$22,000.00**	**$33,000**	$1.32	$1.32	$2.64	$1.98	$1.98	$3.96	$2.64	$2.64	$5.28	$3.96	$3.96	$7.92	$6.60	$6.60	$13.20	$11.88	$11.88	$23.76
$22,000.01	**$22,666.66**	**$34,000**	$1.36	$1.36	$2.72	$2.04	$2.04	$4.08	$2.72	$2.72	$5.44	$4.08	$4.08	$8.16	$6.80	$6.80	$13.60	$12.24	$12.24	$24.48
$22,666.67	**$23,333.33**	**$35,000**	$1.40	$1.40	$2.80	$2.10	$2.10	$4.20	$2.80	$2.80	$5.60	$4.20	$4.20	$8.40	$7.00	$7.00	$14.00	$12.60	$12.60	$25.20
$23,333.34	**$24,000.00**	**$36,000**	$1.44	$1.44	$2.88	$2.16	$2.16	$4.32	$2.88	$2.88	$5.76	$4.32	$4.32	$8.64	$7.20	$7.20	$14.40	$12.96	$12.96	$25.92
$24,000.01	**$24,666.66**	**$37,000**	$1.48	$1.48	$2.96	$2.22	$2.22	$4.44	$2.96	$2.96	$5.92	$4.44	$4.44	$8.88	$7.40	$7.40	$14.80	$13.32	$13.32	$26.64
$24,666.67	**$25,333.33**	**$38,000**	$1.52	$1.52	$3.04	$2.28	$2.28	$4.56	$3.04	$3.04	$6.08	$4.56	$4.56	$9.12	$7.60	$7.60	$15.20	$13.68	$13.68	$27.36
$25,333.34	**$26,000.00**	**$39,000**	$1.56	$1.56	$3.12	$2.34	$2.34	$4.68	$3.12	$3.12	$6.24	$4.68	$4.68	$9.36	$7.80	$7.80	$15.60	$14.04	$14.04	$28.08
$26,000.01	**$26,666.66**	**$40,000**	$1.60	$1.60	$3.20	$2.40	$2.40	$4.80	$3.20	$3.20	$6.40	$4.80	$4.80	$9.60	$8.00	$8.00	$16.00	$14.40	$14.40	$28.80
$26,666.67	**$27,333.33**	**$41,000**	$1.64	$1.64	$3.28	$2.46	$2.46	$4.92	$3.28	$3.28	$6.56	$4.92	$4.92	$9.84	$8.20	$8.20	$16.40	$14.76	$14.76	$29.52
$27,333.34	**$28,000.00**	**$42,000**	$1.68	$1.68	$3.36	$2.52	$2.52	$5.04	$3.36	$3.36	$6.72	$5.04	$5.04	$10.08	$8.40	$8.40	$16.80	$15.12	$15.12	$30.24
$28,000.01	**$28,666.66**	**$43,000**	$1.72	$1.72	$3.44	$2.58	$2.58	$5.16	$3.44	$3.44	$6.88	$5.16	$5.16	$10.32	$8.60	$8.60	$17.20	$15.48	$15.48	$30.96
$28,666.67	**$29,333.33**	**$44,000**	$1.76	$1.76	$3.52	$2.64	$2.64	$5.28	$3.52	$3.52	$7.04	$5.28	$5.28	$10.56	$8.80	$8.80	$17.60	$15.84	$15.84	$31.68
$29,333.34	**$30,000.00**	**$45,000**	$1.80	$1.80	$3.60	$2.70	$2.70	$5.40	$3.60	$3.60	$7.20	$5.40	$5.40	$10.80	$9.00	$9.00	$18.00	$16.20	$16.20	$32.40
$30,000.01	**$30,666.66**	**$46,000**	$1.84	$1.84	$3.68	$2.76	$2.76	$5.52	$3.68	$3.68	$7.36	$5.52	$5.52	$11.04	$9.20	$9.20	$18.40	$16.56	$16.56	$33.12
$30,666.67	**$31,333.33**	**$47,000**	$1.88	$1.88	$3.76	$2.82	$2.82	$5.64	$3.76	$3.76	$7.52	$5.64	$5.64	$11.28	$9.40	$9.40	$18.80	$16.92	$16.92	$33.84
$31,333.34	**$32,000.00**	**$48,000**	$1.92	$1.92	$3.84	$2.88	$2.88	$5.76	$3.84	$3.84	$7.68	$5.76	$5.76	$11.52	$9.60	$9.60	$19.20	$17.28	$17.28	$34.56
$32,000.01	**$32,666.66**	**$49,000**	$1.96	$1.96	$3.92	$2.94	$2.94	$5.88	$3.92	$3.92	$7.84	$5.88	$5.88	$11.76	$9.80	$9.80	$19.60	$17.64	$17.64	$35.28
$32,666.67	**And Over**	**$50,000**	$2.00	$2.00	$4.00	$3.00	$3.00	$6.00	$4.00	$4.00	$8.00	$6.00	$6.00	$12.00	$10.00	$10.00	$20.00	$18.00	$18.00	$36.00

*Accidental Death & Dismemberment benefits are included for all active and retired employees through age sixty-nine (69).

**Annual Earnings for those academic employees who work less than twelve months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees annual earnings means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

** PENDING CONTRACT APPROVAL **

OFFICE OF GROUP BENEFITS

OFFICIAL SCHEDULE OF MONTHLY PREMIUM RATES

*BASIC AND SUPPLEMENTAL LIFE INSURANCE**

RATES EFFECTIVE JANUARY 1, 2025

Annual Earnings** From		To	Maximum Insurance	Age Group: 65 Employee Share	Age Group: 65 Employer Share	Age Group: 65 Total Premium	Age Group: 66 - 69 Employee Share	Age Group: 66 - 69 Employer Share	Age Group: 66 - 69 Total Premium
Basic Life									
			$4,000	$1.44	$1.44	$2.88	$8.80	$8.80	$17.60
Enhanced Basic									
			$12,000	$4.32	$4.32	$8.64	$26.40	$26.40	$52.80
Basic & Supplemental Life									
$2,000.01	-	**$2,666.66**	**$5,000**	$1.80	$1.80	$3.60	$11.00	$11.00	$22.00
$2,666.67	-	**$4,000.00**	**$6,000**	$2.16	$2.16	$4.32	$13.20	$13.20	$26.40
$4,000.01	-	**$4,666.66**	**$7,000**	$2.52	$2.52	$5.04	$15.40	$15.40	$30.80
$4,666.67	-	**$5,333.33**	**$8,000**	$2.88	$2.88	$5.76	$17.60	$17.60	$35.20
$5,333.34	-	**$6,666.66**	**$9,000**	$3.24	$3.24	$6.48	$19.80	$19.80	$39.60
$6,666.67	-	**$7,333.33**	**$10,000**	$3.60	$3.60	$7.20	$22.00	$22.00	$44.00
$7,333.34	-	**$8,000.00**	**$11,000**	$3.96	$3.96	$7.92	$24.20	$24.20	$48.40
$8,000.01	-	**$9,333.33**	**$12,000**	$4.32	$4.32	$8.64	$26.40	$26.40	$52.80
$9,333.34	-	**$10,000.00**	**$13,000**	$4.68	$4.68	$9.36	$28.60	$28.60	$57.20
$10,000.01	-	**$10,666.66**	**$14,000**	$5.04	$5.04	$10.08	$30.80	$30.80	$61.60
$10,666.67	-	**$13,333.33**	**$15,000**	$5.40	$5.40	$10.80	$33.00	$33.00	$66.00
$13,333.34	-	**$14,000.00**	**$16,000**	$5.76	$5.76	$11.52	$35.20	$35.20	$70.40
$14,000.01	-	**$14,666.66**	**$17,000**	$6.12	$6.12	$12.24	$37.40	$37.40	$74.80
$14,666.67	-	**$16,000.00**	**$18,000**	$6.48	$6.48	$12.96	$39.60	$39.60	$79.20
$16,000.01	-	**$16,666.66**	**$19,000**	$6.84	$6.84	$13.68	$41.80	$41.80	$83.60
$16,666.67	-	**$17,333.33**	**$20,000**	$7.20	$7.20	$14.40	$44.00	$44.00	$88.00
$17,333.34	-	**$18,666.66**	**$21,000**	$7.56	$7.56	$15.12	$46.20	$46.20	$92.40
$18,666.67	-	**$19,333.33**	**$22,000**	$7.92	$7.92	$15.84	$48.40	$48.40	$96.80
$19,333.34	-	**$20,000.00**	**$23,000**	$8.28	$8.28	$16.56	$50.60	$50.60	$101.20
$20,000.01	-	**$21,333.33**	**$24,000**	$8.64	$8.64	$17.28	$52.80	$52.80	$105.60
$21,333.34	-	**$22,000.00**	**$25,000**	$9.00	$9.00	$18.00	$55.00	$55.00	$110.00
$22,000.01	-	**$22,666.66**	**$26,000**	$9.36	$9.36	$18.72	$57.20	$57.20	$114.40
$22,666.67	-	**$24,000.00**	**$27,000**	$9.72	$9.72	$19.44	$59.40	$59.40	$118.80
$24,000.01	-	**$24,666.66**	**$28,000**	$10.08	$10.08	$20.16	$61.60	$61.60	$123.20
$24,666.67	-	**$25,333.33**	**$29,000**	$10.44	$10.44	$20.88	$63.80	$63.80	$127.60
$25,333.34	-	**$26,666.66**	**$30,000**	$10.80	$10.80	$21.60	$66.00	$66.00	$132.00
$26,666.67	-	**$27,333.33**	**$31,000**	$11.16	$11.16	$22.32	$68.20	$68.20	$136.40
$27,333.34	-	**$28,000.00**	**$32,000**	$11.52	$11.52	$23.04	$70.40	$70.40	$140.80
$28,000.01	-	**$29,333.33**	**$33,000**	$11.88	$11.88	$23.76	$72.60	$72.60	$145.20
$29,333.34	-	**$30,000.00**	**$34,000**	$12.24	$12.24	$24.48	$74.80	$74.80	$149.60
$30,000.01	-	**$30,666.66**	**$35,000**	$12.60	$12.60	$25.20	$77.00	$77.00	$154.00
$30,666.67	-	**$32,000.00**	**$36,000**	$12.96	$12.96	$25.92	$79.20	$79.20	$158.40
$32,000.01	-	**$32,666.66**	**$37,000**	$13.32	$13.32	$26.64	$81.40	$81.40	$162.80
$32,666.67	-	**And Over**	**$38,000**	$13.68	$13.68	$27.36	$83.60	$83.60	$167.20

*Accidental Death & Dismemberment benefits are included for all active and retired employees through age sixty-nine (69).

**Annual Earnings for those academic employees who work less than twelve months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees annual earnings means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceding the actual last day of work.

** PENDING CONTRACT APPROVAL **

OFFICE OF GROUP BENEFITS

OFFICIAL SCHEDULE OF MONTHLY PREMIUM RATES

*BASIC AND SUPPLEMENTAL LIFE INSURANCE**

RATES EFFECTIVE JANUARY 1, 2025

Annual Earnings** From	-	To	Maximum Insurance	Active Employees Age Group: 70 & Older Employee Share	Active Employees Age Group: 70 & Older Employer Share	Active Employees Age Group: 70 & Older Total Premium	Retired Employees Age Group: 70 & Older Employee Share	Retired Employees Age Group: 70 & Older Employer Share	Retired Employees Age Group: 70 & Older Total Premium
Basic Life									
			$3,000	$6.60	$6.60	$13.20	$6.54	$6.54	$13.08
Enhanced Basic									
			$8,000	$17.60	$17.60	$35.20	$17.44	$17.44	$34.88
Basic & Supplemental Life									
$2,000.01	-	**$4,000.00**	**$4,000**	$8.80	$8.80	$17.60	$8.72	$8.72	$17.44
$4,000.01	-	**$5,333.33**	**$5,000**	$11.00	$11.00	$22.00	$10.90	$10.90	$21.80
$5,333.34	-	**$6,666.66**	**$6,000**	$13.20	$13.20	$26.40	$13.08	$13.08	$26.16
$6,666.67	-	**$8,000.00**	**$7,000**	$15.40	$15.40	$30.80	$15.26	$15.26	$30.52
$8,000.01	-	**$9,333.33**	**$8,000**	$17.60	$17.60	$35.20	$17.44	$17.44	$34.88
$9,333.34	-	**$10,666.66**	**$9,000**	$19.80	$19.80	$39.60	$19.62	$19.62	$39.24
$10,666.67	-	**$13,333.33**	**$10,000**	$22.00	$22.00	$44.00	$21.80	$21.80	$43.60
$13,333.34	-	**$14,666.66**	**$11,000**	$24.20	$24.20	$48.40	$23.98	$23.98	$47.96
$14,666.67	-	**$16,000.00**	**$12,000**	$26.40	$26.40	$52.80	$26.16	$26.16	$52.32
$16,000.01	-	**$17,333.33**	**$13,000**	$28.60	$28.60	$57.20	$28.34	$28.34	$56.68
$17,333.34	-	**$18,666.66**	**$14,000**	$30.80	$30.80	$61.60	$30.52	$30.52	$61.04
$18,666.67	-	**$20,000.00**	**$15,000**	$33.00	$33.00	$66.00	$32.70	$32.70	$65.40
$20,000.01	-	**$21,333.33**	**$16,000**	$35.20	$35.20	$70.40	$34.88	$34.88	$69.76
$21,333.34	-	**$22,666.66**	**$17,000**	$37.40	$37.40	$74.80	$37.06	$37.06	$74.12
$22,666.67	-	**$24,000.00**	**$18,000**	$39.60	$39.60	$79.20	$39.24	$39.24	$78.48
$24,000.01	-	**$25,333.33**	**$19,000**	$41.80	$41.80	$83.60	$41.42	$41.42	$82.84
$25,333.34	-	**$26,666.66**	**$20,000**	$44.00	$44.00	$88.00	$43.60	$43.60	$87.20
$26,666.67	-	**$28,000.00**	**$21,000**	$46.20	$46.20	$92.40	$45.78	$45.78	$91.56
$28,000.01	-	**$29,333.33**	**$22,000**	$48.40	$48.40	$96.80	$47.96	$47.96	$95.92
$29,333.34	-	**$30,666.66**	**$23,000**	$50.60	$50.60	$101.20	$50.14	$50.14	$100.28
$30,666.67	-	**$32,000.00**	**$24,000**	$52.80	$52.80	$105.60	$52.32	$52.32	$104.64
$32,000.01	**And Over**		**$25,000**	$55.00	$55.00	$110.00	$54.50	$54.50	$109.00

*Accidental Death & Dismemberment benefits are included for all active and retired employees through age sixty-nine (69). If the plan member is still actively employed at age 70, coverage terminates at midnight on the last day of the month in which retirement occurs.

**Annual Earnings for those academic employees who work less than twelve months of the calendar year shall be the salary for that period of time required by their regular job duties as defined at the beginning of the academic year. For retired employees annual earnings means that salary level for which benefits were provided as an active employee on the last day of the month immediately preceeding the actual last day of work.

** PENDING CONTRACT APPROVAL **

OFFICE OF GROUP BENEFITS

OFFICIAL SCHEDULE OF MONTHLY PREMIUM RATES

BASIC AND SUPPLEMENTAL LIFE INSURANCE

RATES EFFECTIVE JANUARY 1, 2025

		Dependents		
	Maximum Insurance	Employee Share	Employer Share	Total Premium
Basic Life				
Option 1	**$1,000**	$1.36	$0.00	$1.36
Option 2	**$2,000**	$2.72	$0.00	$2.72
Enhanced Basic Life				
Option 1	**$1,000**	$1.36	$0.00	$1.36
Option 2	**$2,000**	$2.72	$0.00	$2.72
Basic & Supplemental Life				
Option 1	**$2,000**	$2.72	$0.00	$2.72
Option 2	**$4,000**	$5.44	$0.00	$5.44

Form 1-01
R032021

PRINT ALL INFORMATION
www.lasersonline.org

LASERS
Louisiana State Employees' Retirement System

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000
Fax 225.935.2856

Membership Registration
(For Employer Use Only - Do Not Return to LASERS)

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

A member should read the "Notice of Employees Not Covered by Social Security" disclosing the potential effects of the Government Pension Offset (GPO) and the Windfall Elimination Provision (WEP). A member may **repay a refund** to LASERS upon returning to state service and contributing to the system for eighteen months according to La. R.S. 11:537(D). **The member must complete Form 1-06, *Designation of Beneficiary*, to name a beneficiary, and submit the form to LASERS.**

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Home Area Code/Phone Number	Mobile Area Code/Phone Number	Email Address	Member's Birth Date

SECTION 2: OPTIONAL MEMBERSHIP (Complete ONLY if age 55 or over and not a LASERS rehired retiree)

☐ At the time of employment I was 60 or older and elect to **(please check option A or B below): (OR)**

☐ At the time of employment I was age 55 or older and have at least 40 quarters in Social Security and I elect to (please check option A or B below)**: I will submit a copy of my Social Security Administration's form, *SSA-7005-Earnings and Benefits Statement* to my Human Resources Department, certifying that I have the required 40 quarters of coverage needed for optional membership.**

A) ☐ Join the Louisiana State Employees' Retirement System (LASERS). I understand that if I join the retirement system I must make employee contributions based on my earnings. I may make application for my employee contributions to be refunded to me, without interest, if I terminate employment for at least 30 days. If I join the retirement system and I am also eligible for a benefit from Social Security, the Social Security benefit may be reduced based on the benefit received from the retirement system.

B) ☐ Join FICA (Medicare included), or join/maintain the Louisiana Deferred Compensation Plan (eligibility and rate depend on employee status), or in some cases, employee may not be required to join either.

SECTION 3: PREVIOUS ENROLLMENT

If you were at any time a member of LASERS or another Louisiana public retirement system, give the name of that system under which the membership was reported:	From (MM/DD/YY)	To (MM/DD/YY)

My current status with the Louisiana public retirement system listed above is: ☐ Active ☐ Inactive ☐ Refunded ☐ Retired

If your status is RETIRED from a Louisiana public retirement system OTHER than LASERS, please check one:

☐ I elect NOT to join LASERS ☐ I elect to join LASERS: I shall pay employee contributions and expect to work enough years to be entitled to a monthly benefit; otherwise, I will only be eligible to refund my contributions.

Member's Signature	Date

Social Security Number

SECTION 4: CURRENT ENROLLMENT - FOR AGENCY INFORMATION ONLY

SERVICE HISTORY

☐ New - first time enrolled in LASERS. Regular members hired on or after July 1, 2015, will have a contribution rate of 8.0 percent in the Regular 4 Plan.

☐ New - first time enrolled in LASERS and enrolled in a Hazardous Duty Plan (HAZ Plan) position on or after January 1, 2011. HAZ Plan members must be enrolled in the HAZ Plan and will contribute at 9.5 percent.

☐ Return to service - previous member of LASERS, whether refunded or not, with a break in service

- ☐ Regular member who is a former member of LASERS prior to July 1, 2006, **DID NOT** refund contributions and will contribute at 7.5 percent in the Regular 1 Plan.
- ☐ Regular member who is a former member of LASERS on or after July 1, 2006, and before January 1, 2011, **DID NOT** refund contributions and will contribute at 8.0 percent in the Regular 2 Plan.
- ☐ Regular member who is a former member of LASERS on or after January 1, 2011, and on or before June 30, 2015, **DID NOT** refund contributions and will contribute at 8.0 percent in the Regular 3 Plan.
- ☐ Regular member who is a former member of LASERS on or after July 1, 2015, will contribute at 8.0 percent in the Regular 4 Plan.

☐ Transfer from another agency - transferring from one reporting agency to another within LASERS without a break in service.

☐ Transfer from another agency on or after January 1, 2011, and enrolled in a HAZ Plan position - transferring from any plan other than the HAZ Plan may elect to remain in that plan or join the HAZ Plan. Form 2-18: *Hazardous Duty Services Plan Election* must be submitted to LASERS. Form 1-11: *Certification of Prior Employment in a Hazardous Duty Position* should be submitted, if applicable.

☐ Transfer from another Louisiana state retirement system on or after July 1, 2015, and **DID NOT** refund - transferring from Teachers Retirement System of Louisiana, Louisiana School Employees' Retirement System, or State Police Pension & Retirement System must submit Form 01-10: *Certification of Membership in a State System Prior to July 1, 2015*, and must be enrolled in the retirement plan in place at the earliest date making the member eligible for membership.

☐ Transfer from another Louisiana state retirement system on or after January 1, 2011, and **DID NOT** refund, and employed in a HAZ Plan position - transferring from Teachers Retirement System of Louisiana, Louisiana School Employees' Retirement System, or State Police Pension & Retirement System may elect to remain in that system if eligible, or may elect to join the HAZ Plan.

☐ Dual employee - currently a member of LASERS under one reporting agency and now enrolling with a second reporting agency. (Usually involves part-time employment, but not necessarily.) Contributions are based on employment with all reporting agencies and are mandatory.

TYPE OF EMPLOYMENT

Types of Employees not Eligible (La. R.S. 11:413):

1. Employees who receive a per diem allowance instead of earned compensation
2. Students, interns, and resident physicians employed for temporary, part time, or periodic work
3. Independent contractors
4. Certain pool positions
5. Certain temporary seasonal employees at the Department of Revenue

Types of Employees not Eligible (La. R.S. 11:413(3)) - except those employees who have ten or more years of creditable service in the system or are returning to work as a re-employed retiree:

1. Job appointments (employment for a fixed period not to exceed two years)
2. Intermittent employees (employment for an indefinite schedule, on an as needed basis)
3. Part-time employees (employees who work 20 hours or less per week)
4. Seasonal employees (employees who work less than five months in a year)
5. Temporary employees (employees performing services under a contractual arrangement for less than two years)

Types of Employees Eligible

1. Full-time - working over 20 hours per week
2. Job Appointment - working two years and one day or longer

Social Security Number

EMPLOYEE INFORMATION

Employee Position Title

Hire Date (MM/DD/YY)

☐ Classified ☐ Permanent employee

☐ Unclassified ☐ Temporary employee

☐ Full-time: Full-time status equals _____ hours per day

☐ Part-time: The employee will work _____ hours per week

☐ Job Appointment working 2 years or less

☐ Job Appointment working 2 years and one day or longer

EARNINGS REPORTING: This employee's earnings will be reported as: ☐ 9 months ☐ 10 months ☐ 12 months

SECTION 5: AGENCY CERTIFICATION AND SIGNATURE

I have checked the PA20 and CS02 in ISIS and LASERS Employer Self-Service for previous retirement status. YES ☐ NO ☐

Is this member a LASERS retiree from this or any other state agency? YES ☐ NO ☐

If yes, see Liaison Memos 12-21 and 13-23 to follow the proper rehired retiree enrollment procedures. Failure to properly enroll rehired retirees may result in a cost to the member and agency. If this is a rehired retiree, form 10-2 *Re-employment of Rehired Retiree* must be submitted to LASERS within 45 days of the employment date. If it is not, the member will be rehired under the provisions of re-employed retiree Option 3.

Name of Personnel Officer

Name of Agency

Title

Personnel Officer's Email Address

Daytime Area Code/Phone Number

Signature of Personnel Officer

Date

Agency 3 Digit Number

Form 01-06
R102018

PRINT ALL INFORMATION
www.lasersonline.org

LASERS
Louisiana State Employees' Retirement System

ERBER14

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000
Fax 225.935.2856

Designation of Beneficiary

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Member's Birth Date

SECTION 2: GENERAL INFORMATION

This designation supersedes all prior designations. You must include **ALL** beneficiaries that you wish to designate. If percentages are not provided, any amounts payable will be divided equally among all beneficiaries. Primary and contingent beneficiaries must separately total 100%. The number of primary or contingent beneficiaries that you may name is not limited (attach an additional sheet if necessary). "Contingent" beneficiaries are eligible for payment only if all primary beneficiaries die before the member does. If you are not the member, you must submit a Certified copy of a "Power of Attorney" or other legal documents with this form. **A COPY OF THE SOCIAL SECURITY CARD AND BIRTH CERTIFICATE FOR EACH BENEFICIARY IS REQUIRED.**

SECTION 3: ACTIVE MEMBER BENEFICIARY

Complete this section if you are a non-retired member of LASERS. Named beneficiaries will receive a lump sum of any employee contributions not directed by statute. Do not complete this section if you are completing paperwork to retire and are naming your retirement beneficiaries.

PRIMARY BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

Social Security Number

CONTINGENT BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Contingent Beneficiary's Name (optional)	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

SECTION 4: RETIREMENT BENEFIT BENEFICIARY

This section should only be completed if you are submitting a Retirement, Retirement with IBO, DROP, or Disability Retirement application, or if you are updating your current Maximum or Option 1 monthly retirement beneficiary(ies).

PRIMARY BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

CONTINGENT BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Contingent Beneficiary's Name (optional)	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

SECTION 5: DROP OR IBO ACCOUNT BENEFICIARY

This section should only be completed if you are naming or updating your DROP or IBO account beneficiary(ies).

PRIMARY BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

Social Security Number

Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	Male / Female	Social Security Number
				☐ Male ☐ Female	
				☐ Male ☐ Female	

CONTINGENT BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Contingent Beneficiary's Name (optional)	Relation, Trust, Estate	Birth Date	Percentage	Male / Female	Social Security Number
				☐ Male ☐ Female	
				☐ Male ☐ Female	

SECTION 6: MEMBER SIGNATURE

I hereby request that my beneficiary(ies) be designated as above. I understand that the beneficiary(ies) designated on this form will receive my contributions to the retirement system, unless I have qualifying survivors (spouse, children) entitled to a monthly survivor's benefit.

Member's Signature

Date

Reset Form

Form 01-13
R112012

DO NOT FAX FORM
PRINT ALL INFORMATION
www.lasersonline.org

LASERS
Louisiana State Employees' Retirement System

ENRLINFO

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000

Benefit Forfeiture
(For Employer Use Only - Do Not Return to LASERS)

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

This form will be completed upon employment of LASERS eligible members hired on or after January 1, 2013. The employing agency will keep the form for their records.

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Member's Birth Date

SECTION 2: MEMBER SIGNATURE AND CERTIFICATION

By accepting this position, I understand that I will be enrolled in the Louisiana State Employees' Retirement System.

I further understand that my retirement benefits and the benefits payable to my spouse or children may be forfeited if I am convicted of a public corruption crime of either of the following types:

- Public corruption crime resulting in financial gain or attempted financial gain for myself or a third party.
- Public corruption crime that involves sexual contact with a minor with whom I come in contact by virtue of my public employment.

Signature of Member	Date of Signature

Reset Form

STATE OF LOUISIANA

LOUISIANA EMPLOYEES ONLINE

EMPLOYEE PAY STATEMENT QUICK REFERENCE

Click here for PRINTABLE VERSION

Best printed in DUPLEX

To View Current Pay Statement:

1. Access **LEO**
   From the ***Louisiana.gov*** page, locate Online Services and click LEO: Louisiana State Employees Online **or** use this address: https://leo.doa.louisiana.gov/
2. Log into LEO
   - **Personnel Number** field enter 8 character P id. Must enter a "P" and all necessary preceding zeros (ex: P00123456). Tab to the **Password** field, enter your password and press enter. Need help? Click and view the **Log On Assistance** quick reference.
   - Enter your **Password**. If you can't remember your password, reset it by clicking on the **Forgot password? Locked?** and follow "on screen" instructions.
3. Click $ View/Print Pay Statement option under the **Shortcuts** area of the Announcement page or click **My Info** tab and select **Pay Statement**.
4. Select the period you wish to display (use Pay Date or Period Begin and End dates to identify statement desired) from the choices on the left. Click MORE to load additional period dates.

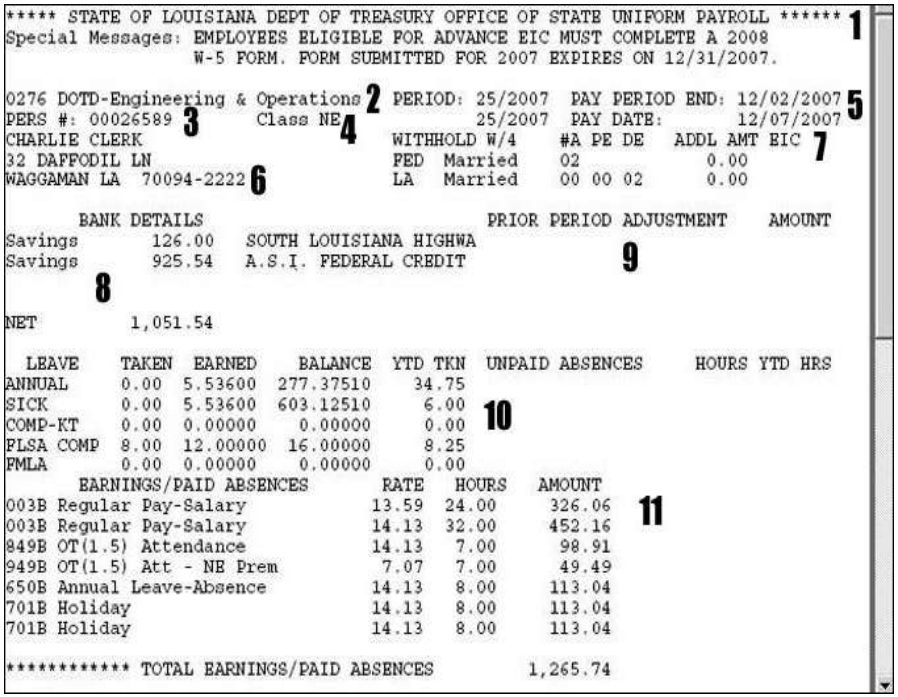
To Print Pay Statement:

Click  . A printer selection box may appear. Select the correct printer and click the PRINT button.

To Save Pay Statement:

Click  the download icon, select where you want to store it, name your file, and then click  . You may want to include the pay date as part of the file name (e.g., Pay12072007).

Division of Administration, Office of Technology Services
P. O. Box 94095, Baton Rouge, LA 70804-9095
Revised: 8/2017



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***** STATE OF LOUISIANA DEPT OF TREASURY OFFICE OF STATE UNIFORM PAYROLL ******
Special Messages: EMPLOYEES ELIGIBLE FOR ADVANCE EIC MUST COMPLETE A 2008
                  W-5 FORM. FORM SUBMITTED FOR 2007 EXPIRES ON 12/31/2007.

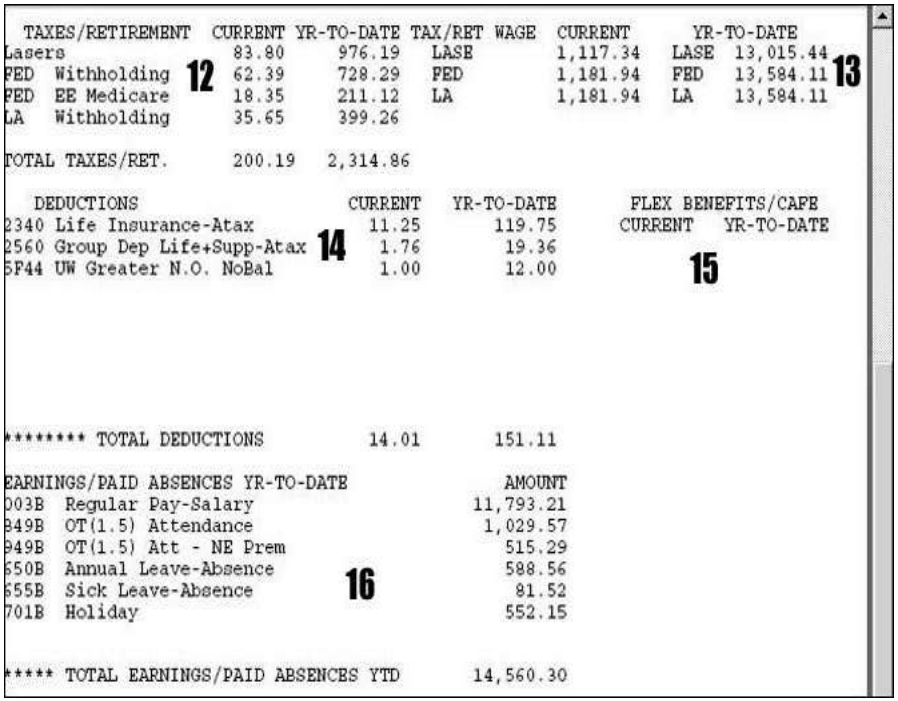
0276 DOTD-Engineering & Operations  PERIOD: 25/2007  PAY PERIOD END: 12/02/2007
PERS #: 00026589      Class NE      25/2007  PAY DATE:      12/07/2007
CHARLIE CLERK                    WITHHOLD W/4    #A PE DE   ADDL AMT EIC
32 DAFFODIL LN                   FED  Married    02           0.00
WAGGAMAN LA  70094-2222          LA   Married    00 00 02     0.00

      BANK DETAILS                              PRIOR PERIOD ADJUSTMENT    AMOUNT
Savings       126.00   SOUTH LOUISIANA HIGHWA
Savings       925.54   A.S.I. FEDERAL CREDIT

NET         1,051.54

  LEAVE    TAKEN  EARNED    BALANCE  YTD TKN  UNPAID ABSENCES     HOURS YTD HRS
ANNUAL      0.00  5.53600  277.37510    34.75
SICK        0.00  5.53600  603.12510     6.00
COMP-KT     0.00  0.00000    0.00000     0.00
FLSA COMP   8.00  12.00000  16.00000     8.25
FMLA        0.00  0.00000    0.00000     0.00
      EARNINGS/PAID ABSENCES          RATE   HOURS   AMOUNT
003B Regular Pay-Salary              13.59   24.00     326.06
003B Regular Pay-Salary              14.13   32.00     452.16
849B OT(1.5) Attendance              14.13    7.00      98.91
949B OT(1.5) Att - NE Prem            7.07    7.00      49.49
650B Annual Leave-Absence            14.13    8.00     113.04
701B Holiday                         14.13    8.00     113.04
701B Holiday                         14.13    8.00     113.04

************ TOTAL EARNINGS/PAID ABSENCES          1,265.74
```



```
  TAXES/RETIREMENT  CURRENT YR-TO-DATE TAX/RET WAGE  CURRENT      YR-TO-DATE
Lasers               83.80     976.19   LASE        1,117.34   LASE  13,015.44
FED  Withholding     62.39     728.29   FED         1,181.94   FED   13,584.11
FED  EE Medicare     18.35     211.12   LA          1,181.94   LA    13,584.11
LA   Withholding     35.65     399.26

TOTAL TAXES/RET.     200.19   2,314.86

   DEDUCTIONS                    CURRENT   YR-TO-DATE      FLEX BENEFITS/CAFE
2340 Life Insurance-Atax           11.25       119.75      CURRENT   YR-TO-DATE
2560 Group Dep Life+Supp-Atax       1.76        19.36
5F44 UW Greater N.O. NoBal          1.00        12.00

******** TOTAL DEDUCTIONS          14.01       151.11

EARNINGS/PAID ABSENCES YR-TO-DATE              AMOUNT
003B  Regular Pay-Salary                   11,793.21
849B  OT(1.5) Attendance                    1,029.57
949B  OT(1.5) Att - NE Prem                   515.29
650B  Annual Leave-Absence                    588.56
655B  Sick Leave-Absence                       81.52
701B  Holiday                                 552.15

***** TOTAL EARNINGS/PAID ABSENCES YTD      14,560.30
```

Detailed Explanation of Pay Statement:

1 Special messages: Messages issued by the Office of State Uniform Payroll.

2 Your Agency Number and Organizational Unit.

3 Personnel Number (also your LEO logon ID).

4 Fair Labor Standards Act (FLSA) classification: **EX** =Exempt, **NE** =Non-exempt

5 Pay period number/year being reported + period end date and pay date.

6 Name and mailing address that is currently on file. (This can be maintained in LEO under **My Info** > **Personal Info** > **Address**.)

7 Current tax withholdings as well as any additional amounts withheld. (Maintained in LEO under **My Info** > **Personal Info** > **Tax Withholdings**)

8 This identifies how much money was deposited in your bank account(s) and the names of the banking institutions. The net amount is your pay minus any deductions or taxes. (Bank accounts maintained in LEO under **My Info** > **Payment Info** > **Bank Information.**) If you receive a paper check, bank details will state check and not list any accounts.

9 Prior pay period adjustment is used only when there is an increase or decrease in your pay resulting from a correction to pay, attendance, absence or deduction information for a previous pay period.

10 Leave hours taken, earned, remaining, as well as year-to-date taken and unpaid for the pay period displayed.

11 All earnings and paid absence hours included in this payment, along with the hourly rate for each.

12 Taxes and retirement withheld this pay period as well as cumulative year to date amounts withheld.

13 Portion of earnings that were subject to taxes and retirement contributions (taxable wages). This is shown for current pay period and year-to-date.

14 Current and year-to-date deduction amounts for insurances, deferred compensation, savings bonds, etc. Deductions with an asterisk (*) indicate they are part of the flexible benefits program.

15 Total deductions that were part of the flexible benefits program for the current pay period as well as year-to-date.

16 Total earnings for hours worked and paid absences year-to-date.

Office of the State Americans with Disabilities Act Coordinator (OSADAC)

VOLUNTARY SELF-IDENTIFICATION OF DISABILITY FORM

Employee Name: _____ Personnel #: _____

Why are you being asked to complete this form?

As an executive branch state agency, the Office of Lieutenant Governor/Department of Culture, Recreation & Tourism is required by La. R.S. 46:2597 to establish annual strategies and goals related to employment of individuals with disabilities. In order to effectively measure and report our progress to this end, La. R.S. 46:2597 requires us to ask employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five (5) years.

Identifying yourself as an individual with a disability is **voluntary**, and we hope that you will choose to do so (if applicable). Your answer will be maintained confidentially and will not be seen by hiring officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way. For more information about this form or the Americans with Disabilities Act, visit the Office of the State Americans with Disabilities Act (ADA) Coordinator's website at https://www.doa.la.gov/office-of-state-ada-coordinator/.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment that substantially limits a major life activity, or if you have a history or record of such an impairment. Disabilities include, but are not limited, to:

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition, for example, migraine headaches, Parkinson's disease or Multiple Sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, Post Traumatic Stress Disorder (PTSD) or major depression

Please check ONE of the boxes below:

☐ **YES**, I have a disability ☐ **NO**, I do not have a disability ☐ I do not wish to answer

You are encouraged to carefully review our agency's policy specific to the Americans with Disabilities Act and/or Disability Rights, and to request workplace accommodations as may be needed for your disability.

Employee Signature: _____

Date: _____

In accordance with La. R.S. 46:2597, this form shall be confidential and filed in a folder separate from the employee's personnel file.