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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Job Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office/Section:</th>
<th>Hire Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select the appropriate Appointment Type:

<table>
<thead>
<tr>
<th>Full-Time Classified Appt with Benefits (check one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probational</td>
</tr>
<tr>
<td>Permanent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Appointment (call HR for explanation of benefits):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unclassified Appointment</td>
</tr>
<tr>
<td>Classified Job Appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part-Time Appointment (No benefits, no leave, no paid holidays, no retirement):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restricted Appointment</td>
</tr>
<tr>
<td>Seasonal or WAE Wage</td>
</tr>
<tr>
<td>Student</td>
</tr>
</tbody>
</table>

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](http://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. **
PERSONAL DATA FORM

Employee’s Name: __________________________________________________
(Print full name as it appears on your Social Security Card)

Social Security Number: ________________ Date of Birth: ________________

Gender: ____Male ____Female

Check one:
Ethnicity: ____Hispanic/Latino ____Non-Hispanic/Latino ____Decline to State

Check one:
Race: ____American Indian/Alaskan ____Asian ____Black or African American
____Hawaiian/Pacific Islander ____White ____Decline to State

Check one:
Marital Status: ____Single ___Married ___Divorce ___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 chosen 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: MALLING ADDRESS:

__________________________________________________________

__________________________________________________________

__________________________________________________________

Telephone Number: ________________ Cell Phone (Optional) ________________

RESIDENCE PARISH: ______________________________________

EMERGENCY CONTACT:

__________________________________________________________

NAME PHONE

________________________________________________________

EMPLOYEE NAME (PRINTED) EMPLOYEE SIGNATURE & DATE
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.

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

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
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)
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)**

<table>
<thead>
<tr>
<th>EMPLOYEE SSN</th>
<th>DEPARTMENT/OFFICE OR AGENCY</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>FINANCIAL INSTITUTION NAME</th>
<th>FINANCIAL INSTITUTION ROUTING (ABA) NUMBER (Bank Key)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BANK ACCOUNT NUMBER</th>
<th>ACCOUNT NAME * (Ex: Mr. and Mrs. John Doe, John or Jane Doe)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>MAIN BANK</th>
<th>FINANCIAL INSTITUTION ROUTING (ABA) NO. (If not provided above)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSONNEL AREA NUMBER</th>
<th>PERSONNEL NUMBER</th>
<th>EFT VALIDITY DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

☐ CHECK HERE IF SECONDARY ACCOUNT FORMS ARE ATTACHED
STATE OF LOUISIANA
LAGOV ERP-HUMAN CAPITAL MANAGEMENT
DIRECT DEPOSIT ENROLLMENT AUTHORIZATION
OTHER BANK (SECONDARY ACCOUNT)

<table>
<thead>
<tr>
<th>EMPLOYEE SSN</th>
<th>DEPARTMENT/OFFICE OR AGENCY</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>FINANCIAL INSTITUTION NAME</th>
<th>FINANCIAL INSTITUTION ROUTING (ABA) NUMBER (Bank Key)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BANK ACCOUNT NUMBER</td>
<td>ACCOUNT NAME * (Ex: Mr. and Mrs. John Doe, John or Jane Doe)</td>
</tr>
</tbody>
</table>

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.

I understand and acknowledge that I must be responsible for any account information indicated on this form as well as any account information that I change 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:

<table>
<thead>
<tr>
<th>OTHER BANK</th>
<th>FINANCIAL INSTITUTION ROUTING (ABA) NO. (If not provided above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSONNEL AREA NUMBER</td>
<td>PERSONNEL NUMBER</td>
</tr>
</tbody>
</table>

CHECK HERE IF ADDITIONAL ACCOUNT FORMS ARE ATTACHED
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 should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 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 willful failure to supply information that would reduce the withholding exemption.

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

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A
- Enter "0" to claim neither yourself nor your spouse, and check “No exemptions or dependents claimed” 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 yourself, and check “Single” under number 3 below. If you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check “Single” under number 3 below.
- Enter "2" to claim yourself and your spouse, and check “Married” under number 3 below.

Block B
- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter “0.”

Employee’s Withholding Allowance Certificate

1. Type or print first name and middle initial
2. Social Security Number
3. Select one
   - No exemptions or dependents claimed
   - Single
   - Married
4. Home address (number and street or rural route)
5. City
6. Total number of exemptions claimed in Block A
7. Total number of dependents claimed in Block B
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits 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:

9. Employer’s name and address
10. Employer’s state withholding account number
# 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.

---

### Step 1: Enter Personal Information

<table>
<thead>
<tr>
<th>(a) First name and middle initial</th>
<th>(b) Social security number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Address**
- **City or town, state, and ZIP code**
- **Does your name match the name on your social security card?**
  - [ ] Single or Married filing separately
  - [ ] Married filing jointly or Qualifying surviving spouse
  - [ ] Head of household (Check only if you’re unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

---

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

### Step 2: Multiple Jobs or Spouse Works

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

- **Do only one** of the following.
  - (a) Reserved for future use.
  - (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or
  - (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate.

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

### Step 3: Claim Dependent and Other Credits

- If your total income will be $200,000 or less ($400,000 or less if married filing jointly):
  - Multiply the number of qualifying children under age 17 by $2,000
  - Multiply the number of other dependents by $500
  - Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here.

### Step 4 (optional): Other Adjustments

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

  $4(a)

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

  $4(b)

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

  $4(c)

### Step 5: Sign Here

- **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)**

---

For Privacy Act and Paperwork Reduction Act Notice, see page 3.
General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

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

Specific Instructions

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

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

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

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

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

Step 4 (optional).

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

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

Step 4(c). Enter in this step any additional tax you want withheld from your pay each pay period, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.
Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

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

$$1 \quad $ \quad \text{_____}$$

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

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the “Higher Paying Job” row and the annual wages for your next highest paying job in the “Lower Paying Job” column. Find the value at the intersection of the two household salaries and enter that value on line 2a.

$$2a \quad $ \quad \text{_____}$$

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the “Higher Paying Job” row and use the annual wages for your third job in the “Lower Paying Job” column to find the amount from the appropriate table on page 4 and enter this amount on line 2b.

$$2b \quad $ \quad \text{_____}$$

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

$$2c \quad $ \quad \text{_____}$$

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.

$$3 \quad \text{_____}$$

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

$$4 \quad \text{_____}$$

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

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income.

$$1 \quad \text{_____}$$

2 Enter: { $20,800 if you’re head of household \[+\] $27,700 if you’re married filing jointly or a qualifying surviving spouse \[+\] $13,850 if you’re single or married filing separately}.

$$2 \quad \text{_____}$$

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter “-0-”.

$$3 \quad \text{_____}$$

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

$$4 \quad \text{_____}$$

5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4.

$$5 \quad \text{_____}$$

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.
<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
</tr>
<tr>
<td>$10,000 - 19,999</td>
<td>$10,000 - 19,999</td>
</tr>
<tr>
<td>$20,000 - 29,999</td>
<td>$20,000 - 29,999</td>
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<tr>
<td>$30,000 - 39,999</td>
<td>$30,000 - 39,999</td>
</tr>
<tr>
<td>$40,000 - 49,999</td>
<td>$40,000 - 49,999</td>
</tr>
<tr>
<td>$50,000 - 59,999</td>
<td>$50,000 - 59,999</td>
</tr>
<tr>
<td>$60,000 - 69,999</td>
<td>$60,000 - 69,999</td>
</tr>
<tr>
<td>$70,000 - 79,999</td>
<td>$70,000 - 79,999</td>
</tr>
<tr>
<td>$80,000 - 99,999</td>
<td>$80,000 - 99,999</td>
</tr>
<tr>
<td>$100,000 - 109,999</td>
<td>$100,000 - 109,999</td>
</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Single or Married Filing Separately</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher Paying Job Annual Taxable Wage &amp; Salary</td>
<td>Lower Paying Job Annual Taxable Wage &amp; Salary</td>
</tr>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
</tr>
<tr>
<td>$10,000 - 19,999</td>
<td>$10,000 - 19,999</td>
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<td>$50,000 - 59,999</td>
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<tr>
<td>$60,000 - 69,999</td>
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<td>$70,000 - 79,999</td>
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<td>$80,000 - 99,999</td>
<td>$80,000 - 99,999</td>
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<tr>
<td>$100,000 - 109,999</td>
<td>$100,000 - 109,999</td>
</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Head of Household</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher Paying Job Annual Taxable Wage &amp; Salary</td>
<td>Lower Paying Job Annual Taxable Wage &amp; Salary</td>
</tr>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
</tr>
<tr>
<td>$10,000 - 19,999</td>
<td>$10,000 - 19,999</td>
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<tr>
<td>$20,000 - 29,999</td>
<td>$20,000 - 29,999</td>
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<td>$30,000 - 39,999</td>
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<td>$40,000 - 49,999</td>
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<td>$50,000 - 59,999</td>
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<td>$60,000 - 69,999</td>
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<td>$100,000 - 109,999</td>
<td>$100,000 - 109,999</td>
</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>
START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

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

### Section 1. Employee Information and Attestation

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

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Last Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>Employee's E-mail Address</th>
<th>Employee's Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

- [ ] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See instructions)
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number):

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

    Some aliens may write "N/A" in the expiration date field. (See instructions)

    Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
    - An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.
    - 1. Alien Registration Number/USCIS Number: 
      - OR 
    - 2. Form I-94 Admission Number: 
      - OR 
    - 3. Foreign Passport Number: 
      - Country of Issuance: 

Signature of Employee 

Today's Date (mm/dd/yyyy)

Preparer and/or Translator Certification (check one):

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

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

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

Signature of Preparer or Translator 

Today's Date (mm/dd/yyyy)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Form I-9  10/21/2019 Page 1 of 3
Section 2. Employer or Authorized Representative Review and Verification

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

**Employee Info from Section 1**

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>M.I.</th>
<th>Citizenship/Immigration Status</th>
</tr>
</thead>
</table>

**List A**

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Issuing Authority</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

**List B**

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Issuing Authority</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

**List C**

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Issuing Authority</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

**Additional Information**

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

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

**Signature of Employer or Authorized Representative**

**Today's Date (mm/dd/yyyy)**

**Title of Employer or Authorized Representative**

**Last Name of Employer or Authorized Representative**

**First Name of Employer or Authorized Representative**

**Employer's Business or Organization Name**

**Employer's Business or Organization Address (Street Number and Name)**

**City or Town**

**State**

**ZIP Code**

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

**A. New Name (if applicable)**

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

**B. Date of Rehire (if applicable)**

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

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

**Signature of Employer or Authorized Representative**

**Today's Date (mm/dd/yyyy)**

**Name of Employer or Authorized Representative**
# Lists of Acceptable Documents

All documents must be UNEXPIRED

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

## List A

<table>
<thead>
<tr>
<th>Documents that Establish Both Identity and Employment Authorization</th>
<th>OR</th>
<th>List B: Documents that Establish Identity</th>
<th>AND</th>
<th>List C: Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td></td>
<td>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</td>
<td></td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td></td>
<td>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</td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
<td></td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td></td>
<td>3. School ID card with a photograph</td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
<td></td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td></td>
<td>4. Voter's registration card</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
<td></td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td></td>
<td>5. U.S. Military card or draft record</td>
<td></td>
<td>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
</tr>
<tr>
<td>a. Foreign passport; and</td>
<td>6. Military dependent's ID card</td>
<td></td>
<td></td>
<td>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td></td>
<td></td>
<td>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
</tr>
<tr>
<td>(1) The same name as the passport; and</td>
<td>8. Native American tribal document</td>
<td></td>
<td></td>
<td>5. Native American tribal document</td>
</tr>
<tr>
<td>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</td>
<td>9. Driver's license issued by a Canadian government authority</td>
<td></td>
<td></td>
<td>6. U.S. Citizen ID Card (Form I-197)</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td>For persons under age 18 who are unable to present a document listed above:</td>
<td>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
<td></td>
</tr>
</tbody>
</table>

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.
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:

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
</table>

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

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, “Windfall Elimination Provision.”

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

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

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

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

Signature of Employee_______________________________Date _________________________

Form SSA-1945 (01-2013)
Destroy Prior Editions
Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

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

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

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

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

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

**Employee's Name:** ____________________________  

**Division/Section:** ____________________________

<table>
<thead>
<tr>
<th>Name of State Agency</th>
<th>Employment Status</th>
<th>Employment Dates</th>
<th>Full Time or Part Time</th>
<th># of Hours Worked Per Week</th>
<th>Leave without Pay Dates</th>
<th>Office Use Only Total Service Years, Months, Days</th>
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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:**

Leaves Balances  

Adjusted Leave Service Date: ____________

Sick: ____________  

Adjusted Service Date: ____________

Annual: ____________  

FMLA: ____________  

Verified By: ____________

OMF 322  
Revised 01/19/01
**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.

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<th>APPOINTEE</th>
<th>AGENCY /DIVISION</th>
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<th>PRESENT STREET ADDRESS</th>
<th>PLACE OF EMPLOYMENT</th>
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<tr>
<th>CITY/ STATE/ZIP</th>
<th>DATE OF BIRTH</th>
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**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:

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<th>DATE</th>
<th>LOCATION</th>
<th>CHARGE</th>
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<th>DISPOSITION</th>
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**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:

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

**D. AS REQUIRED BY LOUISIANA REVISED STATUTE 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

<table>
<thead>
<tr>
<th>DATE</th>
<th>SIGNATURE OF APPOINTEE</th>
<th>SOCIAL SECURITY NO.</th>
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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

07/01/2011
DA 2054
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)

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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.]

<table>
<thead>
<tr>
<th>Y</th>
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</table>

### 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 ____________
- □ □ Other Surgical Procedure Procedure ____________ Year ____________

Employee Signature: _______________________________ Date: __________________________

Employer Representative: _______________________________ Date: __________________________
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](http://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
Education Verification Form

Name ______________________________________     Date_______________________
Address _________________________________________________________________
E-mail Address ____________________________________________________________
Home Phone # ___________________  Mobile Phone # ___________________________

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

<table>
<thead>
<tr>
<th>EDUCATION</th>
<th>Name and location of school</th>
<th>Degree Received</th>
<th>Subjects studied/Major</th>
<th>Start Date</th>
<th>Graduation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
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<tr>
<td>College or University</td>
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<td>Trade, Business or</td>
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<tr>
<td>Correspondence School</td>
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</table>

**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 _______________________________________________
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 OGB/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 OGB/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/HRS/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

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:

<table>
<thead>
<tr>
<th>3. Employer Name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of the Lieutenant Governor (OLG)</td>
<td>(OLG) 72-6000748</td>
</tr>
<tr>
<td>Department of Culture, Recreation and Tourism (DCRT)</td>
<td>(DCRT) 72-0871504</td>
</tr>
<tr>
<td>PO BOX 94361</td>
<td></td>
</tr>
<tr>
<td>7. City</td>
<td>8. State</td>
</tr>
<tr>
<td>Baton Rouge</td>
<td>Louisiana</td>
</tr>
<tr>
<td>70804-9361</td>
<td></td>
</tr>
<tr>
<td>10. Who can I contact about employee health coverage at this job?</td>
<td>11. Phone number (if different from above)</td>
</tr>
<tr>
<td>Tonya Dupuy, Human Resources Specialist</td>
<td>(225) 342-0880</td>
</tr>
<tr>
<td>12. Email address</td>
<td>7. City</td>
</tr>
<tr>
<td><a href="mailto:tdupuy@crt.la.gov">tdupuy@crt.la.gov</a></td>
<td>Baton Rouge</td>
</tr>
</tbody>
</table>

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
All Employees

Basic Term Life Insurance
Basic plus Supplemental Term Life Insurance
Accidental Death and Dismemberment Insurance
Dependent Term Life Insurance

The Prudential Insurance Company of America

IFS-A091258 ECEd.07.01.2014-6649 EXP.01.01.2016 0180444-00008-01
Help Protect the Ones You Love

Life is full of pleasant surprises and, at the same time, life holds many uncertainties. It's easier to plan for happy events you know will occur, such as buying a home, paying for a wedding, or saving for college tuition costs. It's more difficult to plan for the unexpected—a serious accident or death.

For these times, it's important that you have enough life insurance coverage for you and your family. Your current life insurance plans may not offer enough protection.

Together with your employer, The Prudential Insurance Company of America offers you the opportunity to purchase additional term life insurance, which can help further safeguard your earnings and cover your financial obligations in the event of your death.

Our voluntary group term life plans offer:

- **Choice of Coverage**—You have the opportunity to obtain additional life insurance protection and to choose the level of coverage that's right for you.

- **Guaranteed Coverage**—You can obtain coverage under most of our plans without providing any medical information when you enroll within a specified period.

- **Economical Group Rates**—Our plan is available to you at group rates, which are competitive with individual rates.

- **Convenient Payroll Deduction**—Your premium contributions are deducted from your paycheck, so there's no check writing or mail delays.

- **Coverage Conversion**—If your employment ends, your coverage may be converted to an individual life insurance policy issued by The Prudential Insurance Company of America.

- **Peace of Mind**—Having a plan for the unexpected can give both you and your family peace of mind.

*Please review the information in this kit so you can make an informed decision about participating in this program.*
Active Employee & Retiree Coverage

♦ **Basic Term Life:** All Employees: Coverage is available for $5,000.

♦ **Basic plus Supplemental Term Life:** All Active Employees, Retirees after 1/1/1973 and Members of the Legislature of the State of Louisiana: Coverage is available for 1.5 times your covered annual earnings, up to a maximum of $50,000.

♦ **Basic plus Supplemental Term Life:** All Members of Boards and Commissions: Coverage is available for $20,000.

♦ **New Hires:**
  ♦ All Active Employees and Members of the Legislature of the State of Louisiana: You may enroll in either $5,000 or 1.5 times your covered annual earnings to a maximum of $50,000 – no medical questions asked – when enrolling when first eligible in Basic or Basic plus Supplemental Term Life.
  ♦ All Members of Boards and Commissions: You may enroll in either $5,000 or $20,000 – no medical questions asked – when enrolling when first eligible in Basic or Basic plus Supplemental Term Life.

♦ **Current Participants:** Your current coverage amount will be continued. Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all increases in coverage amounts.(does not apply to salary increases)

♦ **Current Employees who were denied coverage in the past, Current Employees who waived coverage in the past or Late Entrants (did not enroll when first eligible):** Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all coverage amounts.

♦ If you are terminally ill, you can get a partial payment of your group life insurance benefit. You can use this payment as you see fit. The payment to your beneficiary will be reduced by the amount you receive with the Accelerated Benefit Option. Refer to the plan booklet for details.

♦ The amount of insurance reduces to 75% at age 65 and to 50% at age 70. Refer to the plan booklet for details.

♦ Coverage will end on your termination of employment or as specified in the plan booklet. You may convert your insurance to an individual life insurance policy issued by The Prudential Insurance Company of America or portability is provided for Basic and Supplemental Active Life.
Basic & Basic plus Supplemental Accidental Death & Dismemberment Insurance AD&D
50% Employee Paid

♦ Basic & Basic plus Supplemental AD&D: you are automatically enrolled for a coverage amount equal to your Basic and Basic plus Supplemental Term Life coverage amount.

♦ Basic AD&D pays you and your beneficiary a benefit for the loss of life or other injuries resulting from a covered accident -- 100% for loss of life and a lesser percentage for other injuries. Injuries covered may include loss of sight or speech, paralysis, and dismemberment of hands or feet. Basic AD&D benefits are paid regardless of other coverages you may have.

♦ Benefits are paid at certain percentages of your coverage amount for specific accidental losses, as indicated in the chart below. Not more than 100% of your coverage amount is payable for all losses due to the same accident.

<table>
<thead>
<tr>
<th>Injury Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>One hand &amp; one foot</td>
<td>100%</td>
</tr>
<tr>
<td>Sight in one eye &amp; one hand or one foot</td>
<td>100%</td>
</tr>
<tr>
<td>Speech &amp; hearing in both ears</td>
<td>100%</td>
</tr>
<tr>
<td>Quadruplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75%</td>
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<tr>
<td>Hemiplegia</td>
<td>50%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight in one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech</td>
<td>50%</td>
</tr>
<tr>
<td>Hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb &amp; index finger on the same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

Seat Belt Benefit—The plan pays an additional benefit of 10% of your coverage amount, up to a maximum of $10,000.

Air Bag Benefit—The plan pays an additional benefit of 10% of your coverage amount, up to a maximum of $10,000.

Additional Benefits -
- Loss Due to Exposure and Disappearance Benefit
- Loss Due to Coma Benefit
- Return of Remains Benefit
- Felonious Assault Benefit
- Spouse Tuition Reimbursement Benefit
- Child(ren) Tuition Reimbursement Benefit
- Day Care Expense Benefit

♦ AD&D exclusions—A loss is not covered if it results from suicide or attempted suicide; intentionally self-inflicted injuries or an attempt at same; sickness; medical or surgical treatment of sickness; certain bacterial or viral infections (unless the infection was the result of an accidental injury or bacterial infection which results from the accidental ingestion of contaminated substances); act of war; certain full-time military duty; commission of, or attempt to commit a felony; legal intoxication or drug use; certain hazardous sports; certain travel or flight in a vehicle used for aerial navigation. This provision may vary by state. Refer to the plan booklet for details.
Dependent Term Life Insurance

100% Employee Paid

- You must be enrolled in Basic or Supplemental Life to be eligible for Dependent Term Life coverage.
- Coverage is available for the following options:
  - **Basic Life**
    - Option 1: $1,000 Spouse/ $500 Child(ren), not to exceed 100% of your Employee Term Life.
    - Option 2: $2,000 Spouse/ $1,000 Child(ren), not to exceed 100% of your Employee Term Life.
  - **Basic plus Supplemental Life**
    - Option 1: $2,000 Spouse/ $1,000 Child(ren), not to exceed 100% of your Employee Term Life.
    - Option 2: $4,000 Spouse/ $2,000 Child(ren), not to exceed 100% of your Employee Term Life.

**Spouse Coverage**

- **New Hires:** You may select to enroll your spouse for the options listed above, without providing evidence of insurability satisfactory to The Prudential Insurance Company of America, if you enroll your spouse when first eligible in Dependent Term Life.
- **Current Spouse Participants:** Your spouse’s current coverage amount will be continued. Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all increases in coverage amounts.
- **Current Employees whose Spouse was denied coverage in the past, Current Employees who waived Spouse coverage in the past or Late Entrants (did not enroll when first eligible):** Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all coverage amounts.
- Coverage will end on your termination of employment or as specified in the plan booklet. Insurance may be converted to an individual life insurance policy issued by The Prudential Insurance Company of America or continue your spouse’s group insurance through a portability provision.

**Child(ren) Coverage**

- Dependent Term Life coverage has one premium rate that covers all eligible children.
- No evidence of insurability satisfactory to The Prudential Insurance Company of America is required.
- Coverage begins at live birth and continues to age 26, if unmarried. Incapacitated dependents are to be covered beyond the limiting age.
- Coverage will end on your termination of employment or as specified in the plan booklet. Insurance may be converted to an individual life insurance policy issued by The Prudential Insurance Company of America or continue your child(ren)’s group insurance through a portability provision.

For your coverage to become effective, you must be actively at work during the enrollment period and on the effective date of the plan. If you apply for an amount that requires satisfactory evidence of insurability to The Prudential Insurance Company of America, you must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability. Refer to the plan booklet for details.
### Section 1 - Primary Plan Participant/Employee Information

<table>
<thead>
<tr>
<th>Name First</th>
<th>M.I.</th>
<th>Last</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Home Phone number</th>
<th>Work/Alt Phone Number</th>
<th>Email Address*</th>
<th>Gender</th>
<th>Mailing Address (Street or P.O. Box)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Country</th>
<th>Physical Address (street)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Country</th>
</tr>
</thead>
</table>

*See footnote below

### 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.

### 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

<table>
<thead>
<tr>
<th>NAME (LAST, FIRST MIDDLE INITIAL)</th>
<th>RELATIONSHIP</th>
<th>SEX</th>
<th>BIRTH DATE (MM/DD/YYYY)</th>
<th>ADD/DELETE</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>HEALTH</th>
<th>DEP. LIFE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPOUSE</td>
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**COMPLETE THE APPLICABLE SECTION BELOW. SELECT ONLY ONE HEALTH PLAN.**

#### Active Employees and Non-Medicare Retirees

- Pelican HRA1000 (Administered by Blue Cross)
- Magnolia Local (Limited Provider Network - Administered by Blue Cross)
- Magnolia Local Plus (Administered by Blue Cross)
- Magnolia Open Access (Administered by Blue Cross)
- Pelican HSA775” (Actives Only - Administered by Blue Cross)

*Note: 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

- Pelican HRA1000 (Administered by Blue Cross)
- Magnolia Local (Limited Provider Network - Administered by Blue Cross)
- Magnolia Local Plus (Administered by Blue Cross)
- Magnolia Open Access (Administered by Blue Cross)

**OGB Secondary Plans:**

- Pelican HRA1000 (Administered by Blue Cross)
- Magnolia Local (Limited Provider Network - 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:**

- Vantage Medicare Advantage Premium HMO-POS Plan
- Vantage Medicare Advantage Standard HMO-POS Plan
- Vantage Medicare Advantage Basic HMO-POS Plan
- 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)

**MEDICARE VERIFICATION**

- [ ] 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 Optum Financial 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.*
## 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
- BASIC PLUS SUPPLEMENTAL
- FLEXIBLE BENEFITS (ACTIVE EMPLOYEES ONLY)
  - 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/Dependent Coverage
  - Eligible Spouse $4,000 Eligible Child $2,000

<table>
<thead>
<tr>
<th>Annual Salary</th>
<th>Date of Last Salary Increase</th>
<th>Face Life</th>
</tr>
</thead>
</table>

## 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 to 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.

**FOR AGENCY USE**

<table>
<thead>
<tr>
<th>PLAN RECOGNIZED QUALIFIED LIFE EVENT (QLE) FOR APPLICATION (REFERENCE 2019 QLE SPREADSHEET):</th>
</tr>
</thead>
<tbody>
<tr>
<td>QLE code or qualified life event description</td>
</tr>
<tr>
<td>Add</td>
</tr>
</tbody>
</table>

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

**Signature of Agency Representative**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

**Printed Name of Agency Representative**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>
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 DataPath Administrative Services 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.

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Email Address</th>
<th>Payroll System</th>
<th>Agency Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Print)</td>
<td>First Name</td>
<td>Middle Initial</td>
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<tr>
<td>Home Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Home Phone</td>
<td>Daytime Phone</td>
<td>Date of Hire</td>
<td>Number of Pay Periods</td>
</tr>
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</table>

Payroll Use only

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>First Payroll Date</th>
</tr>
</thead>
</table>

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 = $11.52).**
- In Box #5, indicate the FSA fee per pay period (paid biweekly is $0.48; paid monthly is $0.96).***

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Dollar Amount</th>
<th>Number of Regular Payroll Checks*</th>
<th>Deduction Amount per Paycheck</th>
<th>Annual FSA Fee Amount**</th>
<th>FSA Fee per Pay Period***</th>
</tr>
</thead>
<tbody>
<tr>
<td>General-Purpose Health Care FSA (GPFSA)</td>
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<tr>
<td>For eligible medical expenses incurred by you, your family members, or both ($600 minimum contribution; $2,850 maximum contribution)</td>
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<tr>
<th>Type</th>
<th>Dollar Amount</th>
<th>Number of Regular Payroll Checks*</th>
<th>Deduction Amount per Paycheck</th>
<th>Annual FSA Fee Amount**</th>
<th>FSA Fee per Pay Period***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited-Purpose Health Care FSA (LPFSA)</td>
<td></td>
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<tr>
<td>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; $2,850 maximum contribution)</td>
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<table>
<thead>
<tr>
<th>Type</th>
<th>Dollar Amount</th>
<th>Number of Regular Payroll Checks*</th>
<th>Deduction Amount per Paycheck</th>
<th>Annual FSA Fee Amount**</th>
<th>FSA Fee per Pay Period***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Care FSA (DCFSA)</td>
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<tr>
<td>For eligible dependent care expenses of an eligible dependent while you work ($600 minimum contribution)</td>
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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.

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Agency or Payroll System Name</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll Officer/Benefits Administrator</td>
<td>Phone Number</td>
<td>OGB Agency Number</td>
</tr>
<tr>
<td>Enrollment Form – State of Louisiana</td>
<td>Agency #_____________</td>
<td>Page 1 of 4</td>
</tr>
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<tr>
<td>The Prudential Insurance Company of America</td>
<td></td>
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<tr>
<td>751 Broad Street, Newark, New Jersey 07102</td>
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<thead>
<tr>
<th>General Information (Employee)</th>
<th>Effective Date of Coverage (for office use only)</th>
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<tbody>
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<tr>
<td>Address</td>
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<tr>
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<td>Marital Status</td>
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<td>Married</td>
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<td>Divorced</td>
<td>Widowed</td>
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<td>Date Employed</td>
<td>Your Annual Earnings</td>
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(For Prudential Use Only)

Control # 33624

Employee Term Life & Accidental Death & Dismemberment (AD&D)

- ☐ Basic Term Life
- ☐ Basic plus Supplemental Term Life

Dependent Term Life

You must be enrolled for Employee Term Life to elect coverage for your dependents. Spouse/Child coverage cannot exceed 100% of your Employee Term Life coverage amount.

Spouse/Child: Basic Life
- ☐ Option 1: Spouse $1,000/Child $500
- ☐ Option 2: Spouse $2,000/Child $1,000

Spouse/Child: Basic plus Supplemental Life
- ☐ Option 1: Spouse $2,000/Child $1,000
- ☐ Option 2: Spouse $4,000/Child $2,000

- ☐ No coverage chosen
- ☐ No coverage chosen

Group Life, and Accidental Death and Dismemberment coverages are issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542. 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 Prudential, the terms of the certificate will govern. Contract provisions may vary by state. California COA #1179, NAIC#68241. Contract Series: 83500. Prudential, the Prudential logo and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.
**Employee General Information**

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**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 monthly contribution for coverage. I also understand that for coverage to become effective, I must be actively at work during the enrollment period an 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.

**FOR RESIDENTS OF ALL STATES EXCEPT ALABAMA, DISTRICT OF COLUMBIA, FLORIDA, KENTUCKY, MARYLAND, NEW JERSEY, NEW YORK, PENNSYLVANIA, RHODE ISLAND, UTAH, VERMONT, VIRGINIA AND WASHINGTON; WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he 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.

- **DISTRICT OF COLUMBIA and RHODE ISLAND 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.

- **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.

- **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.

- **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.

- **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.

- **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.

- **VIRGINIA RESIDENTS**—Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is 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.
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### Employee General Information

- **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.

- **WASHINGTON RESIDENTS**—Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Employee Signature ____________________________ Date (Month/Day/Year) ____/____/_______

Spouse or Domestic Partner Signature ______________ Date (Month/Day/Year) ____/____/_______

**(Michigan and Minnesota Residents only—Dependent Consent for Coverage)**: If you wish to enroll your spouse and/or dependent child(ren) 18 years of age or older for dependent life or accidental death and dismemberment insurance coverage, your spouse and each child must acknowledge consent for coverage.

Child Signature ____________________________ Date (Month/Day/Year) ____/____/_______

Child Signature ____________________________ Date (Month/Day/Year) ____/____/_______

You must also complete a separate beneficiary designation form.
Beneficiary Designation – State of Louisiana

**Employee General Information**

**Page 1 of 2**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Social Security No.</th>
<th>_____ – _____ – _____</th>
</tr>
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</table>

**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.

**Employee Term Life & AD&D – Primary beneficiaries:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td>Date of Birth</td>
<td>Relationship</td>
<td>Percentage</td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
</tbody>
</table>

Check one, if applicable:  
- Trust  
- Estate  
- Corporation  

**Entity Name:**

<table>
<thead>
<tr>
<th>Tax ID #/Tax Exempt #</th>
<th>Creation/Incorporation/Formation Date</th>
<th>Telephone Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
</tbody>
</table>

**Employee Term Life & AD&D – 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.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Telephone Number</th>
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Check one, if applicable:  
- Trust  
- Estate  
- Corporation  

**Entity Name:**

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<th>Tax ID #/Tax Exempt #</th>
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Check one, if applicable:  
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Prudential

### Employee General Information

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<th>Last Name</th>
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The above beneficiary designation only applies to:

- [ ] Basic Term Life/AD&D
- [ ] Basic plus Supplemental Term Life/AD&D

Employee Signature ___________________________ Date (mm/dd/yyyy) ______________

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

Group Term Life and Group AD&D coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 800-524-0542. 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 Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract series: 83500. Prudential, the Prudential logo and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.
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

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

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

B) 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, certifying that I have the required 40 quarters of coverage needed for optional membership.

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

A) 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.

B) I elect NOT to join LASERS

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:

Member's Signature Date

1-01 R122015 CONTINUE ON NEXT PAGE
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, DID refund contributions and 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
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
Designation of Beneficiary

<table>
<thead>
<tr>
<th>Member's First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Today's Date</th>
<th>Social Security Number</th>
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</table>

**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

<table>
<thead>
<tr>
<th>Member's Mailing Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tr>
<th>Daytime Area Code/Phone Number</th>
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### 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%**

<table>
<thead>
<tr>
<th>Primary Beneficiary's Name</th>
<th>Relation, Trust, Estate</th>
<th>Birth Date</th>
<th>Percentage</th>
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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%

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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%

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Continental Beneficiaries' Percentages Must Total 100%

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**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.

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<th>Member’s Signature</th>
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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
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
   o 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.
   o 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).
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

Employee Signature: ____________________________ Date: _____________________

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.

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.