SUBSTITUTE TEACHERS

NEW HIRE BENEFITS PACKET

2014-2015

Forms to Complete and Return to SFUSD Benefits Unit
Statement Concerning Your Employment in a Job
Not Covered by Social Security

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

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

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

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

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

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

Signature of Employee Date

Form SSA-1945 (12-2004)
Information about Social Security Form SSA-1945
Statement Concerning Your Employment in a Job Not Covered by Social Security

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

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

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

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

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/form1945. Paper copies can be requested by email at oplm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.
STATE TEACHERS’ RETIREMENT INFORMATION
Part –Time; less than .50 or Substitutes

PLEASE REVIEW THE STATEMENTS BELOW:

1. You can become a member of the retirement system effective on your first day of employment. Retirement contributions are 8% of your contract or gross salary and are tax deferred. You do not pay taxes on your retirement contributions until such time as you apply for a refund or retire from the retirement system. You are eligible for STRS retirement when you reach age 55 and have 5 years of credited service.

2. Be covered by Social Security and have Social Security contributions (at the rate of 6.2% on a post-tax basis) deducted from your paycheck until such time as you become qualified for membership in STRS. Substitute and hourly teachers qualify after 100 workdays or 100 hours for one employer in any one school year. The membership date is the first day of the next pay period in which service is performed. Once you become a member of STRS, the deduction for Social Security stops and the deductions for retirement contributions begin.

I have read the disclosures above and I will select one (1) of the following options:

☐ As a part-time, .50 or less, part-time or day-to-day sub/hourly sub teacher, I wish to become a member of STRS effective on the first day of employment. I understand that if I do not work during the pay period when the election form is signed, my membership in STRS is revocable.

☐ I am currently a member of STRS.

☐ I have retired from STRS.

☐ I currently work as a d-t-d substitute and/or less than .50 fte. and I decline membership at this time. (Please sign and date the section below)

Under the provisions of the Omnibus Budget Reconciliation Act of 1990, employees who are not covered by a retirement system will be covered by Social Security. If you are currently a member of the State Teachers’ Retirement System (STRS), please check the appropriate statement above. If you are not a member of STRS, please continue reading.

If you are not currently a member of the State Teacher’s Retirement System (STRS) and wish to elect membership at this time, you must complete the attached Retirement System Election form (MR350 attached) unless you have already retired from STRS.

Print Name – (Last, First, Middle Initial)       (Soc. Security #)       (Birth Date)       (M or F)

Signature:____________________________________       Date:____________________

SFUSD IS CURRENTLY PARTICIPATING IN THE DEFINED BENEFIT PLAN

EMPLOYEE ID ____________

Benefits Staff Use Only
VERIFIED IN REAP (INITIALS) _______

ET____ TT____ PROB____ DTD____ TPR1 ____ ADM ____ OTHER____

FTE____ HIRE DATE______       Processed By:_________
PERMISIVE MEMBERSHIP
MR 350 (REV 5/03)

PERMISIVE ELECTION AND ACKNOWLEDGMENT OF RECEIPT OF
CALSTRS DEFINED BENEFIT PLAN MEMBERSHIP INFORMATION

Please Type or Print Legibly in Black Ink

EMPLOYEE CERTIFICATION

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<th>Name:</th>
<th>Social Security Number:</th>
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(Last) (First) (Initial)

Position Title:

Education Code Section 22515 permits an employee who performs creditable service (as defined in Section 22119.5), and who is excluded from mandatory membership pursuant to Section 22601.5, 22602 or 22604, to elect membership in the California State Teachers’ Retirement System Defined Benefit Program at any time while employed to perform creditable service. The election must be in writing and filed at CalSTRS prior to submission of contributions to the program. The employee’s membership date can be no earlier than the first day of the pay period during which the election form is signed.

I certify I have received information from my employer concerning the CalSTRS Defined Benefit Program (DB Program) and understand the criteria for membership in the plan.

I certify that I am eligible to elect membership in the California State Teachers’ Retirement System Defined Benefit Program as provided in Section 22515 of the California Education Code, and make the following election.

I elect membership ☐ I decline membership at this time ☐

Signature: Date:

TO BE COMPLETED BY EMPLOYER

I certify that the above-named employee has been provided with the membership criteria for the CalSTRS Defined Benefit Program as required pursuant to Education Code Section 22455.5; in a timely manner or within 30 days of their hire, if part-time or a substitute employee and, if applicable, the employee has been informed of his or her right to elect into membership in the CalSTRS DB Program.

Official’s Signature: Title:

County (or Other Employing Agency): District:

<table>
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<tr>
<th>Employee#</th>
<th>Sex</th>
<th>Birthdate (Mo/Day/Year)</th>
<th>Membership Date (Mo/Day/Year)</th>
<th>Assignment</th>
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DESIGNATION FOR THE DEFINED BENEFIT AND DEFINED BENEFIT SUPPLEMENT PROGRAMS

Under the Defined Benefit Program this form is for the purpose of designating recipient(s) to receive the One-Time Death Benefit payable in the event of your death. Any accumulated contributions in your account, plus any allowance accrued and unpaid on the date of death, will be paid to the designated recipient(s), subject to the following provisions. These benefits will be paid only if no Option Beneficiary was selected to receive a continuing benefit after your death, or you have no spouse, registered domestic partner or children eligible to receive a Family or Survivor Benefit Allowance after your death, if you are an active member at the time of your death.

Under the Defined Benefit Supplement Program, if your death occurs before retirement, the recipients designated on this form may be eligible to select an ongoing annuity or a lump-sum payment. If your death occurs after retirement, the recipients designated on this form may be eligible for an ongoing annuity you selected at the time of your retirement.

ELIGIBILITY REQUIREMENTS FOR THE DEFINED BENEFIT PROGRAM

The designated recipient(s) is eligible to receive the one-time death benefit if you:

1. Were receiving a service retirement benefit or disability retirement allowance at the time of death.

2. Had earned at least one year or more of service credit and your death occurred during one of the following periods:
   - while in employment for which creditable compensation is paid; or
   - while receiving or eligible to receive a disability allowance; or
   - within four months after you terminated employment or had last earned service credit; or
   - within four months after termination of a disability allowance, if no service was performed; or
   - within 12 months of the last day for which creditable compensation is paid, if you were on an approved leave of absence without compensation for reasons other than disability or military service.

3. Had worked part time and your death occurred within four months after ending employment or earning service credit.

In addition to these qualifications, if you had taken a refund of contributions or had reinstated after retirement, you must also have:

- earned one year of service credit; or
- six months must have elapsed since reinstatement from disability retirement.

IMPORTANT FACTS

This form does NOT designate a beneficiary to receive a continuing monthly retirement option upon your death nor does it alter existing option choices.

This form remains in effect until either a new One-Time Death Benefit Recipient form is filed, or your membership in CalSTRS is terminated by a refund of your accumulated contributions. It is important to keep this form current.

A completed form must be received and accepted by CalSTRS before your death to be valid.

If your designated primary recipient(s) predeceases you, any benefit due will be paid to your secondary recipient(s), unless you file a new form. If CalSTRS is unable to locate your designated recipient(s), the One-Time Death Benefit will be distributed to the best of our ability according to the laws in existence at the time of your death.

For more information, the Member Handbook and Tele-talk messages, under Category 500, are available at www.CalSTRS.com or 800-228-5453, where you can also download or order additional forms.
One-Time Death Benefit Recipient Instructions

Print clearly in DARK INK, or type all information requested. Do not use light colors of ink, pencil or erasable ink. Any corrections on the form must be initialed by the member to meet minimum requirements.

SECTION A—MEMBER INFORMATION
Enter your Social Security number, birth date, full name, telephone number and complete mailing address.

SECTIONS B AND C—PRIMARY AND SECONDARY RECIPIENT(S) OR TRUST
You may name any living person, an estate, a trust, a corporation, a charitable or parochial institution or a public entity as your recipient(s).

- **Person(s)** — Provide their Social Security number, full name, relationship, birth date, address and telephone number.

- **Estate** — To designate your estate, enter the phrase “My Estate” instead of the recipient(s) name. Upon your demise, if your estate is not subject to probate, CalSTRS will pay benefits pursuant to California Probate Code Section 13101.

- **Trust** — If you want a Trust to be the payee, do not list recipient(s). Enter the name of the trust, the trustee’s name, the trustee’s address and the date of creation instead of a birth date. CalSTRS will contact the trustee and pay benefits to the trust. It is not necessary to provide the trust document at this time.

- **Organization** — If you wish to designate an organization, enter the name, address of the organization and the organization tax identification number.

SECTION D—SIGNATURES CHECKLIST
- **Signature Date** — The member’s signature must be dated for the form to be valid.

- **Signature of Spouse or Registered Domestic Partner**
  - If you are not married or registered as a domestic partner, check the box “I am not married;” or
  - If you are married or registered as a domestic partner, your spouse or partner must sign the form; or
  - Check the box that indicates your spouse or registered domestic partner has not signed the form. You must complete the Justification for Non-Signature of Spouse or Registered Domestic Partner section on the reverse side of the form.

SECTION E—ADDITIONAL RECIPIENTS
To designate more recipient(s), additional space is provided on page 2 of the form. Indicate whether the recipients you are designating are primary or secondary recipients by entering “P” for primary or “S” for secondary in the appropriate box.

Valid forms will be processed and filmed. Please retain a copy of the form for your records.

Questions? Contact CalSTRS at 800-228-5453, or TTY for the hearing impaired 916-229-3541. You can also click on Contact Us at www.CalSTRS.com to send a secure message.

Individual Privacy and Access to Records: The California State Teachers’ Retirement System is authorized to maintain One-Time Death Benefit Recipient designations in accordance with Education Code Section 23300. Submission of this designation is voluntary. However, if a recipient is not designated, the possibility exists that the benefits due at the time of your death may not be paid in accordance with your wishes.

You have the right to review your files maintained by CalSTRS upon request and submission of proper identification. You may contact us at 800-228-5453.
Section A Member Information

NAME (LAST, FIRST, INITIAL)    SOCIAL SECURITY NUMBER

ADDRESS (STREET)    DATE OF BIRTH (MM/DD/YYYY)

CITY    STATE    ZIP CODE    E-MAIL ADDRESS    HOME TELEPHONE

I hereby revoke any previous designation(s) and designate the following primary recipient(s) to share and share alike, unless otherwise specified herein, or the survivor(s) among them, as recipient(s) for any benefit payable under the Teachers’ Retirement Law at the time of my death. In the event I survive the primary recipient(s) designated below, then I designate the following secondary recipient(s), share and share alike unless otherwise specified, or the survivor(s) among them, as recipient(s) for any benefit payable under the Teachers’ Retirement Law at the time of my death. Should I survive all of my named recipients, then any benefit payable at the time of my death under said law shall be paid to my estate. This form does not designate a beneficiary to receive a continuing monthly retirement option benefit. This is solely for the members of the Defined Benefit and Defined Benefit Supplement Programs.

Section B Primary Recipient(s) or Trust

Primary Recipient(s)

SOCIAL SECURITY NUMBER    NAME/TRUST (LAST, FIRST, INITIAL)    TELEPHONE NUMBER

BIRTHDATE/TRUST DATE    RELATIONSHIP    ADDRESS    CITY    STATE    ZIP

Trust

SOCIAL SECURITY NUMBER    NAME/TRUST (LAST, FIRST, INITIAL)    TELEPHONE NUMBER

BIRTHDATE/TRUST DATE    RELATIONSHIP    ADDRESS    CITY    STATE    ZIP

Section C Secondary Recipient(s) or Trust

Secondary Recipient(s)

SOCIAL SECURITY NUMBER    NAME/TRUST (LAST, FIRST, INITIAL)    TELEPHONE NUMBER

BIRTHDATE/TRUST DATE    RELATIONSHIP    ADDRESS    CITY    STATE    ZIP

Trust

SOCIAL SECURITY NUMBER    NAME/TRUST (LAST, FIRST, INITIAL)    TELEPHONE NUMBER

BIRTHDATE/TRUST DATE    RELATIONSHIP    ADDRESS    CITY    STATE    ZIP

☐ Check box if additional recipients are listed on the back of this form.

Section D Member Signature

☐ I certify under penalty of perjury that: I am not legally married or registered as a domestic partner; I have never married or registered as a domestic partner; or I am divorced, widowed, or have terminated or dissolved my domestic partnership; or my spouse or partner has died. (Provide divorce settlement.)

SIGNATURE OF MEMBER    DATE

Signature of Spouse or Registered Domestic Partner

If no signature of spouse or registered domestic partner, the member must check the following box:

☐ I am married or registered as a domestic partner, but my spouse or registered domestic partner did not sign. Please complete the Justification for Non-Signature of Spouse or Registered Domestic Partner section on page 2.

SIGNATURE OF SPOUSE OR REGISTERED DOMESTIC PARTNER
Section E  Additional Recipients

Be sure to indicate whether your recipient is a P=Primary or S=Secondary

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<th>P or S</th>
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<th>Name/Trust Relationship &amp; Address</th>
<th>Relationship &amp; Birth Date/Trust Date</th>
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Section F  Justification for Non-Signature of Spouse or Registered Domestic Partner

Pursuant to Education Code Section 22453, any request related to the selection of benefits by a member or retiree in which a spousal or registered domestic partner (partner) interest may be present, such as a One-Time Death Benefit Recipient form, shall contain the signature of the spouse or partner of the member, unless a specified condition exists. If the member is married or registered as a domestic partner and his or her spouse or partner does not sign this designation, the following section MUST be completed and signed by the member to validate this One-Time Death Benefit Recipient form.

I am married or registered as a domestic partner, but my spouse or partner did not sign this One-Time Death Benefit Recipient form because either (appropriate box must be checked to make it valid):

- [ ] I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or partner; or
- [ ] My spouse or partner has been advised of the recipient designated and has refused to sign the acknowledgment. Court action has been initiated to enforce or waive the signature requirement for my spouse or partner. (CalSTRS must have a certified copy of the court order on file before any benefits can be paid. Please submit a certified copy of the court order as soon as you receive it.) Education Code Section 22454; or
- [ ] My spouse or partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition. (Please submit a doctor’s statement certifying the condition); or
- [ ] My spouse or partner has no identifiable community property interest in my benefits (Please submit a certified copy of a legal document.); or
- [ ] My spouse or partner and I have executed a marriage or registered domestic partner settlement agreement that makes the community property law inapplicable to the marriage or registered domestic partnership. (Please submit a certified copy of the agreement.)

I certify under penalty of perjury under the laws of the state of California that the foregoing is true and correct.

_________________________________  ________________________________
SIGNATURE OF MEMBER               DATE (MM/DD/YYYY)
United Educators of San Francisco
For Employees of the San Francisco Unified School District

Print Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Social Security # | Phone# ( ) | Cell Phone # ( )

School or Other Site

Email Address

Check One: ☐ Teacher  ☐ Substitute Teacher  ☐ Other  ☐ Paraprofessional  ☐ Para Sub

Payroll Deduction: Pursuant to state law and current agreement between the District and UESF, all non-supervisory employees represented by UESF, as a condition of initial and continued employment, shall either join the union or pay an agency fee. Such payments are made by payroll deduction and forwarded to the Union each month.

☐ Union Membership: Entitles members to attend meetings, vote and hold office and participate in benefit/discounts/legal protection programs. Dues include membership in the National Education Association, American Federation of Teachers, California Teachers Association, and the California Federation of Teachers.

Every member shall pay UESF/COPE dues ($1.67 per month for teachers, Paras $0.75 per pay period) as defined in item e of the bylaws. If you do not wish to participate in the Committee on Political Education (COPE), please choose one of the alternate uses for that portion of your dues:

☐ UESF Scholarship Fund  ☐ Educational Research and Dissemination  ☐ UESF Public Relations

☐ Agency Fee: If you are not interested in membership with UESF, please read the attached AGENCY FEE PACKET for a complete description of your rights and obligations. Monies will be deducted and forwarded to the Union at the appropriate rate for your classification. Failure to fill out this form will result in automatic payroll deductions as an agency fee payer. (Please read and sign reverse side of this form.)

Pursuant to the agreement between UESF and the SFUSD, I hereby authorize the District to deduct from my salary or wages and to transmit to UESF the authorized agency fees, dues and/or contribution, as certified by the Union. Failure to fill out this form will mean automatic payroll deduction as an agency fee payer.

Your Signature: ________________________________  Today’s Date: ________________________________

Union Members Only - Voluntary Payroll Contributions

☐ UESF-AFT/COPE* Contribution Disclosure: I hereby authorize the San Francisco Unified School District to deduct from my salary the sum of ☐ $5.00 ☐ $10.00 ☐ $20.00 ☐ $__________(other amount) per pay period and forward that amount to the UESF/COPE. This authorization is signed freely and voluntarily and not out of any fear of reprisal and I will not be favored or disadvantaged because I exercise this right. I understand that this money will be used to make political contributions by AFT/COPE. AFT/COPE may engage in joint fundraising efforts with the AFL-CIO.

☐ NEA Fund for Children and Public Education* Disclosure: I hereby authorize the San Francisco Unified School District to deduct from my salary the sum of $__________ per pay period and forward to the NEA Fund for Children and Public Education. *Contributions or gifts to AFT/COPE and/or NEA Fund for Children and Public Education are not deductible as charitable contributions for federal income tax purposes.

☐ Fund for California Teachers FACT: FACT is a nonprofit organization run by CTA teachers to help teachers with a Disaster Relief Fund (fire, earthquake, flood) by authorizing interest-free disaster loans. I wish to make a voluntary monthly contribution of $__________.

To join, complete this form and mail it to: United Educators of San Francisco, 2310 Mason Street, San Francisco, California 94133-1800. If you have questions, please call the Membership Secretary at (415) 956-8373. Our fax number is (415) 956-8374 and our website is www.uesf.org.
UNION Membership Benefits

Members own the union. Your right to participate in determining the direction of the union is the most important benefit of membership. Participation also means elections. Union members elect:

- At your site – the Union Building Committee and Building Representative
- At the district level – the Executive Board and local officers
- At the state and national levels – assembly or convention delegates

Membership also means ownership of the contract – the document that defines your working conditions and children’s learning conditions.

Membership means someone is there to help you and look out for your interests.

Membership means we face problems together.

Membership also provides financial benefits thanks to the collective power of 4,000,000 NEA and AFT educators.

Membership benefits are:

- $1,000,000 professional liability insurance
- Legal representation for job-related problems
- Group-rate legal services and free consultations
- Credit unions
- Group-rate life and disability insurance
- Group-rate homeowner and renters’ insurance
- Group-rate auto insurance
- Low-fee, low interest credit cards
- Discount entertainment
- Discount travel services
- Professional conferences and workshops
- Publications of UESF, NEA/CTA and AFT/CFT

Together We Make the Difference.

Acknowledgement of Agency Fee Material (Hudson Report) (non-union members only)

The undersigned hereby acknowledges receipt of UESF notice concerning union membership, union finances, agency fees and the appeal procedure (Hudson Report).

Signature: ____________________________ Date: __________

Employer: San Francisco Unified School District

SFUSD Representative: ____________________________ Date: __________
DIRECT DEPOSIT/ CFR US BANK PAYCARD
AUTHORIZATION FORM

EMPLOYEE #  LAST NAME  FIRST NAME  MI  LAST 4 DIGITS SSN #

AUTHORIZATIONS

☐ DIRECT DEPOSIT TO CHECKING OR SAVINGS - I authorize the financial institution named below to electronically deposit my net pay from the San Francisco Unified School District (SFUSD) to the specified account each pay day. I also authorize SFUSD to direct the financial institution to debit the account to recover amounts erroneously deposited. My authorization is in effect until I either: 1) submit a new Direct Deposit Authorization form, or 2) submit a request for US Bank paycard or 3) separate my employment from SFUSD.

☐ DIRECT DEPOSIT TO CFR/US BANK PAYCARD - I authorize the financial institution named below to electronically deposit my net pay from the San Francisco Unified School District (SFUSD) to the specified account each pay day. I also authorize SFUSD to direct the financial institution to debit the account to recover amounts erroneously deposited. My authorization is in effect until I either: 1) submit a new Direct Deposit Authorization form, or 2) submit a request for US Bank paycard or 3) separate my employment from SFUSD.

☐ PAPERLESS PAYSTUB - Check this box to receive your paystub paperless (excludes MGT and SCL paygroups who are currently paperless.)

IMPORTANT INFORMATION

1. The transit/ABA number is used by your financial institution for transaction routing purposes. This number can be found at the bottom of your check.

2. Your financial institution issued the account number.

3. You must attach a statement from your financial institution for verification of your account code.

Financial Institution  Transit/ABA No.  Account No.

☐ Checking or share draft account - Staple a voided check to the front of this form or #3

☐ Savings account

☐ CFR/US Bank Paycard

☐ NEW Direct Deposit Account

☐ CHANGE Existing Account

Employee Signature ______________________________   Date ____________ Phone No. ________________

Send completed forms to Payroll Department, 135 Van Ness Ave., Room 324, San Francisco, CA 94102

Change effective pay-period# _________________________   Processed By: ____________________________

Revised 03/13/2013
forms/direct deposit.pmd
revised by: maxima harris
Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:
- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet. See Pub. 505 for information on converting your other credits into withholding allowances.

Note. (This form is not valid unless you sign it.)

Employee's signature

Internal Revenue Service
Department of the Treasury

Employee's Withholding Allowance Certificate

Separate here and give Form W-4 to your employer. Keep the top part for your records.

1 Your first name and middle initial
2 Last name
3 Your social security number

Home address (number and street or rural route)
4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.

City or town, state, and ZIP code

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)
6 Additional amount, if any, you want withheld from each paycheck

7 I claim exemption from withholding for 2014, and I certify that I meet both of the following conditions for exemption:
- Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and
- This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

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

Employee's signature

(For Privacy Act and Paperwork Reduction Act Notice, see page 2.)

OMB No. 1545-0074

2014

Form W-4 (2014)
Deductions and Adjustments Worksheet

Note. Use this worksheet only if you plan to itemize deductions or claim certain credits or adjustments to income.

1. Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details.

2. Enter:
   - $12,400 if married filing jointly or qualifying widow(er)
   - $9,100 if head of household
   - $6,200 if single or married filing separately

3. Subtract line 2 from line 1. If zero or less, enter “–0–”.

4. Enter an estimate of your 2014 adjustments to income and any additional standard deduction (see Pub. 505)

5. Add lines 3 and 4 and enter the total. (Include any amount from credits for the Converting Credits to Withholding Allowances for 2014 Form W-4 worksheet in Pub. 505.)

6. Enter an estimate of your 2014 nonwage income (such as dividends or interest)

7. Subtract line 6 from line 5. If zero or less, enter “–0–”.

8. Divide the amount on line 7 by $3,950 and enter the result here. Drop any fraction.

9. Enter the number from the Personal Allowances Worksheet, line H, page 1

10. Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1.

Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

Note. Use this worksheet only if the instructions under line H on page 1 direct you here.

1. Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet).

2. Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than “3”.

3. If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “–0–”). And on Form W-4, line 5, page 1. Do not use the rest of this worksheet.

4. Enter the number from line 2 of this worksheet.

5. Enter the number from line 1 of this worksheet.

6. Subtract line 5 from line 4.

7. Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here.

8. Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed.

9. Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck.

### Table 1

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from LOWEST paying job are—</td>
<td>Enter on line 2 above</td>
</tr>
<tr>
<td>$0 - $6,000</td>
<td>0</td>
</tr>
<tr>
<td>6,001 - 12,000</td>
<td>1</td>
</tr>
<tr>
<td>12,001 - 24,000</td>
<td>2</td>
</tr>
<tr>
<td>24,001 - 33,000</td>
<td>3</td>
</tr>
<tr>
<td>33,001 - 43,000</td>
<td>4</td>
</tr>
<tr>
<td>43,001 - 60,000</td>
<td>5</td>
</tr>
<tr>
<td>60,001 - 80,000</td>
<td>6</td>
</tr>
<tr>
<td>80,001 - 100,000</td>
<td>7</td>
</tr>
<tr>
<td>100,001 - 115,000</td>
<td>8</td>
</tr>
<tr>
<td>115,001 - 130,000</td>
<td>9</td>
</tr>
<tr>
<td>130,001 - 140,000</td>
<td>10</td>
</tr>
<tr>
<td>140,001 - 150,000</td>
<td>11</td>
</tr>
<tr>
<td>150,001 and over</td>
<td>12</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from HIGHEST paying job are—</td>
<td>Enter on line 7 above</td>
</tr>
<tr>
<td>$0 - $74,000</td>
<td>0</td>
</tr>
<tr>
<td>74,001 - 130,000</td>
<td>1</td>
</tr>
<tr>
<td>130,001 - 200,000</td>
<td>2</td>
</tr>
<tr>
<td>200,001 - 355,000</td>
<td>3</td>
</tr>
<tr>
<td>355,001 - 400,000</td>
<td>4</td>
</tr>
<tr>
<td>400,001 and over</td>
<td>5</td>
</tr>
</tbody>
</table>

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(l)(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 who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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