NEW HIRE BENEFITS PACKET

2011-2012

Forms to Complete and Return to SFUSD Benefits Unit
ENROLLMENT INFORMATION

BENEFITS DO NOT COMMENCE UPON HIRING. DEPENDING ON YOUR JOB CLASSIFICATION AND STATUS, THERE IS A WAITING PERIOD BEFORE ELIGIBILITY FOR COVERAGE BEGINS. BENEFITS ARE NOT AUTOMATIC EITHER; YOU MUST ENROLL BY COMPLETING AND RETURNING THE VARIOUS FORMS TO THE “SFUSD BENEFITS OFFICE” AND THE “HEALTH SERVICE SYSTEM”, EVEN IF YOU DECIDE TO DECLINE BENEFITS DUE TO COVERAGE ELSEWHERE OR PERSONAL REASONS.

YOU WILL BE NOTIFIED OF THE EFFECTIVE DATE OF YOUR COVERAGE UPON VERIFICATION OF YOUR ELIGIBILITY (CHECK YOUR BENEFITS SUMMARY FOR ADDITIONAL INFORMATION).

THE “BENEFITS INFORMATION & ENROLLMENT GUIDE” 2007-2008 BOOKLET ADDRESSES THE RULES AND REGULATIONS. PLEASE READ IT FIRST! KEEP THIS BOOKLET HANDY THROUGHOUT THE YEAR SINCE IT CONTAINS VALUABLE INFORMATION ABOUT BENEFITS UPON ENROLLMENT, DURING THE COURSE OF ACTIVE EMPLOYMENT, LEAVE STATUS, RESIGNATION AND RETIREMENT.

IT IS IMPORTANT THAT YOU REVIEW AND UNDERSTAND THE BENEFIT PROGRAM CHOICES AND COSTS TO BE DEDUCTED FROM EACH PAYCHECK, IF ANY. READ YOUR MATERIALS. ONCE YOUR SELECTIONS HAVE BEEN PROCESSED, THEY CANNOT BE CHANGED UNTIL THE NEXT ANNUAL OPEN ENROLLMENT PERIOD (APRIL) TO BE EFFECTIVE JULY 4th.

IF YOU ADD DEPENDENTS (SPOUSE, DOMESTIC PARTNER, CHILDREN), YOU WILL BE REQUIRED TO SUBMIT THEIR SOCIAL SECURITY NUMBERS, MARRIAGE OR DOMESTIC PARTNERSHIP CERTIFICATES, CHILDREN'S BIRTH CERTIFICATES FOR ELIGIBILITY PURPOSES.

THE HEALTH AND VISION BENEFITS ARE ADMINISTERED BY THE CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT: “HEALTH SERVICE SYSTEM” AT 1145 MARKET ST., 2nd FLOOR. EMPLOYEES WHO DO NOT ENROLL AT H.S.S. WITHIN 30 DAYS OF DATE OF HIRE WILL NOT BE ELIGIBLE TO ENROLL IN A HEALTH/VISION PLAN UNTIL THE NEXT OPEN ENROLLMENT PERIOD.

TEMPORARY APPOINTED SCHOOL-TERM EMPLOYEES ARE NOT ELIGIBLE FOR SUMMER COVERAGE; "COBRA" WILL THEN BE OFFERED DURING THIS PERIOD. PERMANENT SCHOOL-TERM EMPLOYEES RECEIVE YEAR ’ROUND COVERAGE AS LONG AS THEY RETURN IN THE FALL; IF NOT, BENEFITS TERMINATE 7/1/06. CERTAIN LEAVES OF ABSENCE (PERSONAL, PROFESSIONAL) RESULT IN LOSS OF BENEFITS UNLESS FULL COST PREMIUM PAYMENTS ARE MADE BY THE EMPLOYEE TO MAINTAIN COVERAGE.

THE “BENEFITS OFFICE” STAFF WILL BE HAPPY TO ASSIST YOU WITH ANY QUESTIONS YOU MAY HAVE. PLEASE DO NOT HESITATE TO CONTACT US.

EMPLOYEE NAME:
SOCIAL SECURITY NUMBER:
DATE OF BIRTH:
OCCUPATION:
HOME TELEPHONE #:
ADDRESS:

SIGNATURE ___________________________ DATE _______________________
(SIGNING HERE WILL ACKNOWLEDGE THE RECEIPT OF YOUR BENEFITS PACKET)

========================================================================================================

(FOR OFFICE USE ONLY)
CERT _______ CLASS _______ HIRE DATE _________________ EMP ID # ______________
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
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

Applicant:
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 below. 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), you have two options available to you:

1. You can become a member of the retirement system effective on your first day of work. 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 600 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.

PLEASE CHECK THE APPROPRIATE STATEMENT

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

I am appointed to a position identified as creditable service and understand that my STRS membership will be effective on my first day of work_____.

I am currently a member of STRS_____, City Retirement or was a member of City Retirement_____.

I have retired from STRS_____, San Francisco Employees’ Retirement System (SFERS)_____ through ____________________________ (school district).

You must complete the attached Retirement System Election form (MR350) unless you have already retired from STRS or City Retirement.

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

Signature:__________________________________________ Date:________________________

SFUSD IS CURRENTLY PARTICIPATING IN THE DEFINED BENEFIT PLAN

FOR OFFICE USE ONLY: ET____ TT____ PROB____ DTD____ EMPLOYEE ID#______ HIRE DATE______ Processed By:_________
PERMISSIVE MEMBERSHIP
MR 350 (REV 5/03)

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

Please Type or Print Legibly in Black Ink

EMPLOYEE CERTIFICATION

Name: ____________________________

Social Security Number: ____________________________

(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>
<thead>
<tr>
<th>Employee#</th>
<th>Sex</th>
<th>Birthdate (Mo/Day/Year)</th>
<th>Membership Date (Mo/Day/Year)</th>
<th>Assignment</th>
</tr>
</thead>
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<td>FT PT Sub</td>
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</table>
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.

SESSIONS 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

<table>
<thead>
<tr>
<th>NAME (LAST, FIRST, INITIAL)</th>
<th>SOCIAL SECURITY NUMBER</th>
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</thead>
<tbody>
<tr>
<td>ADDRESS (STREET)</td>
<td>DATE OF BIRTH (MM/DD/YYYY)</td>
</tr>
<tr>
<td>CITY STATE ZIP CODE E-MAIL ADDRESS HOME TELEPHONE</td>
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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

<table>
<thead>
<tr>
<th>SOCIAL SECURITY NUMBER</th>
<th>NAME/TRUST (LAST, FIRST, INITIAL)</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIRTHDATE/TRUST DATE</td>
<td>RELATIONSHIP ADDRESS CITY STATE ZIP</td>
<td></td>
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</tbody>
</table>

Trust

<table>
<thead>
<tr>
<th>SOCIAL SECURITY NUMBER</th>
<th>NAME/TRUST (LAST, FIRST, INITIAL)</th>
<th>TELEPHONE NUMBER</th>
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<tr>
<td>BIRTHDATE/TRUST DATE</td>
<td>RELATIONSHIP ADDRESS CITY STATE ZIP</td>
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### Section C Secondary Recipient(s) or Trust

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<tr>
<th>SOCIAL SECURITY NUMBER</th>
<th>NAME/TRUST (LAST, FIRST, INITIAL)</th>
<th>TELEPHONE NUMBER</th>
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<tr>
<td>BIRTHDATE/TRUST DATE</td>
<td>RELATIONSHIP ADDRESS CITY STATE ZIP</td>
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Trust

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<tr>
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<tr>
<td>BIRTHDATE/TRUST DATE</td>
<td>RELATIONSHIP ADDRESS CITY STATE ZIP</td>
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☐ 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.)

<table>
<thead>
<tr>
<th>SIGNATURE OF MEMBER</th>
<th>DATE</th>
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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.

<table>
<thead>
<tr>
<th>SIGNATURE OF SPOUSE OR REGISTERED DOMESTIC PARTNER</th>
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</table>
### Section E  Additional Recipients

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

<table>
<thead>
<tr>
<th>P or S</th>
<th>Social Security Number</th>
<th>Name/Trust Relationship &amp; Address</th>
<th>Relationship &amp; Birth Date/Trust Date</th>
<th>Address</th>
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<td>Last First M.I.</td>
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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

<table>
<thead>
<tr>
<th>Print Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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<tbody>
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<td>Address</td>
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<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Social Security #</td>
<td>Phone# (   )</td>
<td>Cell Phone # (  )</td>
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<tr>
<td>School or Other Site</td>
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<tr>
<td>Email Address</td>
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Check One: [ ] Teacher [ ] Substitute Teacher [ ] Other ____________________________ [ ] Paraprofessional

**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 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. I understand that this money will be used to make local political contributions by 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 $__________
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: ____________

mk opeiu 3 afl cio (209) revised 6/10/08
**Enrollee**

<table>
<thead>
<tr>
<th>Name</th>
<th>Social Security Number</th>
<th>Date Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last First Middle Initial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthdate Gender</td>
<td>Marital Status</td>
<td>Do you have dependent children?</td>
</tr>
<tr>
<td></td>
<td>Single Divorced</td>
<td>Yes No</td>
</tr>
<tr>
<td></td>
<td>Married/Partnered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td></td>
</tr>
<tr>
<td>Employee ID:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DEPENDENTS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Birthdate</th>
<th>If Child is 19 years or older (Check one)</th>
<th>Dependent's Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last First Middle Initial Relation</td>
<td>Male Female</td>
<td>Month Day Year</td>
<td>Full-time Student Disabled</td>
<td>(If Blank Please Add)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Change to Existing Enrollment**

<table>
<thead>
<tr>
<th>Name Change</th>
<th>Add new dependent</th>
<th>Delete dependent</th>
<th>Address change(insert change above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Add / Delete</td>
<td>Add / Delete</td>
<td></td>
</tr>
<tr>
<td>Last First Middle Initial Relation</td>
<td>Add / Delete</td>
<td>Add / Delete</td>
<td>Add / Delete</td>
</tr>
<tr>
<td>Birthdate</td>
<td>If Child is 19 years or older (Check one)</td>
<td>Dependent's Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Month Day Year</td>
<td>Full-time Student Disabled</td>
<td>(If Blank Please Add)</td>
<td></td>
</tr>
</tbody>
</table>

I certify this information to be true and correct.

Employee’s Signature Date
## DIRECT DEPOSIT AUTHORIZATION/CANCELLATION

<table>
<thead>
<tr>
<th>EMPLOYEE #</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>LAST 4 DIGITS SSN #</th>
</tr>
</thead>
</table>

### AUTHORIZATIONS

- [ ] I authorize the financial institution(s) named below to electronically deposit my net pay from the San Francisco Unified School District (SFUSD) to the specified account(s) each pay day. I also authorize SFUSD to direct the(se) financial institution(s) to debit the account(s) to recover amounts erroneously deposited. My authorization is in effect until I either: 1) submit a new Direct Deposit Authorization/Cancellation form, or 2) submit a written cancellation/revocation request, or 3) separate my employment from SFUSD.

- [ ] I do hereby cancel/revoke my authorization permitting the SFUSD payroll department to electronically deposit my net pay to the financial institution named below. I understand that once this revocation is processed, I will begin receiving paychecks.

**Employee Signature ________________________________ Date ________________ Phone No. ________________________**

### For checking or share draft accounts, staple a voided check to this form

<table>
<thead>
<tr>
<th>Financial Institution</th>
<th>Transit/ABA No.</th>
<th>Account No.</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

- [ ] New/Change
- [ ] Cancel/Revoke

- [ ] Checking/Share Draft
- [ ] Savings

**IMPORANT INFORMATION**

1. You must submit a written cancellation/revocation of authorization when closing your checking or savings accounts.
2. 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.
3. Your financial institution issued the account number.
4. Amount - write in the dollar value (i.e. $25.00) of your desired bi-weekly payroll deduction.
5. You must attach a statement from your financial institution for verification of your account code.

Send completed forms to Payroll Department, 135 Van Ness Ave., Room 324, San Francisco, CA 94102
**Form W-4 (2011)**

**Purpose.** Complete Form W-4 so that your employer can withhold 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 2011 expires February 16, 2012. 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 $950 and includes more than $300 of unearned income (for example, interest and dividends).

**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 may 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 allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $100,000 (Single) or $180,000 (Married).

---

**Personal Allowances Worksheet (Keep for your records.)**

<table>
<thead>
<tr>
<th>A</th>
<th>Enter &quot;1&quot; for yourself if no one else can claim you as a dependent</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• You are single and have only one job; or</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Enter &quot;1&quot; if:</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>• You are married, have only one job, and your spouse does not work; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Enter &quot;1&quot; for your spouse. But, you may choose to enter &quot;0&quot; if you are married and have either a working spouse or more than one job. (Entering &quot;0&quot; may help you avoid having too little tax withheld.)</td>
<td>C</td>
</tr>
<tr>
<td>D</td>
<td>Enter number of dependents (other than your spouse or yourself) you will claim on your tax return</td>
<td>D</td>
</tr>
<tr>
<td>E</td>
<td>Enter &quot;1&quot; if you will file as head of household on your tax return (see conditions under Head of household above)</td>
<td>E</td>
</tr>
<tr>
<td>F</td>
<td>Enter &quot;1&quot; if you have at least $1,900 of child or dependent care expenses for which you plan to claim a credit</td>
<td>F</td>
</tr>
</tbody>
</table>

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**G Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children.

**H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.)**

For accuracy, complete all worksheets that apply.

---

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

---

**Employee's Withholding Allowance Certificate**

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

<table>
<thead>
<tr>
<th>1</th>
<th>Type or print your first name and middle initial.</th>
<th>2</th>
<th>Your social security number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Last name</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home address (number and street or rural route)</td>
<td>3</td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td>City or town, state, and ZIP code</td>
<td></td>
<td>Married, but withheld at higher Single rate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note. If married, but legally separated, or spouse is a nonresident alien, check the &quot;Single&quot; box.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional amount, if any, you want withheld from each paycheck</td>
<td>6</td>
<td>$</td>
</tr>
<tr>
<td>7</td>
<td>I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you meet both conditions, write &quot;Exempt&quot; here.</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

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**

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

**Date**

---

**Form W-4 (2011)**

OMBE No. 1545-2159

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

Cat. No. 102299 Form W-4 (2011)
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 2011 itemized deductions. These include: 
- Home mortgage interest 
- Charitable contributions 
- State and local taxes 
- Medical expenses in excess of 7.5% of your income 
- Miscellaneous deductions 

2. Subtract line 2 from line 1. If zero or less, enter "-0-".

3. Subtract line 6 from line 5. If zero or less, enter "-0-".

4. Enter an estimate of your 2011 nonwage income (such as dividends or interest). 

5. Add lines 3 and 4 and enter the total. (Include any amount for credits from the Converting Credits to Withholding Alliances for 2011 Form W-4 Worksheet in Pub. 919.)

6. Enter an estimate of your federal income tax withholding. 

7. Subtract line 6 from line 5. If zero or less, enter "-0-".

8. Divide the amount on line 7 by $3,700 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 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. 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>
<thead>
<tr>
<th>Table 1</th>
<th>Table 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Married Filing Jointly</strong></td>
<td><strong>All Others</strong></td>
</tr>
<tr>
<td><strong>If wages from LOWEST paying job are—</strong></td>
<td><strong>If wages from LOWEST paying job are—</strong></td>
</tr>
<tr>
<td>$0 - $5,000</td>
<td>$0 - $8,000</td>
</tr>
<tr>
<td>5,001 - 12,000</td>
<td>8,001 - 15,000</td>
</tr>
<tr>
<td>12,001 - 22,000</td>
<td>15,001 - 25,000</td>
</tr>
<tr>
<td>22,001 - 25,000</td>
<td>25,001 - 30,000</td>
</tr>
<tr>
<td>25,001 - 30,000</td>
<td>30,001 - 40,000</td>
</tr>
<tr>
<td>30,001 - 40,000</td>
<td>40,001 - 50,000</td>
</tr>
<tr>
<td>40,001 - 45,000</td>
<td>50,001 - 65,000</td>
</tr>
<tr>
<td>45,001 - 55,000</td>
<td>65,001 - 90,000</td>
</tr>
<tr>
<td>55,001 - 65,000</td>
<td>80,001 - 95,000</td>
</tr>
<tr>
<td>65,001 - 72,000</td>
<td>95,001 - 120,000</td>
</tr>
<tr>
<td>72,001 - 85,000</td>
<td>120,001 and over</td>
</tr>
<tr>
<td>85,001 - 97,000</td>
<td></td>
</tr>
<tr>
<td>97,001 - 110,000</td>
<td></td>
</tr>
<tr>
<td>110,001 - 120,000</td>
<td></td>
</tr>
<tr>
<td>120,001 - 135,000</td>
<td></td>
</tr>
<tr>
<td>135,001 and over</td>
<td></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 Code sections 3402(g) 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 non-tax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.
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 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. $11,400 if married filing jointly or qualifying widow(er)

2. Enter:
   - $8,400 if head of household
   - $5,700 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 2010 adjustments to income and any additional standard deduction. (Pub. 919)

5. Add lines 3 and 4 and enter the total. (Include any amount for credits from Worksheet 6 in Pub. 919.)

6. Enter an estimate of your 2010 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 $3,650 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.

Note. If line 1 is less than line 2, enter “0-“ on Form W-4, line 5, page 1. Complete lines 4-9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

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 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. 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

Married Filing Jointly | All Others
---|---
If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above
$0 - $7,000 | 0 | $0 - $6,000 | 0 | $0 - $65,000 | 0 | $0 - $35,000 | 0 | $0 - $35,000 | 0
7,001 - 10,000 | 1 | 6,001 - 12,000 | 1 | 65,001 - 120,000 | 1 | 35,001 - 90,000 | 1 | 35,001 - 90,000 | 1
10,001 - 15,000 | 2 | 12,001 - 19,000 | 2 | 120,001 - 185,000 | 2 | 90,001 - 165,000 | 2 | 90,001 - 165,000 | 2
16,001 - 22,000 | 3 | 19,001 - 26,000 | 3 | 185,001 - 330,000 | 3 | 165,001 - 370,000 | 3 | 165,001 - 370,000 | 3
22,001 - 27,000 | 4 | 26,001 - 35,000 | 4 | 330,001 and over | 4 | 370,001 and over | 4 | 370,001 and over | 4
27,001 - 35,000 | 5 | 35,001 - 50,000 | 5 | | | | | |
35,001 - 44,000 | 6 | 50,001 - 65,000 | 6 | | | | | |
44,001 - 50,000 | 7 | 65,001 - 80,000 | 7 | | | | | |
50,001 - 55,000 | 8 | 80,001 - 90,000 | 8 | | | | | |
55,001 - 65,000 | 9 | 90,001 - 120,000 | 9 | | | | | |
65,001 - 72,000 | 10 | 120,001 and over | 10 | | | | | |
72,001 - 85,000 | 11 | | | | | | | |
85,001 - 105,000 | 12 | | | | | | | |
105,001 - 115,000 | 13 | | | | | | | |
115,001 - 130,000 | 14 | | | | | | | |
130,001 - and over | 15 | | | | | | | |

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(5) 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 administrating their tax laws, and using it 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.
HSS ENROLLMENT APPLICATION 2010-2011: SFUSD

You must submit a completed enrollment application and any required documentation to HSS within 30 days of your initial benefits eligibility date or within 30 days of a qualified change in family status. Please refer to your HSS Benefits Guide or visit myhss.org for details. Keep yellow copy for your records. You may also be eligible for other benefits offered by SFUSD. Contact SFUSD Benefits at (415) 241-5101 for details.

1 APPLICATION TYPE
☐ New Hire  ☐ Rehire/Reinstatement  Status Change:  ☐ Birth/Adoption  ☐ Marriage/Divorce  ☐ Other Coverage
☐ Ineligible  ☐ Other (Please explain.)

2 YOUR PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address (no P.O. boxes)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Birth Date MM/DD/YYYY</th>
<th>Gender M/F</th>
<th>Home / Cell Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>eMail Address</th>
<th>Work Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HSS cannot process mailing address changes for active SFUSD employees. You must contact your department personnel supervisor to update the home address on file with your employer.

3 CHOOSE YOUR MEDICAL PLAN

☐ Blue Shield HMO*  ☐ Kaiser HMO*  ☐ City Plan PPO  ☐ No Medical Coverage

*To enroll in these plans you must live in an area serviced by the HMO. Please refer to your HSS Benefits Guide or contact the HMO to verify your eligibility.

4 TO ADD OR DROP ANY DEPENDENTS FROM YOUR MEDICAL COVERAGE, PLEASE LIST BELOW.

You must submit required eligibility documentation for the initial enrollment of any dependents. See the reverse side of this form for details.

<table>
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<th>Last Name</th>
<th>First Name</th>
<th>MM/DD/YYYY</th>
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5 SIGNATURE & CERTIFICATION

Under penalty of perjury I certify that the information entered on this document is true and correct. I give the persons administering the plans in which I enroll and/or their agents permission to verify any and all information. It is my responsibility to notify the Health Service System when a dependent becomes ineligible. I agree to assume full financial responsibility for all expenses and to reimburse and indemnify the plans and the Health Service System for any benefits paid for myself and/or my dependents if I or my dependents prove to be ineligible to participate in the plans or to receive such benefits. I also understand that the falsification of information on this document may violate applicable laws, rules and regulations and could lead to disciplinary action, dismissal and/or legal action. I have read and accept the terms and conditions on this side and the reverse side of this form. A copy of this form is as valid as the original.

Signature: __________________________ Date Signed: __________

WHERE TO SUBMIT THIS APPLICATION AND REQUIRED DOCUMENTATION

Mail, fax or bring to HSS, 1145 Market Street, 2nd Floor, San Francisco, CA 94103  Fax: (415) 554-1721  Phone: (415) 554-1750

Health Service System

Enrolled by: __________ Date: __________ Processed by: __________ Date: __________

CITY & COUNTY OF SAN FRANCISCO
ENROLLMENT APPLICATION: TERMS AND CONDITIONS

Your signature on the front of this form signifies your authorization, understanding of and agreement to the following:

- The Health Service System will only enroll you and your eligible dependents in the benefit elections indicated on this form and for which you are eligible.
- You agree to complete and submit to the plan provider any necessary forms, consents, releases, assignments, applications, questionnaires and other documents that the plan or HSS may reasonably request.
- You authorize the Health Service System to deduct in advance of each applicable coverage period from wages due you any contributions required on your part to provide healthcare coverage for yourself and any eligible dependents listed on this form, and to remit such amounts to the benefit plans you have designated. This deduction may also include contribution amounts which are delinquent and due to the Health Service System.
- You agree to submit any contribution required on your part directly to the Health Service System during any unpaid leave of absence.
- Your participation in the Health Service System is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of the Health Service System), as the same may be amended, modified or supplemented from time to time.
- You will not be able to make any changes to the benefit elections indicated on this form during the Plan year (July 1-June 30) unless you have a qualifying family status change. Refer to your Benefits Guide for complete details.
- Any misstatement of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to reimbursement of premium and claims costs on a retroactive basis, disciplinary action, dismissal and/or legal action.
- The terms and conditions of each medical plan are contained in the individual plan documents available through each plan provider. If any difference exists between the plan documents and any descriptions, charts or summaries provided by the Health Service System, the terms and conditions of the plan documents will govern.
- THAT SOME OF THE HEALTH PLANS OFFERED BY THE HEALTH SERVICE SYSTEM CONTAIN A CLAUSE REQUIRING RESOLUTION OF MEDICAL MALPRACTICE AND OTHER DISPUTES THROUGH BINDING ARBITRATION. This clause expressly provides that when you select the applicable plan, you give up the right to a jury or court trial for resolution of these disputes. To determine whether the plan you have selected contains such a clause and, if so, what the exact terms and conditions of such clause are, consult the individual plan document available through applicable Plan Provider.
- You authorize any person, hospital or other entity that has rendered medical services to you or any dependent(s) listed on this form to make available to the health plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health plan. Such information may also be released to persons or entities which, in conjunction with, or at the direction of the medical plan are conducting a review of cost, quality and/or appropriateness of services rendered.
- You agree that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through the Health Service System, you will promptly notify the Health Service System and submit all requested documentation.
- All healthcare services provided or benefits paid on behalf of any ineligible employee or dependent are subject to collection by the health plan involved or by HSS.
- The following documentation is required, in addition to a completed HSS Health Benefits Enrollment Application, for any eligible individual's enrollment. HSS may request documentation of eligibility at any time.

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<th>EVIDENCE OF HIRE</th>
<th>BENEFIT AUTH. FORM</th>
<th>MARRIAGE CERTIFICATE</th>
<th>DOMESTIC PARTNER REG.</th>
<th>BIRTH CERTIFICATE</th>
<th>ADOPTION CERTIFICATE</th>
<th>COURT ORDER</th>
<th>INCOME TAX RETURN</th>
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If you have questions about eligibility or required documentation contact HSS Member Services at (415) 554-1750.

Health Service System
CITY & COUNTY OF SAN FRANCISCO
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• Any misstatement of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to disciplinary action, dismissal and/or legal action.

• The terms and conditions of each medical/dental plan are contained in the individual plan documents available through each plan provider. If any difference exists between the plan documents and any descriptions, charts or summaries provided by the Health Service System, the terms and conditions of the plan documents will govern.

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• For a complete description of eligibility requirements consult your Benefits Guide.

Health Service System
CITY & COUNTY OF SAN FRANCISCO  MYHSS.ORG