# *NEW HIRE PACKET*

A New Hire Packet must be completed for each new employee and received by ABC Personnel within three (3) business days of the employee's first day of employment. The hiring supervisor is responsible for ensuring the new employee receives the information included herein signing all acknowledgment forms. The policies are to be kept by the employee while the acknowledgment forms are forwarded to ABC Personnel in the following order:

1. Completed I-9 along with a copy of the List A or List B and List C identification and employment verification documents
2. Industrial Relations New Hire Reporting Form
3. Selective Service Certification (only required for male new hires born after 1960)
4. ABC Personnel Policies and Procedures Manual – EMPLOYEE ACKNOWLEDGMENT FORM
5. Drug Free Workplace Policy with Employee Acknowledgement Form
6. ABC Sales Associate Essential Functions
7. Safe Lifting Procedures and Acknowledgment
8. IT Informed Consent Form
9. Health Insurance Enrollment Forms
10. ERS Enrollment Form
11. A-4 Alabama Employee's Withholding
12. W-4 Federal Employee's Withholding
13. Direct Deposit Request
14. City/County Occupational Tax Notification Form(s) (If applicable to work location)

ABC Personnel Office
2715 Gunter Park Drive, West
Montgomery, AL 36109
334-260-5439 (Telephone)
334-260-5450 (Fax)

# Employment Eligibility Verification

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

**USCIS**
**Form I-9**
OMB No. 1615-0047
Expires 03/31/2016

**▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.**

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

| Address (*Street Number and Name*) | Apt. Number | City or Town | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Date of Birth (*mm/dd/yyyy*) | U.S. Social Security Number | E-mail Address | Telephone Number |
|---|---|---|---|
| | ☐☐☐-☐☐-☐☐☐☐ | | |

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

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

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

**1.** Alien Registration Number/USCIS Number: _____

**OR**

**2.** Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

**3-D Barcode**
**Do Not Write in This Space**

| Signature of Employee: | Date (*mm/dd/yyyy*): |
|---|---|
| | |

## Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

| Signature of Preparer or Translator: | Date (*mm/dd/yyyy*): |
|---|---|
| | |

| Last Name (*Family Name*) | First Name (*Given Name*) |
|---|---|
| | |

| Address (*Street Number and Name*) | City or Town | State | Zip Code |
|---|---|---|---|
| | | | |

STOP ***Employer Completes Next Page*** STOP

## Section 2. Employer or Authorized Representative Review and Verification

*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)*

**Employee Last Name, First Name and Middle Initial from Section 1:**

| **List A** Identity and Employment Authorization | **OR** | **List B** Identity | **AND** | **List C** Employment Authorization |
|---|---|---|---|---|
| Document Title: | | Document Title: | | Document Title: |
| Issuing Authority: | | Issuing Authority: | | Issuing Authority: |
| Document Number: | | Document Number: | | Document Number: |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | Expiration Date *(if any)(mm/dd/yyyy)*: | | Expiration Date *(if any)(mm/dd/yyyy)*: |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | | | |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | | | |

**3-D Barcode**
**Do Not Write in This Space**

### Certification

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

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

| Signature of Employer or Authorized Representative | Date *(mm/dd/yyyy)* | Title of Employer or Authorized Representative | |
|---|---|---|---|
| Last Name *(Family Name)* | First Name *(Given Name)* | Employer's Business or Organization Name | |
| Employer's Business or Organization Address *(Street Number and Name)* | City or Town | State | Zip Code |

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

| **A.** New Name *(if applicable)* Last Name *(Family Name)* | First Name *(Given Name)* | Middle Initial | **B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*: |
|---|---|---|---|

**C.** If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

| Document Title: | Document Number: | Expiration Date *(if any)(mm/dd/yyyy)*: |
|---|---|---|

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

| Signature of Employer or Authorized Representative: | Date *(mm/dd/yyyy)*: | Print Name of Employer or Authorized Representative: |
|---|---|---|

## LISTS OF ACCEPTABLE DOCUMENTS
## All documents must be UNEXPIRED

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

| LIST A<br>Documents that Establish Both Identity and Employment Authorization | OR | LIST B<br>Documents that Establish Identity | AND | LIST C<br>Documents that Establish Employment Authorization |
|---|---|---|---|---|
| **1.** U.S. Passport or U.S. Passport Card | | **1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | **1.** A Social Security Account Number card, unless the card includes one of the following restrictions:<br>(1) NOT VALID FOR EMPLOYMENT<br>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION |
| **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) | | **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | **2.** Certification of Birth Abroad issued by the Department of State (Form FS-545) |
| **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa | | **3.** School ID card with a photograph | | **3.** Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| **4.** Employment Authorization Document that contains a photograph (Form I-766) | | **4.** Voter's registration card | | **4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| **5.** For a nonimmigrant alien authorized to work for a specific employer because of his or her status:<br>**a.** Foreign passport; and<br>**b.** Form I-94 or Form I-94A that has the following:<br>(1) The same name as the passport; and<br>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | | **5.** U.S. Military card or draft record | | **5.** Native American tribal document |
| | | **6.** Military dependent's ID card | | **6.** U.S. Citizen ID Card (Form I-197) |
| | | **7.** U.S. Coast Guard Merchant Mariner Card | | **7.** Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | | **8.** Native American tribal document | | **8.** Employment authorization document issued by the Department of Homeland Security |
| | | **9.** Driver's license issued by a Canadian government authority | | |
| **6.** Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | | **For persons under age 18 who are unable to present a document listed above:**<br>**10.** School record or report card<br>**11.** Clinic, doctor, or hospital record<br>**12.** Day-care or nursery school record | | |

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

**Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.**

**STATE OF ALABAMA, DEPT. OF INDUSTRIAL RELATIONS** **NEW HIRE REPORTING FORM (NH-1, Rev 9/97)**

EMPLOYER FEIN 690640010 00011 EMPLOYER NAME ALCOHOLIC BEVERAGE CONTROL BD

**MARK ONE OF THE FOLLOWING BOXES:** New Hire ☐ Recall ☐ Job Refusal ☐ Mark box like this ☒ NOT like this ● ☑ ☒

**E**

SOCIAL SECURITY NUMBER ___ - __ - ____

FIRST DAY OF WORK (OR DATE OF REFUSAL) MM DD YYYY

EMPLOYER REPRESENTATIVE PHONE NUMBER (Only in case of job refusal) ( ___ ) ___ - ____

**1**

LAST NAME FIRST NAME MI

**2**

STREET NUMBER STREET NAME OR RURAL ROUTE *AND* NUMBER OR P.O. BOX *NUMBER*

**3**

CITY STATE ZIP CODE

THE ABOVE INFORMATION IS TRUE AND CORRECT

**EMPLOYEE** Signature Date

EMPLOYER Representative Signature Date

PLEASE MAKE YOUR CHARACTERS LIKE THE SAMPLES BELOW:

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 1 2 3 4 5 6 7 8 9 0

**SECTION E** – Employer should enter or verify social security number, first day of work, and whether new hire, recall or refusal. (Job-refusal reports should be completed in their entirety by the employer, including phone number.)

**SECTIONS 1, 2, and 3** - May be completed by the employer or employee. Enter employee information indicated on the report form as shown by the example.

The form must be signed by the employee (if available) and the employer (or representative) except for job refusals, which require only the employer's signature.

COMPLETE ONE FORM PER INDIVIDUAL, PRINT IN UPPER CASE LETTERS, WRITE WITHIN THE BOXES, AND USE ONLY BLACK OR BLUE INK.

Employers are required to furnish new hire and/or recall information to the Alabama Department of Industrial Relations, beginning October 1, 1997, within seven (7) days of the first day of work, per Act 97-228, New Hire Act of 1997. This information will be entered into the Alabama Directory of New Hires to help prevent program abuse and to assist the Federal Parent Locator Service, as required by Public Law 104-193. A penalty of up to $25 may be assessed per failure to report New Hire data. New Hire data should be **MAILED TO:**

Alabama Department of Industrial Relations
New Hire Unit
649 Monroe Street, Room 283
Montgomery, AL 36131-0283

(This form is designed to fit a standard No. 10 windowed envelope.)

ALABAMA ABC BOARD

Alabama Alcoholic Beverage Control Board

## *Selective Service Board Certification*

Date: _____

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

I certify that I comply with the provisions of the United States Military Selective Service Act (50 U.S.C. App 453) by having registered with the Selective Service Board or that I am not yet 18 years of age and I will register when required or that I am not required by law to register.

Social Security Number: _____ - _____ - _____

Date of Birth: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTE: This certification is required by State of Alabama Legislative Act 91-584.

ALABAMA ABC BOARD
Alabama Alcoholic Beverage Control Board

H. M. Gipson
Administrator
William E. Thigpen
Assistant Administrator

Robert W. "Bubba" Lee
Board Chairman
Samuetta H. Drew
Board Member
Rickey D. Mobley
Board Member

# ABC PERSONNEL POLICIES AND PROCEDURES MANUAL

## EMPLOYEE ACKNOWLEDGMENT FORM

I acknowledge that the ABC Board Personnel Policies and Procedures Manual (hereinafter "Manual") has been made easily and readily accessible within my designated work area as well as on the ABC Board (hereinafter "Agency") website (www.abc.alabama.gov). I understand that I am responsible for reading and familiarizing myself with the contents of the Manual, ask questions about any items I do not understand, and abide by the policies and procedures included in the Manual throughout my employment with the Agency. I understand that my failure to comply with the contents contained therein and any subsequent revisions, additions, or amendments to said policies may result in adverse action on my employment status up to and including separation from State service.

The information, policies, and benefits described therein are necessarily subject to change and I acknowledge that revisions to the Manual may occur. I understand that the Agency may change, modify, suspend, interpret or cancel, in whole or part, any of the published or unpublished personnel policies or practices, with or without notice, at its sole discretion, without giving cause or justification to any employee. Such revised information may supersede, modify or eliminate existing policies. Any written or oral statement by a supervisor or Division Director contrary to the personnel policy manual is invalid and should not be relied upon by any employee.

This Manual replaces any prior Manuals.

_____

Employee Name (Printed)

_____

Employee Signature

_____

Date

2715 GUNTER PARK DRIVE WEST, MONTGOMERY, ALABAMA 36109 • P.O. BOX 1151, MONTGOMERY, ALABAMA 36101
(334) 271-3840 • FAX # (334) 244-1815 • WEB SITE http://www.abc.alabama.gov

# *Drug-Free Workplace Policy Acknowledgment*

I, the undersigned, an employee of the Alabama ABC Board, hereby acknowledge that I have received and read ABC Personnel Policies and Procedures Chapter ABC-4-4 Drug-Free Workplace and understand the ABC Board's requirements regarding the maintenance of a drug-free workplace. I realize that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited at my workplace. I understand that violating these prohibitions can subject me to discipline up to and including termination. I acknowledge that as a condition of employment, I must abide by the requirements of this policy in this regard and I will notify my supervisor of any criminal drug conviction for a violation occurring in the workplace no later than five (5) work days after such conviction. I further realize that federal law may mandate that the agency appointing authority communicate this conviction to an appropriate federal agency, and I hereby waive any and all claims that may arise for conveying this information to the federal agency.

Employee Name: _____ Classification: _____

Employee Signature: _____ Date: _____

# CHAPTER ABC-4-4
# DRUG-FREE WORKPLACE POLICY

ABC-4-4-.01 POLICY
ABC-4-4-.02 COVERED INDIVIDUALS
ABC-4-4-.03 DEFINITIONS
ABC-4-4-.04 PROHIBITED BEHAVIOR
ABC-4-4-.05 EMPLOYEE NOTIFICATION REQUIREMENTS
ABC-4-4-.06 SEARCH OF PERSONAL PROPERTY
ABC-4-4-.07 DRUG & ALCOHOL SCREENING PROCEDURES
ABC-4-4-.08 DRUG & ALCOHOL SCREEN RESULTS
ABC-4-4-.09 CONSEQUENCES FOR POLICY VIOLATIONS
ABC-4-4-.10 EMPLOYEE ASSISTANCE
ABC-4-4-.11 CONFIDENTIALITY
ABC-4-4-.12 COMMUNICATION OF POLICY

## ABC-4-4-.01 POLICY

The Agency is committed to protecting the safety, health, and well being of all employees and other individuals in our workplace; therefore, the use of alcohol and other illegal or controlled substances is strictly prohibited in the workplace.

This policy is not intended to interfere with an employee's right to make their own lifestyle choices; however, when the use or abuse of any mood or mind-altering substance interferes with an employee's mental and/or physical condition at work, appropriate disciplinary action must and will be taken to maintain a safe workplace. Employees struggling with substance abuse issues are encouraged to seek appropriate levels of assistance. (See Chapter ABC-4-12 Employee Assistance Program)

## ABC-4-4-.02 COVERED INDIVIDUALS

Any individual who conducts business for the Agency, is applying for a position, or is conducting business on Agency property is covered by this Drug-Free Workplace Policy.

## ABC-4-4-.03 DEFINITIONS

**(1) Alcohol Use** – The consumption of any beverage, mixture, or preparation containing alcohol.

**(2) Alcohol** – An intoxicating agent such as ethanol, ethyl alcohol, or other low molecular weight alcohols including methyl and isopropyl alcohol.

**(3) Conviction** – means a finding of guilt (including a plea of nolo contender) or the imposition of a sentence by a judge or jury in any federal or state court.

**(4) Drug Test** – Any chemical, medical, mechanical, or toxicological test or screening process used to test for the presence of ethyl alcohol and/or controlled substances.

**(5) Employee** – For purposes of this policy, any full-time, temporary, or part-time worker.

**(6) Employee Assistance Program (EAP)** – An established program for employee assessment, counseling, and possible referral to an alcohol and/or drug rehabilitation program coordinated through the Department Finance's Division of Risk Management (DORM).

**(7) Non-Prescription Controlled Substance** – This term means the following five (5) drugs and their metabolites plus any added under 49 CFR, Parts 40 and 382: Cannabinoids (Marijuana) (THC); Cocaine; Opiates (including Heroin); Amphetamines; and Phencyclidine (PCP).

**(8) Prescription Controlled Substance** – Medications prescribed to the named employee by a licensed physician.

**(9) Reasonable Suspicion** – A circumstance in which, based upon the observation of abnormal and suspicious behavior or upon oral or written evidence, an employee is believed to have consumed a controlled substance and/or alcohol in violation of this policy.

**(10) Safety Sensitive Area** – Any physical area where the work operations and/or the equipment or materials utilized for such work pose a substantial risk of physical injury or death and in which it has been determined that drug or alcohol impairment increases the level of such risk. This includes all employees who work in the ABC Warehouse and all employees who are required to operate a motor vehicle or other machinery while performing job responsibilities.

**(11) Security Sensitive Job Classification** – Any job classification or task(s) wherein secure, sensitive, and/or private information or material is handled, processed, or stored and where it has been determined that drug or alcohol impairment increases the risk of mishandling such information.

**(12) Under the Influence of Alcohol** – A person who tests 0.02 or greater on the portable breath testing (PBT) instrument or another approved testing method.

## ABC-4-4-.04 PROHIBITED BEHAVIOR

**(1) Alcohol –** Employees are prohibited from the use of alcohol while on state property and/or while operating state-owned or leased vehicles, machinery, equipment, or other property. Employees shall not report for duty or attempt to work under the influence of alcohol. Employees shall not be in possession of any open or unsealed containers of alcohol on Agency property or in State-owned/leased vehicles.

**(2) Non-Prescription Controlled Substances –** Employees are prohibited from the unlawful manufacture, distribution, dispensation, possession, promotion, sale, or use of illegal drugs or drug paraphernalia while performing job duties for the Agency, while on Agency property, while operating state-owned or leased vehicles, machinery, equipment, or other property, while in travel status, or while being responsible for the safety of others.

**(3) Prescription Controlled Substances –** Prescription drugs are not prohibited when taken according to a physician's prescription. Any employee taking prescribed medications will be responsible for consulting the prescribing physician and/or pharmacist to ascertain whether the medication may interfere with safe performance of his/her job. If the use of a medication could compromise the safety of the employee, co-workers, and/or the public, the employee shall report this to his/her immediate supervisor, IN PERSON AND IN WRITING, prior to reporting for work.

Employees who fail to provide this information, prior to reporting for work, shall subject themselves to disciplinary action.

Employees whose consumption of prescribed controlled substances will affect performance of duties, shall be placed on sick leave until such time as the prescribing authority indicates, in writing, the employee is fit for duty. In such case, the employee will have the option of voluntarily taking leave (sick, annual, leave without pay, etc.) or a supervisor will ask that the employee be placed on mandatory leave (which requires approval of the State Personnel Director).

The illegal or unauthorized use of prescription drugs is prohibited. It is a violation of our Drug-Free Workplace Policy to intentionally misuse and/or abuse prescription medications. Appropriate disciplinary action will be taken for job performance deterioration and/or other incidents.

## ABC-4-4-.05 EMPLOYEE NOTIFICATION REQUIREMENTS

**(1) Criminal Drug Offense –** Any employee convicted of a criminal drug violation must notify the ABC Personnel Director in writing within five (5) calendar days of the conviction. Federal contracting agencies will be notified when appropriate. A failure to notify the ABC Personnel Director of such a conviction is grounds for termination from State service.

**(2) Driver's License Revocation –** Employees who are required to operate state-owned or leased vehicles, machinery, equipment, or other property shall inform his/her supervisor at the beginning of the employee's next work period if his/her driver's license has been suspended or revoked. Employees' occupying positions where the possession of a valid driver's license is an essential function could result in his/her termination from State service.

## ABC-4-4-.06 SEARCH OF PERSONAL PROPERTY

Employees suspected of violating the Drug-Free Workplace Policy may be asked to submit to a search or inspection of personal property at any time.

## ABC-4-4-.07 DRUG & ALCOHOL SCREENING PROCEDURES

**(1) Pre-Employment** – It is the policy of the Agency to require prospective employees to pass a pre-employment drug screen as a condition of employment prior to their start date. The Agency will not employ individuals who test positive for the illegal use of a controlled or synthetic substance.

**STEP 1:** After a conditional offer for employment has been made, the prospective employee must read the ABC Board Drug-Free Workplace Policy and sign a Consent to Test for Drugs and Alcohol Form (Exhibit 4-4A).

**STEP 2:** The hiring supervisor is responsible for arranging the drug screen at a designated collection facility. The prospective employee must present a valid personal I.D. in order for the drug screen to be completed.

**STEP 3:** The prospective employee will be required to provide a urine sample. The collection facility will collect the sample and submit it to the appropriate laboratory.

**(a) Candidate Refusal –** If the prospective employee refuses to sign and agree to the terms of the Consent to Test for Drugs and Alcohol Form or go to the collection facility for a drug screen, the conditional employment will be rescinded and s/he will be disqualified from further employment consideration.

**(b) Drug Screen Results**

1. Negative - If the initial drug screen is negative (the candidate passed the drug test), the screening facility will notify the appropriate Agency representative of the results, who, in turn, will notify the hiring supervisor. At this point, a start date can be determined.

2. Positive - If the initial drug screen is positive, the results are sent to a certified laboratory where a complete analysis of the sample is conducted. A certified Medical Review Officer (MRO) receives this information and completes a thorough investigation, including an interview with the candidate to determine if there are any legal medical reasons for the status of the drug screen. The MRO makes a final determination if the drug screen has a positive or negative result and forwards the information to the appropriate Agency representative, who, in turn, notifies the hiring supervisor.

   A positive result will require the conditional employment offer to be withdrawn; thus, disqualifying the prospective employee from further employment consideration. In such a case, the hiring supervisor will notify the candidate that s/he is not eligible for employment consideration. ABC Personnel will then submit a request to the State Personnel Director requesting that the candidate be removed from the hiring register.

**(c) Reasonable Accommodations –** Reasonable accommodations will be made available to candidates who may require assistance (e.g., individuals with visual impairments, etc.). In addition, the collection facility will also follow through on providing reasonable accommodations to individuals with disabilities.

**(2) Safety/Security Sensitive Personnel –** Employees working in a "Safety-Sensitive" area or in a "Security-Sensitive" job classification will be required to participate in pre-employment, random, post-accident, reasonable suspicion, return-to-duty, and follow-up drug testing upon selection or request of management to screen for the use or abuse of alcohol and all controlled substances (legal and illegal) that have the potential to affect safety and/or security.

**(3) Reasonable Suspicion –** Any Agency employee, in any position or grade, who exhibits strange, abnormal, or unusual behavior(s) while on duty that creates a reasonable suspicion that the employee is under the influence of alcohol or controlled substances may be required to submit to a drug and/or alcohol screen. The following criteria provide good reasons for requesting a test:

- Excessive absenteeism or tardiness;
- Significant deterioration in job performance;
- Significant change in personality (such as depression, mood swings, euphoria, secretiveness, abusive behavior), as exhibited by behavior such as insolence, violence, insubordination;
- Unexplained absences from normal work sites;
- Detrimental changes in personal hygiene or demeanor;
- Physical symptoms such as reddened eyes or dilated or constricted pupils;

- Odor of a controlled substance;
- Slurred or incoherent speech;
- Unusual difficulty in motor coordination;
- Information that an employee has caused or greatly contributed to an accident on ABC Board property or while conducting Agency business; and/or
- Direct observation of alcohol and/or controlled substance use and/or possession, physical symptoms, or odors.

**Note:** It is not possible to list every factor that might lead to a decision to test and, while any of the aforementioned factors might also be present for reasons not associated with substance abuse, the list is representative and should be observed and noted appropriately.

**(a) Documentation Procedures –** The behavior leading to reasonable suspicion testing must be documented by observers (e.g., co-workers, supervisors, clients, or others). Each observer shall prepare and sign the Reasonable Suspicion Checklist (Exhibit 4-4A) detailing the employee's behavior prior to testing. The completed form must immediately be forwarded to the ABC Personnel Director or his/her designee for review and consideration. Observers are prohibited from discussing the surrounding circumstances with others who do not have a need to know.

**Note:** Incidents leading to a decision to test occurring outside of normal business hours are required to contact the ABC Personnel Director or his/her designee the following business day unless the observer(s) believe the suspected employee's behavior endangers the safety of others. In this scenario, a supervisor is responsible for either taking the employee home or ensuring that the employee is taken home by another party.

**(b) Drug & Alcohol Screening Procedures –** Once an employee's behavior has been reported and a determination has been made that a drug screen and/or alcohol test is warranted, the following steps are required:

**STEP 1:** The supervisor will inform the employee that s/he will be required to submit to a drug screen and/or alcohol test.

**STEP 2:** The supervisor will have the employee read and sign the Consent to Test for Drugs and Alcohol (Exhibit 4-4B). Refusal to sign the form is considered insubordination and could be grounds for termination.

**STEP 3:** The supervisor and one (1) other co-worker (preferably another supervisor) will transport the employee to and from an authorized testing facility (e.g., LabCorp).

**STEP 4:** The circumstances of each incident will be evaluated carefully by the supervisor in concert with the ABC Personnel Director to determine whether an employee may be permitted to continue work pending the results of a drug screen. In order for an employee to return to work prior to receipt of the test results, it must be clear to the supervisor that the employee's continuation of work will not breach security or risk the health, safety, or property of any person, including the employee, co-workers, the employer, or members of the public, or cause any other problem relating to the Agency's ability to provide services and manage the workplace.

If the supervisor doubts an employee's fitness for duty, it is possible to place the employee on mandatory leave until the test results have been received. Supervisors must coordinate with the ABC Personnel Director to place an employee on mandatory leave as State Personnel Director authorization is required. In this scenario, the supervisor is responsible for ensuring that the employee is transported home by a third party.

**(4) On-the-Job Injury** – Employees who are injured while performing job responsibilities, based on the details associated with the incident, may be subject to a post-accident alcohol and/or drug screen.

**(5) Vehicle Accident** – Employees who are involved in an accident while operating a state vehicle or on Agency business that causes more than one thousand dollars ($1,000) in damage to property or requires medical attention away from premises will be required to submit to an alcohol and/or drug screen.

**(6) Refusal to Participate –** An employee will be subject to the same consequences of a positive test if s/he refuses the screening or the test, adulterates or dilutes the specimen, substitutes the specimen with that from another person or sends an imposter, will not sign the required forms, or refuses to cooperate in the testing process in such a way that prevents completion or alters the results of the test.

## ABC-4-4-.08 DRUG & ALCOHOL SCREEN RESULTS

To ensure the accuracy and fairness of our testing program, all testing will be conducted according to Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines where applicable and will include a screening test, a confirmation test, the opportunity for a split sample, review by an MRO, including the opportunity for employees who test positive to provide a legitimate medical explanation (e.g., physician's prescription) for the positive result, and a documented chain of custody.

**(1) Negative Result –** The MRO shall report the results to the appropriate Agency representative, who, in turn, will notify the ABC Personnel Director. A negative report will be filed in a confidential medical file within the ABC Personnel Division.

**(2) Positive Result –** The MRO shall, after reviewing all relevant medical records, notify the employee, and set up a time to discuss any medical factors (such as taking medications) which could adversely affect the outcome of the test. The MRO will then report results to appropriate Agency representative, who, in turn, will notify the ABC Personnel Director.

**(a) Exceptions –** Positive test results showing the presence of a controlled substance shall not constitute a violation of this policy if:

- The controlled substance has been prescribed by a licensed physician, osteopath, nurse practitioner, or dentist;
- The controlled substance has been dispensed by a licensed dispenser (pharmacist) and a current prescription is held by the employee or applicant; and
- Notice has been given to the appointing authority or the immediate supervisor by the employee or applicant concerning the prescribing, dispensing, and consumption of said

controlled substance.

These exceptions shall not apply if the positive test results are above the normal therapeutic levels established by the United States Food and Drug Administration.

## ABC-4-4-.09 CONSEQUENCES FOR POLICY VIOLATIONS

One of the goals of the Agency's Drug-Free Workplace Policy is to encourage employees to voluntarily seek help with alcohol and/or drug problems. If, however, an employee violates the policy, the consequences are serious as s/he will most likely be terminated from employment.

Applicants who cannot adhere to the Drug-Free Workplace Policy will have the conditional offer of employment withdrawn and negatively impact the applicant's ability to remain on the hiring register in which they were selected.

## ABC-4-4-.10 EMPLOYEE ASSISTANCE

The Agency recognizes that alcohol and drug abuse and addiction are treatable illnesses. Moreover, the Agency realizes that early intervention and support improve the success of rehabilitation. To support our employees, our Drug-Free Workplace Policy:

- Encourages employees to seek help if s/he is concerned about the possibility of a drug and/or alcohol problem of their own or of a family member.
- Offers all employees and their family member's assistance with alcohol and drug problems through the Employee Assistance Program (EAP). Refer to Chapter ABC-4-12 Employee Assistance Program for specific information.
- Allows the use of accrued paid leave while seeking treatment for alcohol and other drug problems.

Treatment for alcoholism and/or other drug use disorders may be covered by the employee benefit plan. However, the ultimate financial responsibility for recommended treatment belongs to the employee.

An employee who participates in an EAP or other program may be eligible for leave under the Family and Medical Leave Act (FMLA). Refer to Chapter ABC-4-9-.07 for additional information.

## ABC-4-4-.11 CONFIDENTIALITY

All information involving medical examinations, testing, counseling, rehabilitation, treatment, or discipline of an employee shall be treated as confidential medical information. Any willful disclosure of such information is in violation of this policy and the Agency policy on confidentiality and will result in disciplinary action up to and including termination.

## ABC-4-4-.12 COMMUNICATION OF POLICY

Communicating the Agency's Drug-Free Workplace Policy to both supervisors and employees is critical to our success. To ensure all employees are aware of their role in supporting our Drug-Free Workplace Program all employees will receive a written copy of the policy. Divisions are

responsible for implementing this policy and all employees must read and sign the Drug-Free Workplace Policy Acknowledgment Form (Exhibit 4-4C). The signed Drug-Free Workplace Policy Acknowledgment Form will be forwarded to the ABC Personnel Division where it will be filed in each employee's Agency work history file.

# *ABC Sales Associate (11706)*

**Job Description**

This is retail and wholesale store work involving the selling and accounting for cash and stock in a state store dispensing alcoholic beverages. Employees must unload shipments of product and be able to life cases of product weighing up to 53 pounds and stack cases of product in stock room up to 6 feet high. Accuracy of shipment must be determined by comparing records of cases of product invoiced and actual cases of product received. Employees in this class are responsible for rendering prompt courteous service to customers and for accurately maintaining simple cash and bookkeeping records. Care must be exercised in dispensing merchandise within the limits of the law, which prohibits selling to underage or intoxicated persons. Employees may assist the manager in the routine management of the store, and, in the absence of a manager or assistant manager, may be in charge of the store. Although state stores serve the public Monday through Saturday, employees normally work five days per week, including night, weekend, and holiday work. Time off will be scheduled to ensure adequate staffing for effective store operation at all times.

**Essential Job Functions**

1. Receiving, assembling, verifying, and delivering merchandise orders for customers to include loading merchandise in the customer's vehicles.
2. Lifting cases of merchandise weighing up to 53 pounds as required to unload trucks and place them in a designated area within the warehouse. In some instances, it may be necessary to lift cases up to six (6) feet.
3. Bending, squatting, and/or kneeling as required to move merchandise from the warehouse to designated areas within the sales area to include placement on shelves display racks, case-stack displays, etc. Again, shelves and other display areas range in height from floor level to approximately six (6) feet.
4. Performing custodial and maintenance duties inside and outside of the retail establishment to specifically include sweeping, mopping, waxing/buffing floors, dusting, washing windows, replacing light bulbs, cleaning the parking lot, cutting grass, maintaining shrubbery, etc.
5. Standing for extended periods of time as required to operate the cash register.
6. For designated positions, operate an automobile as required to conduct store business.

It is the policy of the ABC Board that employees be able to perform <u>all</u> essential functions of their job without restrictions. By signing this form, you acknowledge that you understand the requirements of an ABC Sales Associate and are physically capable of performing each of the aforementioned functions.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

ALABAMA ABC BOARD

Alabama Alcoholic Beverage Control Board

# *Safe Lifting Procedures and Acknowledgment*

## *Procedures for safe lifting:*

1. Stand close to the load and center yourself over it with your feet shoulder width apart.
2. Tighten your abdominal muscles.
3. Keeping your back straight, bend your knees and squat down to the floor.
4. Get a good grasp on the load with both hands.
5. Keeping the load close to your body use your leg muscles to stand up lifting the load off the floor.
6. Your back should remain straight throughout lifting, using only the muscles in the legs to lift the load.
7. Do not twist your body when moving the load. Instead take small steps with your feet turning until you are in the correct position.
8. Again bend at the knees using only your leg muscles and place the load in the appropriate spot.

I, the undersigned, do hereby acknowledge that I have read the lifting instructions above and understand the procedures for correctly lifting objects.

Employee's Signature: _____

Date Signed: _____

# *Information Technology Informed Consent*

**This statement of policy document must be read and affirmed annually by all users of Alabama ABC Information Technology services.**

**Acceptable Use**

**Reference State of Alabama Policy 630-01: Acceptable Use**

System and network activities may be monitored, recorded, and are subject to audit by management or other authorized personnel.

To ensure accountability, every AABC network and/or information system user shall have an individual network and/or system access account (i.e., a unique user identifier).

Organizations shall manage information system accounts, including establishing, activating, modifying, reviewing, disabling, and removing accounts in accordance with State standards.

State IT Standards and (as needed) information system specific procedures shall specify applicable access control requirements.

**Network/Systems/Mainframe Access**

**Reference State of Alabama Policy 620-01_Rev A: Network and Systems Access**

System, network, and mainframe access is a privilege, and accounts will be established for each agency user for the intended purposes of performing their assigned duties/responsibilities of their job. These accounts may be monitored, recorded, and are subject to audit by management or other authorized personnel. Accountability will be sustained by ensuring each information system user having an individual network and/or system access account (i.e., a unique user identifier) - these accounts are not to be shared with other agency users. AABC Information Technology shall manage each account, including establishing, activating, modifying, reviewing, disabling, and removing accounts in accordance with State standards. State IT Policy, Standards and (as needed) information system specific procedures shall specify applicable access control requirements.

**Email**

**Reference State of Alabama Policy 630-03_RevB: Email Usage**

State email systems are to be used for business purposes in serving the interests of the government and of the people it serves in the course of normal operations. Email shall be distributed, stored, and disposed of based on the data content in accordance with State information protection standards.

**Internet/Intranet**

**Reference State of Alabama Policy 630-02: Internet Access**

Access to the Internet/Intranet is provided as a business and informational resource to support and enhance the capability of Internet users to carry out their job responsibilities. Internet/Intranet users are expected to handle their access privileges in a responsible manner and to follow all Internet/Intranet-related policies and procedures All records created as a result of using Internet/Intranet services are government records. As such, these records are subject to the provisions of state laws regarding their maintenance, access, and disposition.

**Users are hereby advised that authorized access does not imply a right to privacy, and any violation or abuse of any of the above may result in revocation of accounts and access and disciplinary action.**

**By signature below, I affirm that I have read and understand the contents of this document.**

Employee's Signature: _____ Date: _____

Employee's Name (Printed): _____

# PAYROLL & BENEFITS

# State Employees' Health Insurance Plan
# 2014 Monthly Premium Rates

| | Current | 1/1/2014 | Increase |
|---|---|---|---|
| **Medical Premium, before Discounts:** | | | |
| **Active Employee** | | | |
| Single | $85.00 | $90.00 | $5.00 |
| Family | $275.00 | $280.00 | $5.00 |
| **Early Retiree** | | | |
| Single | $261.00 | $276.00 | $15.00 |
| Family NonMedicare | $503.00 | $528.00 | $25.00 |
| Family Medicare | $382.00 | $407.00 | $25.00 |
| **Medicare Retiree** | | | |
| Single | $45.00 | $50.00 | $5.00 |
| Family NonMedicare | $287.00 | $302.00 | $15.00 |
| Family Medicare | $166.00 | $171.00 | $5.00 |
| **NonMedicare Surviving Spouse** | | | |
| Single | $377.00 | $397.00 | $20.00 |
| Family NonMedicare | $619.00 | $644.00 | $25.00 |
| Family Medicare | $528.00 | $553.00 | $25.00 |
| **Medicare Surviving Spouse** | | | |
| Single | $196.00 | $216.00 | $20.00 |
| Family NonMedicare | $438.00 | $463.00 | $25.00 |
| Family Medicare | $347.00 | $372.00 | $25.00 |
| **Discounts:** | | | |
| Non-Tobacco Usage Discount | ($45.00) | ($50.00) | ($5.00) |
| Employee Wellness Participation Discount | ($25.00) | ($25.00) | $0.00 |
| **Dental Premium (Optional)** | | | |
| Single | $0.00 | $3.00 | $3.00 |
| Family | $0.00 | $8.00 | $8.00 |
| **Spousal Surcharge with Carve-out*** | | | |
| Single | $0.00 | $0.00 | $0.00 |
| Family | $0.00 | $50.00 | $50.00 |

*The spousal surcharge applies to family contracts where a spouse is eligible to participate in another employer's insurance coverage. If your spouse's monthly single premium with his/her employer is $255 or less, then the $50 surcharge will apply. If your spouse's monthly single premium is more than $255, then you may qualify for a waiver of the $50 surcharge. SEIB will be providing further details on these changes soon. If you have any questions, please feel free to contact us.

IB02

# HEALTH INSURANCE ENROLLMENT FORM

Revised 10/13

**CHECK ONE ONLY**

☐ **SEHIP** (Blue Cross) Basic Medical ☐ **Supplemental Coverage** (Blue Cross) Secondary Medical ☐ **Optional Policies** (Southland) Vision / Dental / Cancer / Hospital Indemnity ☐ **Decline Coverage**

☐ **HRA (must complete & attach Form IB26)** ☐ **Blue Cross – Dental Only** ☐ **Southland – Dental Only** ☐ **Southland – Vision Only**

## SUBSCRIBER INFORMATION

| Name (First, Middle Initial, Last) | | | Sex: |
|---|---|---|---|
| Social Security Number: | | Date of Birth: | |
| Street Address: | | | |
| City | State | ZIP Code | |
| Home Telephone Number: | Work Telephone Number: | E-Mail Address: | |

Dependent Coverage is requested for the following individuals, effective on Month _____Day _____Year_____. Direct payment MUST be made for any premiums that will not be payroll deducted. Make check payable to the SEIB and attach to this form.

| First Name Middle Initial Last Name | Documentation is required for SEHIP and dental plans. Relationship to Employee | Date of Birth | Social Security Number |
|---|---|---|---|
| | ☐ Husband** ☐ Wife** | | |
| | ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter | | |
| | ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter | | |
| | ☐ Grandson ☐ Granddaughter ☐ Nephew ☐ Niece | | |

***IMPORTANT*** To be eligible for the non-tobacco and/or wellness discount, you must complete the Non-Tobacco User Discount Application and meet the requirements of the Wellness Program.

** When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount you must submit a Spousal Surcharge Waiver Application (IB25). Forms are available at www.alseib.org

## ADDITIONAL GROUP HEALTH INSURANCE COVERAGE INFORMATION

(Must be completed if choosing supplemental coverage or Southland.)

Does the ***primary coverage*** have a spousal carve-out? ☐ Yes ☐ No

| Health Insurance Company | Contract Holder | Insurance Policy # | Group # | Name of Employer |
|---|---|---|---|---|
| | | | | |

**NOTE: High deductible plans with single deductible of $1250 or more and family deductible of $2500 or more are not allowed to enroll in the supplemental coverage plan. A summary plan description of the other coverage may be requested to document the deductible amount.**

## TO BE COMPLETED BY EMPLOYER

1. EMPLOYMENT STATUS:
   ☐ Full Time ☐ 3/4 Time ☐ ½ Time ☐ 1/4 Time
2. EMPLOYEE'S EFFECTIVE DATE OF COVERAGE: _____
3. PAY FREQUENCY: ☐ Semi-Monthly Arrears
   ☐ Semi-Monthly Current ☐ Monthly

_____
Signature of Payroll Clerk Date

_____
State Agency

## AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the State's behalf.

_____ _____
Employee Signature Date

# State Employees' Health Insurance Plan

## Eligible Dependent

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter,
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
   c. your stepchild,
   d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent on you for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

In the event of the death of an active employee, who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payment to the SEIB. The SEIB must be notified within 90 days of the death.

Exclusion: You may not cover your wife, husband, or other dependents if they are independently covered as a State employee.

**State Employees' Insurance Board**
**P.O. Box 304900**
**Montgomery, AL 36130**
**Phone: 334.263.8341 / FAX: 334.517.9728**

# STATE EMPLOYEES' INSURANCE BOARD
# Active/Retired Dental Insurance Enrollment/Cancellation Form

**SUBSCRIBER INFORMATION**

| Name (First, Middle Initial, Last) | | Sex | Effective Date |
|---|---|---|---|
| Social Security Number | | Date of Birth | ☐ Blue Cross Dental<br>☐ Southland Dental |
| Mailing Address | | | **A minimum enrollment of 12 months required for employees/ dependents** |
| City | State | ZIP Code | ☐ Single Coverage - $3/monthly |
| Home Telephone Number | Work Telephone Number | | ☐ Family Coverage - $8/monthly **(List dependents below.) (Documentation is Required)**<br>☐ Cancel Coverage |

E-mail Address:

| First Name | Initial | Last Name | (Documentation is Required) Relationship to Employee | | Date of Birth | Social Security Number |
|---|---|---|---|---|---|---|
| | | | ☐ Husband | ☐ Wife | | |
| | | | ☐ Son<br>☐ Stepson | ☐ Daughter<br>☐ Stepdaughter | | |
| | | | ☐ Son<br>☐ Stepson | ☐ Daughter<br>☐ Stepdaughter | | |
| | | | ☐ Son<br>☐ Stepson | ☐ Daughter<br>☐ Stepdaughter | | |
| | | | ☐ Son<br>☐ Stepson | ☐ Daughter<br>☐ Stepdaughter | | |
| | | | ☐ Grandson<br>☐ Nephew | ☐ Granddaughter<br>☐ Niece | | |
| | | | ☐ Grandson<br>☐ Nephew | ☐ Granddaughter<br>☐ Niece | | |

## AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the SEIB's behalf.

Signature _____ Date _____

# GENERAL INFORMATION

## Eligible Dependent

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter,
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
   c. your stepchild,
   d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent on you for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who otherwise meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

In the event of the death of an active employee, who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payment to the SEIB. The SEIB must be notified within 90 days of the death.

**STATE EMPLOYEES' INSURANCE BOARD**
**POST OFFICE BOX 304900**
**MONTGOMERY, ALABAMA 36130-4900**
**334-263-8341 / 1-866-836-9737 / FAX: 334-517-9728**

# STATE EMPLOYEES' HEALTH INSURANCE PLAN
# SPOUSAL SURCHARGE WAIVER APPLICATION

Return completed form to: State Employees' Insurance Board, P.O. Box 304900, Montgomery, AL 36130-4900
334-263-8341 / 1.866.836.9737 / Fax 334.517.9728

**Employee Name:** _____ **Contract Number:** _____

**THIS WAIVER APPLICATION MUST BE RETURNED BY NOVEMBER 30, 2013**

If your spouse is enrolled in the State Employees' Health Insurance Plan (SEHIP) effective January 1, 2014, you will be subject to a monthly spousal surcharge of $50. In order to apply for a waiver of the spousal surcharge you must submit this application form, and the appropriate documentation, to the State Employees' Insurance Board (SEIB), on or before November 30, 2013. Additional documentation may be required after your application is reviewed.

To be eligible for the spousal surcharge waiver, one of the following must apply. Check the appropriate box below that applies to you, then sign and date this application form and return it to the SEIB with the required documentation.

I hereby declare that my:

| Check one | Spouse's Status | Description | Documentation required |
|---|---|---|---|
| ☐ | Spouse's premiums are more than $255 | My spouse is eligible for other group coverage through his/her employer but the individual premium, for the lowest cost option, is more than $255 per month. | Spouse's current or former employer must verify that the lowest cost option for the monthly individual premium is more than $255. |
| ☐ | Spouse is not eligible for insurance | My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer. | A letter, on your spouse's employer's letterhead [with an employer contact person's name and phone number], that states that your spouse is not offered employer group health benefits. |
| ☐ | Spouse is unemployed | My spouse is unemployed or retired and not covered or eligible for any other employer group health benefits. | A copy of the most recent state or federal tax return verifying your spouse's employment status*. If your spouse became unemployed or retired after the most recent state or federal tax return was filed, you must submit a signed statement which verifies that your spouse is currently unemployed or retired and not covered or eligible under any other employer group health benefits. |
| ☐ | Spouse can't be covered by his/her employer's insurance by January 1, 2014 | My spouse's current or former employer offers group health benefits, but the enrollment rules of my spouse's health plan do not allow my spouse to enroll for coverage by January 1, 2014. The earliest date that my spouse can enroll in his/her current or former employer's health plan is _____. (provide date) | Documentation from your spouse's current or former employer or health insurance carrier verifying its enrollment rules. |

I certify that the answers provided on this application form are true and correct. I also understand that if I knowingly and willfully submit false information to the SEIB in order to obtain a waiver of the spousal surcharge or fail to immediately notify the SEIB that my spouse is no longer eligible for a waiver of the spousal surcharge, I will be subject to disciplinary action, up to and including termination of employment, and I will be required to repay all surcharges that were waived as well as all claims and other expenses, plus interest, incurred by the SEHIP.

I understand that if my application is approved my spousal surcharge waiver will expire after twelve months, at which time I will be required to reapply for the premium waiver.

Signed: _____ _____ _____

State Employee | Date | Daytime Phone Number

**Spousal Authorization**

(To be signed only if spouse is eligible for other employer group coverage.)

By signing below I authorize my current or former employer or my health insurance carrier to disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) to the SEIB in order to verify the representations made on this waiver application form.

Signed:

_____ _____ _____

Spouse of State Employee | Spouse's Employer and Contact Number | Spouse's Employer's Group Health Insurance Plan Number

*The SEIB only requires the following information from the state or federal tax return be provided if your spouse is unemployed: The portion of the return which shows the name of the member and the member's spouse and the signature block that contains the member's spouse's signature and occupation. All other information on the tax return can be redacted (blacked out). On State Form 40 and Federal Form 1040, that information is found on the top of page 1 (member's name and member's spouse's name) and the bottom of page 2 (member's spouse's signature and occupation). If you file a Federal Form 1040EZ, that information is found on the top of page 1 (member's name and member's spouse's name) and the bottom of page 1 (member's spouse's signature and occupation). If the unemployed spouse files a separate tax return, he/she must submit his/her return showing the same information.

# STATE EMPLOYEES' INSURANCE BOARD
# NON-TOBACCO USER DISCOUNT APPLICATION

| CONTRACT HOLDER NAME (please print) | SOCIAL SECURITY NUMBER # |
|---|---|
| E-MAIL ADDRESS | |

## Declaration

I declare that I am not currently using or have used tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last 12 months.

If my spouse is covered as a dependent under the State Employees' Health Insurance Plan (SEHIP), I declare further that my spouse is not currently using or has used tobacco products in any form within the last 12 months.

I understand that if it is determined that I (or my spouse if covered as a dependent under the SEHIP) have used tobacco products within the last 12 months or if I (or my spouse if covered as a dependent under the SEHIP) start using tobacco products subsequent to the date of this application without notifying the State Employees' Insurance Board, that I will be subject to disciplinary action, including termination of employment, and will be required to repay all discounts as well as all claims and other expenses incurred by the SEHIP, plus interest.

**Signed:** _____ **Date:** _____
Contract Holder

## Authorization

By signing below, I/we hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, any government agency or other organization or person that has any records or knowledge of my health to provide to the State Employees' Insurance Board any information related to my/our use of tobacco products.

**Signed:** _____ **Date:** _____
Contract Holder

**Signed:** _____ **Date:** _____
Spouse (if covered under SEHIP)

Return to:

State Employees' Insurance Board
201 South Union Street, Suite 200
Post Office Box 304900
Montgomery, AL 36130-4900
334.263.8341 / 1.866.836.9737 / Fax: 334.517.9728

IB13

Revised 10/2013

# State Employees' Insurance Board
# State Employees' Health Insurance Plan
# Provider Screening Form

**Instructions: If you cannot or choose not to participate in SEIB's Worksite Wellness screenings, you may submit your health screening results through your healthcare provider. You are to complete Section 1 of the form and your provider is to complete Section 2. The completed form must be returned to SEIB no later than October 31. NOTE: Incomplete forms will not be processed. Refunds are not allowed.**

**SECTION 1 (To Be Completed by Member)**

| Member Name (Please print) | Date of Service | Male ☐ Female ☐ | Age: _____ |
|---|---|---|---|
| Contract Number | Social Security # | Date of Birth (00/00/00) | Day Time Phone Number ( ) |

**What best describes your race/ethnicity?**

☐ White ☐ Black/African American ☐ Asian ☐ Indian or Alaska Native
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Other

**Do you have (or have you been told you had) any of the following? (Mark all that apply.)**

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

**Do you take Medication for any of the following? (Mark all that apply.)**

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

**SECTION 2 (To Be Completed by Provider)**

| | |
|---|---|
| Blood Pressure _____ / _____ | Height _____ft. _____ in |
| Total Cholesterol _____ mg/dL | Weight _____ |
| HDL Cholesterol _____ mg/dL | BMI _____ |
| LDL Cholesterol _____ mg/dL | Waist Measurement _____ |
| Triglycerides _____ mg/dL | Waist/Ht Ratio _____ |
| Blood Glucose _____ mg/d | |

**Provider's Name: (Please print)** _____

**Provider Signature:** _____

**Provider Address:** _____

**Please return completed form to:**
**STATE EMPLOYEES' INSURANCE BOARD**
**P O BOX 304900**
**MONTGOMERY AL 36130-4900**
**1.866.838.3059**
**FAX: 334.517.9980**

# State Employees Premium Only Plan
# Enrollment Form

**Return completed form to: State Employees' Insurance Board, PO Box 304900, Montgomery AL 36130-4900**
**Telephone: 334.263.8312 Toll Free: 1.866.833.3378 Fax: 334.517.9908**

**EMPLOYEE INFORMATION (PLEASE PRINT)**

| **Name:** | **SEHIP Contract or SSN #** | **Date of Birth** _____/_____/_____ |
|---|---|---|

**Address:**

**City, State and Zip:**

**Telephone Numbers** (**work number is required**)

**Work: (  )** **Ext:** **Home: (  )**

**Email Address:**

**Name of health plan for which you will be seeking reimbursement of premiums:**

**Employer Name:** **Group Number:** **Contact number: (  )**

**What is the State Employees' Premium Only Plan (SEPOP)?**
The SEPOP is a premium only Health Reimbursement Arrangement (HRA) funded solely by the State of Alabama from which active employees are reimbursed for other employer group health insurance premiums.

**Who is eligible?**
Any active full-time employee of the State of Alabama eligible for coverage under the State Employees' Health Insurance Plan (SEHIP) who has opted out of the SEHIP is eligible to enroll in the SEPOP.

**What's the benefit to enrolling in the SEPOP?**
When you enroll in the SEPOP an account will be established for you into which the State will credit $150 each month. You can then use these tax free Benefit Dollars to pay premiums for other employer group health insurance (e.g. coverage offered through your spouse's employer). That's a free benefit of up to $1,800 per year.

**Can SEPOP Benefit Dollars be used for any health care premium?**
No. SEPOP Benefit Dollars can only be applied toward premiums of other employer group health plans meeting the minimum value and essential health benefits criteria as defined under the Affordable Care Act (employers should provide their employees with this information).

**Will Benefit Dollars in your SEPOP account roll over each year?**
Yes. If you don't spend all your Benefit Dollars in a Plan Year, any unused SEPOP Account balance rolls over into the next Plan Year. In this manner your SEPOP Account may "grow" almost like a savings account.

**How do you enroll?**
You can enroll in the SEPOP at any time during the year by completing this form and returning it to the SEIB. Remember you must first opt out of the SEHIP before you can enroll in the SEPOP.

**How do you disenroll?**
You can disenroll in the SEPOP and re-enroll in the SEHIP at any time during the year. When you disenroll in the SEPOP or terminate your employment, any Benefit Dollars in your SEPOP Account will revert back to the Plan.

**Important – Read Carefully Before Signing**

The SEPOP is intended to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and 2013-54 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended, and the Plan will be interpreted at all times in a manner consistent with such intent. I understand that I will only seek reimbursement for premiums for health insurance coverage that qualify for such reimbursement under IRS regulations. I hereby certify that I have completely read and fully understand the terms and conditions of the SEPOP and all information furnished is true and complete.

Employee Signature: _____ Date: _____

ERS 100
12/12
EF 100N

# ERS ENROLLMENT
# MEMBER INFORMATION RECORD

**Employees' Retirement System of Alabama**
**P. O. Box 302150 ♦ Montgomery, AL 36130-2150**
**334-517-7000 or 877-517-0020**
**www.rsa-al.gov**

**FOR EMPLOYEES' RETIREMENT SYSTEM USE ONLY**

Comments: _____

_____

_____

**Check One:**

☐ **New Member**

☐ **Transfer from another ERS Agency**

**No Initials Please**

**Name:** _____
First Middle Given Last Maiden

**Social Security Number:** _____ **Sex:** ☐ Male ☐ Female **Status:** ☐ Married ☐ Widowed ☐ Single ☐ Divorced

**Date of Birth:** _____ **Email Address:** _____

**Address:** _____
Street or P. O. Box City State Zip

**Phone Number:** _____

**Classification or title of position or elected office you hold:** _____

**Employing Agency:** _____ **Section or Division:** _____

**Are you an Elected Official?** ☐ Yes ☐ No

**Have you ever been employed by any agency of public education in Alabama?** ☐ Yes ☐ No

**Have you ever been a member of the Employees' Retirement System of Alabama?** ☐ Yes ☐ No

**Were you a member before beginning employment with your current employer?** ☐ Yes ☐ No

**Have you ever withdrawn contributions from the Retirement Systems?** ☐ Yes ☐ No

**If you answered yes to any of the preceding four questions, please provide the information requested below, listing most recent employment first.**

| Employing Agency | City | Year | Under What Name | Date Terminated |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**I certify that I am not presently a contributing member of any other state supported retirement plan in Alabama and have completed to the best of my knowledge and belief all statements and answers printed herein.**

**Signature of Member:** _____ **Date:** _____

## TO BE COMPLETED BY EMPLOYING AGENCY

**Employing Agency:** _____

**Annual Salary:** _____ **Date of Employment:** _____

**Number of Pay Periods Per Year:** _____ **Employment Status** (full-time, ½ time, ¾ time, etc.) _____

**Employer Signature:** _____ **Date Submitted:** _____

**Title:** _____

**Please give complete information.**

## DESIGNATION OF PRIMARY BENEFICIARY(IES)

I, the undersigned, do hereby designate the following individuals as my primary beneficiary(ies) to whom I instruct the Board of Control of the Employees' Retirement System of Alabama to pay, in the event of my death before retirement on pension, the total amount of the accumulated contributions standing to my credit in the retirement system:

Name:_____ Relationship: _____ Date of Birth: _____

Address: _____
Street or P. O. Box City State Zip Code

Name:_____ Relationship: _____ Date of Birth: _____

Address: _____
Street or P. O. Box City State Zip Code

## DESIGNATION OF CONTINGENT BENEFICIARY(IES)

In the event the primary beneficiary(ies) designated above does **not** survive me, I hereby authorize the Employees' Retirement System of Alabama to pay the benefits to the beneficiary(ies) named below:

Name:_____ Relationship: _____ Date of Birth: _____

Address: _____
Street or P. O. Box City State Zip Code

Name:_____ Relationship: _____ Date of Birth: _____

Address: _____
Street or P. O. Box City State Zip Code

I agree on behalf of myself, my heirs and assigns that payment so made shall be a complete discharge of the claim and shall constitute a release of the System from any further obligation on account of the benefit. I hereby direct that should I survive either or both of the before mentioned beneficiaries, the amount which otherwise would have been payable to the beneficiary had he/she been living shall be paid to my estate or to such other beneficiary as I shall hereafter nominate by written designation filed with the Employees' Retirement System of Alabama in accordance with the rules and regulations prescribed by the Board of Control.

**Signature of Applicant:** _____ **Date:** _____

**Please have your signature acknowledged before a Notary Public.**

**STATE OF ALABAMA, COUNTY OF** _____

On this _____ day of _____, 20 ___, personally appeared before me the said named _____ to me known and known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged that he/she executed the same and being duly sworn by me, made oath that the statements in the application are true.

Signature of Notary Public _____

(Seal)

My Commission Expires _____

THIS FORM MAY BE REPRODUCED.

**Employee:** Complete Form A-4 and file it with your employer. Otherwise, tax will be withheld without exemption.

**Employer:** Keep this certificate on file. If an employee is believed to have claimed more exemptions than that which they are legally entitled to claim, the Department should be notified. Any correspondence concerning this form should be sent to the AL Dept of Revenue, Withholding Tax Section, PO Box 327480, Montgomery, AL 36132-7480 or by fax to 334-242-0112. Please include contact information with your correspondence.

**Penalties: Section 40-18-73, *Code of Alabama 1975.*** Every employee, on or before the date of commencement of employment, shall furnish his or her employer with a signed Alabama withholding exemption certificate relating to the number of withholding exemptions which he or she claims, which in no event shall exceed the number to which the employee is entitled. In the event the employee inflates the number of exemptions allowed by this Chapter on Form A-4, the employee shall pay a penalty of five hundred dollars ($500) for such action pursuant to Section 40-29-75.

**Exempt Status: Military Spouses Residency Relief Act.** This exemption applies to a spouse of a US Armed Service member who is present in Alabama in compliance with military orders and who maintains domicile in another state. Employee should provide their employer with valid military identification and a copy of a current leave and earnings statement or Form DD-2058. Complete line 6 on front of Form A-4 if you qualify for this exemption.

**Exempt Status: No tax liability.** An exemption from withholding may be claimed if you filed an Alabama income tax return in the prior year, had a zero tax liability on that return, and you anticipate a zero tax liability on your current year return. If you had any tax withheld in the prior year and did not receive a full refund of that amount, you will not qualify and should complete the front of Form A-4.

**CHANGES IN EXEMPTIONS**: You may file a new certificate at any time if the number of your exemptions INCREASE. You must file a new certificate within 10 days if the number of exemptions previously claimed by you DECREASES for any of the following reasons:

(a) Your spouse for whom you have been claiming exemption is divorced, legally separated, or claims her or his own exemption on a separate certificate.

(b) You no longer provide more than half of the support for someone you previously claimed a dependent exemption for.

DECREASES in exemption, such as the death of a spouse or dependent, will not require the filing of a new exemption certificate until the following year.

**DEPENDENTS:** To qualify as your dependent (Line 4 on other side), a person must receive more than one-half of his or her support from you for the year and must be related to you as follows:

Your son or daughter (including legally adopted children), grandchild, stepson, stepdaughter, son-in-law, or daughter-in-law;

Your father, mother, grandparent, stepfather, stepmother, father-in-law, or mother-in-law;

Your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law, or sister-in-law;

Your uncle, aunt, nephew, or niece (but only if related by blood).

**PLEASE CUT HERE**

FORM **A-4** REV. 11/10

ALABAMA DEPARTMENT OF REVENUE

# Employee's Withholding Exemption Certificate

Reset Form

EMPLOYEE'S FULL NAME | SOCIAL SECURITY NO.

HOME ADDRESS | CITY | STATE | ZIP CODE

SIGNED | DATE

**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. See reverse side for penalty details.**

**HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS**

1. If you claim no personal exemption for yourself and wish to withhold at the highest rate, write the figure "0", sign and date Form A-4 and file it with your employer. ..... _____
2. If you are SINGLE or MARRIED FILING SEPARATELY, a $1,500 personal exemption is allowed. Write the letter "S" if claiming the SINGLE exemption or "MS" if claiming the MARRIED FILING SEPARATELY exemption. ..... _____
3. If you are MARRIED or SINGLE CLAIMING HEAD OF FAMILY, a $3,000 personal exemption is allowed. Write the letter "M" if you are claiming an exemption for both yourself and your spouse or "H" if you are single with qualifying dependents and are claiming the HEAD OF FAMILY exemption. ..... _____
4. Number of dependents (other than spouse) that you will provide more than one-half of the support for during the year. See instructions for dependent qualifications. ..... _____
5. Additional amount, if any, you want deducted each pay period. ..... $ _____
6. **Exempt Status:** If you meet the conditions set forth under the Military Spouses Residency Relief Act and will have no Alabama income tax liability, skip lines 1-5, write "EXEMPT" on line 6, sign and date Form A-4 and file it with your employer. See instructions on the back of Form A-4 for the documentation you must provide to your employer in order to qualify. ..... _____
7. **Exempt Status:** If you had no Alabama income tax liability last year and you anticipate no Alabama income tax liability this year, you may claim an exemption from Alabama withholding tax. Skip lines 1-6, write "EXEMPT" on line 7, sign and date Form A-4 and file it with your employer. See instructions on the back of Form A-4 to be sure you qualify. ..... _____

**LINE 8 BELOW TO BE COMPLETED BY YOUR EMPLOYER**

8. TOTAL EXEMPTIONS (Example: Employee claims "M" on line 3 and 2 on line 4. Employer should use column headed M-2 in the Withholding Tax Tables and Instructions for Employers.) ..... _____

EMPLOYER NAME | EMPLOYER FEIN | EMPLOYER STATE ID

# Form W-4 (2014)

**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 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 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. 505 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 iincome, see Pub. 505 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. 505 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. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

**Future developments.** Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

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

**A** Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

**B** Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** _____

**C** Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

**D** Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

**E** Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** _____

**F** Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** _____
(**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 $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children.
- If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . . **G** _____

**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.) ▶ **H** _____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

# 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.**

OMB No. 1545-0074
**2014**

| | | |
|---|---|---|
| **1** Your first name and middle initial | Last name | **2 Your social security number** |
| Home address (number and street or rural route) | **3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.<br>**Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. | |
| City or town, state, and ZIP code | **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.** ▶ ☐ | |

| | | |
|---|---|---|
| **5** | Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | **5** |
| **6** | Additional amount, if any, you want withheld from each paycheck . . . . . | **6** $ |
| **7** | I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption.<br>• Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**<br>• This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.<br>If you meet both conditions, write "Exempt" here . . . . . ▶ | **7** |

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** ▶

| | | |
|---|---|---|
| **8** Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | **9** Office code (optional) | **10** Employer identification number (EIN) |

## 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 . . . . 1 $

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 } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

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

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

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

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

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

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

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 10

## 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**) 1

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" . . . . . 2

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 . . . . . 3

**Note.** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 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 . . . . . 4

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

6 **Subtract** line 5 from line 4 . . . . . 6

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

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

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 9 $

### 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 |
| $0 - $6,000 | 0 | $0 - $6,000 | 0 |
| 6,001 - 13,000 | 1 | 6,001 - 16,000 | 1 |
| 13,001 - 24,000 | 2 | 16,001 - 25,000 | 2 |
| 24,001 - 26,000 | 3 | 25,001 - 34,000 | 3 |
| 26,001 - 33,000 | 4 | 34,001 - 43,000 | 4 |
| 33,001 - 43,000 | 5 | 43,001 - 70,000 | 5 |
| 43,001 - 49,000 | 6 | 70,001 - 85,000 | 6 |
| 49,001 - 60,000 | 7 | 85,001 - 110,000 | 7 |
| 60,001 - 75,000 | 8 | 110,001 - 125,000 | 8 |
| 75,001 - 80,000 | 9 | 125,001 - 140,000 | 9 |
| 80,001 - 100,000 | 10 | 140,001 and over | 10 |
| 100,001 - 115,000 | 11 | | |
| 115,001 - 130,000 | 12 | | |
| 130,001 - 140,000 | 13 | | |
| 140,001 - 150,000 | 14 | | |
| 150,001 and over | 15 | | |

### Table 2

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **HIGHEST** paying job are— | Enter on line 7 above | If wages from **HIGHEST** paying job are— | Enter on line 7 above |
| $0 - $74,000 | $590 | $0 - $37,000 | $590 |
| 74,001 - 130,000 | 990 | 37,001 - 80,000 | 990 |
| 130,001 - 200,000 | 1,110 | 80,001 - 175,000 | 1,110 |
| 200,001 - 355,000 | 1,300 | 175,001 - 385,000 | 1,300 |
| 355,001 - 400,000 | 1,380 | 385,001 and over | 1,560 |
| 400,001 and over | 1,560 | | |

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person 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.

**A VOIDED CHECK OR DEPOSIT SLIP MUST BE ATTACHED TO THIS FORM!**

ABC-4-11-23
Revised 1/2010

# *Direct Deposit Request*

ABC BOARD

The State of Alabama is requested to send my periodic employee payroll payments to the bank or financial institution listed below.

Name of Bank or Financial Institution: _____

Account Type: ☐ Checking ☐ Savings Account Number: _____

Bank Routing Number: _____

**Employee Verification**
Each payroll payment is to be credited to my account, as indicated on the attached deposit slip or voided check, at the financial institution specified herein and such payment will be in full payment, satisfaction, and discharge of the amount then falling due and payable to me on account of such employment.

If my death shall occur prior to the due date of any payment which shall have been made by you in compliance with this request or if adjustments are required for any credit entries to my account, I authorize you to make the necessary debit entries to my account. I hereby reserve the right to revoke or cancel this request, such revocation or cancellation to take effect within thirty (30) days of receipt of written notice by the State.

**Joint Account Holder Certification**
I agree to notify the State immediately of the death of the recipient of employee payroll being deposited to this joint account, and I will return all payments to the State that are deposited to this account after said death. The State is authorized to make any necessary debit entries to this joint account for any credits that were made in error.

A copy of my deposit slip or voided check for this account is attached.

1. I (We) have read and understand the JOINT ACCOUNT HOLDER STATEMENT above.

_____ ☐ None
Name(s) of any joint signer(s) authorized for this account. (Print or type names of specify "None").

2. I have read the agreements as stated above and agree to the terms contained therein for the State to send payments due me directly to the above named financial institution.

_____ _____
Type or Print Employee's Name as it appears on Payroll Records — Employee's Department of Agency

_____ _____
Employee's Signature — Employee's Social Security Number

_____ Employee's Home Phone: _____
Employee's Home Mailing Address

_____ AL _____ Employee's Work Phone: _____
City — State — Zip Code

ABC Personnel Form
Revised 1/2010

# *City Occupational Tax Notification*

ABC BOARD

TO: ABC Personnel Payroll Clerk Date: _____

Employee Name: _____ SSN: _____

Division: _____ Work City: _____ , AL

Percent of Work Time Within the City: _____ % From: _____ To: _____

This is to certify that the employee identified above will work within the above indicated city during the stated time period. By working within the city, it is understood that the employee will pay the current city occupational tax during this period.

If conditions arise that the employee does not work the stated time within the city, the employee will request from the city identified above a refund in the amount of the overstated tax.

_____ _____

Immediate Supervisor's Signature Employee's Signature

ABC Personnel Form
Revised 1/2010

# *County Occupational Tax Notification*

ABC BOARD

TO: ABC Personnel Payroll Clerk Date: _____

Employee Name: _____ SSN: _____

Division: _____ Work County: _____ , AL

Percent of Work Time Within the County: _____ % From: _____ To: _____

This is to certify that the employee identified above will work within the above indicated county during the stated time period. By working within the county, it is understood that the employee will pay the current county occupational tax during this period.

If conditions arise that the employee does not work the stated time within the county, the employee will request from the county identified above a refund in the amount of the overstated tax.

_____ _____

Immediate Supervisor's Signature Employee's Signature

# DEFERRED COMPENSATION PLAN INFORMATION

# (OPTIONAL)

Deferred Compensation – Employees have the option to increase their personal savings and add to their financial security by investing in a governmental 457(b) deferred compensation plan (457 Plan). Two (2) 457 plans, RSA-1 (www.rsa-al.gov) and Great West (https://alabamaretire.gwrs.com) are available for State employees. A 457 Plan allows eligible employees to supplement any existing retirement and pension benefits by investing before-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred for federal and Alabama income tax purposes until a distribution is taken. Distributions are usually taken at or during retirement. Distributions are subject to ordinary income taxes.

Visit the websites using the links provided previously if you are interested in learning more about these plans as well as enrollment information.