



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 <i>(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.)</i>						
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: _____

3-D Barcode
Do Not Write in This Space

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)

Signature of Employee:	Date (mm/dd/yyyy):
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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



Employer Completes Next Page



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:		<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>3-D Barcode Do Not Write in This Space</p> </div>		
Issuing Authority:				
Document Number:				
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):				

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):
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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:
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LISTS OF ACCEPTABLE DOCUMENTS

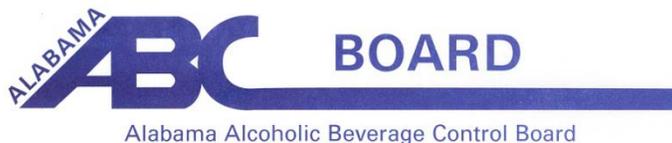
All documents must be UNEXPIRED

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 Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (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. 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 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) 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. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) 8. Employment authorization document issued by the Department of Homeland Security

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.



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.



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

Alabama Alcoholic Beverage Control Board

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

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: _____

ALABAMA ABC BOARD PERSONNEL POLICIES AND PROCEDURES

CHAPTER ABC-4-4

DRUG-FREE WORKPLACE POLICY

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

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 contendere) 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.



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

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

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	<input type="checkbox"/> Blue Cross Dental <input type="checkbox"/> Southland Dental A minimum enrollment of 12 months required for employees/dependents <input type="checkbox"/> Single Coverage - \$3/monthly <input type="checkbox"/> Family Coverage - \$8/monthly (List dependents below.) (Documentation is Required) <input type="checkbox"/> Cancel Coverage
Mailing Address			
City	State	ZIP Code	
Home Telephone Number		Work Telephone Number	

E-mail Address:

First Name	Initial	Last Name	(Documentation is Required) Relationship to Employee		Date of Birth	Social Security Number
			<input type="checkbox"/> Husband	<input type="checkbox"/> Wife		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Nephew	<input type="checkbox"/> Granddaughter <input type="checkbox"/> Niece		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Nephew	<input type="checkbox"/> Granddaughter <input type="checkbox"/> 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
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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: _____
Contract Holder

Date: _____

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: _____
Contract Holder

Date: _____

Signed: _____
Spouse (if covered under SEHIP)

Date: _____

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

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 <input type="checkbox"/>	Age: _____
		Female <input type="checkbox"/>	
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 _____ / _____ Total Cholesterol _____ mg/dL HDL Cholesterol _____ mg/dL LDL Cholesterol _____ mg/dL Triglycerides _____ mg/dL Blood Glucose _____ mg/d	Height _____ ft. _____ in Weight _____ BMI _____ Waist Measurement _____ Waist/Ht Ratio _____
--	--

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 (<u>work number is required</u>)		
Work: ()	Ext:	Home: ()
Email Address:		
Name of health plan for which you will be seeking reimbursement of premiums:		
Employer Name:	Group Number:	Contact number: ()
<p>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.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p>		
Important – Read Carefully Before Signing		
<p>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.</p>		
Employee Signature: _____		Date: _____

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, 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

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
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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 income, 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: <ul style="list-style-type: none"> • 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 _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • 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	<h2>Employee's Withholding Allowance Certificate</h2> <p>▶ 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.</p>	OMB No. 1545-0074 <h1 style="font-size: 2em;">2014</h1>
1 Your first name and middle initial _____ Last name _____		2 Your social security number _____
Home address (number and street or rural route) _____		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. 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. ▶ <input type="checkbox"/>
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. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. 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

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$6,000	0	\$0 - \$6,000	0	\$0 - \$74,000	\$590	\$0 - \$37,000	\$590
6,001 - 13,000	1	6,001 - 16,000	1	74,001 - 130,000	990	37,001 - 80,000	990
13,001 - 24,000	2	16,001 - 25,000	2	130,001 - 200,000	1,110	80,001 - 175,000	1,110
24,001 - 26,000	3	25,001 - 34,000	3	200,001 - 355,000	1,300	175,001 - 385,000	1,300
26,001 - 33,000	4	34,001 - 43,000	4	355,001 - 400,000	1,380	385,001 and over	1,560
33,001 - 43,000	5	43,001 - 70,000	5	400,001 and over	1,560		
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						

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.

City Occupational Tax Notification

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

County Occupational Tax Notification

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.