Basic Employment Information Sheet

Employee Information

Full Name: _____

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____

Social Security Number or Government ID: _____

Birth Date: _____ Marital Status: _____

Spouse's Name[1]: _____

Spouse's Employer: _____ Spouse's Work Phone: ( ) _____

Job Information

Title: _____ Supervisor: _____

Work Location: _____ E-mail Address: _____

Work Phone: ( ) _____ Cell Phone: ( ) _____

Start Date: _____ Salary: $ _____

Emergency Contact Information

Full Name: _____

Address: _____

Primary Phone: ( ) _____ Cell Phone: ( ) _____

Relationship: _____

Dependent Information (For insurance purposes only)

Name(s) of Dependent(s)	Relationship to Employee
_____	_____
_____	_____
_____	_____

[1] A number of jurisdictions now allow domestic partners to register and they are then entitled to many of the benefits of spouses. If your jurisdiction permits such domestic partnerships, you may modify the form to read "Spouse/Domestic Partner." Given the proliferation of domestic partnerships, your company should carefully evaluate its policy with regard to such couples, both opposite-sex and same-sex.

BOYD COUNTY E-MAIL AND INTERNET USER AGREEMENT

EMPLOYEE AGREEMENT

I have received a copy of Boyd County Fiscal Court's Policy Guidelines on e-mail/internet acceptable use (Chp. 13). I recognize that the County's e-mail/Internet is to be used for conducting the County's business only. I understand that use of this equipment for private purposes is strictly prohibited.

As part of Boyd County and user of Boyd County's gateway to the internet and e-mail system, I understand that this e-mail/internet County guideline applies to me.

I understand that it is my obligation to read the aforementioned document and agree to follow all policies and procedures that are set forth therein. I further agree to abide by the standards set in the document for the duration of my employment with Boyd County Fiscal Court. Should I have any questions related to the Boyd County Administrative Code, it is my obligation to seek assistance from my supervisor, director or Department Head.

I am aware that violations of this County guideline on acceptable e-mail/internet use may subject me to disciplinary action, up to and including dismissal from employment.

I further understand that my communications on the internet and e-mail reflect on Boyd County Fiscal Court. Furthermore, I understand that this policy can be amended at any time or that I may receive further direction from my superiors related to proper e-mail/internet usage.

_____ _____

Employee Signature Date

_____

Employee Printed Name

Received by:

_____ _____

County Judge/Executive Signature Date

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last 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	Employee's E-mail Address	Employee's 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 boxes):

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one)

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

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

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

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

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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)*				

Additional Information

QR Code - Sections 2 & 3
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	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing 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	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C 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: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (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 report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
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.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		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		
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				

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

Refer to the instructions for more information about acceptable receipts.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household.** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

▶ _____ **Employee's signature** (This form is not valid unless you sign it.) ▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

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

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

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

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

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

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

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

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

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

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

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

1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $ _____

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

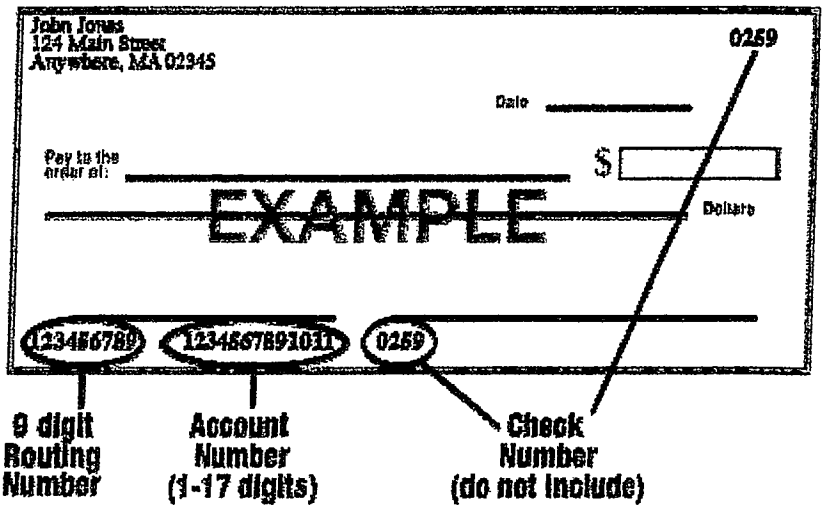
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: Checking Savings (Circle One)

Please attach a voided check for each bank account to which funds should be deposited.

[*Company Name*] is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

Kentucky Retirement Systems
Perimeter Park West •1260 Louisville Rd. • Frankfort KY 40601-6124
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Print Form

Form 2001
Revised 07/2015

Membership Information

Member Information Please provide your Member ID or Social Security number in the Member ID box below.			
Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Date of Birth:	Home Phone:	Work Phone:	
Email address:	Marital Status:	Sex: ☐ Male ☐ Female	
Full Name of Employing Agency:			
Date of Employment with Agency:	Other Name Under Which You May Have Been Previously Employed:		

Previous County, City or State Employment

Department or Agency	Position	From Month Day Year	To Month Day Year	Administrative Use Month Day Year

Statement of Active Duty Military Service

Certification

I understand that no benefits may be paid to me or my beneficiary until this completed form is filed at the retirement office.

Signature: _____ Date: _____

KENTUCKY PUBLIC PENSIONS AUTHORITY
1260 Louisville Road • Frankfort, KY 40601
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Print Form

Form 2035
Revised 06/2019

Beneficiary Designation

Member Information Please provide your Member ID or Social Security Number in the Member ID box below.

Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Member's Date of Birth:	Sex:	Email:	

Notice: This form is not valid unless it is completed correctly and received in the retirement office prior to the member's death.

The member and a witness must sign this form or it will not be accepted. You may name one or more individuals, your estate, or a trust as principal or contingent beneficiary of your retirement account. If you wish to name more than four individuals as principal or contingent beneficiaries, please contact our office. Your beneficiary designation may be changed at any time prior to retirement by filing a new Form 2035.

Principal Beneficiary Section: Please select one of the beneficiary types below by checking the appropriate box. The principal beneficiary will receive benefits in the event of your death.

☐ **Person**

You cannot name yourself as principal beneficiary. You also cannot name the same person as both principal and contingent beneficiary. If you name a single individual as beneficiary, that individual may be eligible for a lifetime benefit upon your death, depending on your total service credit. If you name multiple individuals, your estate or a trust, no lifetime benefit is available. If you name more than one individual as principal beneficiary you may indicate the percentage each beneficiary is to receive. Percentages for the principal beneficiary section should total but not exceed 100%. If you do not indicate percentages, disbursement of payment will be divided equally among living principal beneficiaries, or if all principal beneficiaries have died, among all living contingent beneficiaries, as provided in KRS 61.542.

1. Name:	%:	2. Name:	%:
Social Security Number:	Sex:	Social Security Number:	Sex:
Date of Birth:	Relationship:	Date of Birth:	Relationship:
Address:		Address:	
City: State: Zip Code:		City: State: Zip Code:	
3 Name:	%:	4 Name:	%:
Social Security Number:	Sex:	Social Security Number:	Sex:
Date of Birth:	Relationship:	Date of Birth:	Relationship:
Address:		Address:	
City: State: Zip Code:		City: State: Zip Code:	

☐ **My Estate**

If you name your estate as a principal beneficiary, you cannot name a contingent beneficiary. No additional information required.

☐ **Living Trust**

The following information is required to designate a living trust. You must write the name of the trust as it appears in the trust document and submit a copy of the trust with this form. A charitable organization or a religious charity cannot be named as beneficiary unless it is a trust.

Name of Trust:	Trust Tax ID:	Date of Trust:

Trustee or Successor Trustee Contact Information: Our office will contact the trustee listed below following your death.

Name:		Phone:	
Address:	City:	State:	Zip Code:

☐ **Testamentary Trust**

A testamentary trust is established by the member's will and takes effect following the member's death. No additional information required.

Contingent Beneficiary Section: Please select one of the beneficiary types below by checking the appropriate box. The contingent beneficiary will receive benefits in the event of your death only if all of the named principal beneficiaries are deceased.

☐ **Person**

You cannot name yourself as contingent beneficiary. You also cannot name the same person as both principal and contingent beneficiary. If you name more than one individual as contingent beneficiary you may indicate the percentage each beneficiary is to receive. Percentages for the contingent beneficiary section should total but not exceed 100%. If you do not indicate percentages, disbursement of payment will be divided equally among living principal beneficiaries, or if all principal beneficiaries have died, among all living contingent beneficiaries, as provided in KRS 61.542.

1 Name: _____ %: _____

Social Security Number: _____ Sex: _____

Date of Birth: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

2 Name: _____ %: _____

Social Security Number: _____ Sex: _____

Date of Birth: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

3 Name: _____ %: _____

Social Security Number: _____ Sex: _____

Date of Birth: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

4 Name: _____ %: _____

Social Security Number: _____ Sex: _____

Date of Birth: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ **My Estate**

If you name your estate as a principal beneficiary, you cannot name a contingent beneficiary. No additional information required.

☐ **Living Trust**

The following information is required to designate a living trust. You must write the name of the trust as it appears in the trust document and submit a copy of the trust with this form. A charitable organization or a religious charity cannot be named as beneficiary unless it is a trust.

Name of Trust: | Trust Tax ID: | Date of Trust:

Trustee or Successor Trustee Contact Information: Our office will contact the trustee listed below following your death.

Name: | Phone:

Trustee Address: | City: | State: | Zip Code:

☐ **Testamentary Trust**

A testamentary trust is established by the member's will and takes effect following the member's death. No additional information required.

This form is not valid unless signed by the member and witnessed. Please ensure that you have only checked one beneficiary type box in the principal beneficiary section and one beneficiary type box in the contingent beneficiary section. If you select more than one beneficiary type in either section, this form will be considered invalid. Please initial all corrections you have made to the form. Failure to initial changes may cause the form to be invalid.

Your Signature: | Member ID:

Witness Signature: (REQUIRED) | Date:

Boyd County Fiscal Court

Employee Election Notice

Benefit Period:
1/1/22 – 12/31/22

Employee Name: _____ Date of Hire: _____
(Please print)

Department: _____ SSN: _____ Birthday: _____

Home Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Work Phone: _____ Home/Cell Phone: _____

Payroll Deductions: 24 Gender: *(Circle one)* F M Martial Status: *(Circle one)* Single Married Divorced.

I have reviewed the information for Boyd County Fiscal Court's benefit options and I would like to take the following action. All prices are based on 24 deductions.

Important: You must complete additional paperwork if you are making any changes to health.

Anthem Dental Coverage

(Employer pays 85%)
No change in premium

	Dental Blue *Per Pay Cost*
_____ Employee Only	$ 1.62
_____ Employee / Spouse	$ 3.45
_____ Employee / Child	$ 3.45
_____ Employee / Children	$ 5.81
_____ Family	$ 5.81

_____ *Waive Dental Coverage*

_____ Existing Coverage
_____ New Application Completed
_____ Change Form Completed

Anthem Vision Coverage

No change in premium

	Per Pay Cost
_____ Employee Only	$ 2.73
_____ Employee / Spouse	$ 6.52
_____ Employee / Child(ren)	$ 5.90
_____ Family	$ 11.49

_____ *Waive Vision Coverage*

_____ Existing Coverage
_____ New Application Completed
_____ Change Form Completed

PLEASE SIGN BACK OF FORM

Boyd County Fiscal Court
Election Notice 2022

Completing Living Well Promise Rates

Employee Name:
SSN:
Date of birth:
Department:
Email Address:

Dependent Name:
Date of Birth:
SSN:
Gender:
Relationship: Spouse Child
Tobacco: Yes No

Dependent Name:
Date of Birth:
SSN:
Gender:
Relationship: Spouse Child
Tobacco: Yes No

Dependent Name:
Date of Birth:
SSN:
Gender:
Relationship: Spouse Child
Tobacco: Yes No

Dependent Name:
Date of Birth:
SSN:
Gender:
Relationship: Spouse Child
Tobacco: Yes No

Address:
Phone:
Date of Hire:
Tobacco Status: non-tobacco tobacco

Circle One

Non Tobacco Rates		**Tobacco Rates**	
LW CDHP		***LW CDHP***	
Employee Only	$53.46	Employee Only	$93.46
Employee/Children	$137.06	Employee/Children	$217.06
Employee Spouse	$339.34	Employee Spouse	$419.34
Family	$398.92	Family	$478.92
Family Cross Ref	$86.90	Family Cross Ref	$126.90
LW PPO		***LW PPO***	
Employee Only	$89.14	Employee Only	$129.14
Employee/Children	$254.10	Employee/Children	$334.10
Employee Spouse	$571.76	Employee Spouse	$651.76
Family	$716.64	Family	$796.64
Family Cross Ref	$170.48	Family Cross Ref	$210.48
LW Basic CDHP		***LW Basic CDHP***	
Employee Only	$28.34	Employee Only	$68.34
Employee/Children	$67.52	Employee/Children	$147.52
Employee Spouse	$281.42	Employee Spouse	$361.42
Family	$337.68	Family	$417.68
Family Cross Ref	$31.50	Family Cross Ref	$71.50
LW Limited HDHP		***LW Limited HDHP***	
Employee Only	$25.50	Employee Only	$65.50
Employee/Children	$60.78	Employee/Children	$140.78
Employee Spouse	$253.28	Employee Spouse	$333.28
Family	$303.92	Family	$383.92
Family Cross Ref	$28.34	Family Cross Ref	$68.34

Signature: _____ Date: _____

Employee Enrollment Application
For 51+ employee groups
Kentucky

Anthem AnthemLife

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name	Group no.	Subsection
Boyd County Fiscal Court	W26136	

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner	

Employee email address

Employment status	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section 2: Reason for application – Select one

- ☐ New enrollment
- ☐ Annual open enrollment (not applicable to life and disability)
- ☐ New hire
- ☐ Rehire – Rehire date: _____ (MM/DD/YYYY)
- ☐ Marriage – Date of marriage: _____ (MM/DD/YYYY)
- ☐ Birth of child
- ☐ Add dependent (Fill in section 4)
- ☐ Loss of eligibility for other coverage – Date previous coverage ended: _____ (MM/DD/YYYY)
- ☐ COBRA – Select qualifying event
  - ☐ Left employment
  - ☐ Reduction in hours
  - ☐ Death
  - ☐ Medicare
  - ☐ Loss of dependent child status
  - ☐ Divorce or legal separation
  - ☐ Covered employee's Medicare entitlement

  Qualifying event date: _____ (MM/DD/YYYY)
- ☐ Waiver (To decline ALL coverage skip to section 8.)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage

Large Group 51–99 options

☐ Anthem Essential (PPO)
☐ Blue Access (PPO)
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA (with Copay)
☐ Blue Access PPO HRA (with Copay)

Large Group 100+ options

☐ Anthem Essential (PPO)
☐ Blue Access (PPO)
☐ Blue Preferred (HMO)
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA (with Copay)
☐ Blue Access PPO Deductible First HRA
☐ Blue Access PPO HRA
☐ Blue Access PPO HRA (with Copay)

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Flexible Spending Account (FSA) coverage – More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Limited-Purpose FSA (for dental and vision services)
☐ Dependent Care FSA
☐ Commuter Parking
☐ Commuter Transit
☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice ☐ Complete Essential Choice ☐ Other: _____

Member dental coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage

☐ Vision

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Life and disability coverage

If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

☐ Basic Life
☐ Basic Life and Accidental Death and Dismemberment
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and Accidental Death and Dismemberment. . . . . $_____ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse . . . . . $_____ (spouse amount)
☐ Optional Supplemental/Voluntary Dependent Life Child. . . . . $_____ (child amount)
☐ Voluntary Accidental Death and Dismemberment . . . . . $_____ (employee amount)
☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage)
☐ Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage)
☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income – For employer/Anthem use	Occupation	Life and disability class no.– For employer/Anthem use
$_____		

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Life and disability coverage — Continued

Primary beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent beneficiary — If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

Spousal consent for community property states only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature	Spouse name	Date
X		

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 4: Coverage information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.
Note: Domestic partner coverage is not available for life and disability plans.

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No **If yes, please enter:** ____			

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No **If yes, please enter:** ____			

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No **If yes, please enter:** ____			

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 5: Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: ____________________

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Medicare eligibility reason (check all that apply) ☐ Age- ☐ Disability ☐ ESRD: Onset date: [ ] (MM/DD/YY)

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MM/DD/YY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: [ ] End: [ ]
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: [ ] End: [ ]
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: [ ] End: [ ]
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: [ ] End: [ ]
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: [ ] End: [ ]

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 6: Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. I understand that I may not assign any payment under my Anthem program unless allowable by law.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. I represent that my answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my approval date may cause a material change in coverage or premium rates. Any materially false statement or misrepresentation found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

I certify each Social Security number listed on this application is correct.

By signing this application, I understand that I will get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. After I enroll, I can change my communication preferences by calling Member Services or going to anthem.com. I can also call Member Services to request a free copy of specific materials by mail.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature – Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 6 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date (MM/DD/YYYY)
X	

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 8: Waiver/Declining coverage

Medical coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Dental coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Vision coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Life and disability coverage

***Life/AD&D** coverage declined for: ☐ Myself
Spouse and dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for: ☐ Spouse and dependents

Optional Supplemental/Voluntary coverage declined for: ☐ Myself

Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse and dependents

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:

- ☐ Life/AD&D declined for religious reasons
- ☐ Do not elect to enroll in Dependent Life
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary coverage
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary Dependent Life coverage
- ☐ Do not elect to enroll in Voluntary Short Term Disability
- ☐ Do not elect to enroll in Voluntary Long Term Disability

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd. Louisville, KY 40223

Anthem Life Insurance Company: P.O. Box 105448, Atlanta, GA 30348-5448

*Anthem is required by the Internal Revenue Service to collect this information.

Department of Employee Insurance
Kehp.ky.gov Personnel.ky.gov
888-581-8834
DO NOT STAPLE

KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

2022 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

Section 1: To be completed by the IC/HRG – IN OFFICE USE ONLY

KHRIS Personnel #	Organizational Unit #	Cost Center #	Company Name	Company #	Coverage Effective Date	Hire/QE/Transfer/Term Date

Reason(s) for Application:
- ☐ New Hire
- ☐ Rehire/Reinstate
- ☐ New Group
- ☐ Qualifying Event
- ☐ Change or Update
- ☐ ACA
- ☐ Exception
- ☐ Open Enrollment
- ☐ Update Demographics

Change in Employee Status:
- ☐ Transfer
- ☐ Begin LWOP
- ☐ End LWOP
- ☐ Begin Military Leave
- ☐ End Military Leave
- ☐ Retired
- ☐ Termination
- ☐ Summer Transfer

Qualifying Event:
- ☐ Marriage
- ☐ Birth/Adoption/Placement
- ☐ Court Order for Child
- ☐ Divorce
- ☐ Death
- ☐ Loss of Individual Health
- ☐ Loss of Group Health
- ☐ Begin Medicare/Medicaid
- ☐ End Medicare/Medicaid
- ☐ Sp/Dep Start Employment
- ☐ Sp/Dep Termed Employment
- ☐ Other:_____

Transfer from one KEHP covered entity to another KEHP covered entity:
This section is to be completed by the **NEW** company & no changes to current coverage allowed. Prior Agency #: Last Day Worked:

Section 2: Employee Information

Employee's SSN	Employee Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)
Mailing Address	City, State Zip	County
Primary Phone #	Secondary Phone #	Email Address-Preferably Work Email
Sex: ☐Male ☐Female	Married: ☐Yes ☐No	**Dental** ☐Add ☐ Drop ☐Remain **Vision** ☐Add ☐ Drop ☐Remain

Section 3: Spouse Information

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)
Sex: ☐Male ☐ Female	**Health** ☐Add ☐ Drop ☐Remain ~~**Dental** ☐Add ☐ Drop ☐Remain **Vision** ☐Add ☐ Drop ☐Remain~~	

☐I wish to utilize the cross-reference payment option (two KEHP members, married with children – no LRP or JRP)

Spouse's Personnel Number	Spouse's Hire Date	Spouse's Organizational Unit #	Spouse's Company #
Spouse's Primary Phone #	Spouse's Secondary Phone #	Spouse's Email Address-Preferably Work Email	

Section 4: Dependent Information

				Health	Dental	Vision
Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #7 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain

Employee: **Employee SSN:**

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found online at kehp.ky.gov. You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.

Planholder: Within the past 6 months, have you used tobacco regularly? ☐Yes ☐No

Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? ☐Yes ☐ No

Have any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months? ☐Yes ☐No

Section 6: Health Insurance Plan Options-All plans require the LivingWell Promise to receive the monthly premium discount of $40 for the next plan year. Instructions and more information on fulfilling the LivingWell Promise can be found at livingwell.ky.gov.

☐ LivingWell CDHP ☐ LivingWell PPO ☐ LivingWell Basic CDHP ☐ LivingWell Limited High Deductible

Select a Health Premium Level ☐ Single (self only) ☐ Parent Plus (self + child(ren)) ☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

☐ Waiver (General Purpose) HRA – with $ (I declare that I and, if applicable, my spouse and my dependents, have other group health plan coverage that provides minimum value. To the extent applicable, I have listed my spouse and all dependents whose medical expenses can be reimbursed under the HRA in Sections 3 and 4 of this application.)

Source of other coverage: ☐ Covered w/my spouse's employer (does not include TRICARE) ☐ Covered w/my parent's employer ☐ Dual group coverage/my own 2nd employer/retirement plan

***Note:** *if you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/Exchange, you are not eligible for the Waiver GP HRA but can elect the Waiver Limited Purpose HRA.*

☐ Waiver Limited Purpose HRA – with $

☐ Waiver without HRA – No $

☐ Default LivingWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enroll online with KHRIS ESS.

Section 7: Anthem Dental Insurance Options

☐ Dental Bronze ☐ Dental Silver ☐ Dental Gold

Select a Dental Premium Level

☐ Single (self only) ☐ Parent Plus (self + child(ren))

☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren)) *If cross-reference, please list the employee to carry the coverage* _____

Section 8: Anthem Vision Insurance Options

☐ Vision Bronze ☐ Vision Silver ☐ Vision Gold

Select a Vision Premium Level

☐ Single (self only) ☐ Parent Plus (self + child(ren))

☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren)) *If cross-reference, please list the employee to carry the coverage* _____

Section 9: Flexible Spending Accounts

Healthcare Flexible Spending Account

I request to (check one) ☐ Enroll in or ☐ Change my Healthcare FSA for calendar year 2022. I understand that the minimum allowable contribution is $10 per month ($5 per semi-monthly period).

Total Calendar Year Contribution: divisible by 24: $ _____

If cross-ref, please list the amount for each employee:

Employee Name: _____ *Amount:* _____

Employee Name: _____ *Amount:* _____

*New hires should calculate year contribution from effective date to the end of the year.

- Maximum calendar year contribution is $2,750 per eligible Planholder.
- Minimum calendar year contribution is $120 (or $10 per month).
- Maximum annual carryover amount is $550.
- Minimum annual carryover amount is $50.

Child and Adult Daycare Flexible Spending Account

I request to (check one) ☐ Enroll in or ☐ Change my Child and Adult Daycare FSA for calendar year 2022. I understand that the minimum allowable contribution is $10 per month ($5 per semi-monthly period).

Total Calendar Year Contribution: divisible by 24: $ _____

If cross-ref, please list the amount for each employee:

Employee Name: _____ *Amount:* _____

Employee Name: _____ *Amount:* _____

*New hires should calculate year contribution from effective date to the end of the year.

- Maximum contribution per tax filing status is $2,500 married filing separately, $5,000 married filing, or $5,000 married head of household.
- Minimum calendar year contribution is $120 (or $10 per month).
- For daycare expenses such as preschool, summer day camp, before/after school programs, and child or elder daycare.

Section 10: Signatures – Please submit this application to your Company IC/HRG By signing this application, I certify that the information provided in this application is true and correct to the best of my knowledge. I also certify that I have read, understand and agree to the Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found online at kehp.ky.gov and personnel.ky.gov. By typing my name in the space provided below, I am signing this application electronically and am agreeing to conduct this transaction by electronic means.

Employee Signature | Spouse Signature-REQUIRED if electing cross-reference | Date

Trisha Leach **606-739-6585**

IC/HRG Signature | IC/HRG Printed Name | IC/HRG Phone# | Date

Spouse's IC/HRG Signature-REQUIRED if electing cross-reference | Spouse's IC/HRG Printed Name | IC/HRG Phone# | Date