FOOTHILL-DE ANZA
Community College District

NEW EMPLOYEE ORIENTATION MATERIALS CHECKLIST (CLASSIFIED/ADMINISTRATORS)

Before orientation, please **READ** and **REVIEW** the following information:

- Foothill College Campus Map & Legend (The **District HR Office** is located in D120) **[p. 3]**
- Employee/Retiree Monthly Contribution Rates **[p. 4]**
- Summary of Medical Benefits Table (HMO) **[p. 5-6]**
- Summary of Medical Benefits Table (PPO) **[p. 7-8]**
- Notice of Right to Continue Coverage Under COBRA **[p. 9-13]**

Note: Up-to-date information regarding benefits plans and rates can be reviewed online on our website: http://hr.fhda.edu/benefits.

Before orientation, please **PRINT**, **COMPLETE** and **SIGN** the following documents:

☐	**Universal Enrollment Form** • Choose one of the six (6) plan choices for your entire family • For **EACH** person you insure please include: ❑ Marriage Certificate **or** a California State Declaration of Domestic Partnership (Form NP/SF DP-1) **or** a California State Confidential Declaration of Domestic Partnership (Form NP/SF DP-1A) (if applicable) ***OR*** CalPERS Affidavit of Marriage/Domestic Partnership** (Form PERS-HBSD-1965) (**information will be verified by CalPERS. Claims must be reimbursed if false or inaccurate information is provided.) ❑ Copies of Birth Certificates for **all** eligible dependents (including spouse or domestic partner) ❑ Copies of Social Security cards for **all** eligible dependents (including spouse or domestic partner) ❑ Legal adoption notice and/or court orders (if applicable)	[p. 14-16]
☐	**CalPERS Declaration of Health Coverage form** (form HBD-12A)	[p. 17-18]
☐	**CalPERS Health Benefit Plan Enrollment form** (form PERS-HBD-12)	[p. 19-20]
☐	**CalPERS Affidavit of Parent-Child Relationship form** (optional; if applicable) (form HBD-40)	[p. 21-22]
☐	**Member Questionnaire for the CalPERS Disabled Dependent Benefit**(form HBD-98) (optional; if applicable)	[p. 23-24]
☐	**Medical Report for the CalPERS Disabled Dependent Benefit** (form HBD-34) (optional; if applicable)	[p. 25-27]
☐	**Flexible Benefits Spending Account: Dependent Care and/or Health Care** (optional)	[p. 28]
☐	**General Employee Information form**	[p. 29-30]
☐	**Hartford Life Insurance Beneficiary Designation form**	[p. 31]
☐	**U.S. Department of Justice I-9 form**	[p. 34]

(OVER)

☐	**W-4 (Federal) and DE-4 (State) Employees' Withholding Allowance Certificate**	[p. 37,39]
☐	**Drug-Free Workplace Policy Statement** (read and sign)	[p. 43-44]
☐	**Illness & Injury Prevention Memo** (General Safety Guidelines) (read and sign)	[p. 49]
☐	**Retirement Election form** (read and sign)	[p. 50]
Please **BRING** the following to orientation:		
☐	**Employee's Social Security card and government-issued picture ID** (see the I-9 form for acceptable documents) **Note**: You will need to provide the *actual* documents, not photocopies; Social Security card exempted	-
☐	**Any documentation for dependents you are enrolling into the health plan** (see documents listed under Universal Enrollment Form above)	-
☐	**All of the above (applicable) documents—printed, signed and dated**	-
After orientation, please **COMPLETE** the following forms and tasks:		
☐	**TB (Tuberculosis) Test form** (Visit Health Services on the Foothill or De Anza campuses for the test. After results are read, the form will be automatically returned to HR by Health Services. Service is *free* for employees.)	[p. 51]
☐	**Request for Live Scan Service form** (Complete the middle section only. ** Required process; you will receive this form during orientation. Service is *free* for employees.)	**
☐	**Direct Deposit** (follow-up with Personnel (650-949-6219) within 7-10 days to confirm your employee CWID so that you may access https://myportal.fhda.edu and sign up for direct deposit. **You may only do this online**. Until you sign up, you will continue to receive paper paychecks in the mail.)	--
OTHER NECESSARY INFORMATION:		
FYI	**Change of Address** (Can only be done online via MyPortal: https://myportal.fhda.edu Address must be changed within 10 calendar days of new effective date.)	--
FYI	**Change of Name** (Can only be done by notifying Personnel in writing. Must provide a copy of new official social security card. Only the names presented on your social security card will be acknowledged as official. Must notify Personnel within 10 calendar days of name change effective date.)	--

FOOTHILL-DE ANZA
Community College District

Universal Enrollment Form

Medical/Dental/Vision - For Active, Retiree, COBRA, Surviving Spouse Participants

OFFICE USE ONLY: Plan Type_____ **Plan Code**_____ **Coverage Code**_____ **Effective Date**_____

Medical Regional Code: _____ **(Bay Area; Sacramento; No. CA; Los Angeles; So. CA; Out-of-State)**

Retiree Annuity Status: **PERS ID:** _____ **STRS ID:** _____

Plan Selection:

☐ **Blue Shield Access+ HMO** ☐ **Blue Shield NetValue HMO** ☐ **Kaiser Permanente HMO**	☐ **PERS Select PPO (Anthem Blue Cross)** ☐ **PERS Choice PPO (Anthem Blue Cross)** ☐ **PERS Care PPO (Anthem Blue Cross)**	☐ **Delta Dental of California** ☐ **Vision Service Plan (VSP)**

Employee Information:

Name (Last, First, M.I.)	Social Security Number	Date of Birth	Hire Date

Physical Home Address (NO P.O. Box)	Home Phone: Alternative Phone:

Sex ☐ Female ☐ Male Hrs worked per week: ____	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Legal Separation Date of Marriage/Partnership:_____ Job Occupation: _____ Campus Location:_____

Classification:
☐ FT Faculty ☐ PT Faculty ☐ Confidential ☐ Supervisor ☐ Classified ACE ☐ Administrator
☐ Classified CSEA ☐ Board Member ☐ Retiree ☐ Surv. Spouse ☐ OE3 ☐ COBRA Enrollee

	MEDICAL		**DENTAL & VISION**
☐	Employee Only	☐	Employee Only
☐	Employee + Spouse	☐	Employee + Spouse
☐	Employee + Same-Sex Domestic Partner (DP/CA Reg)	☐	Employee + Same-Sex Domestic Partner (DP/CA Reg)
☐	Employee + Same-Sex Domestic Partner (DP/Non-Reg)	☐	Employee + Same-Sex Domestic Partner (DP/Non-Reg)
☐	Employee + Child	☐	Employee + Child
☐	Employee + Children	☐	Employee + Children
☐	Employee + Family	☐	Employee + Family
☐	Employee + DP (CA Reg) + DP's Child(ren)	☐	Employee + DP (CA Reg) + DP's Child(ren)
☐	Employee + DP (CA Reg) + EE's Child(ren)	☐	Employee + DP (CA Reg) + EE's Child(ren)
☐	Employee + DP (Non-Reg) + DP's Child(ren)	☐	Employee + DP (Non-Reg) + DP's Child(ren)
☐	Employee + DP (Non-Reg) + EE's Child(ren)	☐	Employee + DP (Non-Reg) + EE's Child(ren)
☐	WAIVED	☐	WAIVED

	This Election is for:	**COBRA/Surviving Spouse Qualifying Event Date:**
☐	New Enrollment	_____
☐	Marriage/Divorce: _____ Effective date	☐ Termination of Employment ☐ Change of Employment Hours
☐	Name Change: _____ Former name	☐ Death of Subscriber ☐ Divorce or legal separation

☐	Birth of Child	☐	Dependent reached age limit according to PLAN
☐	Adoption or Placement of Adoption (Court Ordered Coverage: Please attach a copy of court order)	☐	Retirement (when ineligible for District paid benefits)

Medical / Dental / Vision Coverage:

(A)dd (C)hange (D)elete	Relationship	Name (Last, First, M.I.)	Social Security Number	Date of Birth	Gender	Disabled?
	☐ Spouse ☐ Domestic Partner					
	Daughter/Son					
	Daughter/Son					
	Daughter/Son					

Do your children reside with you? ☐ YES ☐ NO

If no, your children's physical address is :_____

Do you or your dependents have other health coverage? If yes, please complete this section.

	Name	Name and address of other insurance Carrier	Effective Date
Self			
Spouse/DP			
Daughter/Son			
Daughter/Son			
Daughter/Son			

Medicare Section:

Are you retired? ☐ Yes ☐ No
If Yes … Part A ☐ Yes ☐ No
Part B ☐ Yes ☐ No

If yes for Medicare for you and/or your Dependent(s), please provide your and/or their SSN and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

Do any of your dependents have Medicare?
☐ Yes ☐ No

If yes, for your dependents
……. Part A ☐ Yes ☐ No
……. Part B ☐ Yes ☐ No

Name(s) of Medicare Dependent(s)

_____

_____

_____

Retiree:

SSN # _____
Entitlement Reason:
☐ Over 65
☐ Disabled
☐ OTHER
Effective Date of Medicare _____/_____/_____

Dependent(s):

SSN # _____

Name _____
Entitlement Reason:
☐ Over 65
☐ Disabled
☐ OTHER
Effective Date of Medicare _____/_____/_____

Payroll Deduction Contributions

The plan administrator may reduce or cancel the amount of my payroll deduction contributions or otherwise modify this agreement if this becomes necessary to satisfy certain provisions of the Internal Revenue Code. The amount of my monthly payroll deduction contributions is shown on a schedule that has been provided to me and the amount may change in the future.

HMO Arbitration Agreement

I apply for Health Plan membership for myself and my covered family dependents. We agree to abide by the provisions of the Service Agreement and Health Plan policies. We understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between me, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

PPO Arbitration Agreement:

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

Your Authorization:

I acknowledge that I have received and read the enrollment materials for the Employee Benefits Program and I have read the information on this form. I acknowledge that the information submitted represents my enrollment choice(s) and I am authorizing contributions to be withheld from my pay for the healthcare covered selected.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim 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 and subjects such person to criminal and civil penalties.

Active employees only: I understand that any premiums I am obligated to pay for health care coverage for myself and/or any of my dependents will be deducted from my pay on a PRE-TAX basis.

This signature also verifies the accuracy of the information on this form.

I have read, understand, and agree to the terms and conditions above.

Subscriber Signature: _____ **Date:** _____

Employer Information (to be completed by Human Resources Department)

Authorized Signature of Employer:_____

Effective Date of Coverage: _____

CalPERS

Office of Employer and Member Health Services
PO Box 942714
Sacramento, CA 94229-2714
Toll Free: (888) CalPERS (225-7377) Fax: (916) 795-1313
Telecommunications Device for the Deaf: (916) 795-3240

Declaration of Health Coverage: HBD-12A **(INSTRUCTIONS ON REVERSE)**

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME (FIRST) (MIDDLE) (LAST)

PART A ☐ I elect to enroll myself and all eligible dependents.	
PART B-1 ☐ I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage. **If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.**
PART B-2 ☐ I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.	
PART C-1 ☐ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
PART C-2 ☐ I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. **You must wait at least 90 days after you request enrollment or until the next Open Enrollment period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.**

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependents, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependents, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

Member's Signature

Date Signed

Health Benefits Officer's Signature

Rev (3/09)

Original: Employee's Personnel File

Copy: Employee

INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

Please contact your Health Benefits Officer if you have any questions regarding the HB-12A	
Employee Information	Complete with the appropriate employee information.
PART A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
PART B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage.
PART B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
PART C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
PART C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not eligible to be enrolled in a CalPERS-sponsored health plan on the date you separate employement, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are enrolled on your CalPERS-sponsored health plan at this time, they may be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.

California Public Employees' Retirement System
P.O. Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM

PERS-HBD-12 (Rev.8/10)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

CalPERS **USE ONLY - DOCUMENT REFERENCE NUMBER**

PLEASE TYPE

1. TYPE OF ACTION (Check One)
- ☐ a. NEW enrollment
- ☐ b. CHANGE of coverage
- ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER ___ ___

3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER ___ ___

4A. Name

Mailing Address (FIRST) (MI) (LAST)

City, State, ZIP | Daytime Phone | Evening Phone

4B. RESIDENCE ZIP CODE (If different from 4A)

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. GENDER ☐ Male ☐ Female

7. MARRIED ☐ Yes ☐ No

8. PLAN CODE

9. NAME OF HEALTH PLAN

10. GROSS PREMIUM $

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Reason Code

15. Permitting Event Date Mo. Day Yr.

16. EFFECTIVE DATE Mo. Day 01 Yr.

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	GENDER M	F	CODE
	17. BASIC PLAN							
	(FIRST) (MI) (LAST)				SELF			
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							
	(FIRST) (MI) (LAST)							
	SSN							
	18. SUPPLEMENTAL PLAN	DATE OF BIRTH Mo.	Day	Yr.	Relationship			CODE
	(FIRST) (MI) (LAST)							

19. CHECK ONE

- ☐ I **DO NOT** elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy) | TELEPHONE NUMBER ( )

21. DATE SIGNED Mo. Day Year

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE

23. Type of action (Check One) 1. ☐ New 2. ☐ Cancel 3. ☐ Change

24. PAY PERIOD Month Year

25. PARTY CODE

26. EMPLOYEE DESIGNATION

27. BARGAINING UNIT

28. AGENCY NAME (or Retirement System)

29. PAYROLL OFFICE CODE

30. AGENCY CODE

31. UNIT CODE

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in employing office Mo. Day Year

34. PHONE NUMBER ( )

35. REMARKS

_____ of _____ Forms

WHITE - HB PINK - Agency BLUE - Employee

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, PERS, P.O. Box 942714, Sacramento, CA 94229-2714.

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and state benefits. Furthermore, the Office of Employer and Member Health Services requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits. Specifically, the California Public Employees' Retirement System uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Payroll deduction and state contribution for state employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to the Public Employees' Retirement System and other state agencies.
5. Coordination of benefits among carriers.

BINDING ARBITRATION

Enrollment in certain plans constitutes an agreement to have any issue of medical malpractice decided by neutral arbitration and waiver of any right to a jury or court trial. Refer to the health plan Evidence of Coverage booklet to determine if this provision is applicable to your plan.

Affidavit of Parent-Child Relationship

California Code of Regulations section 599.500(o)

The Public Employees' Medical and Hospital Care Act (PEMHCA), allows employees and annuitants to enroll family members in a CalPERS-sponsored health plan. Pursuant to Title 2, California Code of Regulations (CCR), section 599.500(o), an employee or annuitant may enroll a child, other than an adopted, step or recognized natural child, in the health plan if the employee or annuitant has assumed a "parent-child relationship" with that child in lieu of the child's adoptive, step or natural parent, up to age 26.

A parent-child relationship occurs when the employee or annuitant assumes a parental role and is considered the primary care "parent." Evidence of this relationship may include assuming responsibilities such as providing shelter, clothing, food, child care or education for the child, as well as assuming parental duties, such as providing permission for school activities, health care services, extracurricular, and recreational activities.

A parent-child relationship must be certified at the time of enrollment for each child and annually thereafter up to age 26. Spouses of your recognized natural, adopted, or stepchild are **not** eligible for enrollment.

Employee/Annuitant Information

Name: (First) (M.I.) (Last)

Social Security Number:

What is the date you assumed the primary custodial parental role for the child?

What is your relationship to the child?

Child Information

Name: Date of Birth:

Social Security Number: (First) (M.I.) (Last)

Address (if different from employee/annuitant):

Have you enrolled other children as family members under CCR section 599.500(o)? Yes ☐ No ☐

If yes, what is the number of children enrolled under CCR section 599.500(o)? _____

Note: *A new Affidavit of Parent Child-Relationship form must be submitted for each child.*

Eligibility

I hereby certify I have assumed a parent-child relationship with the child named above, as evidenced by the following:		Internal Use Only (HBO Initials)
1. I have assumed a primary custodial role for this child.	Yes ☐ No ☐ Initials ___	_____
2. I am considered the primary care "parent."	Yes ☐ No ☐ Initials ___	_____
3. I have assumed responsibility for providing the essential needs for this child, such as food, shelter, clothing, and education.	Yes ☐ No ☐ Initials ___	_____
4. Has the child been placed in your care as a result of foster care?	Yes ☐ No ☐ Initials ___	_____
5. I am listed as the primary contact on school, health, and other emergency forms.	Yes ☐ No ☐ Initials ___	_____
6. I provide parental permission for the child regarding health care services, school, extracurricular, and other activities.	Yes ☐ No ☐ Initials ___	_____
7. The child is living with me. (If the child is not currently living with you, please state the reason why.) _____	Yes ☐ No ☐ Initials ___	_____
8. I claim the child as my dependent for income tax purposes.	Yes ☐ No ☐ Initials ___	_____
9. Other (please explain or attach explanation): _____ _____	Yes ☐ No ☐ Initials ___	_____

I recognize this affidavit is a legally binding document. I accept full responsibility for notifying my Health Benefits Officer in writing if there are any changes pertaining to this parent-child relationship. Active employees contact your Health Benefits Officer. Retirees contact CalPERS. I further understand the provision of California Government Code 20085, which states:

(a) It is unlawful for a person to do any of the following:
  (1) Make, or cause to be made, any knowingly false material statement or material representation, to knowingly fail to disclose a material fact, or to otherwise provide false information with the intent to use it, or allow it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by this system.
  (2) Present, or cause to be presented, any knowingly false material statement or material representation for the purpose of supporting or opposing an application for any benefit administered by this system.

I hereby certify under penalty of perjury, that the information provided by me is true and correct to the best of my knowledge. I also agree to provide supporting documentation such as, but not limited to, court records, birth certificate, tax returns, statement of financial liability, or any other documents, when requested by my employer or CalPERS. I understand that each child, other than recognized natural, adopted, or stepchild, for whom I assume a parent-child relationship, must be certified at the time of enrollment and annually thereafter up to age 26.

_____ _____

Employee/Annuitant Signature **Date**

For Employer Use:

I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified, and acting officer of the below named agency.

☐ I hereby certify I have reviewed the above application and verified the identity of the employee submitting this affidavit.

☐ Based on the information provided and any attached documentation, I am approving the enrollment of this child according to CCR section 599.500(o).

☐ Recommend not approving the enrollment of this child.

_____ _____ _____

Health Benefits Officer Signature **Agency Name** **Date**

_____ _____

Personnel Officer/Human Resources Manager ☐ **Approve** ☐ **Disapprove** **Date**

P.O. Box 942714
Sacramento, CA 94229-2714
TTY for Speech & Hearing Impaired (916) 795-3240
Phone: (888) CalPERS (or **888**-225-7377); Fax (916) 795-1313

C

Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)
TDD - (916) 795-3240
FAX (916) 795-1277

MEMBER QUESTIONNAIRE for the CalPERS DISABLED DEPENDENT BENEFIT

MEMBER: PLEASE COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING A DELAY IN BENEFITS.

PART A: **MEMBER INFORMATION:**	**DEPENDENT INFORMATION:**
Name: _____ **Social Security Number (SSN):** _____-_____-_____ **Address:** _____ **Telephone: ( )** _____	**Name:** _____ **Social Security Number (SSN):** _____-_____-_____ **Address:** _____ **Date of Birth:** _____

PART B: Please provide the following information about the dependent who is seeking initial or continued enrollment or recertification in the health plan under the disabled dependent benefit. For purposes of this benefit, a person is considered disabled if the person is incapable of self-support (i.e., incapable of any substantial gainful activity) as a result of a physical or mental disabling injury, illness or condition. Mail this completed form to the above address.

MEMBER QUESTIONNAIRE			
			Marital Status
1.	**Yes**	**No**	Is the dependent married or has he or she ever been married? If yes, do not complete the remainder of this form. The dependent is **NOT** eligible to continue enrollment in the CalPERS Health Benefit Program.
			Health Insurance and Health Care
2.			Is the dependent entitled to:
	Yes	**No**	Medi-Cal? (If yes, attach a copy of the dependent's Medi-Cal card.)
	Yes	**No**	Medicare Part A (hospital care)? (If yes, attach a copy of the dependent's Medicare card.)
	Yes	**No**	Medicare Part B (medical care)? (If yes, attach a copy of the dependent's Medicare card.)
	Yes	**No**	Other insurance? (If yes, specify the plan name and type of coverage.)
3.	**Yes**	**No**	Has the dependent received In-Home Supportive Services or in-home skilled nursing care in the past year?
			Income and Support
4.	**Yes**	**No**	Is the dependent economically dependent upon you for his or her support? (If yes, attach a list of the dependent's monthly living expenses that you provide including housing, food, clothing, medical, etc.)
5.			Is the dependent entitled to receive:
	Yes	**No**	Social Security Disability Insurance (SSDI)?
	Yes	**No**	Supplemental Security Income (SSI)?
6.	**Yes**	**No**	Does the dependent currently attend school? (If yes, specify the name of the school(s) and course(s) of study.)
			Employment History
7.	**Yes**	**No**	Has the dependent *ever* worked (including work through a sheltered workshop)? (If yes, attach the date(s) of employment and employer name(s) and address(es).)
8.	**Yes**	**No**	Is the dependent working now?
9.	**Yes**	**No**	If the answer to question 7 or 8 is yes, attach proof of the dependent's earnings for the current calendar year (January to December) and the two previous years.

PART C: CERTIFICATION:
I hereby certify that, to the best of my knowledge, the above information is complete and correct.

_____ _____
Member Name Date

PRIVACY INFORMATION

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You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, PO Box 942702, Sacramento, CA 94229-2702.

Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System requests each enrollee's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other agencies for identification purposes, the Office of Employer and Member Health Services may be unable to verify eligibility for benefits without the Social Security account number.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and state contribution for state employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to the California Public Employees' Retirement System and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals/complaints/grievances with health plan carriers

Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)
TDD - (916) 795-3240
FAX (916) 795-1277

C

MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT

COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING DELAY IN BENEFITS.

MEMBER PART A: THE MEMBER IS TO COMPLETE THE INFORMATION IN PART A: MEMBER INFORMATION	DEPENDENT INFORMATION
NAME:_____	**NAME:**_____
SOCIAL SECURITY NUMBER (SSN)_____	**SSN**_____
ADDRESS:_____	**ADDRESS:**_____
TELEPHONE ( )_____	**DATE OF BIRTH:**_____

PART B: DEPENDENT AUTHORIZATION: *The **dependent**, or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:*

I hereby authorize my attending physician_____ to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that CalPERS will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

_____ _____
Signature of Dependent **OR** Date Signed

_____ _____
Person authorized to act on his/her behalf Relationship to the dependent

PHYSICIAN PART C: *The **physician** is to complete all requested information in PARTS C and D. All responses must be legible. Mail this completed form to CalPERS at the address found at the top of this page.*

Please DO NOT send information copied directly from the patient's medical record at this time.

Dear Doctor:
The patient requests you to complete this **Medical Report** form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.

Medical Report	
1.	I attended the patient for the current disabling medical problem or condition from _____ to _____; At intervals of _____. I last examined the patient on _____.
2.	Medical History (related to disability): Date of Disability Onset:_____
3.	Diagnosis (REQUIRED): _____ ICD-9 Disease Code, Primary (Required) : _____ ICD-9 Disease Code(s), Secondary : _____ DSM IV Code(s) (if any) : _____
4.	Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings)
5.	Current Treatment(s) and /or Medication(s) (rendered to the patient for this disability): ☐ The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.)

(See page 2 of this for additional required information.)

MEMBER:_____ DEPENDENT NAME:_____
SSN: _____ SSN: _____

Medical Report	
6	Functional Assessment of Activities of Daily Living (ADLS): Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in this ADL skill or ability. These functional disabilities limit the patient's capacity for self support. **Mobility Skills**: ____walking, ____sitting, ____standing, ____lifting, ____bending **Self-Care Skills**: ____feeding, ____bathing, ____toileting, ____dressing **Sensory Skills**: ____hearing, ____seeing, ____speech, ____touch **Cognitive Skills**: ____judgment, ____memory, ____planning/follow through, ____thinking/processing information
7.	Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behaviors, if any, that affect the patient's ADLs and limit his or her capacity to be self-supporting:

PART D: Medical Certification of Disability and Incapacity of Self Support: For purposes of this benefit, a CalPERS member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 23 years of age.

1. Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?
   ____ NO, the patient does NOT have a physically of mentally disabling injury, illness or condition.
   ____ YES (Please answer Question 2.)

2. In your medical or psychiatric opinion, please select **A**, **B**, or **C**:
   ____**A**. The patient's current disability DOES NOT render him or her incapable of self-support.

   ____**B**. The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by _____.
   (projected DATE—mm / yy)
   If the condition is likely to improve or resolve, make SOME "estimate" of when this will occur.
   Please DO NOT leave the DATE blank. Answers such as "indefinite" or don't know" will not suffice.

   ____**C.** The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self support within the foreseeable future (e.g., more than 5 years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self support, and that I am a _____, _____
(Type of Physician) (Specialty, if any)
licensed to practice by the State of _____.

PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS OR HER ADDRESS, TELEPHONE AND FAX NUMBERS:

_____ _____
PHYSICIAN'S NAME AS SHOWN ON LICENSE ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

_____ _____
LOCAL ADDRESS STATE LICENSE NUMBER

_____ (_____)_____
CITY STATE TELEPHONE NUMBER

_____ (_____)_____
DATE FAX NUMBER

PART E: CalPERS USE ONLY:

____ Claim approved for enrollment through _____ _____
DATE (for next review) REVIEWED BY

____ Claim rejected. _____
DATE

PRIVACY INFORMATION

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5. Coordination of benefits among carriers
6. Resolve member appeals/complaints/grievances with health plan carriers

Health Care and Dependent Care Flexible Spending Accounts Enrollment Form

Employer Use Only
Re-enrollment __ New __ Change __
Effective Date _____
1st Deduction Date _____
Payroll Mode W B S M Q
Division Code _____

I. Personal Information (Please print clearly and provide complete and accurate information.)

Your Employer: _____

Member # _____ **Your Name** _____
(This may be your SSN or employer assigned number) (Last) (First) (MI)

Address _____ **City** _____ **State** _____ **Zip** _____-_____

☐ *Check if this address is new within last year.* **Date of Birth** ____/____/____ **Hire Date** ____/____/____

II. Election Information (Please check the appropriate box to indicate if you wish to enroll, or do not wish to enroll, and sign below.)

☐ Yes, I wish to participate in the flexible spending account plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ I have been offered the opportunity to enroll in the flexible spending account plan and do not wish to enroll at this time. However, my employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

BENEFIT CHOICES	PER PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		PLAN YEAR AMOUNT
Healthcare Flexible Spending Account • The minimum and/or maximum contribution amounts are determined by your employer.	$_____.___	x	_____	=	$_____.___
Dependent Day Care Flexible Spending Account • The minimum contribution amount is determined by your employer; however the maximum contribution amount of $5,000 is set by the IRS. • If married, and your spouse is disabled, a full-time student or earns less than you, lower limits may apply. Please refer to the IRS guidelines for further information.	$_____.___	x	_____	=	$_____.___

I understand that:

- This election can only be changed or revoked during the Plan Year if I have a change in status as defined in the Plan or if I am no longer eligible to participate. The new election must be consistent with my change in status, must be applied for within 30 days of the change, and is subject to final approval by my employer.
- This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required employer-sponsored benefit contributions increase or decrease.
- The maximum exclusion under a Dependent Care Reimbursement Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- Any amounts remaining in my reimbursement accounts at the end of the Plan Year will be forfeited.
- Salary contributed into one reimbursement account cannot be transferred and used for expenses in any other account.
- A new Enrollment Form must be completed each Plan Year. If I do not complete and return an Enrollment Form during Open Enrollment, I forfeit the opportunity to participate in the Benefit Choices outlined above.
- Social Security and Medicare taxes are not being withheld on the amount of my salary reduction under this election.
- The amount of salary reductions may not be claimed on my or my spouse's income tax returns.
- If my employment terminates, only medical expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- I understand all claims submitted for reimbursement are subject to substantiation requirements and I am required to, and agree to, provide documentation as requested.
- If using the PayFlex Debit Card, I agree to use the card for eligible expenses only and retain all itemized receipts/statements. I agree to read and adhere to the cardholder statement I receive with the card and I understand the card is subject to inactivation if I do not comply with the provisions or upon termination of employment.
- Any expenses I pay for with the PayFlex Debit Card or for which I claim reimbursement will not have been nor will I seek to have reimbursed elsewhere.

III. Pre-Authorization for Direct Deposit (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

☐ I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements. This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement.
A "VOIDED" CHECK MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

✍ ***Employee Signature*** _____ ***Date*** _____ ***Rev.1/2012***

IMPORTANT! You should review this agreement with the agent representing each issuing company from which an annuity contract must be established before you file the agreement with the Office of Payroll Services.

Amendment of Employment Contract

It is agreed by the Foothill-DeAnza Community College District, hereinafter referred to as the "District," and _____, hereinafter referred to as the "Employee," that the Employment contract between them for the 20___-20___ school year be amended as follows:

- Beginning with the salary warrant payable on _____, 20___ the District shall reduce the salary due the employee by $_____ per month under pre-tax basis 403(b) and $_____ per month under after-tax basis Roth 403(b).

- The District will apply the monthly reduction specified in the above paragraph to the purchase of a non-transferable annuity contract (or contracts), and the monthly payment of premiums thereon, as follows:

Tax Shelter Annuity Program (Pre-tax basis)

Name of Issuing Company	Remittance Address	Account Number	Monthly Amount
_____	_____	_____	$_____
_____	_____	_____	$_____
	Total Pre-tax Reduction:		$_____

Roth 403(b) Program (After-tax basis)

Name of Issuing Company	Remittance Address	Account Number	Monthly Amount
_____	_____	_____	$_____
_____	_____	_____	$_____
	Total After-tax Reduction:		$_____

Total Monthly Reduction: $_____ **Total Annual Estimated Reduction:** $
(Pre-tax basis+ After-tax basis)

Such annuity contract (or contracts) shall be non-forfeitable except for the failure to pay future premiums. At no time is the total monthly reduction in salary, or the amount applied to the purchase of any single contract, to be less than $10.00.

- The District may use the services of a remitting agency (i.e. a commercial bank that has agreed to perform such fiscal services for the District) in making any annuity purchase under this salary reduction agreement. The District's remitting agency shall transmit the amounts to be applied to the purchase of an annuity contract (or contracts) under this agreement to each issuing company in the manner specified above no later than 10 working days after the end of the pay period for which the corresponding salary reduction was made.

- The employee, for him/herself, spouse, heirs, administrators, executors, and representatives hereby releases all rights, present and future, to receive in any other form than payments from the issuing company the amounts to be applied toward annuity premium payments under this agreement.

- The purpose of this agreement is to enable the employee to participate in an annuity program, as described in Section 403, Subdivision (b) of the Internal Revenue Code of 1954, as amended, and corresponding provisions of the California Revenue and Taxation Code. The employee acknowledges that the District has made no representation to the employee regarding the advisability or tax consequences of the purchase described herein. Furthermore, the employee assumes full responsibility for conforming all computations in connection with the salary reduction to the requirements of the Internal Revenue Code, the California Revenue and Taxation Code, and all regulations thereunder. Finally, the employee releases the District, its officers, and employees, from any liability for loss resulting from any such computations, his or her selection of an issuing company or companies, or from the solvency of, operation of, or benefits provided by said company or companies.

- This amendment shall automatically apply to the employment contract entered into between the District and the employee for each succeeding school year unless it is amended or terminated by written notice to the District, received by the Office of Payroll Services at least 15 days before the amendment or termination is to take effect.

THIS AGREEMENT SUPERSEDES ALL PREVIOUS SALARY REDUCTION AGREEMENTS FILED WITH THE DISTRICT UNDER ITS TAX SHELTER ANNUITY PROGRAM. ON AND AFTER THE EFFECTIVE DATE OF THIS AGREEMENT THE ONLY SALARY REDUCTION THAT WILL BE MADE WILL BE THE REDUCTION SPECIFIED IN THIS AGREEMENT.

_____ _____
Employee's Signature Date

_____ By _____
Social Security Number FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

_____ _____ _____
Agent's Signature Agent's Name Agent's Phone Number

FOOTHILL-DE ANZA
Community College District

Office of Human Resources and Equal Opportunity
12345 El Monte Road, Los Altos Hills, CA 94022

GENERAL EMPLOYEE INFORMATION

Section A – Employee Information

Social Security #_____ Name: _____
(Name as it appears on Social Security Card)

Preferred Name: _____ Telephone: _____
(First Name ONLY: name desired to be addressed as by colleagues)

Address_____ City/State/Zip: _____

Person to contact in case of emergency:

Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Relationship to employee: _____

Section B – Oath of Office (Required under Government Code Section 3102)

I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign or domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

Signature: _____ Date: _____

Section C - Affidavit of Designation to Receive Warrants

The text of Government Code Section 53245 is as follows:

> 53245. 'Any person now or hereafter employed by a county, city, municipal corporation, district, or other public agency may file with his/her appointing power a designation of a person who, notwithstanding any other provision of law, shall, on the death of the employee, be entitled to receive all warrants or checks that would have been payable to the decedent had he/she survived. The employee may change the designation from time to time. A person so designated shall claim such warrants or checks from appointing power. On sufficient proof of identity, the appointing power shall deliver the warrants or checks to the claimant. A person who receives a warrant or check pursuant to the section is entitled to negotiate it as if he/she were the payee.'

In the event of my death, I designate _____ ,

my _____ (relation, if any), of _____

_____

(Address to receive all warrants of checks that would have been payable to me had I survived.)

Signature: _____Date:_____

PLEASE COMPLETE OTHER SIDE

Section D – Equal Opportunity Survey

The Foothill-De Anza Community College District is committed to diversity and actively recruits women, persons with disabilities, members of underrepresented ethnic groups, and veterans of the Vietnam era. We are required to provide demographic information to state and federal agencies to demonstrate our commitment. Therefore, please provide the information requested below so that we may have accurate data for reporting our Diversity goals. Completion of this form is voluntary. Failure to complete this form will not impact your employment and the information you provide is confidential.

Gender: __Male __Female

Ethnic Identification (**Check only one**)

Are you Hispanic or Latino?

____NO ____YES (1)

If yes, please select all that apply:

__Mexican, Mexican American or Chicano (2)
__Central American (3)
__South American (4)
__Other Hispanic (5)

In addition to the previous answer, please select one or more of the following to describe your racial background:

__Asian Indian (6)
__Asian Chinese (7)
__Asian Japanese (8)
__Asian Korean (9)
__Asian Laotian (10)
__Asian Cambodian (11)
__Asian Vietnamese (12)
__Filipino (13)
__Asian other (14)
__Black or African American (15)
__American Indian/Alaskan Native (16)
__Pacific Islander Guamanian (17)
__Pacific Islander Hawaiian (18)
__Pacific Islander Samoan (19)
__Pacific Islander Other (20)
__White (21)

Do you have a disability?
(An individual with a disability is a person who has (1) a physical or mental impairment that substantially limits one or more major life activities; or (2) a record of such impairment; or (3) is regarded as having such impairment.)

__ Yes Specify: _____

__ No

Are you a Vietnam Era Veteran? Service Dates must be between August 5, 1964 and May 7, 1975.
__ Yes __ No

_____ I choose not to complete this portion of the form.

Signature: _____ Date: _____

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name	Social Security Number ☐☐☐☐☐☐☐☐☐
Employee Address	Telephone Number
Policyholder/Employer	Policy/Employer Number

NAMING THE BASIC LIFE AND AD&D BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, and relationship. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related." If more than one primary or contingent beneficiary is named without a percentage indicated, the proceeds will be divided equally. On the reverse side of this form you will find examples of common beneficiary designations. If you need assistance, contact your Company representative or your own legal counsel.

PRIMARY BENEFICIARY(IES) ☐ **Basic** ☐ **Supplemental** ☐ **Basic and Supplemental**

Name: _____ Date of Birth _____

Address: _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____

Name: _____ Date of Birth _____

Address: _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____

CONTINGENT BENEFICIARY(IES) ☐ **Basic** ☐ **Supplemental** ☐ **Basic and Supplemental**

Name: _____ Date of Birth _____

Address: _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____

Name: _____ Date of Birth _____

Address: _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____

Spousal Consent For Community Property States Only: If you live in a community property state- Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: spousal consent does not apply to ERISA plans.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries) of group life insurance under the above policy 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 supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse _____ **Date** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee _____ **Date** _____

Form W-4 (2013)

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 2013 expires February 17, 2014. 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).

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 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2013

1 Your first name and middle initial	Last name	**2 Your social security number**	
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code		**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2013, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. 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 2013 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, 1949) of your income, and miscellaneous deductions. For 2013, you may have to reduce your itemized deductions if your income is over $300,000 and you are married filing jointly or are a qualifying widow(er); $275,000 if you are head of household; $250,000 if you are single and not head of household or a qualifying widow(er); or $150,000 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,200 if married filing jointly or qualifying widow(er); $8,950 if head of household; $6,100 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 2013 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 2013 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2013 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 $3,900 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 2013. 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 2013. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $8,000	0
5,001 - 13,000	1	8,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 30,000	3
26,001 - 30,000	4	30,001 - 40,000	4
30,001 - 42,000	5	40,001 - 50,000	5
42,001 - 48,000	6	50,001 - 70,000	6
48,001 - 55,000	7	70,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 75,000	9	95,001 - 120,000	9
75,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 - 110,000	12		
110,001 - 120,000	13		
120,001 - 135,000	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $72,000	$590	$0 - $37,000	$590
72,001 - 130,000	980	37,001 - 80,000	980
130,001 - 200,000	1,090	80,001 - 175,000	1,090
200,001 - 345,000	1,290	175,001 - 385,000	1,290
345,001 - 385,000	1,370	385,001 and over	1,540
385,001 and over	1,540		

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.

Employment Development Department
State of California

This form can be used to manually compute your withholding allowances, or you can electronically compute them at **www.taxes.ca.gov/de4.pdf**

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD
City, State, and ZIP Code	

1. Number of allowances for Regular Withholding Allowances, Worksheet A _____

   Number of allowances from the Estimated Deductions, Worksheet B _____

   Total Number of Allowances (A + B) when using the California Withholding Schedules for 2013 _____

   OR

2. Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C _____

   OR

3. I certify under penalty of perjury that I am not subject to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Signature _____ Date _____

Employer's Name and Address	California Employer Account Number

cut here

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME TAX MAY BE UNDERWITHHELD IF YOU DO NOT FILE THIS DE 4 FORM.

IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

You should complete this form if either:

(1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,

(2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. **If you rely on the number of withholding allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld.** This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your Form W-4 and/or DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form, and for federal withholding use the Internal Revenue Service (IRS) Publication 919 or federal withholding calculations.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption automatically expires on February 15 of the next year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted before February 15. If you are not having federal income tax withheld this year but expect to have a tax liability next year, the law requires you to give your employer a new Form W-4 by December 1.

EXEMPTION FROM WITHHOLDING (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD.

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES — 800-852-5711 (voice), 800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) — 916-845-6500

The *California Employer's Guide* (DE 44) provides the income tax withholding tables. This publication may be found on the Employment Development Department (EDD) website at **www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm**. To assist you in calculating your tax liability, please visit the Franchise Tax Board website at: **www.ftb.ca.gov/individuals/index.shtml**.

NOTIFICATION: Your employer is required to send a copy of your DE 4 to the Franchise Tax Board (FTB) if it meets either of the following two conditions:

- You claim more than 10 withholding allowances.
- You claim exemption from state or federal income tax withholding and your employer expects your usual weekly wages to exceed $200 per week.

IF THE IRS INSTRUCTS YOUR EMPLOYER TO WITHHOLD FEDERAL INCOME TAX BASED ON A CERTAIN WITHHOLDING STATUS, YOUR EMPLOYER IS REQUIRED TO USE THE SAME WITHHOLDING STATUS FOR STATE INCOME TAX WITHHOLDING IF YOUR WITHHOLDING ALLOWANCES FOR STATE PURPOSES MEET THE REQUIREMENTS LISTED UNDER "NOTIFICATION." IF YOU FEEL THAT THE FEDERAL DETERMINATION IS NOT CORRECT FOR STATE WITHHOLDING PURPOSES, YOU MAY REQUEST A REVIEW.

To do so, write to:

W-4 Unit
Franchise Tax Board MS F180
P.O. Box 2952
Sacramento, CA 95812-2952
Fax: 916-843-1094

Your letter should contain the basis of your request for review. You will have the burden of showing the federal determination incorrect for state withholding purposes. The FTB will limit its review to that issue. The FTB will notify both you and your employer of its findings. Your employer is then required to withhold state income tax as instructed by FTB. In the event FTB or IRS finds there is no reasonable basis for the number of withholding exemptions that you claimed on your Form W-4/DE 4, you may be subject to a penalty.

PENALTY: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided for by Section 19176 of the California Revenue and Taxation Code.

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Are you going to itemize your deductions?
— Do you have more than one income coming into the household?

TWO-EARNER/TWO-JOBS: When earnings are derived from more than one source, underwithholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with one employer. Do not claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 or Form W-4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you at any time during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; and
(3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the entire year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A — REGULAR WITHHOLDING ALLOWANCES

(A) Allowance for yourself — enter 1	(A)	
(B) Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)	
(C) Allowance for blindness — yourself — enter 1	(C)	
(D) Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)	
(E) Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)	
(F) Total — add lines (A) through (E) above	(F)	

INSTRUCTIONS — 2 — ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim one or more additional withholding allowances. Use last year's FTB 540 form as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

WORKSHEET B — ESTIMATED DEDUCTIONS

1. Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB 540 form		1.
2. Enter $7,682 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $3,841 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3. Subtract line 2 from line 1, enter difference	=	3.
4. Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5. Add line 4 to line 3, enter sum	=	5.
6. Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
7. If line 5 is greater than line 6 (if less, see below); Subtract line 6 from line 5, enter difference	=	7.
8. Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number Enter this number on line 1 of the DE 4. Complete Worksheet C, if needed.		8.
9. If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10. Enter amount from line 5 (deductions)		10.
11. Subtract line 10 from line 9, enter difference Complete Worksheet C		11.

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California Personal Income Tax (PIT) withholding and PIT wages. This new law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of Section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 888-745-3886.

WORKSHEET C **TAX WITHHOLDING AND ESTIMATED TAX**

1. Enter estimate of total wages for tax year 2013 . . . . . 1. _____
2. Enter estimate of nonwage income (line 6 of Worksheet B) . . . . . 2. _____
3. Add line 1 and line 2. Enter sum . . . . . 3. _____
4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest) . . . . 4. _____
5. Enter adjustments to income (line 4 of Worksheet B) . . . . . 5. _____
6. Add line 4 and line 5. Enter sum . . . . . 6. _____
7. Subtract line 6 from line 3. Enter difference . . . . . 7. _____
8. Figure your tax liability for the amount on line 7 by using the 2013 tax rate schedules below . . . . . 8. _____
9. Enter personal exemptions (line F of Worksheet A x $114.40) . . . . . 9. _____
10. Subtract line 9 from line 8. Enter difference . . . . . 10. _____
11. Enter any tax credits. (See FTB Form 540) . . . . . 11. _____
12. Subtract line 11 from line 10. Enter difference. This is your total tax liability . . . . . 12. _____
13. Calculate the tax withheld and estimated to be withheld during 2013. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2013. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2013 . . . . . 13. _____
14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld . . . . . 14. _____
15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4 . . 15. _____

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2013 ONLY

SINGLE OR MARRIED WITH DUAL EMPLOYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS*
$0	$7,455 ...	1.100%	$0	$0.00
$7,455	$17,676 ...	2.200%	$7,455	$82.01
$17,676	$27,897 ...	4.400%	$17,676	$306.87
$27,897	$38,726 ...	6.600%	$27,897	$756.59
$38,726	$48,942 ...	8.800%	$38,726	$1,471.30
$48,942	$250,000 ...	10.230%	$48,942	$2,370.31
$250,000	$300,000 ...	11.330%	$250,000	$22,938.54
$300,000	$500,000 ...	12.430%	$300,000	$28,603.54
$500,000	$1,000,000 ...	13.530%	$500,000	$53,463.54
$1,000,000	and over	14.630%	$1,000,000	$121,113.54

MARRIED FILING JOINT OR QUALIFYING WIDOW(ER) TAXPAYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS*
$0	$14,910 ...	1.100%	$0	$0.00
$14,910	$35,352 ...	2.200%	$14,910	$164.01
$35,352	$55,794 ...	4.400%	$35,352	$613.73
$55,794	$77,452 ...	6.600%	$55,794	$1,513.18
$77,452	$97,884 ...	8.800%	$77,452	$2,942.61
$97,884	$500,000 ...	10.230%	$97,884	$4,740.63
$500,000	$600,000 ...	11.330%	$500,000	$45,877.10
$600,000	$1,000,000 ...	12.430%	$600,000	$57,207.10
$1,000,000	and over	14.630%	$1,000,000	$106,927.10

UNMARRIED HEAD OF HOUSEHOLD TAXPAYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS*
$0	$14,920 ...	1.100%	$0	$0.00
$14,920	$35,351 ...	2.200%	$14,920	$164.12
$35,351	$45,571 ...	4.400%	$35,351	$613.60
$45,571	$56,400 ...	6.600%	$45,571	$1,063.28
$56,400	$66,618 ...	8.800%	$56,400	$1,777.99
$66,618	$340,000 ...	10.230%	$66,618	$2,677.17
$340,000	$408,000 ...	11.330%	$340,000	$30,644.15
$408,000	$680,000 ...	12.430%	$408,000	$38,348.55
$680,000	$1,000,000 ...	13.530%	$680,000	$72.158.15
$1,000,000	and over	14.630%	$1,000,000	$115,454.15

*marginal tax

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL FRANCHISE TAX BOARD:

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES 800-852-5711 (voice)
800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) 916-845-6500

The DE 4 information is collected for purposes of administering the Personal Income Tax law and under the authority of Title 22 of the California Code of Regulations and the Revenue and Taxation Code, including Section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California income tax return.

FOOTHILL–DE ANZA COMMUNITY COLLEGE DISTRICT

STATEMENT TO EMPLOYEES

DRUG-FREE WORK PLACE POLICY

The Foothill–De Anza Community College District, in compliance with federal law, is providing all employees including student employees with the following statement regarding the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in the workplace.

Any employee convicted of a violation of any federal or state criminal drug statute is required to report that conviction to the Director of Human Resources within 5 days of the conviction.

Definitions:
The term "Workplace" is any location where an employee performs assigned duties on behalf of the District.

The term "Controlled Substance" means a controlled substance defined in Schedules I through V of Section 202 of the Controlled Substances Act, 21 U.S.C. 812.

The term "Controlled Substance Offense," as used in Education Code Section 87405, means any one or more of the following offenses:

A. Any offense in Sections 11350 to 11355, inclusive, (offenses involving controlled substances formerly classified as narcotics), 11366 (opening or maintenance of unlawful places), 11368 (forged or altered prescriptions), 11377 to 11382, inclusive, (offenses involving controlled substances formerly classified as restricted dangerous drugs), and 11550 (unlawful acts) of the California Health and Safety Code.

B. Any offenses committed or attempted in any other state or against the laws of the United States, which if committed or attempted in this state, would have been punished as one or more of the above-mentioned offenses.

C. Any offense committed under former Sections 11500 to 11503, inclusive, 11557, 11715, and 11721 of the California Health and Safety Code.

D. Any attempt to commit any of the above-mentioned offenses.

The term "conviction" means a finding of guilt, including a plea of nolo contendere, or an imposition of sentence or both by any judicial body charges with the responsibility to determine violations of federal or state criminal drug statutes.

District Policy:
It is the policy of the District to impose appropriate disciplinary sanctions on employees for the unlawful possession, use or distribution of illicit drugs or alcohol. Appropriate disciplinary sanctions may result in the District requiring the employee to participate satisfactory in a drug-abuse assistance or rehabilitation program and may also include suspension or termination. The standards of conduct and sanctions applicable to employees are contained in the Foothill-De Anza Community College Board policy number 4500 and in the applicable collective bargaining agreements or employee handbooks.

Dangers of Drugs in the Workplace:
The use of drugs and alcohol may pose significant health risks, dependency, disability and death, and may result in apathy, impaired judgment, lack of concentration and coordination, absenteeism, injuries, illness, ineffective supervision and destruction of property.

Available Assistance:
If you are a full-time employee, drug and alcohol counseling is available to you through the District's Employee Assistance Program. Information is available from the Human Resources Office. All employees can receive information on referrals to drug or alcohol counseling and rehabilitation programs from the Health Offices at both Foothill and De Anza Colleges.

Please print and sign below and return this form to the designated department as follows:

Status:		**Return To:**
• Full-time contract employees **(**Faculty, Classified, Administrative, Supervisor, Confidential)	_	Office of Human Resources
• Casual hourly employees	_	Office of Human Resources
• Part–time faculty	_	Administrative Services at the campus at which you were hired
• Student employees	_	Financial Aid Office at the campus at which you were hired

EMLOYMENT STATUS:

- ❑ CLASSIFIED
- ❑ FULL-TIME FACULTY
- ❑ ADMINISTRATIVE
- ❑ SUPERVISOR
- ❑ CONFIDENTIAL
- ❑ PART-TIME FACULTY
- ❑ CASUAL/TEMPORARY
- ❑ STUDENT EMPLOYEE

I have read the "Statement to Employees" regarding the District's Drug-Free Workplace Policy.

_____
Print Name

_____
Signature

_____
Date

I have received, read, and understand the General Safety Guidelines. I also understand that I am obligated to follow them in my work activities.

Signature_____

Print Name_____Date:_____

Campus_____Department_____

IMPORTANT

PLEASE SIGN AND DATE THIS SIGNATURE PAGE AND RETURN IT TO PERSONNEL AT THE DISTRICT OFFICE. IT IS REQUIRED TO BE RETAINED IN YOUR PERSONNEL FILE.

Please circle one: Administrative Faculty (PT) (FT) Classified Casual Student

FOOTHILL-DE ANZA
Community College District

Office of Human Resources and Equal Opportunity
12345 El Monte Road, Los Altos Hills, CA 94022

RETIREMENT PLAN INFORMATION/ELECTION FORM

It is important that you provide accurate information regarding your current retirement status. This information is used to determine appropriate payroll deductions.

Please answer the following questions:	YES	NO
A. Are you a current member of CalSTRS (CA State Teacher Retirement System)? *(i.e., Do you still have an active account with STRS?)*	☐	☐
If so, what is your ID number under the Retirement System?*		
B. Are you a current member of CalPERS (CA Public Employees' Retirement System)? *(i.e., Do you still have an active account with PERS?)*	☐	☐
If so, what is your ID number under the Retirement System?**		
C. Are you a retired annuitant (retiree) under STRS?	☐	☐
If so, what is your ID number under the Retirement System?*		
D. Are you a retired annuitant (retiree) under PERS?	☐	☐
If so, what is your ID number under the Retirement System?**		
E. Have you withdrawn your funds from STRS?	☐	☐
F. Have you withdrawn your funds from PERS?	☐	☐

If you need to find your ID Number, please contact the appropriate agency: *CalPERS: (888) 225-7377 or **CalSTRS: (800) 228-5453

Current Employment Status:

List other schools/districts that you are now employed by:	Full-Time	Part-Time	Employer Contact Information (address and phone)
1.	☐	☐	
2.	☐	☐	

NOTE: It is the employee's responsibility to notify the District of any changes in his/her retirement status.

Employee Signature

Social Security Number (last four digits)

Name (please print)

Date

INFORMATION AND INSTRUCTIONS FOR CalPERS BENEFICIARY DESIGNATION FORM

If you die before you retire, the Public Employees' Retirement Law provides for payment of specific Death Benefits to your surviving beneficiaries. Please see your personnel officer for a description of the benefits. The benefits are payable to the following beneficiaries:

A. If you are a safety member and your death is job-related, or if you are not a safety member but you are fatally attacked while performing your official job duties, the Special Death Benefit may be payable. This benefit is payable by law to your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death) or, if none, to your unmarried children/step-children under age 22, whether or not you have filed a beneficiary designation.

B. If you are eligible for retirement or you are a State member with at least 20 years of State service credit, a monthly death benefit allowance may be payable. If you do not have a valid beneficiary designation on file, the benefits will be payable to your surviving spouse/registered domestic partner to whom you have been married to or in a partnership with for either one year or prior to the onset of the injury or illness that resulted in death. Or, if there is no eligible surviving spouse/registered domestic partner, the allowance will be payable to your unmarried minor children, if any.

   If you *do have* a valid beneficiary designation on file your spouse/registered domestic partner may still be entitled to a community property share of your lump sum contributions or monthly death benefit allowance. However, your non-spouse/non-domestic partner designated beneficiaries will receive the portion of your lump sum benefits which are not payable to your spouse/registered domestic partner as his/her community property share.

C. If A and B do not apply and *there is no* valid Beneficiary Designation on file at the time of death, the benefits will be payable to your survivors in the following order:

   1. Your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death); or, if none
   2. Natural and adopted children, including (in limited situations) a natural child adopted by another, share and share alike; or, if none,
   3. Parents, share and share alike; or if none,
   4. Brothers and sisters, share and share alike, or if none,
   5. Your estate (if probated, or subject to probate), or if not,
   6. Your trust (if one exists), or if not,
   7. Stepchildren, share and share alike, or, if none,
   8. Grandchildren, including step-grandchildren, share and share alike, or, if none,
   9. Nieces and nephews, share and share alike, or, if none,
   10. Great-grandchildren, share and share alike, or, if none,
   11. Cousins, share and share alike.

   If A and B do not apply and *there is* a valid Beneficiary Designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form. **However, if you are married or have a registered domestic partner at the time of death, your spouse/domestic partner may still be entitled to a community property share of your lump sum contributions.**

D. You may designate or change your beneficiaries at any time by completing another Beneficiary Designation form. You may name as beneficiary any person or persons, a corporation or your estate. Payment will be made to your estate only if probated. You may designate a trust as your beneficiary; however, you must provide the name of the trust, the date of the trust, and the name and address where the trust is filed. It is not necessary to provide the name of the trustee. Reminder: **If you are married or in a domestic partnership at the time of your death and you do not name your spouse/domestic partner as beneficiary, he/she may still be entitled to a community property share of your lump sum contributions or a share of any monthly allowance that may be payable.**

E. Your Beneficiary Designation will be revoked automatically, and benefits will be payable to the closest survivor listed in section C, if any of the following events occur after your designation form is received by CalPERS:

   1. Marriage/Registration of Domestic Partnership; or
   2. Dissolution or annulment of your marriage/domestic partnership. However, a designation filed after the initiation of a dissolution/annulment of marriage or domestic partnership is <u>*NOT*</u> revoked when the dissolution/annulment is finalized; or
   3. Birth or adoption of a child; or
   4. Termination of membership that results in a refund of your contributions.

INSTRUCTIONS (See Reverse Side of This Page)

INSTRUCTIONS

1. Print clearly with ball point pen or type all information requested. If you make an error, make the necessary correction by lining through the error and initialing the change. *No erasures or correction fluid will be accepted*.

2. Enter on the form the full name of your beneficiaries, relationship, social security number (if known), and the complete address for each. (If the form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries. You must sign, date, and write your social security number at the top of each additional sheet.)

3. If a (%) is entered make sure the total equals 100%.

4. Your spouse/registered domestic partner must sign the form to acknowledge the names of the beneficiaries you are designating. **IMPORTANT:** If you are unable to obtain your spouse's/domestic partner's signature, you MUST complete the BSD-800, "Justification for Absence of Spouse or Domestic Partner's Signature" form, on the reverse side of the designation form or your designation form may be rejected.

5. Enter the date you signed the form and your current mailing address.

6. Mail the completed form to the Public Employees' Retirement System at the address shown, or you may fax it to (916) 795-3933.

7. After CalPERS receives and reviews the form a confirmation letter will be mailed to you within 6 weeks. If the form is not acceptable a new form will be mailed to you to complete.

IMPORTANT INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000, et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Failure to supply all of the requested information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to: state and public agency employers, California State Attorney General, Office of the State Controller, Teale Data Center, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare microfiche/microfilm for CalPERS. Disclosure to these parties is done in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the California Public Employees' Retirement System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229

CalPERS

BENEFICIARY DESIGNATION

PERS-BSD-241 (Revised 12/04)

TO: CalPERS/ Benefit Services Division
P.O. Box 942711
Sacramento, CA 94229-2711
Fax:(916) 795-3933
Phone:(888) CalPERS (225-7377)

MEMBER'S FULL NAME (PLEASE PRINT)	SOCIAL SECURITY NUMBER	BIRTH DATE	TELEPHONE NUMBER

I understand that if I am married or in a registered domestic partnership but do not name my spouse or domestic partner as beneficiary, she/he may still be entitled to a community property share of my 'Lump Sum Contributions' or a share of any monthly allowance that may be payable. My 'Non-Spouse or Non-Partner' designated beneficiaries will receive the portion of my lump sum benefits, which are not payable to my spouse or domestic partner as his/her community property share. I further understand that if my death is determined to be "Industrial," special death benefits will be paid in the manner prescribed by law. If no percentage (%) is given, the applicable benefits will be paid SHARE AND SHARE ALIKE.

PRIMARY BENEFICIARIES

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*

In the event that I survive the person(s) named above, I hereby designate the following person(s) who survive me, as BENEFICIARIES. If no percentage (%) is given, benefits will be paid SHARE AND SHARE ALIKE.

SECONDARY BENEFICIARIES

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*

Should I survive all of the persons named above, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to the Board of Administration, all in accordance with the applicable provisions of law.

BY THIS BENEFICIARY DESIGNATION, I HEREBY REVOKE ANY PREVIOUS DESIGNATION I HAVE FILED. I UNDERSTAND THAT MY MARRIAGE OR REGISTERED DOMESTIC PARTNERSHIP, DISSOLUTION OR ANNULMENT OF MY MARRIAGE OR DOMESTIC PARTNERSHIP, OR THE BIRTH OR ADOPTION OF A CHILD OR TERMINATION OF MEMBERSHIP SUBSEQUENT TO THE DATE I FILE THIS FORM WITH CALPERS, WILL AUTOMATICALLY VOID THIS DESIGNATION. HOWEVER, A DESIGNATION FILED AFTER THE INITIATION OF A DISSOLUTION/ANNULMENT OF MARRIAGE OR REGISTERED DOMESTIC PARTNERSHIP IS NOT REVOKED WHEN THE DISSOLUTION/ANNULMENT IS FINALIZED.

Signatures Required

Are you legally married or have a registered domestic partner? ☐ No ☐ Yes

If yes, your spouse or registered domestic partner must sign this form

If no, please indicate: ☐ Never married/or Never in Domestic Partnership ☐ Divorced/Annulled ☐ Widowed

IMPORTANT – Y*ou must complete the BSD-800 on the reverse side of this form if you are married or have a registered domestic partnership but your spouse or domestic partner is unable to sign below.*

MEMBER SIGNATURE: _____ **Date:** _____

MEMBER ADDRESS: _____

(*Number and Street*) *(City)* *(State)* *(Zip Code)*

SPOUSAL/REGISTERED DOMESTIC PARTNER ACKNOWLEDGEMENT: ***By signing this beneficiary designation form, I acknowledge the information entered by my spouse/domestic partner.***

SPOUSE/DOMESTIC PARTNER SIGNATURE: _____

Benefit Services Division
P.O. Box 942711
Sacramento, CA 94229-2711
(888) Cal-PERS (225-7377)
TDD - (916) 795-3240; FAX (916) 795-3933

JUSTIFICATION FOR ABSENCE OF SPOUSE OR REGISTERED DOMESTIC PARTNER'S SIGNATURE

Pursuant to Government Code Section 21261, the member's current spouse or registered domestic partner must be made aware of the selection of benefits or change in beneficiary made by the member. The spouse or domestic partner of a CalPERS member must acknowledge the submission of a request for refund of contributions; election of retirement optional settlement; and designation of beneficiary for Pre-retirement Death Benefits.

If a spouse or domestic partner's signature does not appear on one of the above-mentioned documents, the following information **MUST** be completed by the member and submitted with the application/form.

MEMBER'S NAME (TYPED OR PRINTED)	SOCIAL SECURITY NUMBER
APPLICATION SUBMITTED	
BENEFICIARY DESIGNATION (PERS-BSD-241)	

Select either 1 or 2 and indicate specifics:

1. ☐ By checking this box, I indicate that I am not legally married or in a registered domestic partnership because:

   ☐ Never married or never in registered domestic partnership.

   ☐ Divorced/marriage annulled or domestic partnership terminated. _____
   Date (mm/dd/yyyy)

   ☐ Widowed. _____
   Date (mm/dd/yyyy)

2. ☐ By checking this box, I indicate that I am married or have a domestic partner, but my spouse or domestic partner did not sign this form because:

   ☐ I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or domestic partner, **OR**,

   ☐ My spouse or domestic partner has been advised of the application and has refused to sign the written acknowledgement; **OR**

   ☐ My spouse or domestic partner is incapable of executing the acknowledgement because of an incapacitating mental or physical condition; **OR**,

   ☐ My spouse or domestic partner has no identifiable community property interest in the benefit, **OR**,

   ☐ My spouse or domestic partner and I have executed a marriage settlement or partnership agreement that makes the community property law inapplicable to the marriage or partnership.

I certify under penalty of perjury that the foregoing information is true and correct.

MEMBER'S SIGNATURE	**DATE SIGNED**

FOOTHILL-DE ANZA
Community College District

Foothill – De Anza Community College District
Office of Human Resources
and Equal Opportunity

LIVESCAN SERVICE AND TB TESTING SCHEDULE

LiveScan (fingerprinting) Service is available on the Foothill College **OR** De Anza campus. **A time is reserved for you on the day of your New Hire Orientation (unless otherwise noted during orientation)**. You will be given your staff ID card and directed to the LiveScan facility located in the police department in the Foothill College campus center.

Livescan Contact information: Phone: (650) 949-7925
Email: livescan@fhda.edu

TB testing can be done on **either** the Foothill College or De Anza College campus ***on a walk-in basis.***

After the TB test is administered, you must return to get the results read within 48-72 hours. Please reference the contact and schedule information below, and plan accordingly:

Campus	Location and Phone	Test Administered (Day/Time)	Test Results Read* (Day/Time) *remember to return within 48-72 hours
De Anza College	Health Office Hinson Campus Center Lower Level *(408) 864-8732*	**Mon** 9:00 a.m. – 10:00 a.m. 2:00 p.m. – 3:00 p.m. 5:30 p.m. – 7:00 p.m. **Tues** 10:00 a.m. – 11:00 a.m. 3:00 p.m. – 4:00 p.m. 5:30 p.m. – 7:00 p.m.	**Wed/Thurs/Fri** 10:00 a.m. – 11:00 a.m. 3:00 p.m. – 4:00 p.m. 5:30 p.m. – 7:00 p.m.
Foothill College	Health Office Campus Center Lower Level, Room 2126 (next to the police station) *(650) 949-7243*	**Mon/Tues** 8:30 a.m. – 12:15 p.m. 2:00 p.m. – 3:00 p.m.	**Wed** 8:30 a.m. – 12:15 p.m. 2:00 p.m. – 3:00 p.m. **Fri** Walk-ins only** ***However, a reading must be done on Monday—within 72 hours!—or require a re-test.*

*****please call to confirm this time slot; availability fluctuates with staffing***

NOTE: You must have your staff card (if received) and government picture ID (CDL, CID, or passport) to complete these services.

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

Office of Human Resources

TB (TUBERCULOSIS) TEST FORM

Pursuant to Education Code Section §897408.6, all new employees (unless they have previously tested positive, followed by a negative chest x-ray) are required to have a PPD test and any follow up completed within sixty (60) days from **the first day of service**.

THE CAMPUS HEALTH SERVICES OFFICE OFFERS THE PPD TEST FREE OF CHARGE.
You may contact the Health Services office on either campus at:
DE ANZA: (408) 864-8732
FOOTHILL: (650) 949-7243

Those employees who test positive with a PPD must have a chest x-ray to rule out active TB. Employees will be referred by the Health Service Office to the appropriate medical facility.

Those employees who have tested positive previously are required to provide evidence of the positive PPD test followed by a negative chest x-ray. Such evidence shall be taken in person to the Campus Health Services Office.

PLEASE TAKE THIS FORM WITH YOU WHEN YOU HAVE YOUR TB TEST TAKEN.

To be completed by Employee:

Last Name (Print) First Name Initial _____ Social Security Number _____

To be completed by Health Care Provider

CERTIFICATION OF TUBERCULOSIS EXAMINATION AND REPORT:

PPD TEST
DATE GIVEN _____
DATE READ _____

RESULTS
POSITIVE ☐ _____
NEGATIVE ☐ _____

X-RAY DATE _____

FOLLOW UP
YES ☐
NO ☐

SURVEILLANCE DATE _____

SIGNATURE OF HEALTH CARE PROVIDER _____ **DATE** _____

Please return results/certificate to
Foothill-De Anza Community College District
Office of Human Resources
12345 El Monte Road
Los Altos Hills, CA 94022

HR: 01/2013