Clarinda Community School District

Permanent Record Form

Name_____

Email address _____

Address_____

City, State, Zip_____

Phone Number_____

Social Security Number_____

Birth Date_____

If married, name of spouse_____

If applicable, names of children_____

Emergency Contact _____Phone _____

Emergency Contact _____Phone _____

Ethnicity: (check one) Hispanic or Latino_____ Not Hispanic or Latino_____

Race: (check one) American Indian or Alaskan Native_____ Asian_____

Black or African American _____ Native Hawaiian or Other Pacific Islander_____

White_____

Position :_____Start Date:_____

Position :_____Start Date:_____

Signature:_____

Employment Eligibility Verification

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

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

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(If any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

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

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

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

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

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

A. New Name *(If applicable)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(If any) (mm/dd/yyyy)*

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the Instructions for more information about acceptable receipts.

Iowa Department of
REVENUE

2024 IA W-4
Employee Withholding Allowance Certificate
tax.iowa.gov

Each employee must file this Iowa W-4 with their employer. Do not claim more in allowances than necessary or you will not have enough tax withheld. If the amount of allowances you are eligible to claim increases, you may file a new W-4 at any time. If the amount of allowances you are eligible to claim decreases, you must file a new W-4 within 10 days.

Penalties apply for willfully supplying false information or for willful failure to supply information. If you file as exempt from withholding and you incur an income tax liability, you may be subject to a penalty for underpayment of estimated tax.

Marital Status: Other ☐ Head of Household ☐ Married filing jointly ☐ If so, does your spouse also have earned income? Yes ☐ No ☐

Print your full name:_____ Social Security Number: _____

Home address: _____

City: _____ State:_____ ZIP: _____

Exemption from withholding

If you do not expect to owe any Iowa income tax and have a right to a full refund of ALL income tax withheld, enter "EXEMPT" here _____and the year effective here _____ .

Nonresidents may not claim this exemption.

Check this box if you are claiming an exemption from Iowa income tax as a military spouse based on the Military Spouses Residency Relief Act of 2009 or the Veterans Benefits and Transition Act of 2018 ..... ☐

If claiming the military spouse exemption, enter your state of domicile or residence here _____

If you are not exempt, complete the following:

1. Personal allowances. See instructions ..... 1.$_____
2. Allowances for dependents. You may claim $40 for each dependent you claim on your Iowa income tax return ..... 2.$_____
3. Allowances for itemized deductions. See instructions ..... 3.$_____
4. Allowances for adjustments to income. Estimate allowable adjustments to income for payments such as an IRA, Keogh, or SEP; penalty on early withdrawal of savings; and student loan interest, which are reflected on the IA 1040. Divide this amount by 15, round to the nearest whole dollar, and enter on line 4 ..... 4.$_____
5. Allowances for child and dependent care credit. See instructions ..... 5.$_____
6. **Total allowances.** Add lines 1 through 5 ..... 6.$_____
7. Additional amount, if any, you want deducted each pay period ..... 7.$_____

I, the undersigned, declare under penalties of perjury or false certificate, that I have examined this claim, and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee signature: _____ Date: _____

Employers: The employer must maintain records of the W-4s. If the employee is claiming exemption from withholding when wages are expected to exceed $200 per week, complete the information below and within 90 days send a copy to: **Compliance Services, Iowa Department of Revenue, PO Box 10456, Des Moines, Iowa 50306-0456.**

Employer name: _____

Federal Employer Identification Number (FEIN):_____

Employer address:_____

City: _____ State:_____ ZIP: _____

Questions about Iowa taxes: Call Taxpayer Services at 515-281-3114 or 800-367-3388 or email idr@iowa.gov.

IA W-4 Instructions – Employee Withholding Allowance Certificate

Exemption from withholding

Nonresidents may not claim this exemption.

Claim exemption from withholding if you are an Iowa resident and both of the following situations apply:

(1) for 2023 you had a right to a refund of all Iowa income tax withheld because you had no tax liability, and, (2) for 2024 you expect a refund of all Iowa income tax withheld because you expect to have no tax liability.

You must complete a new W-4 within 10 days from the day you anticipate you will incur an Iowa income tax liability for the calendar year (or your fiscal year). If you anticipate you will incur an Iowa income tax liability for the following year, then you must complete a new W-4 on or before December 31 of the current year. If you want to claim an exemption from withholding next year, you must file a new W-4 with your employer on or before February 15.

Taxpayers 64 years of age or younger: See your payroll officer to determine how much you expect to earn in a calendar year. You are exempt if:

a. your filing status is single, your total income is less than $5,000, and are claimed as a dependent on another person's Iowa return; or
b. your filing status is single, your total income is less than $9,000, and you are not claimed as a dependent on another person's Iowa return; or
c. your filing status is other than single and your combined total income is $13,500 or less.

Taxpayers 65 years of age or older: Only one spouse must be 65 or older to qualify for the exemption. Any federal standard or itemized deduction taken on the federal return, personal exemption allowed for federal purposes, or qualified business income deduction allowed for federal purposes, must be added to total income for purposes of determining the low-income exemption. You are exempt if:

a. you are single and your total income is $24,000 or less; or
b. your filing status is other than single and your combined total income is $32,000 or less.

Military personnel in active duty status, as defined in Title 10 of the U.S. Code, are exempt from withholding. Under the Military Spouses Residency Relief Act of 2009 and the Veterans Benefits and Transition Act of 2018, you may be exempt from Iowa income tax on your wages if: (1) your spouse is a member of the uniformed services present in Iowa in compliance with military orders; (2) you are present in Iowa solely to be with your spouse; and (3) you maintain your domicile or residence in another state; or (4) you have elected to use your servicemember spouse's domicile or residence in another state for income tax purposes. If you claim this exemption, check the appropriate box, enter the state other than Iowa you are claiming as your state of domicile or residence, and attach a copy of your spousal military identification card to the IA W-4 provided to your employer.

Line 1. Personal allowances: You can claim the following personal allowances:

(a) $40 allowance for yourself or $80 allowance if you are unmarried and eligible to claim head of household status. Add $20 additional allowance if you are 65 or older, and $20 additional allowance if you are blind.

(b) If you are married and your spouse either does not work or is not claiming allowances on a separate W-4, you may claim the following allowances for them: $40 for your spouse, $20 additional allowance if your spouse is 65 or older, and $20 additional allowance if your spouse is blind.

(c) If you are single and hold more than one job, you may not claim the same allowances with more than one employer at the same time. If you are married and both you and your spouse are employed, you may not both claim the same allowances with both of your employers at the same time.

(d) To have the highest amount of tax withheld claim "$0" on line 1.

Line 3. Allowances for itemized deductions:

(a) Enter total amount of estimated federal itemized deductions ..... (a) $ _____

(b) Enter amount of your federal standard deduction using the following information ..... (b) $ _____

If single or married filing separate returns, enter $14,600

If unmarried head of household, enter $21,900

If married filing a joint return or qualifying widow(er), enter $29,200

(c) Subtract line (b) from line (a) and enter the difference or zero, whichever is greater..... (c) $ _____

(d) Divide the amount on line (c) by 15, round to the nearest whole dollar and enter on line 3.

Note: If you are married and both you and your spouse are employed, you may not both claim the same allowances for itemized deductions. Each spouse should report their proportionate share of the estimated federal itemized deductions on line 3(a) and use the single federal standard deduction amount on line 3(b) .

Line 5. Allowances for child and dependent care credit: Persons having child/dependent care expenses qualifying for the federal and Iowa child and dependent care credit may claim additional Iowa withholding allowance amounts based on their total incomes. Taxpayers with a total income of $90,000 or more cannot claim withholding allowances for the child and dependent care credit. Married persons, regardless of their expected filing status, must calculate their withholding allowance amounts based on their combined total incomes. Total allowances for child and dependent care that you and your spouse may claim cannot exceed the total allowances shown below.

Iowa total income between $0 - $19,999 Allowances: $200
Iowa total income between $20,000 - $34,999 Allowances: $160
Iowa total income between $35,000 - $44,999 Allowances: $120
Iowa total income between $45,000 - $89,999 Allowances: $40

Line 7. Additional amount of withholding deducted: You may need to have additional tax withheld if you have two or more jobs are married and you both work, or have income other than wages. Income other than wages would include: interest and dividends, capital gains, rent, gambling winnings, etc. If you are not having enough tax withheld, you may request your employer to withhold more by filling in an additional amount on line 7. Estimate the amount you will be under-withheld, and divide that amount by the number of pay periods per year. If you reside in a school district that imposes school district surtax, consider reducing the amount of allowances shown on lines 1-5, or have additional tax withheld on line 7.

Centralized Employee Registry Reporting Form

To be completed by the employer within 15 days of hire.

New Hire Reporting

An employer doing business in Iowa is required to report newly hired employees, rehires, and contractors to the Centralized Employee Registry. Use one of the following methods to report.

Online Reporting- Online reporting saves time and money and is the preferred method of reporting. Enter employee information or upload data at iowachildsupport.gov.

Fax and Mail Reporting- To report new hires and rehires, submit the following form or an equivalent form. To report contractors by fax or mail, use the Contractor Reporting form found at iowachildsupport.gov.

Magnetic Media- Record layout instructions and media types are available at iowachildsupport.gov.

Employer Information

1. Federal Employer Identification Number (FEIN): .....
2. Employer name: _____
3. Address: _____

   City: _____ State: _____ ZIP: _____
4. Employer contact and phone number: _____
5. Income provider name and address where income withholding and garnishment orders should be sent, if different from above.

   Name: _____

   Address: _____

   City: _____ State: _____ ZIP: _____

Employee Information

6. Is dependent health care coverage available? ..... Yes ☐ No ☐
7. Approximate date this employee qualifies for coverage (MM/DD/YYYY): .....
8. Employee start date (MM/DD/YYYY): .....
9. Employee date of birth (MM/DD/YYYY): .....
10. Employee Social Security Number: .....
11. Last name: _____ First name: _____ Middle initial: _____
12. Address: _____

    City: _____ State: _____ ZIP: _____

Mailing and contact information:

Fax to: 800-759-5881 or 515-281-3749 (local)

Phone: 877-274-2580

Mail to: Centralized Employee Registry
PO Box 10322
Des Moines, IA 50306-0322

Centralized Employee Registry Reporting Form

Employer Reporting Requirements

Federal and state law (42 U.S. Code § 653a and Iowa Code chapter 252G) requires that an employer doing business in Iowa who hires or rehires an employee or contractor to report the hire within 15 days of the start date. All items on this form must be completed.

Use one of the listed methods to report your new hires. Please include your FEIN. Fax this form (page 44-019c) to 800-759-5881 or mail it to Centralized Employee Registry, PO Box 10322, Des Moines, IA 50306-0322. If you have questions about employer reporting requirements, call the Employers Partnering in Child Support (EPICS) Unit at 877-274-2580.

Multistate employers have two reporting options: to report newly hired employees in the states in which they are working, or alternatively, to identify one state where all hires will be reported. If you choose to report to one state, your new hire reports must be submitted electronically or by magnetic media, and you must register to identify the state you will report to. To register, visit ocsp.acf.hhs.gov.

Employer Information

1. **Federal Employer Identification Number (FEIN).** Provide the same 9-digit FEIN used on your quarterly wage reports, plus the 3-digit suffix used when filing Iowa withholding tax. For a business with only one location, the default suffix is 000.
2. **Employer name.** Provide the trade name or doing business as (DBA) name, if applicable, rather than the legal name of the employer.
3. **Employer address.** Include any applicable post office box, unit number, etc.
4. **Employer contact and phone number (optional).** Include any applicable phone and extension.
5. **Income Provider name and address for income withholding orders or garnishment, if different from the employer address above.** This may be the legal name of the business or other entity that handles withholding and garnishment. This information is needed for income withholding and garnishment purposes.

Employee Information

6. **Is dependent health care coverage available?** This question does not relate to insurability of employee's dependents. Mark yes if the employer or union offers coverage.
7. **Approximate date this employee qualifies for coverage.** Example: Is dependent insurance coverage offered upon hire or after six months of employment? This question does not relate to insurability of employee's dependents. Enter in month, day, and year format.
8. **Employee start date.** Indicate the first day for which the employee is owed compensation. For a rehire, list the return date. Enter in month, day, and year format. (Required by 42 U.S. Code § 653a)
9. **Employee date of birth.** Enter in month, day, and year format.
10. **Employee Social Security Number (SSN).** SSN is required for all individuals, including minors.
11. **Employee name.** Provide the employee's full name including middle initial.
12. **Employee address.** Provide the employee's current home address.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . 2 $

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

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

CLARINDA COMMUNITY SCHOOL DISTRICT
PAYROLL DIRECT DEPOSIT EMPLOYEE AUTHORIZATION

Please print all information:

Employee Name _____

Bank Name _____

Type of Account:

Checking _____ Account Number _____

Savings _____ Account Number _____

Savings _____ Account Number _____

I authorize **Clarinda Community School District** and the bank listed above to deposit my net pay electronically to my account each payday. If funds that I am not entitled to are deposited to my account, I authorize **Clarinda Community School District** to direct the bank to return said funds. This authority will remain in effect until I have filed a new authorization.

_____ New _____ Change _____ Cancel

TAPE YOUR VOIDED CHECK HERE

☐ Place an X in the appropriate box:
Please email my pay stub to the following email address:

_____

_____
Employee Signature

_____
Date

This authorization will remain in force until written notification to terminate or change is received in the McKinley Central Office.

STAFF TECHNOLOGY USE REGULATION

General

The following rules and regulations govern the use of the school district's computer network system, employee access to the Internet, and management of computerized records:

- Employees will be issued a school district e-mail account. Passwords must be changed periodically.
- Each individual in whose name an access account is issued is responsible at all times for its proper use.
- Employees are expected to review their e-mail regularly throughout the day, and shall reply promptly to inquiries with information that the employee can reasonably be expected to provide.
- Communications with parents and/or students must be made on a school district computer, unless in the case of an emergency, and should be saved and the school district will archive the e-mail records according to procedures developed by the technology committee.
- Employees may access the Internet for education-related and/or work-related activities.
- Employees shall refrain from using computer resources for personal use, including access to social networking sites.
- Use of the school district computers and school e-mail address is a public record. Employees cannot have an expectation of privacy in the use of the school district's computers.
- Use of computer resources in ways that violate the acceptable use and conduct regulation, outlined below, will be subject to discipline, up to and including discharge.
- Use of the school district's computer network is a privilege, not a right. Inappropriate use may result in the suspension or revocation of that privilege.
- Off-site access to the school district computer network will be determined by the superintendent in conjunction with appropriate personnel.
- All network users are expected to abide by the generally accepted rules of network etiquette. This includes being polite and using only appropriate language. Abusive language, vulgarities and swear words are all inappropriate.
- Network users identifying a security problem on the school district's network must notify appropriate staff. Any network user identified as a security risk or having a history of violations of school district computer use guidelines may be denied access to the school district's network.

Prohibited Activity and Uses

The following is a list of prohibited activity for all employees concerning use of the school district's computer network. Any violation of these prohibitions may result in discipline, up to and including discharge, or other appropriate penalty, including suspension or revocation of a user's access to the network.

- Using the network for commercial activity, including advertising, or personal gain.
- Infringing on any copyrights or other intellectual property rights, including copying, installing, receiving, transmitting or making available any copyrighted software on the school district computer network. *See Policy 605.7, Use of Information Resources* for more information.
- Using the network to receive, transmit or make available to others obscene, offensive, or sexually explicit material

STAFF TECHNOLOGY USE REGULATION

- Using the network to receive, transmit or make available to others messages that are racist, sexist, and abusive or harassing to others.
- Use of another's account or password.
- Attempting to read, delete, copy or modify the electronic mail (e-mail) of other system users.
- Forging or attempting to forge e-mail messages.
- Engaging in vandalism. Vandalism is defined as any malicious attempt to harm or destroy school district equipment or materials, data of another user of the school district's network or of any of the entities or other networks that are connected to the Internet. This includes, but is not limited to, creating and/or placing a computer virus on the network.
- Using the network to send anonymous messages or files.
- Revealing the personal address, telephone number or other personal information of oneself or another person.
- Intentionally disrupting network traffic or crashing the network and connected systems.
- Installing personal software or using personal disks on the school district's computers and/or network without the permission of the building administrator.
- Using the network in a fashion inconsistent with directions from teachers and other staff and generally accepted network etiquette.

Other Technology Issues

Employees, who are coaches or sponsors of activities, may create a text list of students and parents in order to communicate more effectively as long as the texts go to the student(s) and the Principal and/or Athletic Director is included in the text address list.

SUBSTANCE-FREE WORKPLACE NOTICE TO EMPLOYEES

EMPLOYEES ARE HEREBY NOTIFIED it is a violation of the Substance-Free Workplace policy for an employee to unlawfully manufacture, distribute, dispense, possess, use, or be under the influence of in the workplace any narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana or any other controlled substance or alcohol, as defined in Schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation at 21 C.F.R. 1300.11 through 1300.15 and IOWA CODE Chapter 124.

"Workplace" is defined as the site for the performance of work done in the capacity as an employee. This includes school district facilities, other school premises or school district vehicles. Workplace also includes nonschool property if the employee is at any school-sponsored, school-approved or school-related activity, event or function, such as field trips or athletic events where students are under the control of the school district or where the employee is engaged in school business.

Employees who violate the terms of the Substance-Free Workplace policy may be required to successfully participate in a substance abuse treatment program approved by the board. The superintendent retains the discretion to discipline an employee for violation of the Substance-Free Workplace policy. If the employee fails to successfully participate in such a program the employee is subject to discipline up to and including termination.

EMPLOYEES ARE FURTHER NOTIFIED it is a condition of their continued employment that they comply with the above policy of the school district and will notify their supervisor of their conviction of any criminal drug statute for a violation committed in the workplace, no later than five days after the conviction.

SUBSTANCE-FREE WORKPLACE ACKNOWLEDGMENT FORM

I, _____, have read and understand the Substance-Free Workplace policy. I understand that if I violate the Substance-Free Workplace policy, I may be subject to discipline up to and including termination or I may be required to participate in a substance abuse treatment program. If I fail to successfully participate in a substance abuse treatment program, I understand I may be subject to discipline up to and including termination. I understand that if I am required to participate in a substance abuse treatment program and I refuse to participate, I may be subject to discipline up to and including termination. I also understand that if I am convicted of a criminal drug offense committed in the workplace, I must report that conviction to my supervisor within five days of the conviction.

_____ _____

(Signature of Employee) (Date)

Clarinda CSD	BENEFIT DECLINE FORM (PLAN YEAR 7/1/22 TO 6/30/23)
	EMPLOYEE NAME (Please Print):

Instructions: A) Print your name at the top of this form.
B) If you wish to decline to participate in the District's group plan please check the box below.
C) State the reason that you are declining to participate in the District's Group plan. (Coverage through spouse or parent)
D) If declining, please provide a copy showing proof of coverage under a qualified group plan from your spouse's employer or from your parent's employer.
E) Sign & date at the bottom of this form.

☐ I decline to participate in the Clarinda CSD group plan.

Please state the reason for declining to participate in the Clarinda CSD group plan in the space below. You must provide the District with proof of coverage under a qualified group plan from your spouse's employer or from your parent's employer in order to waive coverage.

AUTHORIZATION – I understand I cannot change my elections during the plan year unless I have a qualified event and apply within 31 days of the qualifying event. I understand if I have checked no above I am declining the opportunity to apply for that benefit for myself and/or dependents and we may have to wait until the next enrollment period to enroll unless there is a qualified event. I understand this enrollment form does not state all terms and conditions of the benefits that I am declining and I have received the enrollment materials explaining each benefit. My effective date will be based on my employer's waiting period and insurance carrier guidelines. My signature certifies that I have been informed of the options available and I have declined the benefits offered by the District.

Employee Signature _____ Date _____

Advantage™
ADMINISTRATORS

PARTICIPATION FORM FOR THE FLEXIBLE BENEFITS PLAN

*Please Print

Participant Name _____ Employer _____

Date of Birth ___/___/___ Social Security No. _____ Employer ID _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Direct Deposit Yes _____ No _____ Checking _____ Savings _____

Routing Number _____ Bank Account Number _____

A set of two Flex Visa Debit Cards will be issued to all participating employees at no cost.

Debit Card Agreement: *I understand that the flex debit card is available to pay only qualified expenses and that the qualified expenses paid with the card cannot be reimbursed by any other plan. I understand that when using the flex debit card I must keep all receipts and that I may be asked for documentation of charges made with my card. I also understand that if a payment is made that is not for a qualified expense, it must be repaid. For any expense not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).*

	Annual	Per Pay Period
1. Medical Flex Spending Account (Medical, Dental, Vision)	$ _____	$ _____

☐ **OPTIONAL:** My spouse has a High Deductible plan (HDHP) and intends to make or receive contributions to a Health Savings Account (HSA). **As such, this election does not apply to expenses incurred by my spouse.**

Or Limited Account (Dental/Vision, and Post-Deductible only)	$ _____	$ _____

USE ONLY WHEN you or your spouse are making or receiving contributions to an HSA; this election will only apply to dental, vision, and post-deductible expenses for you, your spouse, and your dependents.

2. Dependent Care Expenses (Daycare)	$ _____	$ _____
3. Health Savings Account (if offered by your employer)	$ _____	$ _____

4. Agreement to Save on Insurance Premiums

☐ On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premiums for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my election will automatically be adjusted to reflect that change.

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. My employer and I agree that my compensation will be reduced each pay period during the year by an equal portion of the benefit elections set forth above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand the Flexible Spending Amount will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I acknowledge that I have received, read and understand the Summary Plan Description.

Employee Signature _____ Date _____

To be completed by employer:
Effective Date if not renewal (mm/dd/yy) ___/___/___ First payroll date ___/___/___ Number of Payrolls for deduction _____

NFDC

Flex Benefit Plan WORKSHEET

Visit www.advantageadmin.com for a list of covered items

Now that you know about the many ways you can use pre-tax earnings to keep more of what you earn, take a moment to fill out this worksheet to determine how much money you'll save annually by participating in your employer's flex benefit plan.

Simply check off the items you wish to save for and budget how much you'll spend in the upcoming year on those products and services. Fill in the estimate in the space next to each item. Then add up each category and place those totals in the corresponding section below the checklist.

HEALTHCARE EXPENSES (estimated)
FOR EXPENSES NOT COVERED BY INSURANCE

- Co-pays to doctors & pharmacies $_____
- Oxygen, insulin, syringes & supplies $_____
- Dual Purpose Items (Letter of Medical Necessity is needed in order for these items to be flex eligible) $_____
- Special schooling for disabled child $_____
- Prescription drugs $_____
- Wigs for hair loss caused by disease $_____
- Office visits & checkups $_____
- Reconstructive surgery (birth defect, disease) $_____
- Prescribed sunglasses & eyeglasses $_____
- Medical alert bracelet & fees $_____
- Contact lenses, solutions & supplies $_____
- Alcoholism & drug treatment $_____
- Eye exams, surgery & LASIK $_____
- Dental cleanings, fillings & x-rays $_____
- Breast pump and related accessories $_____
- Sealants, crowns, bridges & dentures $_____
- Walkers, canes & wheelchairs $_____
- Braces, invisalign, spacers & retainers $_____
- Arches $_____
- Wisdom teeth, implants & oral surgery $_____
- Artificial limbs & braces $_____
- Psychologist & psychiatrist fees $_____
- Physical & speech therapy $_____
- Obstetrics & fertility $_____
- Hearing aids, batteries & exams $_____
- Lab tests & body scans $_____
- Chiropractic & podiatrist fees $_____
- Travel & mileage to doctor or hospital, etc. $_____
- Misc/Other $_____

TOTAL OPTION 1 $_____

DEPENDENT CARE EXPENSES (estimated)
SO YOU CAN WORK

- Nanny & babysitter $_____
- Day camp $_____
- Pre-K or nursery school $_____
- Daycare for a disabled adult or child $_____
- Before & after-school care $_____
- Elder daycare for parent or dependent $_____

TOTAL OPTION 2 $_____

ESTIMATED ANNUAL EXPENSES AND TAX SAVINGS

TOTAL 1 _____ + TOTAL 2 _____ + Other _____ = $_____

x 36%

Save between 25% and 40% on FICA, federal & state income tax (in applicable states).
Based on national averages, you'll save 25% if your annual household earnings are less than $30,000, 36% if you earn $30,000 to $60,000, or 40% if you earn more than $60,000.
Federal and/or plan limits apply to all options. See your summary plan description for plan limit

YOU SAVE $_____

ISEBA

IOWA SCHOOLS EMPLOYEE BENEFITS ASSOCIATION
ENROLLMENT / CHANGE FORM

New Hire ☑ Effective Date

SECTION 1: EMPLOYER AND EMPLOYEE INFORMATION

Employer Name: Clarinda Comm School District

Employee Name (Last, First, MI):	Social Security #:	Gender: ▪ ▪	Date of Birth:	Marital Status: ▪ Married ☐ Single
Employee's Home Address (Street, City, State, Zip):				Home Phone #:
Date of Hire:	Effective Date of Coverage:	▪ Active ☐ Retired	Occupation Class:	Hours Worked Per Week: / Annual Salary:

SECTION 2: CHECK TYPE OF COVERAGE

Please specify Medical Plan _____

Please specify Dental Plan _____

COVERAGE TYPE	MEDICAL		VISION		DENTAL		LIFE / AD&D		LIFE / AD&D OPTION	LTD		LTD OPTION	VOL LIFE / AD&D		VOL LIFE/ AD&D AMOUNT	DEP LIFE		DEP LIFE AMOUNT
A = Accept W = Waive	A	W	A	W	A	W	A	W		A	W		A	W		A	W	
Employee Only	◉	○	◉	○	◉	○	◉	○		◉	○		◉	○		☐	☐	
Family	◉	○	◉	○	◉	○										◉	○	

Accident Expense / Critical Illness			
To be covered	AE	Unit	CI
Employee Only	☐		☐
EE & Spouse	☐		☐
EE & Children	☐		☐
Family	☐		☐

If applying for Critical Illness (CI) coverage this question must be answered: During the past 12 months, has any Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum? Employee: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

SECTION 3: ELIGIBLE PARTICIPANTS (if additional dependents, attach separate sheet)

	Last Name (if different from employee)	First Name	Social Security #	Date of Birth MM	DY	YR	Sex M / F	ADD	REMOVE
Spouse									
Dependent									
Dependent									
Dependent									
Dependent									

SECTION 4: MEDICARE INFORMATION

Name of Person Covered by Medicare	Medicare ID Number	EFFECTIVE DATES PART A	PART B	DISABLED? YES	NO	ESRD? YES	NO

SECTION 5: BENEFICIARY INFORMATION – *Please note the employee is the beneficiary for dependent life or spouse or child(ren) voluntary life*

Name of Beneficiary (Last Name, First, MI)	Relationship	Benefit %
Primary:		
Secondary:		

Employee Signature: _____ Date _____

SECTION 6: REASON FOR ADDING COVERAGE

		EFF. DATE OF CHANGE
☐	Open Enrollment	
☐	Birth / Adoption	
☐	Marriage	
☐	Loss of Other Group Coverage	
☐	Court Order (attach a copy)	
☒	Employment Status Change	
☐	Other (explain)	

SECTION 7: REASON FOR TERMINATING COVERAGE

☐	Termination of Employment		
☐	Divorce	☐	Spouse's Group Coverage
☐	Age Limit	☐	Individual Coverage
☐	Medicare	☐	Deceased
☐	Other (explain)		
Effective Date of Change	/ /		

SECTION 8: NAME and/or ADDRESS CHANGES

New Name:	
Former Name	
New Address	

Secondary Coverage :

_____

_____

_____

IMPORTANT: PLEASE READ AND SIGN FORM.

I represent that all information supplied in this application is true and complete.

Rev. 04/2020

Wellmark Blue Cross and Blue Shield Alliance Select ISEBA Plan Comparisons

Clarinda Community School District

$1,000 / $2,000 ALLIANCE SELECT HEALTH PLAN

BENEFIT	SELECT PROVIDERS (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)
Benefit Period Deductible Single Family	$1,000 / Single $2,000 / Family	
Out-of-Pocket Maximums Single Family	$2,000 / Single $4,000 / Family	
Coinsurance	20%	40%
Lifetime Benefits Maximum	Unlimited	
Lifetime Infertility Maximum	$25,000	
Office Visit Services	$25 Copay/$50 Specialist Copay *deductible & coinsurance waived*	40% coinsurance after deductible
Specific Preventive Care Includes: One routine physical per benefit period, a separate gynecological exam is also covered, related services, well-child care to age 7 and mammography.	Routine Health Care (age 7 or older) Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*
	Well-Child Care (under age 7) Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*
	Childhood Immunization (under age 7) Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*
Inpatient Hospital Services	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Physician Services	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital Services	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Services Physician's Office	$25 Copay/$50 Specialist Copay *deductible & coinsurance waived*	40% coinsurance after deductible
Emergency Room	$200 Copay Copay Waived if Admitted	$200 Copay Copay Waived if Admitted
Chiropractic Care	$25 Copay/$50 Specialist Copay *deductible & coinsurance waived*	40% coinsurance after deductible
Maternity Care Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Infertility Treatment Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Office Visit	$25 Copay/$50 Specialist Copay *deductible & coinsurance waived*	40% coinsurance after deductible
Mental Health/Chemical Dependency Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Office Services	$25 Copay/$50 Specialist Copay *deductible & coinsurance waived*	40% coinsurance after deductible
Prescription Drug **Retail** Generic (30 Day Supply) Formulary (Brand PPO) (30 Day Supply) Non-Formulary (30 Day Supply) **Mail Order** Generic (90 Day Supply) Formulary (Brand PPO) (90 Day Supply) Non-Formulary (90 Day Supply)	$25 Copay Generic $50 Copay Brand Name $50 Copay Other Brand Name $50 Ded Single/$100 Ded Family (Waived for Generic) $50 Copay Generic $100 Copay Brand Name $100 Copay Other Brand Name	
Rates 7/1/24 Single Family	$850.00 $2,100.00	

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate you will receive after you enroll and the enrollment

Effective Date: 7/1/2023

Group Number: 60790-1200

Plan Number: 150130IZ3-L7

Iowa School Employees Benefits Association

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Contact Lens Fit and Follow-up		
Standard Contact Lens Fitting	Covered in full	Up to $25
Custom Contact Lens Fitting	Covered in full	Up to $25
Materials[1]	$15 copay (Materials copay applies to frame or spectacle lenses, if applicable.)	
Frame Allowance (Up to 20% discount above frame allowance.)	$150 allowance	Up to $50
Standard Spectacle Lenses		
Single Vision	Covered in full after $15 copay	Up to $25
Bifocal	Covered in full after $15 copay	Up to $40
Trifocal	Covered in full after $15 copay	Up to $50
Lenticular	Covered in full after $15 copay	Up to $80
Preferred Pricing Options Level 7 Option Package		
Polycarbonate (Single Vision/Multi-Focal)	Covered in full	Up to $10
Standard Scratch-Resistant Coating	Covered in full	Up to $5
Ultra-Violet Screening	Covered in full	Up to $6
Solid or Gradient Tint	Covered in full	Up to $4
Standard Anti-Reflective Coating	Covered in full	Up to $24
Level 1 Progressives	Covered in full	Up to $40
Level 2 Progressives	Covered in full	Up to $48
All Other Progressives	$140 allowance + up to 20% discount	Up to $48
Transitions® (Single Vision/Multi-Focal)	$70/$80	N/A
Polarized	$75	N/A
PGX/PBX	$40	N/A
Other Lens Options	Up to 20% discount	N/A
Contact Lenses[1] (in lieu of frame and spectacle lenses)		
Elective (10% discount on amount exceeding allowance)	$130 allowance	Up to $110 / Up to $250
Medically Necessary	Covered in full	
Refractive Laser Surgery	Onetime/lifetime $150 allowance Provider discount up to 25%	Onetime/lifetime $150 allowance
Frequency		
Lenses or contact lenses	Once every 12 months	
Frame	Once every 24 months	

[1]Discounts are not insured benefits.
[2]Prior authorization is required for medically necessary contacts.

Reliable & Dependable

Avēsis is a national leader in providing exceptional vision care benefits for millions of commercial members throughout the country.

The Avēsis vision care products give our members an easy to use wellness benefit that provides excellent value and protection.

Rates

Employee Only	$12.24
Employee + Family	$30.90

Underwritten by: Fidelity Security Life Insurance Company, Kansas City, MO

Policy #: VC-16, Form M-9059

How can we help you?

Avēsis Website:
www.avesis.com

Customer Service:
800-828-9341
7 a.m. - 8 p.m. EST

LASIK Provider:
877-712-2010

Here's How It Works

When you need to see an eye care professional, simply visit www.avesis.com or contact Avēsis' Customer Service Monday through Friday, 7 a.m. to 8 p.m. (EST) at 800-828-9341 to receive a listing of providers in your area.

1 Select a provider

2 Make an appointment

3 Visit provider for service

4 Pay any copayment, additional expenses

[1]At participating Walmart/Sam's locations, retail pricing for your plan is $82 . At participating Costco locations, retail pricing is $84.99 .

Using Out-of-Network Providers

Members who elect to use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avēsis for reimbursement. Reimbursement levels are in accordance with the out-of-network reimbursement schedule previously listed. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits, and limitation and exclusion provisions of the plan, and are in lieu of services provided by a participating Avēsis provider. Out-of-network claim forms can be obtained by contacting Avēsis' Customer Service Center or your group administrator, or by visiting www.avesis.com.

Limitations and Exclusions

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence.

Limitations:

This plan is designed to cover corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the participating Avēsis provider. Benefits are payable only for services received while the group and individual member's coverage is in force.

Exclusions:

There are no benefits under the plan for professional services or materials connected with and arising from:

1) Orthoptics or vision training;
2) Subnormal vision aids and any supplemental testing, aniseikonic lenses;
3) Plano (non-prescription) lenses, sunglasses;
4) Two pair of glasses in lieu of bifocal lenses;
5) Any medical or surgical treatment of eye or supporting structures;
6) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services;
7) Any eye examination or corrective eyewear required by an employer as a condition of employment and safety eyewear;
8) Services or materials provided as a result of Workers' Compensation Law, or similar legislation, required by any governmental agency whether Federal, State, or subdivision thereof.
9) Any vision examination;
10) Services or materials provided by any other group benefit plan providing vision care.

Refractive Surgery Vision Benefit Exclusions:

Benefits are not payable for any of the following:

1) Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames, or contact lenses; or
2) Medical or surgical procedures, services, or treatments:
    a. not specifically covered under this Rider;
    b. provided free of charge in the absence of insurance
    c. payable under any Workers' Compensation law or similar statutory authority
    d. payable under governmental plan or program, whether Federal, state, or subdivisions thereof.

Termination Provisions

Coverage will end on the earliest of: the date the policy ends, the date the employee's employment ends, or the date the employee is no longer eligible.

Notes and Disclaimers

The contact lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only. Refractive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Avēsis is not responsible for the outcome of any refractive surgery. Discounts on materials are not available at Walmart locations. Members may not use their contact lens allowance toward fitting fees at Walmart and are responsible for any out-of-pocket fees associated with fittings there. Discounts on materials are not available at Costco locations. ID cards are not required for services.

ISEBA — VOLUNTARY TRUST

SUMMARY OF COVERAGE

	PLAN B		
	PPO℠	Premier®	Out-of-Network
Deductible			
Individual	$50*	$50*	$75*
Annual Period Maximum per person per calendar year	$1,000		

BENEFIT CATEGORIES

	Coinsurance paid by member		
Diagnostic & Preventive Services** (check-ups, teeth cleaning, x-rays, space maintainers, sealant applications, flouride)	0%	0%	20%
Routine & Restorative Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	10%	20%	40%
Posterior Composites (tooth-colored filling on back teeth without alternative processing)	40%	50%	60%
Endodontic Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings, pulpotomy)	40%	50%	60%
Periodontal Services (gum and bone diseases, complex procedures)	40%	50%	60%
High Cost Restorations (cast restorations - crowns, inlays, onlays, posts, cores)	50%	50%	60%
Prosthetics (bridges and dentures)	50%	50%	60%
Implants	60%	60%	70%
Orthodontic Services***	50%		
Enhanced Benefits Program Included	Yes		

MONTHLY RATES

	PLAN B
Single	$34.34
Employee / Spouse	$67.62
Employee / Child(ren)	$76.72
Family	$129.48

Eligible children through age 25. Full-time (unmarried) students eligible through age 99. Percentages shown are what the member pays.
*Deductible is waived for all diagnostic and preventive care.
**Fluoride applications through age 18. Sealants for Plans A and B through age 18, and Plan C through age 13.
***Plan B orthodontic lifetime maximum is $1,000. Dependents and full-time students eligible through age 18.

Dental plans and rates are effective July 1, 2023 through June 30, 2024. The information on this page summarizes your benefits and payment obligations. This is a general description of your benefiw s. Please see your benefits document for a full description of coverage.

Iowa
Retirement Investors' Club (RIC)
Look *forward* to retirement!

403b Salary Reduction Form

Personal Information

Name_____ Social Security # _____
Last First MI

Address_____ City_____ State_____ Zip_____

Birth Date_____ Telephone (daytime)_____ Telephone (home) _____

Email Address_____ Employer Name_____

Salary Reduction Election

Horace Mann, MassMutual, VALIC, and Voya - Access to provider websites and contact information, a list of available investment options, total and individual fund fees, current fixed rates, historical fund performance, and self-directed brokerage options are available on the RIC website.

	Pretax	Roth (post-tax)	ER $*		Pretax	Roth (post-tax)	ER $*
Horace Mann	$_____ /check	$_____ /check	☐ Yes	VALIC	$_____ /check	$_____ /check	☐ Yes
MassMutual	$_____ /check	$_____ /check	☐ Yes	Voya	$_____ /check	$_____ /check	☐ Yes

AXA Equitable, EFS Advisors, GWN Securities, National Life Group, Security Benefit, and TCG Administrators – Access to provider websites and contact information is available on the RIC website. Investment options, fund fees, fixed rates, historical fund performance, and product restrictions (if any) are available directly from the provider upon request.

	Pretax	Roth (post-tax)	ER $*		Pretax	Roth (post-tax)	ER $*
AXA Equitable	$_____ /check	$_____ /check	☐ Yes	National Life Group	$_____ /check	$_____ /check	☐ Yes
EFS Advisors	$_____ /check	$_____ /check	☐ Yes	Security Benefit	$_____ /check	$_____ /check	☐ Yes
GWN Securities	$_____ /check	$_____ /check	☐ Yes	TCG Administrators	$_____ /check	$_____ /check	☐ Yes

Participant Signature

I authorize my employer to direct my contributions and make salary reductions (if requested) as indicated above. I have access and agree to the terms and conditions of the Iowa Retirement Investors' Club (RIC) as disclosed in the Plan Document. I have established a 403b account in one of the RIC provider's currently offered products. I understand that RIC does not give investment advice and investment returns are not guaranteed by the State of Iowa. I understand that withdrawals may only be made upon termination of employment or qualification for an in-service distribution as defined by my employer's plan elections. I understand that the total of all salary-deferred 403b contributions made in the calendar year may not exceed the federal limits as required by the Internal Revenue Code section 403b.

X_____ _____
Participant Signature Date

Submit Form Submit this form to your payroll office.

Agent Use Only *(Not required for existing accounts or online provider enrollment if available)* I am authorized to open accounts for this employee and verify that he/she has established a 403b account in one of the RIC provider's currently offered products.

Print Agent Name | Agent Signature | Agent Phone Number | Date

Payroll Office Date Received:_____ Paycheck Effective Date:_____ Name:_____

*Employer money - If your employer contributes to your 403b, indicate which provider is to receive the employer contributions.

Visit the RIC website at https://das.iowa.gov/RIC/403b to access additional program information and your employer's RIC plan elections (under *Your Plan Details*).

Print Form