JEFFERSON PILOT FINANCIAL

Jefferson Pilot Financial Insurance Company
P.O. Box 2616, Omaha NE 68103-2616
(800) 423-2765 fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID:	GROUP POLICY #:	Billing Division or Location:

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)			County	Employer ZIP	State
Demo Inc.					
Employee Last Name	**First Name**	**Middle Initial**	**Social Security Number**		**Date of Birth**
Johnson	Sara		223553535		05/05/1975
Street Address		**City**	**State**	**Zip**	
321 Some Street		Somecity	ID	83815	

Gender:	Marital Status:	Home Phone	Occupation	Average Hours Worked Per Week:
☐Male ☑Female	☑Married ☐Single	208 456-6565	Receptionist	33

Completed By Employer

Earnings: $40000 ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly	Date of Full-Time Employment: 01/02/2003	Rehire Date:

Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Short Term Disability ☐**Yes** ☐**No**	**$**	**$**
		Long Term Disability ☐**Yes** ☐**No**	**$**	**$**

Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ❑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by Jefferson Pilot Financial Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ❑ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- ❑ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Jefferson Pilot Financial Insurance Company, and the initial premium is paid to Jefferson Pilot Financial Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name: Sara Johnson Employee Signature:_____ Date:_____

UnumProvident

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Term Life and AD&D Insurance Enrollment Form

FOR EMPLOYEE TO COMPLETE GROUP PLAN #: _____ DIVISION: _____

EMPLOYEE NAME *(last name, first, middle initial)*			EMPLOYER NAME	
Johnson Sara			Demo Inc.	
EMPLOYEE ADDRESS *(street, city, state, zip code)*			SOCIAL SECURITY NUMBER	DATE OF BIRTH
321 Some Street Somecity ID 83815			223553535	05/05/1975
SEX ☐ *Male* ☑ *Female*	DATE OF EMPLOYMENT	HOURS WORKED PER WEEK	OCCUPATION	
	02/06/2000	33	Receptionist	
ANNUAL EARNINGS	HAVE YOU USED ANY TOBACCO PRODUCTS IN THE LAST 12 MONTHS? ☐ *Yes* ☐ *No*			
40000				

COVERAGE ELECTIONS Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. The coverage amounts you indicate will replace all prior coverage amounts you have on file with UnumProvident. Any items left blank will result in a coverage amount equal to $0.

AMOUNT OF COVERAGE SELECTED FOR:

	YOU:	YOUR SPOUSE:	EACH CHILD:
Life	$_____	$_____	$_____
AD&D	$_____	$_____	$_____

NOTE: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date UnumProvident approves your Evidence of Insurability form. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. This applies to Life coverage only.

Spouse Information *(complete only if spouse coverage is selected)*

NAME:	**SOCIAL SECURITY #:**	**DATE OF BIRTH:**

Beneficiary Information

NAME *(last name, first, middle initial)*:	**RELATION TO YOU:**	**BENEFIT %:**
IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:		

REQUEST FOR SIGNATURE *Please read the back of this form carefully before signing below.*

CERTIFICATION: I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES and EXCLUSIONS on the reverse side of this enrollment form. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

_____ __ __/__ __/__ __ __ _____ _____
Employee Signature *Date* *Work Phone* *Home Phone*

1335-03 (10/04)

AA

LIMITATIONS AND EXCLUSIONS

DELAYED EFFECTIVE DATE

Employee:

Insurance will be delayed for employees not in active employment until the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents:

Coverage for totally disabled dependents will be delayed until the date the individual is no longer totally disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of sickness or injury, the dependent is unable to perform each of the usual and customary duties or activities of a person of the same age and sex in good health.

EXCLUSION FOR SUICIDE

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date of insurance; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

AD&D BENEFIT EXCLUSIONS

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body, mental infirmity, or diagnostic, medical or surgical treatment
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while insane;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Committing or attempting to commit an assault or a felony;
- Voluntary use of any controlled substance. (This is defined in Title II of the Comprehensive Drug Abuse Prevention Control Act of 1970 and all amendments.) This exclusion will not apply if the controlled substance is prescribed for the individual by a physician;
- The presence of that percentage of alcohol in the individual's blood which raises a presumption that he was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the event occurred;
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while it is being used for test or experimental purposes; you or your dependent is operating, learning to operate, or serving as a member of the crew; it is being operated by, or for, or under the direction of any military authority. (This exclusion does not apply to transport type aircraft operated by the Military Airlift Command of the United States; or similar air transport service of any other country.)
- Travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned or leased by, or on behalf of your employer.
- Bacterial infection. This exclusion does not apply to you or your dependent when the bacterial infection is due directly to an accidental cut or wound.
- Service on full-time active duty in the Armed Forces of any country or international authority.

WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST

EMPLOYEE ENROLLMENT APPLICATION W/_____

ENROLLMENT INFORMATION:

Requested Effective Date of Enrollment or Change	Reason for Enrollment		Reason for Change
01/01/2001 (mm dd yy)	**(Check One)** ❑ Open Enrollment (new or renewing groups) ❑ New to Eligible Class ❑ COBRA / Continuation - start date ___/____/___ ❑ Add Dependent(s) (Specify qualifying event at right) ❑ Special Enrollment (Specify qualifying event at right)	**Qualifying Events for Special Enrollment (See Benefit Booklet)** ❑ Marriage/DomesticPartnership(DP) Date of marriage or DP _____/_____/_____ ❑ Involuntary Loss of Coverage ❑ Divorce ❑ Court Order (Dep. Child) ❑ Birth ❑ Adoption/Legal Guardian (Legal Documents Required) ❑ Death	❑ Name Change ❑ Address Change ❑ Beneficiary Change ❑ Delete Employee ❑ Delete Dependent(s)

EMPLOYER INFORMATION: (To be completed by the employer) (★ indicates mandatory field) **EMPLOYER - PLEASE REVIEW FOR ACCURACY BEFORE SUBMITTING**

★Employer Name	Demo Inc.	★Employee's Date of Hire	02/06/2000	Date Employee entered eligible class (if different than Date of Hire)	

Is this employee an owner who is waiving State Industrial Insurance? ❑ YES ❑ NO Class (If Applicable) ❑ Class 1 ❑ Class 2 ❑ Class 3

Employee's Medical Plan Selection

❑ Alliance ┼	❑ Choice 1	❑ Choice 2	❑ Choice 3A	❑ Choice 3B	❑ Choice 4	
❑ Solutions 750	❑ Solutions 1000A	❑ Solutions 1000B	❑ Solutions 1250	❑ Solutions 2000	❑ HSA 1500	❑ HSA 2500

EMPLOYEE INFORMATION: (To be completed by the Employee – (★ indicates mandatory field) - PLEASE PRINT CLEARLY

★First Name	Middle	★Last Name	Suffix (Jr, Sr, etc.)	Phone	★Employee's Birth Date	★Gender
Sara		Johnson		208 456-6565	05/05/1975	❑ Male ☑ Female

★Mailing Address	★City	★State	★Zip	Marital Status	Social Security #	Annual Salary (for STD or Salary-Based Life)
321 Some Street	Somecity	ID	83815	Married	223553535	

Employee's Prior Coverage Information

Enrollees who have been covered by health insurance during the 3 calendar months prior to enrolling in this plan must provide information below:

Date Prior Coverage Began	Date Prior Coverage Ended	Name of Insurance Company

DEPENDENT ENROLLMENT: To enroll a dependent(s) circle "Add" and provide information below; to cancel dependent coverage circle "Delete" and provide complete information. If you have more than five dependents, please attach a second form. If any of your dependents had health insurance coverage during the prior 3-month period before their enrollment date on this plan, please be certain to provide PRIOR COVERAGE information. Changes in dependent coverage must comply with the rules governing the Trust, including Qualifying Events as outlined in your benefit booklet.

★Add or Delete CircleOne	★Name of Dependent (If dependent has different mailing address, please attach) First	Last	★Birth Date (Over Age 25 requires certification)	★Relationship (Spouse, DP, Son, Daughter)	★Gender Circle One	Social Security #	Prior Coverage Information: Covered under what subscriber's name?	Date Coverage Began	Date Coverage Ended	Name of Insurance Co
Add/Delete					M F					
Add/Delete					M F					
Add/Delete					M F					
Add/Delete					M F					
Add/Delete					M F					

BENEFICIARY FOR EMPLOYEE'S BASIC LIFE / AD&D INSURANCE BENEFIT:	Beneficiary Name	Beneficiary Address	Relationship

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that WAHIT and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. WAHIT and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

★Employee Signature	Employee's Email Address (Required for web access)	★Date

Employee eligibility will not be forwarded to the carrier and service providers without employee signature. Please return this form to your employer. ┼ Only available if currently on Alliance

Demo Inc.

FAMILY AND MEDICAL LEAVE POLICY

(Employers with 25-49 employees)

Attached is our organization's policy on family and medical leave, the Family and Medical Leave Request Form, and Certification of Health Care Provider Form. To apply for family and medical leave, you must return this information data sheet showing that you have read and understand the following information and the organization policy which explains your rights and responsibilities under family and medical leave laws. In addition, you must submit the Family and Medical Leave Form and the Certification of Health Care Provider Form according to the guidelines in the organization's policy.

Important Points

1. In the event of a personal medical emergency that would prevent you from filling out the necessary forms, you may designate someone else to act in your place.

2. Everyone requesting family and medical leave is required to provide certification by a health care provider. Failure to do so will result in disciplinary action up to and including termination. In adoption situations or foster child placements, the provider may be a legal representative or representative of an authorized agency who can attest to the validity of the adoption or foster placement situation.

3. The organization will require the use of any paid vacation and/or sick leave to be counted as part of your family and medical leave. When these paid coverages are exhausted, your leave will be switched to unpaid leave.

4. If you wish to continue your health insurance you are responsible for paying the monthly insurance premiums. Failure to pay these premiums will result in canceling your health insurance coverage (after a 30-day grace period). We strongly recommend that you meet with the [_____] who will calculate the premiums you will owe while on leave and provide you with information about how and when premium payments will need to be made.

5. If you fail to return to work at the end of the leave period, you may be responsible for reimbursing the organization for the cost of organization-provided health insurance premiums during the unpaid leave period, unless you fail to return to work because of circumstances beyond your control.

I have read the above information and the organization's policy on family and medical leave and understand my rights and responsibilities with regard to family and medical leave.

Signature *Date*

Form W-4 (2006)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

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 2006 expires February 16, 2007. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $850 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may 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 line **E** below.

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. 919, How Do I Adjust My Tax Withholding, 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.

Two earners/two 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.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2006. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

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 $1,000 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 $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____
(**Note.** Do **not** include child support payments. See **Pub. 503,** Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit):
- If your total income will be less than $55,000 ($82,000 if married), enter "2" for each eligible child.
- If your total income will be between $55,000 and $84,000 ($82,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four or more eligible children.

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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $35,000 ($25,000 if married) see the **Two-Earner/Two-Job 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.

---------- **Cut 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
2006

1 Type or print your first name and middle initial.	Last name	2 Your social security number
Sara	Johnson	223553535

Home address (number and street or rural route)
321 Some Street

City or town, state, and ZIP code
Somecity ID 83815

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.

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 new 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 2006, 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
(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)
Demo Inc.		

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2006 tax return.

1 Enter an estimate of your 2006 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2006, you may have to reduce your itemized deductions if your income is over $150,500 ($75,250 if married filing separately). See *Worksheet 3* in Pub. 919 for details.) . . . **1** $ _____

2 Enter: { $10,300 if married filing jointly or qualifying widow(er) / $ 7,550 if head of household / $ 5,150 if single or married filing separately } . . . . . **2** $ _____

3 **Subtract** line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $ _____

4 Enter an estimate of your 2006 adjustments to income, including alimony, deductible IRA contributions, and student loan interest **4** $ _____

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 7* in Pub. 919) . **5** $ _____

6 Enter an estimate of your 2006 nonwage income (such as dividends or interest) . . . . . **6** $ _____

7 **Subtract** line 6 from line 5. Enter the result, but not less than "-0-" . . . . . **7** $ _____

8 **Divide** the amount on line 7 by $3,300 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-Earner/Two-Job 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-Earner/Two-Job Worksheet (See *Two earners/two 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 . . . . **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 4–9 below to calculate 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 2006. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2005. 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: Two-Earner/Two-Job Worksheet

Married Filing Jointly						All Others	
If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $42,000	$0 - $4,500	0	$42,001 and over	32,001 - 38,000	6	$0 - $6,000	0
	4,501 - 9,000	1		38,001 - 46,000	7	6,001 - 12,000	1
	9,001 - 18,000	2		46,001 - 55,000	8	12,001 - 19,000	2
	18,001 and over	3		55,001 - 60,000	9	19,001 - 26,000	3
$42,001 and over	$0 - $4,500	0		60,001 - 65,000	10	26,001 - 35,000	4
	4,501 - 9,000	1		65,001 - 75,000	11	35,001 - 50,000	5
	9,001 - 18,000	2		75,001 - 95,000	12	50,001 - 65,000	6
	18,001 - 22,000	3		95,001 - 105,000	13	65,001 - 80,000	7
	22,001 - 26,000	4		105,001 - 120,000	14	80,001 - 90,000	8
	26,001 - 32,000	5		120,001 and over	15	90,001 - 120,000	9
						120,001 and over	10

Table 2: Two-Earner/Two-Job Worksheet

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 - $60,000	$500	$0 - $30,000	$500
60,001 - 115,000	830	30,001 - 75,000	830
115,001 - 165,000	920	75,001 - 145,000	920
165,001 - 290,000	1,090	145,001 - 330,000	1,090
290,001 and over	1,160	330,001 and over	1,160

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. 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 also 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, and the District of Columbia for use in administering their tax laws, and using it 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.

OMB No. 1615-0047; Expires 03/31/07

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

Employment Eligibility Verification

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1- Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1)** document title; **2)** issuing authority; **3)** document number, **4)** expiration date, if any; and **5)** the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, 5 minutes; **2)** completing the form, 5 minutes; and **3)** assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachuetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS

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

OMB No. 1615-0047; Expires 03/31/07

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Johnson	Sara		
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
321 Some Street			05/05/1975
City	State	Zip Code	Social Security #
Somecity	ID	83815	223553535

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

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

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien #) A _____
- ☐ An alien authorized to work until _____

(Alien # or Admission #) _____

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title:				
Issuing authority:				
Document #:				
Expiration Date *(if any)*:				
Document #:				
Expiration Date *(if any)*:				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* 02/06/2000 **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*
Demo Inc.		

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): _____

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

Signature of Employer or Authorized Representative	Date *(month/day/year)*

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

LISTS OF ACCEPTABLE DOCUMENTS

LIST A

Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship *(Form N-560 or N-561)*
3. Certificate of Naturalization *(Form N-550 or N-570)*
4. Unexpired foreign passport, with *I-551 stamp or* attached *Form I-94* indicating unexpired employment authorization
5. Permanent Resident Card or Alien Registration Receipt Card with photograph *(Form I-151 or I-551)*
6. Unexpired Temporary Resident Card *(Form I-688)*
7. Unexpired Employment Authorization Card *(Form I-688A)*
8. Unexpired Reentry Permit *(Form I-327)*
9. Unexpired Refugee Travel Document *(Form I-571)*
10. Unexpired Employment Authorization Document issued by DHS that contains a photograph *(Form I-688B)*

OR

LIST B

Documents that Establish Identity

1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card *(Form I-197)*
6. ID Card for use of Resident Citizen in the United States *(Form I-179)*
7. Unexpired employment authorization document issued by DHS *(other than those listed under List A)*

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