EMPLOYEE DATA FORM

School Name: ______________________________ **Location Code:** ________________________

PERSONAL INFORMATION:

Employee Name: Social Security Number:

____ ______/_____/______

Last First Middle

____

Address City State Zip Code

Sex: Male Female

Marital Status: Married Single

Spouse's Birth Date: ____________________________

***Contact Information*:**

Home Phone: ________________________

Cell Phone: ________________________

Email Address: ________________________________

***Emergency Contact*:**

Name: _________________________________

Relation: ______________________________

Phone: ________________________________

PAY INFORMATION:

Start Date: ______________ Effective Date: ______________ Birth Date: ____________________

Pay Type: Hourly Salary Contract Priest

Pay Frequency: Monthly

Rate of Pay: Hourly $ _____________ Salary $ ______________ Contract $ ______________

Hours Worked Per Week: ____

Position Title: ____

** Employee must work 20 hours or more per week in order to qualify for pension benefits and 403(b).

** Employee must work **30 hours** or more per week in order to qualify for health insurance (via website)/LTD.

*** 403(b) deduction of 3% automatically deducted UNLESS declined through website.

PAYROLL INFORMATION:

Please indicate all benefits or deductions employee is electing at this time:

Qualify for Pension	Y	N	Medical Insurance	Y	N
403-B *** Mass Mutual will send mat'l.			Dependent Insurance	Y	N
Direct Deposit	Y	N	125-Cafeteria Plan	Y	N

Employee Signature: (***Applicable to School Employees Only***)

I authorize the Roman Catholic Diocese of Boise to conduct a background check if I fail to clear the State Department of Education's FBI Background Check within the first 30 Days of employment from my official start date.

____

Employee Signature Date

PASTOR/ADMINISTRATOR SIGNATURE: ____

DATE: ____________________________________

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

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

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

Section 1. Employee Information and Attestation

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

Form **W-4** (Rev. December 2020) 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

2021

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) **Social security number**
	Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov.*
	City or town, state, and ZIP code		
	(c) ☐ **Single** or **Married filing separately** ☐ **Married filing jointly** or **Qualifying widow(er)** ☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents	If your total income will be $200,000 or less ($400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by $2,000 ▶ $ Multiply the number of other dependents by $500 . . . . ▶ $ Add the amounts above and enter the total here	3	$
Step 4 (optional): Other Adjustments	**(a) Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	$
	(c) Extra withholding. Enter any additional tax you want withheld each **pay period** .	4(c)	$

Step 5: Sign Here

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

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

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

General Instructions

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 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 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, 2022.

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

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

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

1. Expect to work only part of the year;

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

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

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

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

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

Specific Instructions

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

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

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

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

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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . 1 $ ________

2 Enter:
- $25,100 if you're married filing jointly or qualifying widow(er)
- $18,800 if you're head of household
- $12,550 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 $

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$190	$850	$890	$1,020	$1,020	$1,020	$1,020	$1,020	$1,100	$1,870	$1,870
$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

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	$440	$940	$1,020	$1,020	$1,410	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040	$2,040
$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

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	$820	$930	$1,020	$1,020	$1,020	$1,420	$1,870	$1,870	$1,910	$2,040	$2,040
$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

IDAHO State Tax Commission

Form ID W-4
Employee's Withholding Allowance Certificate

Complete Form ID W-4 so your employer can withhold the correct amount of state income tax from your paycheck. Sign the form and give it to your employer. **Use the information on the back** to calculate your Idaho allowances and any additional amount you need withheld from each paycheck. If you plan to itemize deductions, use the worksheet at **tax.idaho.gov/w4**.

Withholding Status

Check the "**A**" box (Single) if you're:

- Single with one job or single with multiple jobs
- Filing as head of household

Check the "**B**" box (Married) if you're:

- Married filing jointly with one job and your spouse doesn't work
- A qualifying widow(er)

Check the "**C**" box (Married, but withhold at Single rate) if you're:

- Married filing jointly and both people work (or you have multiple jobs)
- Married filing separately

- -

IDAHO State Tax Commission

Form ID W-4
Employee's Withholding Allowance Certificate

WITHHOLDING STATUS (see information above)

A ☐ (Single) **B** ☐ (Married) **C** ☐ (Married, but withhold at Single rate)

1. Total number of Idaho allowances you're claiming .... ____________
2. Additional amount (if any) you need withheld from each paycheck (Enter whole dollars) .... ____________

			Your Social Security number (required)
Your first name and initial	Last name		
Current mailing address			
City		State	ZIP Code

Under penalties of perjury, I declare that to the best of my knowledge and belief I can claim the number of withholding allowances on line 1 above.

Your signature	Date

1. Total number of allowances you're claiming.

Enter the number of children in your household age 16 or under as of December 31, 2021. If you have no qualifying children, enter "0." If your filing status will be head of household on your tax return, add "2" to the number of qualifying children. **Don't claim allowances for you or your spouse**. You can claim fewer allowances but not more.

If you're married, claim your allowances on the W-4 for the highest-paying job for the most accurate withholding. If you're married filing jointly, only one of you should claim the allowances. The other should claim zero allowances.

If you work for more than one employer at the same time, you should claim zero allowances on your W-4 with any employer other than your principal employer.

Write **Exempt** on line 1 if you meet **both** of the following conditions:

- Last year I had no Idaho income tax liability **and**
- This year I expect to have no Idaho income tax liability

Nonresident Aliens

Exempt income. If you're a nonresident alien and all your income is exempt from withholding, write "Exempt" on line 1.

Exempt income from a treaty. If a treaty exempts a portion of your income from withholding, complete federal Form 8233 to claim your treaty benefits and complete the Idaho W-4 to withhold on income that's not exempt by your treaty.

Idaho taxable income. If you're a nonresident alien and have Idaho taxable income, do all of these:

1. Check the "Single" withholding status box regardless of your martial status.
2. Enter 0 on line 1.
3. Using the Pay Period table below, enter the additional amount of income tax to be withheld for each pay period on line 2. *Exception*: If you're a student or business apprentice from India, report $0 on line 2.

Pay Period Table				
If your pay period is:	Weekly	Biweekly	Semimonthly	Monthly
Enter this amount on line 2:	$17	$33	$36	$72

The withholding table calculations for employers include the standard deduction. Because nonresident aliens don't qualify for the standard deduction, the Pay Period table helps ensure that employers withhold enough.

2. Additional amount, if any, you need withheld from each paycheck.

If you're single or married filing separately and have more than one job at a time, complete the worksheet below to calculate any additional amount you need withheld from each paycheck.

1. Other than your primary job, how many jobs do you expect to have at the same time during 2021? (Don't count your primary job.) .... ______
2. Multiply the number on line 1 by $12,400 .... ______
3. Enter an estimate of your 2021 income from other jobs (not including your primary job) .... ______
4. Enter the smaller of lines 2 or 3 .... ______
5. If you completed the itemized deduction worksheet for Idaho (**tax.idaho.gov/w4**), enter the number from line 4. Otherwise, enter "0" .... ______
6. Multiply the number on line 5 by $2,960........ ______
7. Subtract line 6 from line 4 .... ______
8. Multiply line 7 by 6.925% (.06925). This is the additional amount you need to withhold annually .... ______
9. Divide the amount on line 8 by the number of your remaining pay periods in 2021. Enter the number on line 2 of the W-4 as the additional amount you need withheld from each paycheck .... ______

Contact us:

In the Boise area: (208) 334-7660 | Toll free: (800) 972-7660
Hearing impaired (TDD) (800) 377-3529
tax.idaho.gov/contact

Direct Deposit Authorization

Custom Payroll & HR Solutions

YOU MUST COMPLETE A SEPARATE FORM FOR EACH ACCOUNT YOU ARE ADDING OR CHANGING.

If this is a new account:

1. The account must be established and active at your bank before you request direct deposit.
2. Confirm the bank accepts direct deposits and verify the transit routing and account numbers.
3. For savings accounts, you MUST confirm the transit routing number with your bank.
4. Notify the bank that you are going to set up direct deposit through payroll.

Please check the appropriate box and complete:

- ☐ New direct deposit or new account (A through E or F through J below)
- ☐ Direct deposit is already set up, changing dollar amount only (C through E or H through J below)
- ☐ A new account to replace an existing direct deposit (A through E or F through J below)
- ☐ Account number you are replacing (REQUIRED): ____________________
- ☐ Cancel direct deposit or close account (Direct deposit MUST be cancelled before account is closed.)

FIRST ACCOUNT

A. Bank Name: ____________________

B. Bank Transit Routing Number: ____________________

C. Bank Account Number ____________________

D. Checking ☐ Savings ☐

E. Full Deposit ☐ Balance of Check ☐ **OR** ________ % of check **OR** Only $ ________

Staple Voided Check Here

SECOND ACCOUNT

F. Bank Name: ____________________

G. Bank Transit Routing Number: ____________________

H. Bank Account Number ____________________

I. Checking ☐ Savings ☐

J. Full Deposit ☐ Balance of Check ☐ **OR** ________ % of check **OR** Only $ ________

Staple Voided Check Here

Please return to HR, with a voided check for checking, or a deposit slip for savings accounts.
Each direct deposit account will take 1-2 pay periods to process.

* I authorize QTS and the bank listed above to deposit my net pay or portion thereof as indicated into my account each paydate.
* If funds to which I am not entitled are deposited to my account, I authorize QTS to direct the bank to return said funds to QTS.
* I understand that my deposit may not be credited to my account until the paydate indicated on the check voucher.

____________________ ____________________ ____________________

SIGNATURE PRINTED NAME DATE

Form #1511-0300

Roman Catholic Diocese of Boise

CRIMINAL BACKGROUND CHECK
Permission to Procure an Investigation Report

Diocesan/Parish Employees, Volunteers & Clergy

Location of Ministry _______________ Parish or School ___________
Are you an Employee/Volunteer/Clergy (circle one)
Name the Ministry you will be working in. ________________________

(Please <u>do not</u> leave blank)

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes. I hereby release all persons, agencies, and entities providing information or reports about me from any and all liability arising out of the requests for or release of any of the above mentioned information or reports.

Fax Page 1 & 2 of this document to the Office of Child, Youth and Adult Protection Attention Veronica Childers (208) 489-7475

Please type or print legibly

Name: ____________________ ____________________ ____________________
FIRST MIDDLE LAST

Address: ____

City: ____________________ State: ____________________ Zip: ___________

Please list other names/alias used and dates of name change (including maiden name):

____
FULL NAME DATE

____
FULL NAME DATE

____
FULL NAME DATE

Date of Birth: _____/_____/_____ Social Security Number: _____/_____/_____
Phone Number: _____/_____/_____ Cell Number: _____/_____/_____
E-Mail Address: ____

RESIDENCES: If you have lived in a state other than Idaho in the past 10 years, please list the following information, including the years in which you lived there. *Please continue on a separate sheet of paper if more room is needed.*

State: _____City: ____________________________ County: ___________Years: ______ to____
State: _____City: ____________________________ County: ___________Years: ______ to____
State: _____City: ____________________________ County: ___________Years: ______ to____
State: _____City: ____________________________ County: ___________Years: ______ to____

Has the applicant ever been convicted of a crime involving children? Yes _______ No _______

Has the applicant ever been convicted of a crime? Yes ______ No _______

Is this background check a New Request or Renewal? ____________________________

INVESTIGATIVE CONSUMER REPORT AUTHORIZATION

In connection with my application I understand that an investigative consumer report may be requested that may include information regarding my court records both civil and criminal, my driving records, educational and professional credentials, and personal and professional references. This may come from either public or private sources and may contain information regarding my character, experience, work habits, and reasons for termination from past employers. I understand that this document shall be kept on file and may be used at any time during my employment to procure an investigative report. I hereby release and discharge to the extent permitted by law, Roman Catholic Diocese of Boise, its employees, any individual or agency obtaining information for Roman Catholic Diocese of Boise, my personal and professional references, and my former employers, from any and all claims known or unknown, damages, losses, liabilities, cost, or other expenses arising from the retrieving, reporting, and/or disclosure of information in connection with this background investigation. I also understand that I may (1) request in writing the nature of the information obtained, and (2) request a written summary of my rights under the Fair Credit Reporting Act.

I hereby agree that a photographic copy or a telephonic facsimile of this document shall be valid for all purposes present and future. I have read, understand and agree with the above.

____

Signed Date

____

Witnessed (trainers or parish/school personnel signature) Date

A Summary of Your Rights under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of "consumer reporting agencies." A criminal background check is a consumer report under the FCRA. For purposes of this check CICS Employment Services, Inc. is the consumer reporting agency. No other consumer reports, such as credit reports, etc., will be obtained under the release and disclosure signed by you. Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** If the Roman Catholic Diocese of Boise uses a consumer report (criminal background check) to deny your employment or volunteer service - or to take another adverse action against you – we must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about yourself as reported by CICS Employment Services, Inc. You can contact them at 800-660-0507. You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your criminal background check;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.
  In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need — usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. For more information, go to visit www.ftc.gov/credit.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit. States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General.

QUESTIONS AND ANSWERS ABOUT CRIMINAL BACKGROUND CHECKS

What is the purpose of requiring checks?

We, as a church, value the relationship we have with the youngest and most vulnerable of our faith. Our children are precious, and we must do everything in our power to protect them from harm. While a criminal background check on those who work with children is not a foolproof method of keeping our children safe, it is one small thing that we can do to assure that those who work with our children do not have a history that would make their presence incompatible with our safe environment program. Our goal is to do what we can to create the safest environment possible for our children and young people. We hope that our employees and volunteers understand the importance of this objective, and cooperate fully with this program.

Is a credit check being done?

NO. The only check is of the applicant's criminal background. The federal law that requires us to provide information and a summary of rights is called the Fair Credit Reporting Act, but it covers any kind of an "investigation" of an applicant or employee's background, and thus it covers criminal background checks. Under that law, a criminal background check is included in the definition of "consumer report." Do not be confused by the references to "credit" and "consumer report" because the only check being performed is a criminal background check.

Who is required to complete the check?

All church personnel, including priests, deacons, religious, seminarians, educators, parish and school personnel, Diocesan staff, and volunteers who have regular contact with children are required to have a criminal background check as a condition of employment, or as a condition of continuing with the program.

How is the check completed?

The Diocese has contracted with CICS Employment Services, Inc. to coordinate the background checking program. Certified and classified staff, including Day Care providers, employed at our Diocesan Catholic Schools shall receive background checks through the State Department of Education. Each person who is checked through the Diocese will be required to sign release and disclosure forms.

What information will be disclosed to the Diocese when this check is completed?

Various types of information will be received in a report prepared by the vendor. This report will be received by the Diocese. Once the employee or volunteer has completed the release forms, the following types of checks will be done:

(1) Social Security Validation: This is a report that allows the Diocese to determine if the employee or volunteer has provided a validly issued Social Security number, and that the name given is the correct name for that person. The report will disclose if that person has previously used other names, so that a criminal history check can be performed.

(2) National Crime Check: This report provides information available in a national criminal history database which contains information from various Departments of Corrections and prison systems across the country. This report will reveal if the employee or volunteer has been in the prison system anywhere in the country.
(3) Federal Convictions: This report provides a report that includes any time spent in Federal custody.
(4) Sex Offender Report: This report provides a hit if the name, date of birth or social security number is tied to a registered sex offender.
(5) Statewide Crime Report: This is the most reliable way to assure that all relevant criminal history is revealed. In many states, the only way to assure that all relevant criminal records are checked is to physically check the records in the county of residence. This check will reveal the type of offense, the date it occurred, and the disposition. Many misdemeanor charges are also included in this report.

What information will we be required to provide in order to have the check completed?

In order to complete the check, employees and volunteers will be required to provide the following information:

(1) Name
(2) Date of Birth
(3) Social Security Number
(4) Telephone Number

Who will review the results?

The completed report will be provided to Diocesan staff for a review. The Director of Child, Youth and Adult Protection will review the reports and note any potential problems.

Will I receive a copy of the report?

If your criminal background check does not reveal any problems, you will not receive any information. Thus, you can assume that if you do not hear anything you are cleared to work with children. If the check reveals a problem, we will proceed as noted below.

How will the Diocese track who has completed the checks?

The Department of Child, Youth and Adult Protection will be responsible for keeping track of who has completed the checks. The Diocese already has records for employees, and can track which employees have completed the check. Parishes and schools will then be notified regularly who has completed the required checks.

How long does a criminal check take?

Many of the checks noted above are computerized and the turnaround time for the checks is usually two to three business days.

Can the employee or volunteer continue to work while the check is being performed?

Neither employees or volunteers may start work for the Diocese until the check is completed.

What will happen if a criminal offense appears on the report?

Criminal offenses that appear on a report will be screened by the Director of Child, Youth and Adult Protection to determine whether they indicate a potential problem with the safety and security of children. A criminal history which does raise a potential problem, however, will be reviewed, with the employee or volunteer, appropriate Diocesan personnel, the pastor or principal.

What if an employee or volunteer has recently completed a background check?

If a criminal background check has been performed within the last 24 hours, and adequate written proof of the results of that check can be provided, then no check is necessary. The written documentation must be forwarded to the Director of Child, Youth and Adult Protection. Questions concerning the sufficiency of such a check should also be directed to the Director of Child, Youth and Adult Protection.

What is meant by "regular contact with children?"

Volunteers must be screened if they have regular contact with children. Clearly, those who work in classrooms, either in schools or in religious education programs, are included in the definition of regular contact with children. Also included are counselors, nurses, coaches, bus drivers, Boy Scout leaders, youth ministers, core team members, school staff, lunchroom volunteers, playground supervisors, music teachers, etc. Any person whose contact with children is sufficient to allow the children to form a relationship with the volunteer should be checked. Questions about specific circumstances can be directed to the Director of Child, Youth and Adult Protection.

How does this check help the Diocese in its Safe Environment program?

These background checks are only one part of the complete safe environment program. For new employees and volunteers, not only should this criminal background check be completed, but we should also check references and require the potential employee or volunteer to answer questions regarding their background in working with children, and their understanding of appropriate behavior. We can screen for those with potential problems, but we must also make sure that there are standards of behavior in our church, and that everyone understands the appropriate behavior that will help create a safe environment for children and young people in our church. Thus, our safe environment program also includes Sexual Misconduct policies, and a Safe Environment workshop. All employees and volunteers will be required to attend that program as well, and acknowledge receipt of the Sexual Misconduct policies. Sexual Misconduct Policies can be found on the diocesan website.

What if we have questions or problems in completing the required authorization forms?

Contact the Safe Environment Coordinator, Veronica Childers at (208) 350-7556 or via email at vchilders@rcdb.org or the Director of Child, Youth and Adult Protection, Mark Raper, at (208) 342-1311 or via email at mraper@rcdb.org

ROMAN CATHOLIC DIOCESE OF BOISE

CAFETERIA PLAN

BENEFIT ELECTION AND COMPENSATION

REDUCTION AGREEMENT

NAME: ______________________________

ADDRESS: ______________________________

____

SOCIAL SECURITY NUMBER: ________ - ________ - ________

On the accompanying benefit enrollment form(s), I have enrolled for certain dental and medical benefit coverages.

I elect to receive both my dental and medical benefit coverages under the Roman Catholic Diocese of Boise Cafeteria Plan. Any previous Benefit Election and Compensation Reduction Agreement under the Cafeteria Plan relating to the same benefits is hereby revoked.

I and the Roman Catholic Diocese of Boise agree that my pay will be reduced by the amount of my required contribution for the benefit options I have elected under the Cafeteria Plan, effective __________*, and continuing for each succeeding pay period until this Agreement is amended or terminated. The amount of my required contribution for the benefit options selected is set forth on a schedule that has been provided to me.

I understand that:

-- I cannot change or revoke this Benefit Election and Compensation Reduction Agreement as of any date prior to the next January 1, unless I have a change in the family status (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Plan Administrator determines will permit a change or revocation of an election).

*The pay reduction may not be effective for any period that begins before you have signed this form and returned it to the Plan Administrator.

-- If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease.

DIOCESE OF BOISE
1501 S. Federal Way, Suite 400 • Boise, Idaho 83705
www.catholicidaho.org

Roman Catholic Diocese of Boise

Benefit Summary

Reta Health Insurance Plan (Anthem Network)

All employees who work a minimum of 30 hours per week are eligible for health insurance.

- $25 co-pay for "in network" providers
- $10-60 co-pay for prescription drugs
- Diocese pays 80% of employee's premium (premiums vary according to subscriber age)
- Spouse and dependant coverage available, paid by employee pre-tax.

Group Dental Plan **(Provided with the Health Insurance Plan)**

Vision Plan **(Provided with the Health Insurance Plan)**

403b Investment Plan

3% Auto enroll retirement plan that allows employees to contribute to their own account with pre-tax or post-tax dollars.

Lay Pension Plan

Employees who regularly and customarily work at least 20 hours a week are eligible for participation in the Diocese of Boise pension plan. Employees are 50% vested after 5 years of service, 100% vested after 10 years of service. This is a defined benefit plan funded by employer contributions.

Long Term Disability and Group Life Insurance

Long-Term Disability is affective on the first day of the month following employment. Benefits are available after 90 days of disability.

Life Insurance with Accidental Death and Dismemberment provision is provided for all employees working a minimum of 30 hours per week. The life insurance is $50,000 with an additional $50,000 for accidental death. The benefit does decrease 35% at age 65 and 50% at age 70.

Disability Guidance is provided for support, resources and information for personal and work-life issues. This is company-sponsored, confidential and provided at no charge to you or your dependents.

Flexible Spending Account

Health care – Employees may contribute up to $2,650 pre-tax dollars per year to pay for medical, dental and vision expenses not covered by insurance Dependent care – Employees may contribute up to $5000 pre-tax dollars to pay for daycare expenses. Flexible spending accounts may not be modified during the calendar year.

Tuition Benefit

All full-time employees (those who work 30+ hours per week) are entitled to free tuition for their children at any of the Catholic Schools in the Diocese.

Sick Leave

All regular full time and regular part time employees who work at least 20 hours per week are eligible for sick leave.

Holiday Pay

All regular full time employees who work a minimum of 35 hours per week are eligible for paid holiday time. Regular part-time employees scheduled to work at least 20, but fewer than 40 hours per week are paid holiday time which is pro-rated based on the hours regularly worked each week. Regular part-time employees must be normally scheduled to work on a given paid holiday in order to receive pay. Employees scheduled to work less than 20 hours per week are not eligible for holiday pay.

Vacation Leave

All regular full time employees and regular part time employees are eligible for paid vacation time. Accrual is based upon number of hours worked and length of service.

Note: Refer to Personnel Policies for additional information.

Health, Dental and Vision Insurance

You must go online to complete the enrollment process for health, dental and vision insurance coverage. You will receive an email from MyEnrollServices within 2-3 weeks of your start date. If you do not receive the email, please contact your payroll person. Please follow the attached instructions from RetaEnroll.

We highly recommend you complete this process by the 10th of the month. If the information is not entered in the Reta site in a timely manner, you run the risk of having double premiums withheld in one month.

RetaEnroll

Welcome to the Reta Trust!

As a new employee of The Roman Catholic Diocese of Boise you are eligible to enroll for employee benefits. You may elect your benefits using RetaEnroll, the Reta Trust online enrollment system at www.retatrust.org.

During your New Hire Enrollment period, you must go online to elect your benefits and enter dependent information for this year's benefit plan. Your New Hire Election Period begins 30 days following your date of hire for a duration of 45 days. With RetaEnroll, you can view all of your insurance benefits and related information anytime, including:

- **Personal Data** (home address, birth date, etc.)
- **Dependents** (names, birth dates, student status, etc.)
- **Benefit Elections** (medical, dental, life, disability, etc.)
- **Beneficiaries** (life insurance beneficiaries)

A User ID and Password is required to access the site.

Obtaining a User ID and Password

You may obtain your unique User ID and Password by going to the Reta Trust home page (www.retatrust.org) and clicking on the "Help" link for assistance with log-in. You will be prompted to enter your:

- First Name
- Last 4-Digits of you Social Security Number
- Date of Birth, and
- 5-digit Zip Code

RetaEnroll will verify your information and ask you to enter an email address, after which, RetaEnroll will immediately send you two separate emails. The first email will contain your User ID; and the second will contain your Password. Once you receive both your User ID and Password, return to www.retatrust.org and enter your new User ID and Password in the upper right corner and you will be directed to the **Enrollment Wizard.**

Once logged in, you will have the opportunity to modify your system-assigned User ID and/or Password to values you find easier to remember. Please save your confidential information in a secure place. Neither your HR department nor BAS can provide you with your User ID or Password. You must use the self-service "Help" link at www.RetaTrust.org to obtain this information.

Making your Online Elections

The enrollment site is available 24 hours a day, 7 days a week during your New Hire Enrollment period. When you are ready to make your elections, follow these five steps:

1. **Go to www.retatrust.org and enter your User ID and Password in the upper right hand corner.**
2. **Follow the easy enrollment steps using the Enrollment Wizard.**
3. **Confirm or change your benefit options.**
4. **Approve your elections.**

5. **Print your benefits confirmation statement.**

If you need to go back and make changes, you may do so as long as it is within your New Hire Enrollment period.

Please note: If you do not elect any benefits during your New Hire Enrollment Period, you will automatically be waived from all optional benefit plans.

If you Need more Detailed Information or Assistance

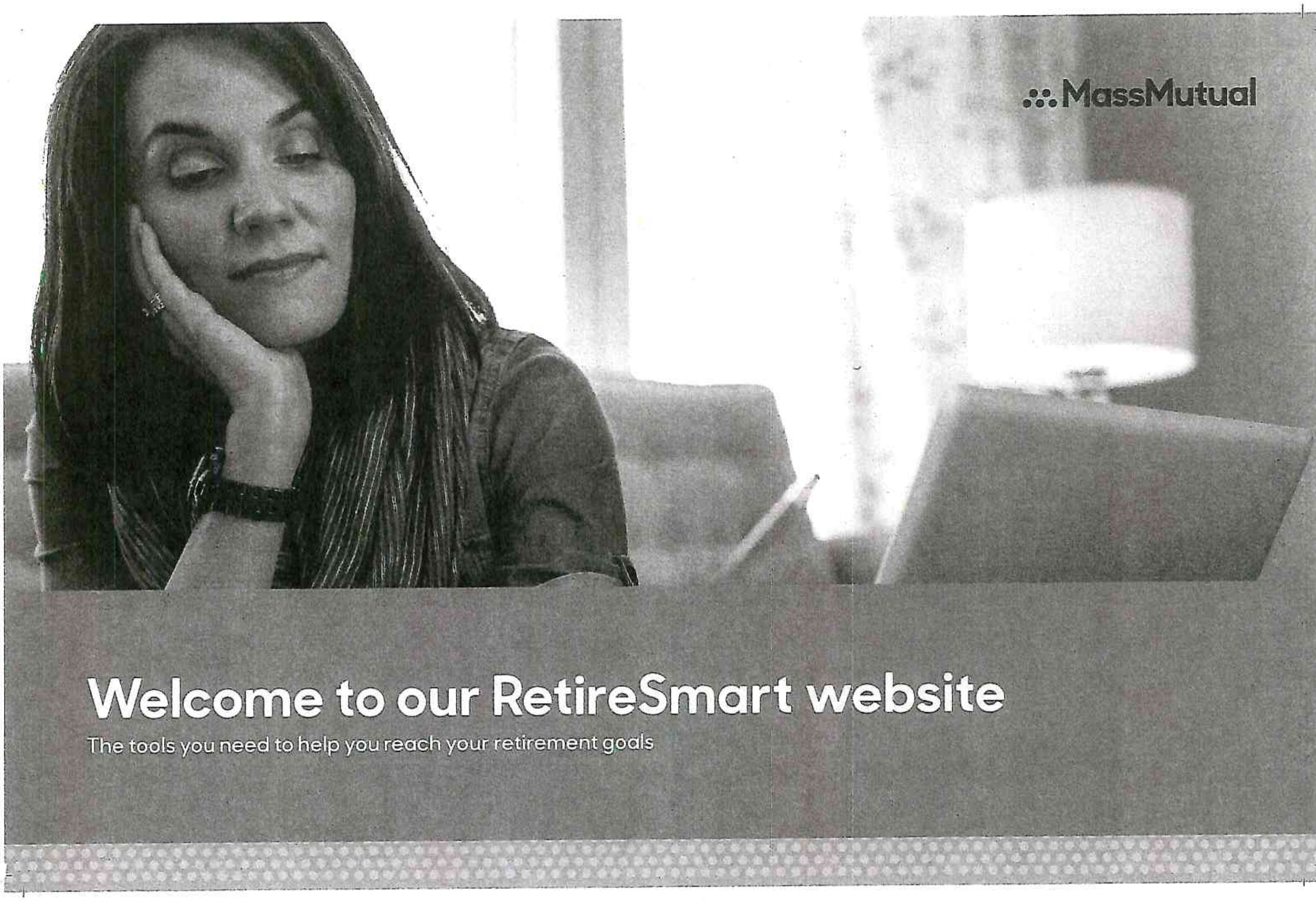
Detailed information about your benefits plan is available in the online Reference Library link under "Tools" in the left menu bar. You must log-in with your User ID and Password to access this resource. If you require assistance with accessing your account (or you do not have access to the Internet), please call the Reta Enroll Client Services Department toll free at 1.877.303.7382 from 8:30 AM to 8:00 PM EST, Monday through Friday, or send an e-mail to Service@Retaenroll.org. If you need further assistance regarding your individual benefit plan options, contact your HR Department.

403(b) Investment Plan through Mass Mutual

Employees who work 20 hours or more per week are eligible to participate in the 403(b) plan administered by Mass Mutual. Mass Mutual will mail your packet of instructions within a week of your start date. This packet will have instructions for setting up your account online and selecting your contribution amount or declining to contribute.

If you do nothing, you will automatically be set up for a 3% monthly deduction from your payroll.

You can reach the Mass Mutual website at www.retiresmart.com, or call them at 1-800-743-5274. If you'd like to speak with someone personally, please contact Frank Erstad (ferstad@financialguide.com) or 208-343-8899.



Helping you make RetireSMART Moves

You're just a few steps away from MassMutual's RetireSmart website, where you can:

- Access information about your retirement account.
- Raise your financial awareness with our online tools and educational articles.
- View messages related to your plan, and much more!

To get started, log in to **www.retiresmart.com** and click **Create Account**, located in the upper right corner. Follow the instructions and answer a few validation questions, then you can create your username, password and PIN.

If you need assistance, contact our Participant Information Center at **1-800-743-5274** Monday – Friday between 8 a.m. and 8 p.m. ET. Representantes españoles están disponibles.

RSD4003 1017 C:RS-21152-03

MassMutual

PO Box 219062
Kansas City, MO 64121-9062

THE DIOCESE OF BOISE LAY PENSION PLAN

BENEFICIARY DESIGNATION

(No Erasures. Type or use ink).

This designation supersedes and replaces all previous designations under this Plan.

Name ______________________ Social Security No. ______________

Location ______________________ Location No. ______________

IMPORTANT NOTICE

If you are **legally married**, your primary beneficiary is automatically your spouse. Neither you nor your spouse may elect otherwise.

If you are **not married**, your primary beneficiary is any person that you designate to receive death benefits under the plan, if any are payable.

Regardless of your marital status, it is important to designate a beneficiary — and to keep your designation up-to-date. If you fail to designate a beneficiary — or your beneficiary is not living at the time of your death — then the benefits due will be paid in accordance with the plan and the plan's administrative procedures.

Should your spouse or other beneficiary fail to survive you by at least 30 days — or if you and your beneficiary die in a common accident or disaster — you will have been deemed to have died last.

Beneficiary designation. See opposite side for sample designations. Attach a separate page if more space is necessary.

____

____

____

____

Beneficiary Address ______________________________
Street Address

____
City State Zip Code

Use separate page if more than one address and indicate name of each addressee.

EMPLOYEE SIGNATURE

I hereby make the above designation, revoking and replacing all previous designations under this plan. I understand if I am legally married at my death, my spouse has priority over any other claim presented.

Employee Signature ▷ Signature of Employee ______________________ Date ______________ ◁ Employee Signature

Mail or deliver this copy to the address on the reverse side

BSE201 (1/94)

INSTRUCTIONS

1. Use this form to designate or change your primary and/or secondary beneficiary.
2. When your relationship to your beneficiary is other than by blood, show your relationship as "nonrelative".
3. Where more than one primary and/or secondary beneficiary is designated, the amount to be paid to each beneficiary must be clearly set forth by designating fractions or portions to be received.
4. Your secondary beneficiary will receive the balance in your account only if your primary beneficiary dies before you.
5. If your death occurs and a minor is designated, or your beneficiary is incapable of giving valid receipt, the Plan Administrator may direct that payment be made to the person or institution responsible for the care and maintenance of such individual.
6. The proper wording for standard nominations of beneficiary is shown below. In the event none of the following nominations provide the disposition desired, you should consult your attorney.
7. *Common Accident or Disaster.* The plan provides that if you and your spouse or other beneficiary die in a common accident or disaster, you will be deemed to have died last.

Designations *in bold type mean* your spouse is your primary beneficiary

Type of Beneficiary	Language To Be Used
1. Estate	Estate
2. One Primary Beneficiary	Peter Jones, father.
3. Two Primary Beneficiaries	Peter Jones, father and Anna Jones, mother, equally, or the survivor.
4. Three or More Primary Beneficiaries	Peter Jones, father, Anna Jones, mother, and Mary Jones, daughter, or the survivors, equally or the survivor.
5. One Primary Beneficiary and One Secondary Beneficiary	**Dorothy Q. Jones, spouse, if living,** otherwise Mary Jones, daughter.
6. **One Primary Beneficiary and Two Secondary Beneficiaries**	**Dorothy Q. Jones, spouse, if living,** otherwise Mary Jones, daughter, Quincy Jones, son, equally, or the survivor.
7. One Primary Beneficiary and Three or more Secondary Beneficiaries	**Dorothy Q. Jones, spouse, if living,** otherwise Mary Jones, Quincy Jones, and Edna Jones, children, or the survivor, or survivors, equally.
8. One Primary Beneficiary and Unnamed Children as Secondary Beneficiaries	**Dorothy Q. Jones, spouse, if living,** otherwise the children born of the marriage of the designator and said wife, or the survivor, or the survivors, equally.
9. Two Primary Beneficiaries and One Secondary Beneficiary	Peter Jones, father, and Anna Jones, mother, equally, or the survivor, if either survives; otherwise Mary Jones, daughter.
10. Two Primary Beneficiaries in Unequal Beneficiary	Peter Jones, father, as to three-fourths (3/4) and Anna Jones, mother, as to one-fourth (1/4), or the survivor.
11. Trustee or Business Partner	____________________ (trustee or business partner) under a (trust agreement or partnership agreement dated __________.

Designations in bold *type mean* your spouse is your primary beneficiary

PLAN ADMINISTRATOR'S ADDRESS

Finance Officer
Roman Catholic Diocese of Boise
Diocesan Pastoral Center
1501 South Federal Way Suite 400
Boise ID 83705
(208) 342-1311

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 | MERIDIAN, IDAHO 83680-7777
Phone Number: 800-657-6351
www.unitedheritage.com

UNITED HERITAGE Insurance

Group Insurance Beneficiary Form

Please fill out Sections 1-6 for personal information on the employee.

1. Employee's Full Name			Date of Birth (Month/Day/Yr.)
Address (Including City, State & Zip Code)			Group Number 3797
2. Name of Employer Roman Catholic Diocese of Boise	Employee Job Title	Full-Time Employment (Month/Day/Yr.)	Hours Worked Per Week
3. Male ☐ Female ☐	4. Social Security Number	5. Gross Monthly Salary	

Your primary beneficiary will receive your death benefit in the event of your death.
The contingent beneficiary will receive your death benefit if the primary beneficiary is no longer living.

6.	Yes	No
Employee Life Insurance	☑	☐
Dependent Life Insurance	☐	☑
Number of Eligible Dependents Including Spouse: n/a		
Supplemental/Voluntary Group Life Insurance	☐	☑
Voluntary Accidental Death & Dismemberment	☐	☑

	Yes	No
Short Term Disability Insurance	☐	☑
Additional Buy-Up STD Plan	☐	☑
Long Term Disability Insurance	☑	☐
Additional Buy-Up LTD Plan	☐	☑

☐ Employee Only
☐ Family

Amount Requested $ n/a ($10,000 increments to a max of $300,000)

NOTE: EVIDENCE OF INSURABILITY MAY BE REQUIRED.

7. Primary Beneficiary's Last Name	First	Middle Initial	Relationship to You
Full Address of Beneficiary			Phone
Contingent Beneficiary's Last Name	First	Middle Initial	Relationship to You
Full Address of Contingent Beneficiary			Phone

8. **Unless otherwise provided herein, Beneficiaries designated to share proceeds shall share equally and the share of any Beneficiary who does not survive me shall be paid to the Contingent Beneficiary. If no Beneficiary survives me, the payment shall be made according to the terms of the policy, subject to revocation by me by written notice to my employer. I request the insurance provided by my employer's group insurance plan(s), and authorize the required deduction, (if any) from my wages.**

United Heritage Life Insurance Company assumes no responsibility for the beneficiary designation complying with any community property laws relating to the designation. Community property states include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Date Signed__________ **Employee Signature**__________

FLEXIBLE BENEFITS PLAN ELECTION FORM & COMPENSATION REDIRECTION AGREEMENT

Admin America

Company:

ALL FIELDS ARE REQUIRED – PLEASE PRINT

PLAN YEAR DATES: January 1, 2020 **To** December 31, 2020

DIVISION: N/A ____________ (if applicable) **DOH** ____________ **EFF DATE** ____________

SOCIAL SECURITY NUMBER: ____________________________

FULL NAME: ____________________________

HOME ADDRESS: Street ____________________________

City ____________ **State** ________ **Zip Code** ____________

EMAIL ADDRESS: ____________________________

DATE OF BIRTH: ____________ **HOME PHONE:** ____________

ELECTION OF BENEFITS

In accordance with my rights under the Plan, I elect the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the Plan Year designated above.

I receive my paychecks:

☐ **Weekly**(52) ☐ **Biweekly**(26) ☐ **Biweekly**(24) ☐ **Semimonthly**(24) ☑ **Monthly**(12)

FLEXIBLE SPENDING ACCOUNT OPTIONS	PAY PERIOD ELECTION AMOUNT (Plan Year Amt ÷ # Pay Periods)	PLAN YEAR ELECTION AMOUNT (Pay Period Amt x # Pay Periods)
1. Health Care Reimbursement Arrangement *(maximum $ $2,700 per plan year)*		
a.) Traditional Health Care FSA	$ ________	$ ________
b.) Limited Purpose Health Care FSA (if have HSA)	$ N/A	$ N/A
2. Dependent/Child Care Reimbursement Account *(maximum $ $5,000 per tax year)*	$ ________	$ ________

After completing your election above, **read the back of this form carefully**. Please **sign and date** the reverse side of this form **if you want to participate** in any of the **spending arrangement options above.**

EMPLOYER USE ONLY – PLEASE COMPLETE BEFORE SENDING COPY TO ADMIN AMERICA

FIRST DEDUCTION/PAY DATE: ____________ **TOTAL NUMBER OF DEDUCTIONS:** ________

HEALTH CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available for "**qualifying <u>health</u> <u>care</u> expenses**" as described in the **Summary Plan Description.**
- **I <u>cannot</u> change or revoke my Health Care Reimbursement Arrangement at any time during the plan year unless I experience a "change in status" event.** Such change in status events are described in the **Summary Plan Description.**
- **If either my spouse or I participate in an HSA then I am not eligible to participate in the Traditional Health Care FSA offered by my company.** However, I may sign up for the **Limited Purpose FSA offered by my company for vision and dental expenses only.**

DEPENDENT CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available for "**qualifying <u>dependent</u> <u>care</u> expenses**" as described in the **Summary Plan Description.**
- **I <u>cannot</u> change or revoke my Dependent Care Reimbursement Arrangement at any time during the plan year unless I experience a "change in status" event.** Such change in status events are described in the **Summary Plan Description.**

OTHER IMPORTANT TERMS AND CONDITIONS

I understand that:

- Before the first day of each plan year I will be offered the opportunity to make my benefit election for the new year. **If I do NOT complete and return a new election form prior to the first day of the new year**, I will be treated as having elected NOT to participate in reimbursement arrangements effective for the new plan year.
- **I am solely responsible for notifying the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.** I also agree to indemnify and reimburse the Employer on demand for any liability it incurs for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive for a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it is required in order to satisfy federal law.
- **Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year. Plans that offer the rollover provision are subject to the aforementioned forfeiture for account balances over the rollover limit. See your plan documents for additional details. Plans that offer the grace extension allow dates of service after the plan year end up to the final grace date. See your plan documents for additional details.**
- My Social Security benefits may be slightly reduced as a result of my election.

This agreement (1) is subject to the terms of the employer's Flexible Benefits Plan, Health Care Reimbursement Plan and/or Dependent Care Assistance Plan in effect as amended from time to time, (2) shall be governed by and construed in accordance with applicable laws, (3) shall take effect as a sealed instrument under applicable laws, and (4) to the extent allowed by law, revokes any prior election and compensation redirection agreement relating to such plan(s) for the corresponding Plan Year.

Employee's Signature: ______________________________ **Date:** ______________

Accepted and agreed to by the Employer's Authorized Representative:

By: ______________________________ **Date:** ______________

Admin America

Flexible Spending Account – Real Savings. Real Simple

Using a Flexible Spending Account (FSA) is great way to stretch your benefit dollars. You use before-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings and increased take-home pay—all with the convenience of a prepaid benefits card. Plus you can rollover $500.00 from one year to the next, reducing your risk of losing dollars at the end of the plan year.

WHAT IS AN FSA?

With a Healthcare and Limited Purpose Medical FSA, you elect to have your annual contribution **(up to 2700.00)** deducted from your paycheck each pay period, in equal installments throughout the year, until you reach the yearly maximum you have specified. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services.

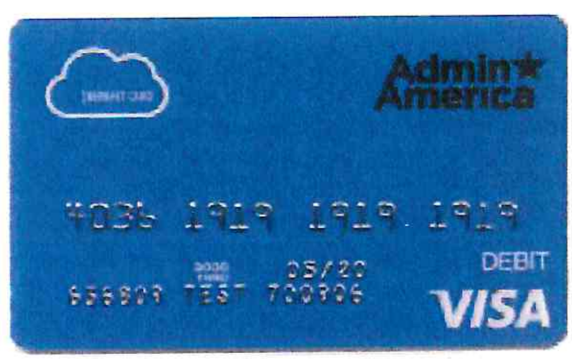
- A Healthcare FSA allows reimbursement of qualifying out-of-pocket medical expenses.
- A Limited Purpose Medical FSA works with a qualified high deductible health plan (HDHP) and Health Savings Account (HSA). A limited FSA only allows reimbursement for vision and dental expenses.
- A Dependent Care FSA allows reimbursement of dependent care expenses, such as daycare) incurred by eligible dependents.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your account transactions, and submit requests for reimbursements.

In addition, you'll receive a convenient prepaid benefits card to make it easy to pay for eligible services and products not covered by your health insurance. When you use the card, payments are automatically withdrawn from your account. Just swipe the card and go. It's that easy! Save your itemized receipts! Many expenses can be validated through the card transaction but you may be prompted to provide a copy of the itemized receipt for certain transactions in accordance to IRS regulations. When required, itemized receipts can be easily uploaded to either the consumer portal online or, through the mobile app. It's as simple as taking a picture of the itemized receipt using the camera on your mobile device!

WITH AN FSA YOU CAN:

- Enjoy significant tax savings with pre-tax deductible contributions and tax-free reimbursements for qualified plan expenses
- Quickly and easily access funds using the prepaid benefits card at point of sale, or request reimbursement online or through the mobile app
- Reduce filing hassles and paperwork by using your prepaid benefits card *(HINT: You will still need to save all itemized receipts in case you are asked to show any of them to confirm expense eligibility.)*
- Enjoy secure access to accounts using a convenient Participant Portal available 24/7/365. When you enroll you will receive a "Next Steps Document" via email that includes detailed login instruction or call Admin America for assistance. You may access the portal via www.adminamerica.com and click on "Participants LOGIN".
- Manage your FSA "on the go" with an easy-to-use mobile app (*see page 2 for more mobile app info*)
- File claims easily online (when required) and let the system determine approval based on eligibility and availability of funds
- Stay up to date on balances and action required with automated email alerts and convenient portal and mobile home page messages
- Use it or Roll It Over Up to 500.00 of your unused Healthcare Flexible Spending Account balance can be carried over into the next plan year instead of you "losing it" - making enrollment in an FSA much less risky. This gives you more flexibility to spend your FSA money when you need it rather than feeling pressured to spend it unnecessarily at the end of the year.



IS AN FSA RIGHT FOR ME?

An FSA is a great way to pay for expenses with pre-tax dollars.

A Healthcare FSA could save you money if you or your dependents:

- Have out-of-pocket expenses like co-pays, coinsurance, or deductibles for health, prescription, dental or vision plans
- Have a health condition that requires the purchase of prescription medications on an ongoing basis
- Wear glasses or contact lenses or are planning LASIK surgery
- Need orthodontia care, such as braces, or have dental expenses not covered by your insurance

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. This benefit may make sense if you (and your spouse, if married) are working or in school, and:

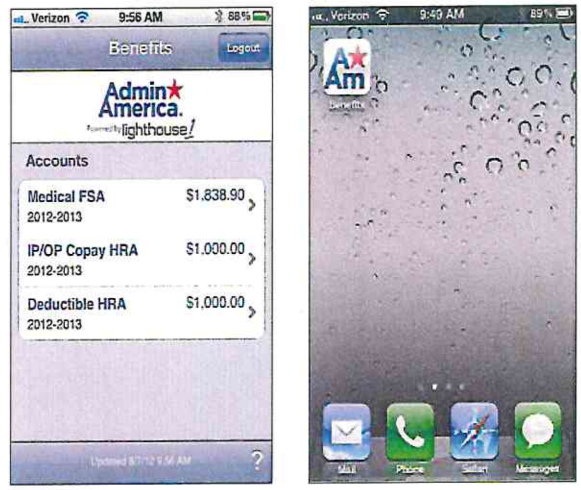
- Your dependent children under age 13 attend daycare, after-school care or summer day camp
- You provide care for a person of any age whom you claim as a dependent on your federal income tax return and who is mentally or physically incapable of caring for himself or herself

PLAN AHEAD

Before you enroll, you must first decide how much you want to contribute to your account(s). You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the plan year, but know that you don't have to worry about losing unused funds from the Limited Purpose FSA **(up to** 500.00 **)**.

Be sure to estimate your expenses carefully as money left unspent in your FSA at the end of the year will be forfeited if you are not able to spend it within the allotted grace period. Expenses incurred during this grace period are charged to the prior year's balance before the current year's money is touched.

Be sure to check out the Mobile App available for your Android or iOS smartphone! The Mobile App makes account access and claim management easy and quick.



Above: With the convenience of a mobile device, you can see your available balance anywhere, anytime as well as file claims and upload receipts.

Install the mobile app in one of the following ways:

iPhone App

Search the App Store for "Benefits by Admin America" or via the following link:
http://itunes.apple.com/us/app/benefits-by-admin-america/id475793441?mt=8&uo=4

Android App

Search the Android Market for "Benefits by Admin America" or via the following link:
https://market.android.com/details?id=com.lighthouse1.mobilebenefits.aam

The amount you save in taxes with a Flexible Spending Account will vary depending on the amount you set aside in the account; your annual earnings; whether or not you pay Social Security taxes; the number of exemptions and deductions you claim on your tax return; your tax bracket and your state and local tax regulations. Check with your tax advisor for information on how participation will affect your tax savings.

Admin America®

Know Your Health Care FSA Eligible and Ineligible Expenses

Maximize the Value of Your Reimbursement Account - Your Health Care Flexible Spending Account (FSA) dollars can be used for a variety of out-of-pocket health care expenses that qualify as federal income tax deductions under Section 213(d) of the Internal Revenue Code ("IRC"). Health Care FSA dollars can be used to reimburse you for medical and dental expenses incurred by you, your spouse or eligible dependents (children, siblings, parents and other dependents which are defined in your Plan Documents).

Eligible Expenses

BABY/CHILD TO AGE 13
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

DENTAL
- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES
- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

HEARING
- Hearing Aids and Batteries
- Hearing Exams

LAB EXAMS/TESTS
- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL EQUIPMENT/SUPPLIES
- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICAL PROCEDURES/SERVICES
- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

MEDICATIONS
- Insulin
- Prescription Drugs

OBSTETRICS
- Breast Pumps and Lactation Supplies
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

THERAPY
- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

IMPORTANT: **Not all expenses are eligible under all plans. An employer may limit which expenses are allowable under their Health Care FSA plan. If you are unsure of what your Health Care FSA dollars may be used for, please contact your Plan Administrator. The following is a list of expenses currently eligible and not eligible by the Internal Revenue Service ("IRS") as deductible medical expenses. This list is not necessarily inclusive or exclusive, and may be subject to change based on regulations, IRS revenue rulings and case law. It is solely based on our current interpretation of IRC Section 213(d) and is not intended to be legal advice.**

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact your Plan Administrator.

Please Note: Currently, the IRS does NOT allow the following expenses to be reimbursed under Health Care FSAs , as they are not prescribed by a physician for a specific ailment.

Ineligible Expenses

- Contact Lens or Eyeglass Insurance
- Cosmetic Surgery/Procedures
- Electrolysis
- Marriage or Career Counseling
- Swimming Lessons
- Personal Trainers
- Sunscreen (spf less than 30)

Note: This list is not meant to be all-inclusive.

Please Note: Currently, the IRS does NOT allow Over-the-Counter (OTC) medicines or drugs to be purchased with Health Care FSA funds unless accompanied by a prescription and the prescription is filled by a pharmacist. If you have an OTC prescription, you can use your benefits card for these purchases.

Ineligible Over-the-Counter Medicines and Drugs (unless prescribed in accordance with state laws)

- Acid controllers
- Acne medications
- Allergy & sinus
- Antibiotic products
- Antifungal (Foot)
- Antiparasitic treatments
- Antiseptics & wound cleansers
- Anti-diarrheals
- Anti-gas
- Anti-itch & insect bite
- Baby rash ointments & creams
- Baby teething pain
- Cold sore remedies
- Contraceptives
- Cough, cold & flu
- Denture pain relief
- Digestive aids
- Ear care
- Eye care
- Feminine antifungal & anti-itch
- Fiber laxatives (bulk forming)
- First aid burn remedies
- Foot care treatment
- Hemorrhoidal preps
- Homeopathic remedies
- Incontinence protection & treatment products
- Laxatives (non-fiber)
- Medicated nasal sprays, drops, & inhalers
- Medicated respiratory treatments & vapor products
- Motion sickness
- Oral remedies or treatments
- Pain relief (includes aspirin)
- Skin treatments
- Sleep aids & sedatives
- Smoking deterrents
- Stomach remedies
- Unmedicated vapor products

For additional information, please contact your Plan Administrator and/or tax advisor.