***Instructions: Document the date of completion of each item and sign below.***

## ACCESSORY NEW HIRE CHECKLIST

EMPLOYEE NAME: _____

POSITION: _____

**Date**

**1. Employment Application**
*Employment Applications* are checked for completeness and signed at the beginning of applicant's interview. It should now be placed in the personnel file. If another copy for signature and filing is needed, print it from **Hiring**. _____

**2. Background Report (if required)**
*Background Reports* are provided by the contracted Background Reporting Agency. _____

**3. Drug Test Results**
The contracted Drug Screening Service reports *Drug Test Results*. _____

**4. Employee Driver's License**
File photocopy in personnel file. _____

**5. Photocopy of Sales License (if applicable)**
File photocopy in personnel file. _____

**6. Employee Handbook Acknowledgment**
New hire should review the complete *Employee Handbook Policies. Employee Handbook Acknowledgment and Agreement* is printed upon review and acknowledgment. A copy should be placed in the personnel file. _____

**7. Group Medical Benefits Election Form (if applicable)**
The company's Medical Insurance Provider provides *Group Medical Benefits Election Forms*. Store completed form in personnel file. _____

**8. Compensation Plan (if applicable)**
File completed and signed Compensation Plan provided by company in personnel file. Note: this is required for all commissioned positions. _____

**9. Anti-Harassment Training**
New hire should complete either *Employee Anti-Harassment Training* or *Management Anti-Harassment Training* in **Training**. Certificate of completion is printed upon finishing the training and a copy should be placed in the personnel file. _____

**10. Sexual Harassment Prevention Training (managers only)**
New hire manager should complete all three sections of the *Sexual Harassment Prevention Training* in **Training**. Certificate of completion is printed upon finishing the training and a copy should be placed in the personnel file. _____

**11. Customer Information Security Training**
New hire should complete either *Customer Information Security Training* or *Manager Customer Information Security Training* in **Training**. Certificate of completion is printed upon finishing the training and a copy should be placed in the personnel file. _____

**I affirm that the above documents are complete and that the dates are accurate.**

_____
Authorized Manager's Signature

**CONSENT TO ALCOHOL AND DRUG TESTING**

I hereby consent to submit to a test for the presence of drugs in my system prior to employment and at any time during my employment, to the extent permitted by law and understand and agree that any offer of employment is contingent upon the passing of that drug test. I understand and agree that at any time after I am hired, the Company may require me to submit to a test for the presence of alcohol or drugs in my system to the extent permitted by law. I consent to the disclosure of the results of any drug or alcohol tests to the Company.

In consideration of my initial or continued employment, I release my employer, its employees, officers and agents from liability and damages which may arise from collection and testing of any specimen, the test results or adverse employment action taken as a result of the testing or test results, except for any acts of negligence by those who collect or test specimens.

_____

Signature -

_____

Date

## AGREEMENTS

Between _____ "Company"

and _____ "Employee"

### At Will Employment Agreement

I agree as follows: My employment and compensation are terminable at will, are for no definite period, and my employment and compensation may be terminated by the Company (employer) at any time and for any reason whatsoever, with or without good cause at the option of either the Company or myself. Consequently, all terms and conditions of my employment, with the exception of the at will nature of my employment and arbitration agreements, may be changed or withdrawn at Company's unrestricted option at any time, with or without good cause. No implied, oral or written agreements contrary to the express language of this agreement are valid, and no changes to the arbitration agreement and/or my at will employment status may be made, unless they are in writing and signed by the President of the Company (or majority owner or owners if Company is not a corporation). No supervisor or representative of the Company, other than in writing signed by the President of the Company (or major owner or owners if Company is not a corporation), has any authority to make any agreements contrary to the foregoing. This agreement is the entire agreement between the Company and the employee regarding the rights of the Company or employee to terminate employment with or without good cause and this agreement takes the place of all prior and contemporaneous agreements, representations, and understandings of the employee and the Company.

_____ _____

Signature - Date

### Binding Arbitration Agreement

I also acknowledge that the Company utilizes a system of alternative dispute resolution that involves binding arbitration to resolve all disputes that may arise out of the employment context. Because of the mutual benefits (such as reduced expense and increased efficiency) which private binding arbitration can provide both the Company and myself, I and the Company both agree that any claim, dispute, and/or controversy (including, but not limited to, any claims of discrimination and harassment, whether they be based on the Pennsylvania Human Relations Act, the Wage Discrimination law (e.g., Equal Pay and Comparable Worth requirements), Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, the Age Discrimination in Employment Act, as amended, as well as all other applicable local, state or federal laws or regulations) which would otherwise require or allow resort to any court or other governmental dispute resolution forum between myself and the Company (or its owners, directors, officers, managers, employees, agents, and parties affiliated with its employee benefit and health plans) arising from, related to, or having any relationship or connection whatsoever with my seeking employment with, employment by, or other association with the Company, whether based on

tort, contract, statutory, or equitable law, or otherwise, (with the sole exception of claims arising under the National Labor Relations Act which are brought before the National Labor Relations Board, claims for medical and disability benefits under the provisions of the Pennsylvania workers' compensation law before the Pennsylvania Bureau of Workers' Compensation and claims for unemployment compensation pursuant to the Pennsylvania Unemployment Compensation Law brought before the Department of Labor and Industry) shall be submitted to and determined exclusively by binding arbitration. I understand and agree that nothing in this agreement shall be construed so as to preclude me from filing any administrative charge with, or from participating in any investigation of a charge conducted by the Pennsylvania Human Relations Commission and/or the Equal Employment Opportunity Commission; however, after I exhaust such administrative process/investigation, I understand and agree that I must pursue any such claims through this binding arbitration procedure. I acknowledge that the Company's business and the nature of my employment in that business affect interstate commerce. I agree that the arbitration and this Agreement shall be controlled by the Federal Arbitration Act, 9 U.S.C. section 1, et seq., in conformity with the procedures of the Pennsylvania rules of civil procedure (including all mandatory and permissive rights to discovery) provided that said rules do not contradict the Federal Arbitration Act. However in addition to requirements imposed by law, any arbitrator herein shall be a retired trial court judge and shall be subject to disqualification on the same grounds as would apply to a judge of a state court. To the extent applicable in civil actions in Pennsylvania state courts, the following shall apply and be observed: all rules of pleading (including the right of demurrer/motion to strike), all rules of evidence, and all rights to resolution of the dispute by means of motions for summary judgment and/or judgment on the pleadings. The arbitrator shall be vested with authority to determine any and all issues pertaining to the dispute/claims raised, any such determinations shall be based solely upon the law governing the claims and defenses pleaded, and the arbitrator may not invoke any basis (including but not limited to, notions of "just cause") for his/her determinations other than such controlling law. The arbitrator shall have the immunity of a judicial officer from civil liability when acting in the capacity of an arbitrator, which immunity supplements any other existing immunity. Likewise, all communications during or in connection with the arbitration proceedings are privileged as though in connection with a state court civil litigation proceeding. The arbitrator shall modify the times set by the rules of civil procedure for the giving of notices and setting of hearings. Awards shall include the arbitrator's written reasoned opinion. The allocation of costs and arbitrator fees shall be governed by statute or controlling case law. Both the Company and I agree that any arbitration proceeding must move forward under the Federal Arbitration Act (9 U.S.C. §§ 3-4), even though the claims may also involve or relate to parties who are not parties to the arbitration agreement and/or claims that are not subject to arbitration: thus, a court may not refuse to enforce this arbitration agreement and may not stay the arbitration proceeding despite any state law provision to the contrary. I UNDERSTAND BY AGREEING TO THIS BINDING ARBITRATION PROVISION, BOTH I AND THE COMPANY GIVE UP OUR RIGHTS TO TRIAL BY JURY.

_____ _____

Signature - Date

**CONFIDENTIALITY AND NON-SOLICITATION AGREEMENT**

_____ , ("Employee"),

in consideration for and as a condition of Employee's continued employment with

_____ , ("Employer") or

Employer's assignee or successor, agrees as follows:

1. Employee agrees that all information communicated to him/her concerning the work conducted by or for Employer is confidential. Employee also agrees that all financial data, sales information, product specifications, customer names and addresses, vendor information, commission vouchers, pricing and bid information, personnel information, and any documents generated by Employer, or by Employee in the course of his/her employment, are confidential. Employee further agrees that information concerning the work conducted by Employer, including, but not limited to information concerning future and proposed products, projects or sales which are planned, under consideration or in production/process, as well as existing work/sales additionally constitute confidential information of Employer. Information intentionally placed in the public domain by Employer does not constitute trade secrets and are not governed by the confidentiality provisions of this agreement.
2. Employee agrees that all confidential information described herein is and constitutes trade secret information as defined by applicable federal and state law, and is the exclusive property of Employer.
3. Employee promises and agrees that he/she shall not disclose any confidential or trade secret information of Employer to any other person.
4. Employee shall use his/her best efforts to prevent inadvertent disclosure of any confidential information to any third party by using the same care and discretion that he/she uses with information he/she considers confidential.
5. Employee agrees that the sale or unauthorized use or disclosure of any of Employer's confidential information or trade secrets obtained by Employee during or following his/her employment with Employer constitutes misappropriation as defined by federal and state law. Employee promises and agrees not to engage in any misappropriation at any time, whether during or following the completion of his/her employment with Employer.
6. Employee promises and agrees that during his/her employment with Employer, he/she shall not, directly or indirectly, either as an employee, employer, consultant, agent, principal, partner, stockholder, corporate officer, director or in any other individual or representative capacity, engage or participate in any competitive activity relating to the subject matter of his employment with Employer.
7. Upon termination of employment or upon Employer's request, Employee shall promptly return to Employer all confidential information and materials in his possession and shall promptly return all original and copies of documents, records, software programs, media, other materials and/or property provided by Employer to Employee or obtained by Employee as a result of or in connection with Employees' employment with Employer.
8. Employee agrees that for a period of twelve months after termination of employment status for any reason, which would include, but not limited to resignation, layoff, termination with or

without cause or otherwise at the Employer or its successor in interest; Employee will not, on behalf of herself or on behalf of any other person, firm or Employer, directly or indirectly, call on any of the Employer's customers. Employee will not encourage or otherwise influence any customers of the Employer to seek the services of a competing business, even if the Employee has no connection with the competing business. Employee further agrees not to contact any customers of the Employer at any time for the purpose of disparaging or injuring the Employer, its products, services or employees. For purposes of this Agreement and after termination of employment only, customer is defined as any person or entity that has contacted the Employer with the express purpose of inquiry into the purchase of goods or services from the Employer within two years of the date on which employment of Employee with the Employer was terminated for whatever reason or any person who is maintained on the Employer's customer lists. Furthermore, the restrictions and limitations set forth in this paragraph shall only apply to those customers within a 150 mile radius of the Employer's places of business.

9. While employed by the Employer and for a period of twelve months from the date of termination of Employee's employment (regardless of reason), Employee agrees not to induce or attempt to influence directly or indirectly through another person any Employee of the Employer to work for you any other person or entity with whom Employee is or may become professionally associated, without the written consent of the President or Owner of the Employer's company.
10. Employee agrees that, in the event of a breach or threatened breach of this Agreement, monetary damages would be inadequate and extremely difficult, if not impossible, to measure. Therefore, Employee agrees that Employer shall be entitled to seek immediate and permanent injunctive relief to prevent or remedy a threatened or actual violation of this Agreement.
11. If any provision of this Agreement is determined to be unenforceable for any reason, the remainder shall be fully enforceable under the laws of the State of Pennsylvania. This Agreement supersedes and extinguishes any prior or contemporaneous verbal agreements and may not be modified except in a writing signed by Employer's President or Owner.

I have read and understand all provisions of this Agreement and agree to all the provisions herein. I agree that the provisions are fair and reasonable and are required to protect the Employer's information and property. I also acknowledge that I have received a copy of this Agreement upon signing it.

_____ _____

Signature - Date

Dear Employee and Dependents with Coverage:

This notice summarizes your rights and obligations under the group health continuation coverage provision of COBRA. You and your spouse should read this notice carefully. Should you qualify for COBRA coverage in the future, the group health plan administrator or the company will send you the appropriate notification.

Federal law requires your employer to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

**TO QUALIFY FOR COBRA COVERAGE**

**Employees.** As an employee of the company covered by our health plan, you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

**Retirees.** As a retiree, spouse of a retiree, or dependent child of a retiree, of the company you have the right to elect this continuation coverage if you lose your group health coverage because the company declares certain forms of bankruptcy and you lose your group health care coverage within one year before or after the bankruptcy proceedings.

**Spouses.** As the spouse of an employee covered by our benefits plan you have the right to choose continuation coverage for yourself if you lose group health coverage under our plan for any of the following reasons:

- The death of your spouse who was an employee of the company
- A termination of your spouse's employment (for reasons other than gross misconduct)
- A reduction in your spouse's hours of employment
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare

**Dependent Children.** In the case of a dependent child of an employee covered by our health plan, he or she has the right to continuation coverage if group health coverage under our health plan is lost for any of the following reasons:

- The death of a parent who was an employee of the company.
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the company
- Parent's divorce or legal separation
- A parent who was an employee of the company becomes entitled to Medicare
- The dependent ceases to be a "dependent child" under our health plan.

**YOUR NOTICE OBLIGATIONS**

Under the law, the employee or a family member has 60 days from (1) the date of the event or (2) the date on which coverage would be lost, whichever is later, to inform the Plan Administrator (whose address is available from the Business Office) of the employee's divorce or legal separation, or of the employee's child losing dependent status under our health plan. Please give notice by placing your notice in writing and mailing it to the Business Office. Failure to give notice within the time limits can

result in COBRA coverage being forfeited.

The company has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction in hours, or Medicare entitlement.

**TO ELECT COVERAGE**

When the plan administrator is notified that one of these events has happened, the plan administrator will in turn notify the employee, spouse and dependents that they have the right to choose COBRA continuation coverage. The employee and spouse have independent election rights. The employee, spouse and dependents have 60 days from either (1) the date coverage is lost under our health plan or (2) the date of the notice, whichever is later, to respond informing the plan administrator that they want to elect continuation coverage. There is no extension of the election period.

If an employee, spouse or dependent does not elect continuation coverage within this election period, then rights to continue group health insurance will end.

If an employee, spouse or dependent chooses continuation coverage and pays the applicable premium, the company is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated active employees or family members. If the company changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

**DURATION OF COBRA COVERAGE**

**Termination or Reduction in Hours.** If group health coverage was lost because of a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, the continuation coverage period is 18 months from the date of the qualifying event, if elected.

**Employees, Spouses or Dependents with Disabilities.** The 18 months of continuation coverage can be extended to 29 months if the Social Security Administration determines that the employee, spouse or dependent child was disabled on the date of the qualifying event according to Title II (Old Age Survivors and Disability Insurance) or XVI (Supplemental Security Income) of the Social Security Act. Disabilities that occur after the qualifying event do not meet the criteria for the extended COBRA coverage period.

The employee, spouse or dependent must obtain the disability determination from the Social Security Administration and notify the plan administrator of the result within 60 days of the date of disability determination and before the close of the initial 18-month period. The employee, spouse or dependent has 30 days to notify the plan administrator from the date of a final determination that he or she is no longer disabled.

**Multiple Events.** The 18-month continuation period can also be extended, if during the 18 months of continuation coverage, a second event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent). The 18 months of continuation coverage will be extended to 36 months from the date of the original qualifying event. Upon the occurrence of a second event, it is the employee's, spouse's or dependent's responsibility to notify the plan administrator within 60 days of the event and within the original 18-month COBRA period. COBRA coverage does not last beyond 36 months from the original qualifying event, no matter how many events occur.

**DURATION OF COBRA COVERAGE**

**Other Qualifying Events.** If group health coverage was lost because of the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under our health plan, then the continuation coverage period is 36 months from the date of the qualifying event, if elected.

**COBRA CANCELLATION**

The law provides that continuation coverage may be cut short for any of the following reasons:

- the company no longer provides group health coverage to any of its employees
- The premium for continuation coverage is not paid in a timely manner

- The employee, spouse or dependent becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition
- The employee or spouse becomes entitled to Medicare
- The employee, spouse or dependent extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that he or she is no longer disabled
- The employee, spouse or dependent notifies the plan administrator that they wish to cancel continuation coverage.

**PREMIUMS**

An employee, spouse or dependent does not have to show that they are insurable in order to choose continuation coverage. But an employee, spouse or dependent must have been actually covered by the group health plan the day before the qualifying event in order to elect COBRA coverage.

An employee, spouse or dependent may have to pay all of the applicable premium, which generally can not exceed 102% of the plan costs for a 12-month period. An exception exists for coverage of employees with disabilities during the extension from the 19th month to the 29th month. During that time, 150% of the plan cost may be charged. The group health plan may increase the cost that must be paid for COBRA coverage if the applicable premium increases. The period for paying the initial COBRA premium following the election of coverage is 45 days. The first payment made is to be applied retroactively toward coverage for the period beginning after the date on which coverage would have been lost as a result of the qualifying event.

There is a 30-day grace period following the date regularly scheduled monthly premiums are due. Only in the case of mental incapacity is any further extension permitted, since the group health plan does not permit extensions.

**CONVERSION PRIVILEGES**

At the end of the continuation coverage period, the employee, spouse or dependent must be allowed the option to enroll in an individual conversion health plan provided under our health plan if such conversion plan is available.

**FURTHER INFORMATION**

If you have any questions about the law or your obligations, please contact the Plan Administrator. The name, address, telephone number and name of the plan can be obtained from the business office upon request.

## Employee Contact Information

Employee Name:_____

Physical Address:_____

(Number & Street)

_____

(City, State, Zip)

Mailing Address:_____

(Number & Street)

_____

(City, State, Zip)

Primary Phone:_____

Secondary Phone:_____

---

## Emergency Contact Information

**(Every employee must list 2 emergency contacts)**

Name:_____

Relationship:_____

Physical Address:_____

(Number & Street)

_____

(City, State, Zip)

Primary Phone:_____

Secondary Phone:_____

---

Name:_____

Relationship:_____

Physical Address:_____

(Number & Street)

_____

(City, State, Zip)

Primary Phone:_____

Secondary Phone:_____

# Employment Eligibility Verification

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

**USCIS**
**Form I-9**
OMB No. 1615-0047
Expires 08/31/2019

►**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<br>Documents that Establish Both Identity and Employment Authorization | OR | LIST B<br>Documents that Establish Identity | AND | LIST C<br>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:<br>(1) NOT VALID FOR EMPLOYMENT<br>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>(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:<br>**a.** Foreign passport; and<br>**b.** Form I-94 or Form I-94A that has the following:<br>(1) The same name as the passport; and<br>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | | **5.** U.S. Military card or draft record | | **5.** U.S. Citizen ID Card (Form I-197) |
| | | **6.** Military dependent's ID card | | **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | | **7.** U.S. Coast Guard Merchant Mariner Card | | **7.** Employment authorization document issued by the Department of Homeland Security |
| | | **8.** Native American tribal document | | |
| | | **9.** Driver's license issued by a Canadian government authority | | |
| | | **For persons under age 18 who are unable to present a document listed above:** | | |
| | | **10.** School record or report card | | |
| | | **11.** Clinic, doctor, or hospital record | | |
| | | **12.** Day-care or nursery school record | | |
| **6.** Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | | | | |

**Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).**

**Refer to the instructions for more information about acceptable receipts.**

# Form W-4 (2018)

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

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

## General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

**Filers with multiple jobs or working spouses.** If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

**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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

**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

### Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

**Line C.** ***Head of household please note:*** Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

**Line E. Child tax credit.** When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

**Line F. Credit for other dependents.** When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

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**Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.**

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

## Employee's Withholding Allowance Certificate

**► Whether you're 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

**2018**

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

| | | | |
|---|---|---|---|
| **5** | Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . . | **5** | |
| **6** | Additional amount, if any, you want withheld from each paycheck . . . . . | **6** | $ |
| **7** | I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption.<br>• Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**<br>• This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.<br>If you meet both conditions, write "Exempt" here . . . . . ► | **7** | |

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

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

| | | |
|---|---|---|
| **8** Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.) | **9** First date of employment | **10** Employer identification number (EIN) |

your wages and other income, including income earned by a spouse, during the year.

**Line G. Other credits.** You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

### Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

### Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

**Tip:** If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

## Instructions for Employer

**Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.**

**New hire reporting.** Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/programs/css/employers***.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

**Box 8.** Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

**Box 9.** If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

**Box 10.** Enter the employer's employer identification number (EIN).

## Personal Allowances Worksheet (Keep for your records.)

| | | | |
|---|---|---|---|
| **A** | Enter "1" for yourself | **A** | |
| **B** | Enter "1" if you will file as married filing jointly | **B** | |
| **C** | Enter "1" if you will file as head of household | **C** | |
| **D** | Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. | **D** | |
| **E** | **Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-" | **E** | |
| **F** | **Credit for other dependents.** • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-" | **F** | |
| **G** | **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here | **G** | |
| **H** | Add lines A through G and enter the total here ► | **H** | |

**For accuracy, complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

## Deductions, Adjustments, and Additional Income Worksheet

**Note:** Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

| | | | |
|---|---|---|---|
| **1** | Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details | **1** | $ |
| **2** | Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately | **2** | $ |
| **3** | **Subtract** line 2 from line 1. If zero or less, enter "-0-" | **3** | $ |
| **4** | Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) | **4** | $ |
| **5** | **Add** lines 3 and 4 and enter the total | **5** | $ |
| **6** | Enter an estimate of your 2018 nonwage income (such as dividends or interest) | **6** | $ |
| **7** | **Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses | **7** | $ |
| **8** | **Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction | **8** | |
| **9** | Enter the number from the **Personal Allowances Worksheet,** line H above | **9** | |
| **10** | **Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 | **10** | |

## Two-Earners/Multiple Jobs Worksheet

**Note:** Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

**1** Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . **1** _____

**2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . **2** _____

**3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** _____

**Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

**4** Enter the number from line 2 of this worksheet . . . . . **4** _____

**5** Enter the number from line 1 of this worksheet . . . . . **5** _____

**6** **Subtract** line 5 from line 4 . . . . . **6** _____

**7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** $ _____

**8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . **8** $ _____

**9** **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** $

### Table 1

**Married Filing Jointly**

| If wages from **LOWEST** paying job are— | Enter on line 2 above |
|---|---|
| $0 - $5,000 | 0 |
| 5,001 - 9,500 | 1 |
| 9,501 - 19,000 | 2 |
| 19,001 - 26,500 | 3 |
| 26,501 - 37,000 | 4 |
| 37,001 - 43,500 | 5 |
| 43,501 - 55,000 | 6 |
| 55,001 - 60,000 | 7 |
| 60,001 - 70,000 | 8 |
| 70,001 - 75,000 | 9 |
| 75,001 - 85,000 | 10 |
| 85,001 - 95,000 | 11 |
| 95,001 - 130,000 | 12 |
| 130,001 - 150,000 | 13 |
| 150,001 - 160,000 | 14 |
| 160,001 - 170,000 | 15 |
| 170,001 - 180,000 | 16 |
| 180,001 - 190,000 | 17 |
| 190,001 - 200,000 | 18 |
| 200,001 and over | 19 |

**All Others**

| If wages from **LOWEST** paying job are— | Enter on line 2 above |
|---|---|
| $0 - $7,000 | 0 |
| 7,001 - 12,500 | 1 |
| 12,501 - 24,500 | 2 |
| 24,501 - 31,500 | 3 |
| 31,501 - 39,000 | 4 |
| 39,001 - 55,000 | 5 |
| 55,001 - 70,000 | 6 |
| 70,001 - 85,000 | 7 |
| 85,001 - 90,000 | 8 |
| 90,001 - 100,000 | 9 |
| 100,001 - 105,000 | 10 |
| 105,001 - 115,000 | 11 |
| 115,001 - 120,000 | 12 |
| 120,001 - 130,000 | 13 |
| 130,001 - 145,000 | 14 |
| 145,001 - 155,000 | 15 |
| 155,001 - 185,000 | 16 |
| 185,001 and over | 17 |

### Table 2

**Married Filing Jointly**

| If wages from **HIGHEST** paying job are— | Enter on line 7 above |
|---|---|
| $0 - $24,375 | $420 |
| 24,376 - 82,725 | 500 |
| 82,726 - 170,325 | 910 |
| 170,326 - 320,325 | 1,000 |
| 320,326 - 405,325 | 1,330 |
| 405,326 - 605,325 | 1,450 |
| 605,326 and over | 1,540 |

**All Others**

| If wages from **HIGHEST** paying job are— | Enter on line 7 above |
|---|---|
| $0 - $7,000 | $420 |
| 7,001 - 36,175 | 500 |
| 36,176 - 79,975 | 910 |
| 79,976 - 154,975 | 1,000 |
| 154,976 - 197,475 | 1,330 |
| 197,476 - 497,475 | 1,450 |
| 497,476 and over | 1,540 |

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

You aren't required to provide the information requested on a form that's 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.

CLGS-32-6 (6-13)

# RESIDENCY CERTIFICATION FORM
# Local Earned Income Tax Withholding

**TO EMPLOYERS/TAXPAYERS:**

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change. Use the Address Search Application at www.newPA.com/Act32 to determine PSD codes, EIT rates and tax collector contact information.

## EMPLOYEE INFORMATION – RESIDENCE LOCATION

| NAME (Last Name, First Name, Middle Initial) | | | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| STREET ADDRESS **(No PO Box, RD or RR)** | | | |
| ADDRESS LINE 2 | | | |
| CITY | STATE | ZIP CODE | DAYTIME PHONE NUMBER |
| MUNICIPALITY (City, Borough or Township) | | | |
| COUNTY | RESIDENT PSD CODE | | TOTAL RESIDENT EIT RATE |

## EMPLOYER INFORMATION – EMPLOYMENT LOCATION

| EMPLOYER BUSINESS NAME (Use Federal ID Name) | | | EMPLOYER FEIN |
|---|---|---|---|
| STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK **(No PO Box, RD or RR)** | | | |
| ADDRESS LINE 2 | | | |
| CITY | STATE | ZIP CODE | PHONE NUMBER |
| MUNICIPALITY (City, Borough or Township) | | | |
| COUNTY | WORK LOCATION PSD CODE | | WORK LOCATION NON-RESIDENT EIT RATE |

## CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

| SIGNATURE OF EMPLOYEE | DATE (MM/DD/YYYY) |
|---|---|
| PHONE NUMBER | EMAIL ADDRESS |

**For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:**

**www.newPA.com/Act32**

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 4-30-2017)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

# PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| 3. Employer name | | 4. Employer Identification Number (EIN) |
|---|---|---|
| 5. Employer address | | 6. Employer phone number |
| 7. City | 8. State | 9. ZIP code |
| 10. Who can we contact about employee health coverage at this job? | | |
| 11. Phone number (if different from above) | 12. Email address | |

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Pennsylvania New Hire Reporting Program
Center for Workforce Information & Analysis

# New Hire Reporting Form

COMMONWEALTH OF PENNSYLVANIA
Department of Labor & Industry

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

## 1. Instructions for completing this form.

- Unless noted as optional, all fields on this form are required.
- Please type or print **legibly** in black or blue ink **only**.
- This form may be duplicated as needed.

The table at right provides details on the information to be submitted using this form.

## 2. Submitting this form.

- **By Fax: 866-748-4473 (TOLL FREE)**
  or 717-657-HIRE (717-657-4473) (Local)
- **By Mail:** Commonwealth of Pennsylvania
  New Hire Reporting Program
  P.O. Box 69400
  Harrisburg, PA 17106-9400

## 3. Questions?

Contact New Hire Customer Service at:
888-PAHIRES (888-724-4737) for more information.

## 4. Save time and postage costs.

Online reporting is fast, free and paperless.
For more information about how to get started, please visit

**www.pacareerlink.state.pa.us**

Or contact our customer service at 888-PAHIRES (888-724-4737)

| New Hire Information that Must Be Reported | |
|---|---|
| **Required Employer Information:** | **Required New Hire Employee Information:** |
| **Employer Federal Employer Identification Number (FEIN)**<br>If your company has more than one FEIN, please use the same FEIN used to report your quarterly wage information when reporting new hires. | **Employee Social Security Number**<br>The number assigned to the individual by the Social Security Administration.<br>*Please verify for accuracy.* |
| **Employer Company Name**<br>Legal name associated with the FEIN. | **Employee Full Legal Name**<br>First, middle and last name<br>*Nicknames are NOT acceptable* |
| **Employer Street Address**<br>Address to which income withholding orders should be sent.<br>*P.O. Boxes are not acceptable* | **Employee Street Address**<br>Permanent address of the new hire employee.<br>*P.O. Boxes are not acceptable* |
| **Employer City, State and Zip Code**<br>Self-explanatory. | **Employee City, State of Hire and Zip Code**<br>Self-explanatory. |
| **Employer Contact Person Name**<br>Employer's representative authorized to answer questions on the New Hire Report, should they be contacted by our program for additional information. This can be someone from the payroll company. | **Employee Date of Hire**<br>The first day the new hire employee performs services for wages or any other form of compensation.<br>*This cannot be more than three years from the current date.* |
| **Employer Contact Person Phone Number**<br>Phone number for the Employer Contact Person. | **Employee Date of Birth**<br>Optional – the date of birth for the new hire employee. |
| Note: Multi-state employers MAY NOT use this form to report their new hire information. Multi-state employers MUST report by electronic means (Internet, SFTP), and MUST include the state of hire for each new hire employee being reported. Contact New Hire Customer Service at 888-PAHIRES (888-724-4737) for more information. | |

New Hire Reporting: Lending a Hand to Pennsylvania's Children

Pennsylvania New Hire Reporting Program
Center for Workforce Information & Analysis

# New Hire Reporting Form

COMMONWEALTH OF PENNSYLVANIA
Department of Labor & Industry

**REQUIRED EMPLOYER INFORMATION:**
(Please type or print **LEGIBLY** in blue or black ink **ONLY**)

Employer FEIN:

Employer Name:

Employer Address (Street, City, State, Zip):
*PO Box's are not acceptable*

Employer Contact Name:

Employer Contact Phone Number:

Employer Contact Fax Number:

Employer Contact Email:

Please fax this form to:
**866-PAHIRES (866-748-4473) (TOLL FREE)**
Or 717-657-HIRE (717-657-4473) (Local)

Or mail this form to:

*Commonwealth of Pennsylvania*
*New Hire Reporting Program*
*P.O. Box 69400*
*Harrisburg, PA 17106-9400*

Questions?
Contact New Hire Customer Service at 888-PAHIRES (888-724-4737)
Or by email at: RA-LI-CWDS-NewHire@pa.gov

**This form may be duplicated as needed**

**Save time and postage costs.**

Online reporting is fast, free and paperless.
For more information about how to get started, please visit

**www.pacareerlink.state.pa.us**

Or contact our customer service at 888-PAHIRES (888-724-4737)

**REQUIRED EMPLOYEE INFORMATION:** (Please type or print **LEGIBLY** in blue or black ink **ONLY**)

**ONE EMPLOYEE PER BOX**

Employee Social Security Number

Legal Name (First) (Middle) (Last)

Street Address (Post Office Box is not acceptable) Apartment Number (if available)

Zip Code City State

Date of Hire (MM/DD/YYYY)
(Must be within 3 years of current date)

Date of Birth (MM/DD/YYYY)

**ONE EMPLOYEE PER BOX**

Employee Social Security Number

Legal Name (First) (Middle) (Last)

Street Address (Post Office Box is not acceptable) Apartment Number (if available)

Zip Code City State

Date of Hire (MM/DD/YYYY)
(Must be within 3 years of current date)

Date of Birth (MM/DD/YYYY)

**ONE EMPLOYEE PER BOX**

Employee Social Security Number

Legal Name (First) (Middle) (Last)

Street Address (Post Office Box is not acceptable) Apartment Number (if available)

Zip Code City State

Date of Hire (MM/DD/YYYY)
(Must be within 3 years of current date)

Date of Birth (MM/DD/YYYY)

New Hire Reporting: Lending a Hand to Pennsylvania's Children

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

# WORKERS' COMPENSATION AND THE INJURED WORKER

www.dli.state.pa.us

*This brochure is a general guide for injured workers on the Pennsylvania Workers' Compensation Act for work injuries and illnesses occurring on or after June 24, 1996. This is general information only and does not represent official interpretations of the law. Injured workers are encouraged to discuss questions and concerns regarding the workers' compensation law and the additional options with legal counsel.*

## What is workers' compensation?

If you sustain a job injury or a work-related illness, the Pennsylvania Workers' Compensation Act, or Act provides payment for your medical expenses and, in the event you are unable to work, wage-loss compensation benefits until you're able to go back to work. Additionally, death benefits for work-related deaths are paid to your dependent survivors.

Benefits are paid by private insurance companies (also includes third-party administrators) or the State Workers' Insurance Fund (a state-run workers' compensation insurance carrier) or by self-insured employers.

## Are you covered?

Nearly every Pennsylvania worker is covered by the Act. Employers must provide workers' compensation coverage for all of their employees, including seasonal and part-time workers. Nonprofit corporations, unincorporated businesses and even employers with only one employee must comply with the Act's requirements.

Some employees are covered by other compensation laws, including federal civilian employees, railroad workers, longshoremen, shipyard and harbor workers. Others who may not be covered include volunteer workers, agricultural laborers, casual employees, domestics and employees who have been granted a personal religious exemption from the Act. Certain types of executive officers of corporations may elect exemption from the Act. A worker should seek further information if there is any doubt as to coverage.

If you learn that your employer does not have insurance or is not self-insured for workers' compensation, you may be eligible for benefits from the Uninsured Employer Guaranty Fund. For details, see our website (www.dli.state.pa.us) or call the Bureau of Workers' Compensation, toll free, at 800-482-2383 or locally and outside Pennsylvania at 717-772-4447.

## What is covered?

If your work causes an injury, illness or disease, you may be entitled to WC. No compensation shall be paid when an injury or death is intentionally self-inflicted, or is caused by an employee's violation of the law including, but not limited to, the illegal use of drugs. An injury or death caused by intoxication also may not be covered.

## When am I covered?

Coverage begins on the date of hire. Medical benefits are payable from the first day of injury; payment of lost wages is addressed on Page 3.

## How do I get the benefits?

*Prompt reporting is the key*. Report any injury or work-related illness to your employer or supervisor immediately. You must tell your employer that you were injured in the course of employment and inform your employer of the date and place of injury. Failure to notify the employer can result in the delay or denial of benefits. Once you have lost a day, shift or turn of work, your employer is required to report your injury to the Bureau of Workers' Compensation by filing a first report of injury.

The employer may choose to either accept or deny the claim. If your claim is denied, you have the right to file a claim petition with the bureau for a hearing before a WC judge.

## What are the benefits?

The law provides several types of workers' compensation benefits:

*Payments For Lost Wages*

Wage-loss benefits are available if it is determined that you are totally disabled and unable to work or partially disabled and receiving wages less than your pre-injury earnings. Please see the Total and Partial Disability Benefits Status section for further information as to disability status.

*Death Benefits*

If the injury results in death, surviving dependents may be entitled to benefits.

*Specific Loss Benefits*

If you have lost the permanent use of all or part of your thumb, finger, hand, arm, leg, foot, toe, sight, hearing or have a serious and permanent disfigurement on your head, face or neck, you may be entitled to a specific loss award.

*Medical Care*

Employers are responsible for advising workers of their rights and duties under Section 306(f.1)(1)(i) of the Act. The written notice of these rights and duties is to be provided to the employee at the time of injury or as soon after the injury as is practicable.

In the event of a work-related illness or injury, you are entitled, if covered under the Act, to the payment of related reasonable surgical and medical services rendered by a physician or other health care provider.

Medicine, supplies, hospital treatment and services, orthopedic appliances and prostheses are also covered for as long as they are needed. (To assure payment of medical services, see the Choice of Doctor section.) Even if you have lost no time from work, health care costs for a work-related injury or illness are payable at the fee schedule rate. However, an employee may not be charged the difference between the health care provider's charge and the amount paid by the employer or its insurance carrier. In other words, there can be no balance billing to you.

*If you seek medical treatment outside Pennsylvania, you may be subject to the risk of balance billing by the medical provider. You should discuss this with your medical provider prior to initiating treatment.*

### Choice of Health Care Provider

You are free to choose your own health care provider to treat your work injury unless the employer accepts your claim and has posted in your workplace a list of six or more physicians or health care providers. You are required to visit a provider on the list for initial treatment. You are to continue treatment with that provider or another on the list for a period of 90 days following the first visit. You may see any provider on the list; your employer may not require or direct you to any specific provider on the list.

If a listed provider prescribes invasive surgery, you are entitled to a second opinion that will be paid for by your employer/insurer. Treatment recommended as a result of the second opinion must be provided by a listed provider for 90 days.

If during the 90-day period you visit a provider(s) not on the list, your employer or your employer's insurance carrier may refuse to pay for such treatment. After the 90 days, and in situations where your employer has no posted list or an improper list, you may seek treatment with any physician or other health care provider you select. You must notify your employer of the provider you have selected. During treatment, the employer or the employer's insurance carrier is entitled to receive monthly reports from your physician or provider.

Injured workers should be advised that your health care providers may need information concerning your claim. Some of this information may be contained in correspondence you receive from your insurance carrier, and you may want to provide copies of letters or forms to your health care provider.

Once you begin receiving WC benefits, the employer/insurer has the right to ask you to see a doctor of their choice for examination. If you refuse, the employer is entitled to request an order from the WC judge requiring you to attend an examination. Failure to then attend may result in a suspension of your benefits.

### Occupational Disease

Occupational diseases under the Act are covered if caused by or aggravated by employment. Your disability must occur within 300 weeks of your last employment in an occupation where you were exposed to the hazard.

For certain lung diseases, you must have worked in an occupation with a silica, coal or asbestos hazard for at least two years in Pennsylvania during the 10 years prior to your disability.

### Total and Partial Disability Benefits Status

*Total Disability Benefits Status*

Applies to injured workers for a period during which they are considered totally disabled and unable to work. After 104 weeks of such status, the employer/insurer can require a medical examination to determine if the employee is at least 50 percent impaired based upon his/her work injury according to American Medical Association standards. If the 50 percent threshold is not met, the employee's status can change to partial disability.

*Partial Disability Benefits Status*

This benefit status is for a maximum of 500 weeks. If, while on partial disability status, you obtain a qualified impairment-rating physician's determination of impairment that is equal to or greater than 50 percent, you may file a petition for reinstatement of total disability status.

Partial disability of up to 500 weeks of benefits are paid if you can, or do, return to work at a lower paying job within work-related restrictions or you are found not totally disabled.

### How much are the payments for lost wages?

Wage-loss benefits are equal to approximately two-thirds of your average weekly wage, up to a weekly maximum. WC wage-loss benefits can be offset for 50 percent of Social Security benefits, the employer-paid portion of a retirement pension, severance pay, unemployment compensation or other earnings the employee receives. The law does not allow for a cost-of-living increase.

There are several different ways to calculate the average weekly wage under the Act. The minimum compensation rate is the lower of 90 percent of the workers' average weekly wage or 50 percent of the statewide average weekly wage.

### Reporting Wages and Other Benefits Received

Under the Act, any worker who has filed a petition for total or partial disability benefits or who is receiving such benefits is required to report, in writing to the insurer, any information that is relevant in determining entitlement to, or amount of, compensation including, but not limited to, information

Workers' Compensation & the Injured Worker is published by the Dept. of Labor & Industry,
Bureau of Workers' Compensation, 1171 S. Cameron St., Room 324, Harrisburg, PA 17104-2501

| Employer Information Services | Claims Information Services | Hearing Impaired | Email |
|---|---|---|---|
| 717.772.3702 | toll-free inside PA: 800.482.2383<br>local & outside PA: 717.772.4447 | toll-free inside PA TTY: 800.362.4228<br>local & outside PA TTY: 717.772.4991 | ra-li-bwc-helpline@pa.gov |

regarding the receipt of wages from another employer or from self-employment. The worker is obligated to cooperate with the carrier in an investigation of employment, self-employment, wages and physical condition.

**Insurance Fraud is a Crime**

The above-mentioned reports and other WC forms must be honestly completed to avoid violating PA fraud provisions.

**When are wage-loss payments made**?

You must be disabled more than seven calendar days (including weekends) before WC payments for disability are payable. Benefits for time lost from work are payable on the eighth day after injury. Once you have been off work 14 days, you receive retroactive payment for the first seven days.

If you report the injury promptly, miss more than seven days of work and your claim is accepted by the insurance carrier, you should receive your first compensation check within 21 days of your absence from work. After that, you will receive a check on a regular basis.

Payments of temporary compensation may be made by your employer or the insurance carrier for up to 90 days, even if your claim is not accepted by your employer or its insurance carrier. If your employer or the company's insurance carrier advises you that it will not continue your temporary compensation checks past 90 days, or if they deny your claim, you have the right to file a claim petition with the Office of Adjudication for a hearing if you believe you are entitled to benefits.

**Offer of Employment**

If, after you begin to receive benefits, your employer has evidence to prove that employment is available to you, within your medical restrictions and in your local area, you may receive an offer of employment.

If you decline the job offer, the employer may then petition a WC judge to either reduce or stop your wage-loss benefits based upon that job. The insurer/employer must continue to pay benefits during the hearing process unless the judge orders otherwise.

In open hearings, the judge will hear and receive medical evidence, both from you and your insurer/employer, on the availability of the work and your ability to do it, before rendering a decision.

**When Wage-Loss Payments Stop**

Wage-loss benefits can be stopped by an employer/ insurer that has evidence that you have returned to work at wages equal to or more than your earnings level prior to the injury and after providing a timely notice of that fact. If you are receiving temporary compensation benefits during the 90 days following the report of injury, the insurance carrier/ employer may notify you they are stopping benefits because they are not accepting the claim of a work-related injury.

Other reasons that benefits may be stopped include, but are not limited to: a WC judge stopped benefits after a hearing; the employee signs either a supplemental agreement or an agreement to stop workers' compensation (commonly referred to as a final receipt); the 500-week period of partial disability status expires.

**What if there is a problem?**

If you think you haven't received benefits that you are due, contact your employer or your employer's insurance carrier. The insurance carrier is allowed 21 days from your notice to the employer of your disability to decide to accept or deny your claim or to make payments of temporary compensation for up to 90 days.

Cooperative communication with your insurance carrier and employer is recommended. If the problem is not resolved, it may be necessary for you to file a petition with the Office of Adjudication. Forms can either be obtained online at www.dli.state.pa.us or through the Claims Information Helpline at 800-482-2383. The Office of Adjudication is responsible for resolving disputes by assigning petitions to WC judges who decide each case after holding hearings on the issues.

**Time Limits**

Unless an employer has knowledge of the injury or the employee gives notice to the employer within 21 days of the injury, no compensation is due until notice is given. Notice must be given no later than 120 days after the injury for compensation to be allowed. If your request for WC benefits is denied by your employer or your employer's insurance carrier, you have three years from the date of injury to file a claim petition.

In occupational disease cases, injury/disability must occur within 300 weeks from the date of last employment in an occupation in which you had exposure to a hazard, and a petition must be filed no later than three years from the date of injury/disability.

Failure to file a petition on a timely basis may result in forfeiture of your right to benefits.

If your benefits were terminated, you may file a petition to reinstate WC benefits within three years after the date of your most recent WC check.

If your benefits were suspended, you may file a petition to have benefits reinstated. This petition must be filed within 500 weeks from the date of suspension.

Payment of medical benefits by your employer does not mean that your claim has been accepted or reopened.

**Alternative Dispute Resolution**

In alternative dispute resolution, a WC judge helps the parties settle the case by talking through their differences. Alternative dispute resolution may take the form of mediation, settlement conference or informal conference.

If either you or your employer files a petition with the Office of Adjudication, the WC judge will schedule mediation unless a judge determines it would be futile. If the case does not settle at this mediation, the parties may resume mediation or a settlement conference later in the proceedings. The parties may also request mediation or a settlement conference later in the proceedings if the judge had previously found mediation to be futile.

You may also request an informal conference to try to resolve your issues. If you are not represented by an attorney at an informal conference, your employer is not entitled to be represented either. Informal conference forms are available online at www.dli.state.pa.us or through the Bureau of Workers' Compensation Claims Information Helpline at 800-482-2383.

**Do I need an attorney?**

You may represent yourself in WC proceedings, but a non-attorney cannot represent you. However, you should be aware that WC litigation is complex, and your employer or your employer's insurance carrier will be represented by an experienced attorney. If you hire an attorney, you should discuss fee and cost arrangements. The fee agreement must be approved by a WC judge or the Workers' Compensation Appeal Board. Your local bar association, or the Pennsylvania Bar Association's Lawyer Referral Service at 800-692-7375, can help you find an attorney.

**Appeals**

WC judge decisions can be appealed to the Workers' Compensation Appeal Board and then to Commonwealth Court. You will be informed of appeal rights upon receiving the WC judge's decision.

**Other Benefits**

If the injury is a very serious one where you won't be able to work for a year or more you may be eligible for additional disability benefits from Social Security. For information, visit the Social Security Administration's website at www.socialsecurity.gov or contact your nearest Social Security Administration office.

**General Information**

If you require a special accommodation to participate in a hearing due to a physical impairment, or need a sign language interpreter or an interpreter for your own language other than English, without cost, request one online at www.dli.state.pa.us or contact the Bureau of Workers' Compensation Helpline and describe the accommodation:

Helpline voice telephone numbers:
ra-li-bwc-helpline@state.pa.us
toll free in Pennsylvania: 800-482-2383
local and outside Pennsylvania: 717-772-4447

Only people with hearing loss:
toll free in Pennsylvania TTY: 800-362-4228
local and outside Pennsylvania TTY: 717-772-4991

You may also ask your employer or supervisor for information on WC or contact your employer's WC insurance carrier, your union or an attorney.

The WC Act is available on the department website at www.dli.state.pa.us.

*Auxiliary aids and services are available upon request to individuals with disabilities.*
*Equal Opportunity Employer/Program*

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 SOUTH CAMERON ST., ROOM 324
HARRISBURG, PA 17104-2501

LIBC-100 REV 09-13 (Page 4)

PRESORTED
STATNDARD
U. S. Postage
PAID
Permit No. 568
Harrisburg, PA

*Instructions: Have employee sign and date, give one copy to employee and place one copy in personnel file.*

# PRIVACY POLICY AND SAFEGUARDING AGREEMENT

The nature of our business is such that the Company has confidential and proprietary information relating to its business policies, practices, methods of operations, and customer lists. In addition, we deal with confidential and proprietary information received from our customers. Each employee should understand the importance of making sure this information is protected from disclosure to competitors, suppliers, vendors, and all other persons.

Every employee has a legal and ethical obligation to take all steps reasonably necessary in order to keep the Company's and clients' affairs confidential. This obligation continues even after an employee leaves the Company. Information obtained by the Company and its employees should be treated at all times with the utmost confidentiality and discretion and should not be disclosed to anyone other than Company employees and others having a need to know. For this purpose, all Company information and client information should be considered confidential unless, beyond any doubt, the information is widely known and its disclosure would not be detrimental to the client.

## Conversations in public

Have conversations about Company and client matters only with those who have a need to know, and take care to avoid such conversations where those who do not need to know may overhear. Conversations about such information in public places, such as elevators, restaurants, and airplanes should be avoided, and confidential matters should not be discussed with spouses, other relatives, or friends.

## Client documents and materials

Do not leave Company and client documents or materials where they can be seen by any unauthorized person, such as in unattended conference rooms, on your desk, near the fax machine, on copy machines, in the mail room, or any other public locations. Do not discard documents containing confidential information without first shredding the documents. Do not stay logged in to your computer without having a password-protected screen saver in operation.

## Support Personnel and Vendors

Care should be taken to ensure that persons who are providing support to the Company (such as computerized data services, copy services, and experts) and Vendors receive only information which they have a need to know and the Business Office will inform them of the nature of the confidentiality and the measures taken to protect confidentiality. Support Personnel and Vendors must sign this Policy and Agreement before any customer information is shared with them.

## Safekeeping of financial information

All financial information shall be kept confidential and locked in file cabinets each evening. Employees are not to take any financial information of the Company or its clients home to work on or otherwise remove it from the office unless there is specific business need to do so. Employees are not permitted to keep financial information, including credit applications, credit reports or contracts at their desks or on the fax machine for any purpose other than to collect the information and to immediately transfer/transmit the information to the financial institution or to management staff to be placed in locked storage. Customers and vendors should not be left alone in your office unless all customer information is in locked storage. Financial information

and other personal information should never be left unlocked at your desk for any reason or for any period of time, regardless of the reason or the fact that you are working on the information. You should never share financial information or other personal information with anyone else in the company unless it is necessary for the purpose of completing the business transaction. Such information should only be shared on a need-to-know basis. Customer information must be in a locked storage area at all times. You should check to make sure the storage area (whether it is a room, a cabinet or your desk drawer) is locked each time you access the storage area.

You should never share or divulge your password providing access to the computerized data for any reason under any circumstance. Your password should not be stored where others can access it but should be kept in locked storage or in another place where others cannot access it.

Downloading information on the Internet to our computer systems may provide outside access to our systems. Therefore, you must not download any information from the Internet to our computer system without written authorization from the Security Program Coordinator.

If you need to dispose of any documents containing customer information, you must shred the documents prior to deposing of them.

You should never transmit customer information over the Internet or by email, under any circumstances.

You should never store customers' non-public personal information or financial information on PDA's, portable computers or other electronic devices unless you have written authorization to do so by the Security Program Coordinator so that security issues can be addressed prior to placing such information at risk.

You must never provide customer information to any callers over the telephone even if they appear to be legitimate business inquiries. All communication of customer information should be through written secure means such as facsimile to a known service provider or vendor who has agreed to abide by our policy or through other secure (encrypted) transmission. If you receive a call from a person attempting to obtain customer information, you should immediately transfer them to the Security Program Coordinator who will report the incident to law enforcement officials if necessary.

You must never use or reproduce customer information, whether electronic or non-electronic, for your own personal use or the use of others unless for approved business purposes.

If you cease to be employed at the company, you shall not access and may not review any customer information from the moment you are no longer employed.

**Release of Confidential Information**

In the event that an employee inadvertently releases confidential information, the employee should immediately inform his or her department manager so the appropriate action may be taken. Any release of information, whether or not intentional, may be grounds for disciplinary action, up to and including termination. By signing below, the employee also agrees that he/she will notify the department manager immediately if any anticipated threats or hazards to the security of customers' personal information are suspected or detected or if the employee is aware of unauthorized access or sharing of customer information.

## CONFIDENTIALITY AGREEMENT

As an employee of the Company, the undersigned acknowledges that from time to time he or she will receive confidential and proprietary information concerning the business of the Company. The undersigned further acknowledges that such information, if shared directly or indirectly with third parties, could be detrimental to the Company because it would place the Company at a competitive disadvantage if disclosed, and that but for his or her employment at the Company he or she would not receive such information, as it is not available to the public.

Accordingly, the undersigned agrees that he or she, except as necessary to conduct business of the Company, shall not disclose, copy, communicate, or divulge to, or use the direct or indirect benefit of any person, firm, association, or company other than the Company, any material provided by the Company, including but not limited to business methods, business policies, procedures, techniques, research, or development projects or results, trade secrets, or other knowledge or process of or developed by the Company or any other confidential information relating to our dealing with the business operations or activities of the Company made known to the undersigned or learned or acquired by the undersigned while an employee of the Company.

When the undersigned leaves the employ of the Company, he or she agrees to return all of the Company's documents and property in his or her possession, including but not limited to manuals, drawings, notebooks, reports, customer lists, pricing lists, and/or prospect lists.

Confidential information or material of the Company includes any information or material: (a) generated, collected, or utilized by the Company in its operations relating to the actual or anticipated business or research and development of the Company or (b) suggested by or resulting from any task assigned to me or work performed by me for or on the behalf of the Company and that has not been made available generally to the public.

In addition to confidential information about the Company, the undersigned acknowledges that he or she will also receive confidential information about clients and customers of the Company. The undersigned agrees that all provisions of this agreement and the attached Privacy Statement applicable to confidential information belonging to the Company will also apply to information received from and/or about clients and customers. The undersigned agrees to comply with this agreement and the attached Privacy Statement and the Company's Information Security Program, or any amendments to these documents that may be made from time to time. I also agree to complete the required security training. I agree that I will not access or view any customer information that is not necessary to the performance of my job duties.

The undersigned acknowledges that violation of any part of this agreement is grounds for immediate termination.

_____ _____

Signature - Date

# DIRECT DEPOSIT AUTHORIZATION

I hereby authorize Star Buick GMC - Easton, hereinafter called COMPANY, to initiate credit entries to my Checking and/or Savings accounts indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to credit the same to such account.

DEPOSITORY NAME_____ CHECKING ( ) OR SAVINGS ( )

ROUTING NUMBER_____ ACCOUNT # _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

I also acknowledge that the information provided here with is accurate, and any errors or omissions are my sole responsibility.

_____ _____

SIGNATURE DATE