Authorization to Release Social Security Number and Acknowledgement of Electronic Information Access & Use Regulation

Authorization to Release Social Security Number

I authorize Bloomfield Hills Schools to release my social security number
to the
Oakland Intermediate School District and/or the
Michigan Department of Education.

Printed Name _____

Signature _____

Date _____

Acknowledgment
Electronic Information Access and Use Regulation

I hereby apply for access to the Bloomfield Hills Public Schools network services. I confirm that I have read and understand the Electronic Information Access and Use Regulation and agree to be responsible for and abide by the terms of this agreement. I understand that should I commit any violation, my privileges may be revoked and that school disciplinary or legal action may be taken.

Printed Name _____

Signature _____

Date _____

STUDENTS ONLY
If you are a student, your parent/guardian must also sign

As the parent/guardian of the above-named student, I acknowledge that I have read the Electronic Information Access and Use Regulation and consent to the District's grant of access to network services.

Printed Name of Parent/Guardian _____

Signature _____

Date _____

Bloomfield Hills Schools

Authorization for Release of Information from Current or Former Employer(s)

In accordance with Public Act 189 of 1996 (MCL 380.1230b), I authorize current or former employers to do the following:

- Disclose to Bloomfield Hills Schools any unprofessional conduct by me, and
- Make available to Bloomfield Hills Schools copies of all documents in my personnel record relating to that unprofessional conduct.

"Unprofessional conduct" means one or more acts of misconduct; one or more acts of immorality, moral turpitude or inappropriate behavior involving a minor; or commission of a crime involving a minor. A criminal conviction is not an essential element of determining whether or not a particular act constitutes unprofessional conduct.

I hereby waive and release any current or former employer, and employees or agents acting on behalf of a current or former employer, from any liability for disclosing and/or providing information to Bloomfield Hills Schools relating to acts of unprofessional conduct committed during my employment with my current or former employer, or any other information relating to my current or former employment. I release Bloomfield Hills Schools, its employees, agents, and Board members from liability in connection with the use of such information. I further waive any written notice of disclosure or records required under Section 6 of the Bullard Plawecki Employee Right to Know Act (MCL 423.506).

I understand that Bloomfield Hills Schools shall use the information from my current or former employer(s) for the purpose of evaluating my qualifications for the position(s) for which I have applied, and the information will not be disclosed to persons who are not directly involved in the process or evaluating my qualifications for employment.

I further understand that any offer of employment is contingent upon the information received from my current or former employer(s) being satisfactory to Bloomfield Hills Schools. If the information is not satisfactory to the school district, the offer of employment may be withdrawn at the sole discretion of Bloomfield Hills Schools.

APPLICANT'S NAME (please print) _____

APPLICANT'S SIGNATURE _____ **DATE** _____

Bloomfield Hills Schools

Date: _____

TO: _____

_____

_____

REQUEST FOR INFORMATION RELATING TO UNPROFESSIONAL CONDUCT FROM CURRENT OR FORMER EMPLOYERS IN ACCORDANCE WITH PUBLIC ACT 189 OF 1996.

RE: _____ **Applying for a Position as:** _____

The individual named above is being considered for employment with Bloomfield Hills Schools. The applicant has identified you as his/her current or former employer.

Before hiring an applicant for employment, Public Act 189 of 1996 (MCL 380.1240b) requires Bloomfield Hills Schools to obtain the following information from the applicant's current or former employer: (1) whether there was any unprofessional conduct* by the applicant during their employment, and (2) copies of all documents in the personnel file maintained by the current or former employer relating to the unprofessional conduct.

The applicant has signed an authorization for release of the information. The authorization also releases current or former employers from liability for releasing the requested information. A copy of the authorization is attached. Public Act 189 of 1996 provides that an employer, or an employee acting on behalf of the employer, is immune from civil liability for good faith disclosure of the requested information.

We would appreciate your providing the requested information about the applicant by completing this form and returning it in the enclosed envelope or faxing it to Human Resources at 248.341.5449. Public Act 189 requires current or former employers to provide the requested information no later than 20 business days after receiving the request.

TO BE COMPLETED BY THE CURRENT OR FORMER EMPLOYER OF THE ABOVE NAMED APPLICANT:

Our records indicate the following with respect to the above named individual (please check either 1 or all parts of 2).

1. _____ There was no unprofessional conduct on the part of this individual while he/she was employed.

2 (a). _____ The applicant engaged in the following unprofessional conduct (use additional sheets if necessary):

_____

2 (b). _____ Copies of documents relating to unprofessional conduct by this individual are attached per PA 189.

2 (c). _____ No documents relating to unprofessional conduct are attached because: _____

_____

_____

Signature **Title** **Date**

*Unprofessional conduct means one or more acts of misconduct; one or more acts of immorality, moral turpitude, or inappropriate behavior involving a minor; or commission of a crime involving a minor. A criminal conviction is not an essential element of determining whether or not a particular act constitutes unprofessional conduct.

Christine Barnett, J.D. * Assistant Superintendent for Human Resources & Labor Relations
7273 Wing Lake Road * Bloomfield Hills, MI 48301 * 248.341.5425 * www.bloomfield.org

1st Request ____Date: _____/ 2nd Request ____Date: _____/ 3rd Request ____Date: _____

No Response Letter Sent _____ Date _____

Bloomfield Hills Schools

Employee Emergency Contact Information

Employee Name_____

Emergency Contact Name: _____

Relationship_____

Cell Phone ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Work Phone ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Dependent Data (*please include spouse & children*)

Name_____

Relationship_____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth: Month _____ Day _____ Year _____

Address (if different than employee): _____

Medicare Number (if applicable) _____

Medicare Effective Date (if applicable) _____

Name_____

Relationship_____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth: Month _____ Day _____ Year _____

Address (if different than employee): _____

Medicare Number (if applicable) _____

Medicare Effective Date (if applicable) _____

Name_____

Relationship_____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth: Month _____ Day _____ Year _____

Address (if different than employee): _____

Medicare Number (if applicable) _____

Medicare Effective Date (if applicable) _____

Name_____

Relationship_____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth: Month _____ Day _____ Year _____

Address (if different than employee): _____

Medicare Number (if applicable) _____

Medicare Effective Date (if applicable) _____

Name_____

Relationship_____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth: Month _____ Day _____ Year _____

Address (if different than employee): _____

Medicare Number (if applicable) _____

Medicare Effective Date (if applicable) _____

Bloomfield Hills Schools: . . . . Employment Transaction Form

Type of Employment Transaction	☐ New Hire ☐ Rehire ☐ Unpaid LOA ☐ Paid LOA ☐ Union Code Change ☐ Voluntary Termination ☐ Involuntary Termination ☐ Retirement ☐ Other ☐ Lay Off ☐ Return from LOA ☐ Location/Acct# Change		
Social Security Number		**Date of Birth**	
Name (Last, First, M.I.)			
Seniority Date/Date of Hire	_____/_____/_____	**Date of Event/Date Started**	_____/_____/_____
Benefit Effective Date	_____/_____/_____	**Pay Eff. Date**	_____/_____/_____
Benefit Term Date	_____/_____/_____	**Employee ID#**	
Annual Salary	$	**Gender**	☐ Male ☐ Female
New Union Code **User Name:** _____ **Email Address:**_____ **Check Location:**_____ **Term Log:**_____ **Port Done:**_____ **Cyborg Done:**_____	☐ Administrative: **A D** ___ ___ ☐ Interpreter: **H I** ___ ___/ Intervener ☐ FT ☐ PT ☐ Teacher: **I N** ___ ___ ☐ **< 75%** ☐ **75 – 99%** ☐ **FT** ☐ Parapro: **P P** ___ ___/ Job Coach ☐ 5 hours ☐ Office Personnel: **C L** ___ ___ ☐ Instruct. Assist.: **W L** ___ ___ ☐ Aux Service: **A S** ___ ___	☐ Unaffiliated A: __ ___ ___ ___ ☐ FT ☐ PT ☐ Technician ☐ Unaffiliated B: **U A** ___ ___ ☐ Unaffiliated C: **U A** ___ ___ Nurse 2 ☐ Unaffiliated E: **U A** ___ ___ ☐ Unaffiliated F: **U A** ___ ___ DayCare/PS/LK/ Variable Hrs	
Home Street Address			
City, State, Zip			
Home Phone Number	( )		
General Ledger Allocation	GL# _____- 2100 ___ ___% GL# _____- 2100 ___ ___% GL# _____- 2100 ___ ___% GL# _____- 2100 ___ ___%		

*Date Entered to NGE System:*_____ *By:* _____

Bloomfield Hills Schools

If you are eligible for health benefits, you will be contacted by Sarah Dare, Benefits Coordinator. When you meet with her, please bring the following items with you:

- **Names, birth dates, and social security numbers of all dependents and all life insurance beneficiaries.**
- **If you are married, please bring a copy of your marriage license.**
- **If you have dependent children up to age 26, please bring a copy of their birth certificates or adoption papers.**
- **If you are divorced and insuring children, please bring in a copy of your divorce decree.**
- **If you are opting out of health insurance please bring your current health insurance card.**
- **Complete the emergency contact/dependent data information worksheet. Please be certain to include all information required. Please bring the completed worksheet to our meeting.**

NOTE: You will not be able to enroll dependents without the documents listed above.

Bloomfield Hills Schools

Human Resources,
Payroll & Benefits

Booth Center
7273 Wing Lake Road
Bloomfield Hills, MI 48301

t: 248.341.5430
f: 248.341.5449

www.bloomfield.org

WAIVER OF HEALTH COVERAGE

I hereby decline the Medical Insurance coverage provided by Bloomfield Hills Schools for myself and my qualified dependents.

In order to receive the Opt-Out Credit (if applicable per my work agreement) for waiving the medical insurance plan, I must provide proof of other insurance coverage (ID card copy). Please photocopy the front and back of your medical ID card and return with this signed document to the Benefits Coordinator no later than the time of enrollment. If you qualify for the opt-out credit, Bloomfield Hills Schools will add the cash credit to each paycheck through the flex plan year payroll process.

I understand that I may return to the plan during open enrollment **OR** within 30 days of a mid plan year life status change. I must provide proof of loss of other coverage to do so. Some examples of a life status change are: death, divorce, birth/adoption, marriage, or loss of insurance coverage through another source. Notifications received after 30 days of the life status event will **not** be processed **until** the next open enrollment date.

Signed:_____ Date:_____

Employee

Signed:_____ Date:_____

Spouse

Bloomfield Hills Schools
PRE-EMPLOYMENT CONSENT FOR
CRIMINAL CONVICTION HISTORY CHECK

I am an applicant for employment with Bloomfield Hills Schools. I understand that I have been conditionally offered a position as an employee by the Bloomfield Hills Schools subject to a criminal conviction history check and/or fingerprinting and a pre-employment physical, if requested.

I understand that the Michigan State Police and FBI require the information below, for the criminal conviction history check. I authorize the Bloomfield Hills Schools to utilize this information for the sole purpose of obtaining a conviction-only history file search.

(PLEASE PRINT CLEARLY)

Name: _____
Last First Middle

Additional name(s) you have been known by: _____

Date of Birth: _____ Sex: _____ Race: _____

Driver's License No: _____ State Issued From: _____

Position applied for: _____ Building/Dept. _____

Pursuant to 2005 Public Act 129 &138, I represent that **(you must check one)**:

_____ I have not been convicted of, or pled guilty, or nolo contendre (no contest) to any crimes.

_____ I have been convicted of or pled guilty or nolo contendre (no contest) to the following crimes (use separate sheet to explain nature of conviction, date and court):

a. _____

b. _____

I understand and agree that pursuant to the School Safety Initiative Legislation of 2005:

(1) The Board of Education must request a criminal history check on me from the Central Records Division of the Michigan Department of State Police and FBI for all full time and part time employees, or for any individual who is assigned to regularly and continuously work under contract in the district's schools.

(2) Until the reports are received and reviewed by the School District, I am regarded as a conditional employee; and

(3) If the reports received from either the Department of State Police or the FBI are not the same as my representation(s) above respecting either the absence of any conviction(s) or any crimes of which I have been convicted, my employment contract is voidable at the option of the School District.

(4) I have been told by an agent of Bloomfield Hills Schools that I am to be fingerprinted prior to my 1st day of employment. I authorize release of my prints and/or criminal history report received from these prints to any Michigan public school district personnel department.

(5) I have been fingerprinted pursuant to Public Act 129 & 138 for employment with _____ and authorize the release of my prints and/or criminal history report. *(Name and Address of District previously printed with)*

Signature _____ Date _____

Return this form to the Human Resource Department.

10/10

E-VOUCHER INFORMATION

VIEW PAYCHECK ON-LINE FROM ANYWHERE

JUST FOLLOW THESE SIMPLE STEPS:

Step 1: Go to https://hrweb.resa.net/eEmployee/

Step 2: Log in if you have already registered, or choose *"Not a Registered User? Click Here"* to create a **Log-in** and **Password*** (You will only need to do this once. Please write down your user name and password in a safe place).

Step 3: Enter your user name and password, select **Bloomfield Hills Schools** in the drop-down box and click Log-in. Our name and logo will appear on the left side of the screen.

Step 4: Select a check date and view your voucher.

Step 5: **Logoff** (top right side of screen).

***Your employee ID number is: _____.**

***New Hires**: it may take several days before you are in the system and can access your e-voucher information*

***ALL EMPLOYEES:** You must create an e-voucher account while employed in order to retain access when you are no longer employed by the district.*

Note: If you have any questions regarding the log-in or if you have lost your employee ID number, please contact the Payroll Department at 248.341.5435.

Bloomfield Hills Schools

Authorization Agreement for Direct Deposits

I hereby authorize Bloomfield Hills Schools to make deposits in the account identified below at _____(Deposit Financial Institution, hereinafter referred to as DFI) and authorize the DFI to accept these deposits. Adjusting entries to correct errors and/or over-payments is also authorized. It is agreed that these deposits and adjustments may be made electronically and under the Rules of the National Automated Clearing House Association. This authorization will remain in effect until written notice of termination is given to the Company. I acknowledge my responsibility to retain a copy of this document.

Name_____

Address_____City_____

State_____Zip_____Building_____

Signature_____Date_____

Phone number __ __ __ - __ __ __ - __ __ __ __

DIRECT DEPOSIT CAN NOT BE PROCESSED WITHOUT PROPER REQUIRED ATTACHMENT

DIRECT DEPOSIT TO CHECKING: ATTACH A COPY OR VOIDED CHECK

DIRECT DEPOSIT TO SAVINGS: ATTACH VERIFICATION FORM FROM YOUR BANK WITH ROUTING AND ACCOUNT INFORMATION

Partial direct deposit to the following account:

☐ Checking **OR** ☐ Savings

$_____Account #_____Routing #_____

Partial direct deposit to the following account:

☐ Checking **OR** ☐ Savings

$_____Account #_____Routing #_____

I authorize my **NET/BALANCE** payroll deposit to be distributed as follows:

☐ Checking **OR** ☐ Savings

Account #_____Routing #_____

☐ I would prefer to have my net payroll deposited on a pay card

Bloomfield Hills Schools

NAME _____ **DATE** _____

Please answer BOTH parts (A & B)

Part A **Are you Hispanic/Latina?** ***(Choose only one)***

- ☐ **No,** not Hispanic/Latina
- ☐ **Yes,** Hispanic/Latina (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race).

Part A of the question is about ethnicity, not race. Regardless of what you selected in Part A, **please answer Part B** by marking one or more boxes *to* indicate what you consider your race to be.

Part B **What is your race?** ***(Choose one or more)***

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South American, including Central America)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam).
- ☐ **Black or African-American** (A person having origins in any of the black racial groups of Africa).
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands).
- ☐ **White** (A.person having origins in any of the original peoples of Europe, the Middle East, or North Africa).

NOTE: Both Parts A and B **MUST** be completed. We encourage you to select an answer for **both** parts. If either part (A or B) is not answered, the U.S. Department of Education **requires** the school district to supply an answer on your behalf.

☐ *Please check this box if you **do not** want your telephone number listed in our staff directory.*
☐ *Please check this box if you **do not** want your address listed in our staff directory.*

SIGNATURE _____ **DATE** _____

Bloomfield Hills Schools
7273 Wing Lake Road · Bloomfield Hills, MI 48301 · 248.341.5425 · www.bloomfield.org

BLOOMFIELD HILLS SCHOOLS
VOLUNTARY STAFF IMMUNIZATION-HEPATITIS B VACCINATION CONSENT/DECLINATION

Directions: Please print the following information:

NAME: _____
(Last) (First) (Middle)

PRESENT ASSIGNMENT:_____
(Job Title)

PRESENT LOCATION: _____
(Building)

DATE OF BIRTH: _____ / _____ / _____

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus infection. I have been given the opportunity of receiving Hepatitis B antibody screening (to assess my need for Hepatitis B vaccination) and to be vaccinated with Hepatitis B vaccine, at no charge to me. I also understand that if I am found to be immune to the Hepatitis B virus because I previously received the complete Hepatitis B vaccination series, tested positive for adequate antibodies, or have a medical condition which negates the need or benefit of Hepatitis B vaccination, the vaccine will not be offered to me.

(EMPLOYEE – Please respond to **BOTH** Parts 1 and 2 **OR** Part 3)

PART 1 – HEPATITIS B ANTIBODY SCREENING (Please read carefully and check one (1) of the following):

_____ I wish to be screened for Hepatitis B antibodies to determine my need for Hepatitis B vaccination.

_____ I decline Hepatitis B antibody screening at this time. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be screened for Hepatitis B antibodies, I can receive the testing at no charge to me. Also, I may still elect to receive the Hepatitis B vaccine at no charge to me unless I previously received the complete Hepatitis B vaccination series, tested positive for adequate antibodies, or have a medical condition which negates the need or benefit of Hepatitis B vaccination.

PART 2 – HEPATITIS B VACCINATION (Please read carefully and check one (1) of the following):

_____ I wish to receive the Hepatitis B vaccine.

_____ I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me (unless I am found to be immune to the Hepatitis B virus because I previously received the complete Hepatitis B vaccination series, tested positive for adequate antibodies, or have a medical condition which negates the need or benefit of Hepatitis B vaccination).

PART 3 – NO HEPATITIS B VACCINATION

_____ I have previously received the complete Hepatitis B vaccination series.

_____ Antibody testing has revealed that I am immune to Hepatitis B.

_____ The vaccine is not needed because of medical reasons.

Employee Signature _____ Date _____

Return to the Human Resources Office

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Bloomfield Hills Schools

Human Resources,
Payroll & Benefits

Booth Center
7273 Wing Lake Road
Bloomfield Hills, MI 48301

t: 248.341.5430
f: 248.341.5449

www.bloomfield.org

WORKERS COMPENSATION PROCEDURE ACKNOWLEDGEMENT STATEMENT

USE OF FORM:

The Employee Accident Report form must be used to report all work related injuries to employees of Bloomfield Hills Schools that occur on or off school premises.

Injuries where an employee must be admitted to a hospital must be reported to the Benefits Coordinator (248)341-5431 or the Executive Manager of Human Resources and Payroll (248)341-5432 by telephone as soon as possible. Information on this form is used generally to satisfy State and Federal Information requirements under the Occupational Safety and Health Act (OSHA). All of the information must be provided in full detail.

HOW TO FILE:

This form must be completed and signed by ***both*** the injured employee and the Supervisor. The form must be filed ***immediately*** even if the injured employee cannot sign the report until a later time. If the employee and/or Supervisor is unable to complete the report at the time of injury, it shall be completed within 3 calendar days following the occurrence.

REVIEW OF INJURIES:

The circumstances and conditions of each injury will be investigated by the Supervisor. Where such circumstances indicate, a Supervisor's Investigation Report may be requested.

MEDICAL TREATMENT:

The cost of the medical treatment for work-related injuries or illnesses is covered under Worker's Disability Compensation laws. The procedures for obtaining treatment must follow established requirements in order to have medical costs covered.

1st 28 DAYS

For the first 28 days from the date of reporting job injuries, treatment must be obtained only from medical facilities authorized by the District. After the employee notifies his/her Supervisor or Building Principal, all routine medical services shall be obtained from Emcura Immediate Care, 4050 West Maple Road, Suite 101, Bloomfield Township, MI 48301. Contact the Benefits Coordinator or Executive Manager of Human Resources and Payroll for approval at SDare@bloomfield.org or (248)341-5431 or KHealy@bloomfield.org or (248)341-5432.

Bloomfield Hills Schools

Human Resources,
Payroll & Benefits

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For life-threatening injuries, or accidents outside normal business hours, medical treatment shall be obtained at St. Joseph Mercy Hospital, 900 Woodward Avenue, Pontiac. No other medical facilities may be used by an employee without prior authorization. Contact the Benefits Coordinator or Executive Manager of Human Resources and Payroll for approval.

<u>After 28 DAYS</u>

All medical visits after 28 days may be made only after an Employee has notified the Benefits Coordinator when and where treatment will be obtained. In no event, however, will authorization for service include prior agreements to pay for the costs of the service unless such costs are considered reasonable fees for the service by our insurance service agent.

FAILURE TO FOLLOW THESE WORKERS COMPENSATION PROCEDURES MAY RESULT IN A DISPUTE OF THE CLAIM AND NON PAYMENT BY THE WORKERS COMPENSATION CARRIER. THE EMPLOYEE MAY BE SOLEY RESPONSBILE FOR ALL COSTS INCURRED. THE MEDCIAL INSURANCE CARRIER WILL NOT ACCEPT LIABILITY FOR A WORKERS COMPENSATION INJURY PAYMENT WHEN A DISPUTE AND NON PAYMENT IS MADE FROM THE WORKERS COMPENSATION CARRIER.

I HAVE READ AND ACKNOWLEDGE THE AFOREMENTIONED POLICY ON REPORTING AND TREATING FOR WORK RELATED INJURIES OR ILLNESSES. I UNDERSTAND I MAY BE RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH A DISPUTED CLAIM IF I DO NOT COMPLY WITH THESE INSTRUCTIONS.

Employee Signature:_____

Print Name_____

Date:_____

FOR ONLY: Elementary teachers
Physical Education teachers
Elementary Paraeducators
Physical Education Paraeducators

Completion of on-line training course: All adult participants in youth athletic activities, including coaches, assistant coaches and volunteers are required to complete a concussion awareness online training course. The course takes about 35 minutes to complete. Upon completion of the training session, a certificate is provided for printing. New employees are to print out the certificate and bring it to the new hire appointment.

The on-line course is available here. The course addresses the signs/symptoms and consequences of concussions.

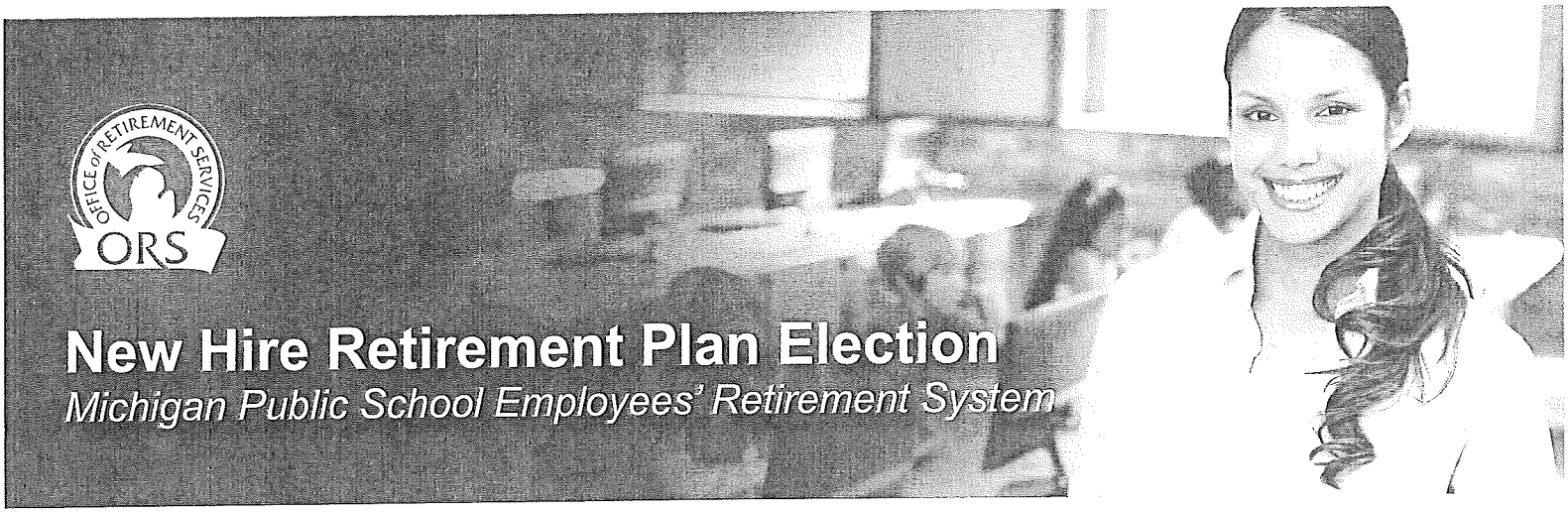
Note: The certificate must be printed at the conclusion of the training session. If the course is closed out without printing the certificate, the employee will have to retake the training in order to recover the certificate.

MICHIGAN PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM (MPSERS) OFFICE OF RETIREMENT SERVICES (ORS)

NEW HIRE RETIREMENT PLAN ELECTION

If you are already a member of MPSERS with previous paid work experience in a Michigan public school, there is no need to complete the election form. This form is for a new employee entering MPSERS for the first time.

If you have any questions concerning your membership or election, please contact ORS at 1.800.381.5111.



New Hire Retirement Plan Election

Michigan Public School Employees' Retirement System

Get ready to make your retirement plan election

If you first worked for a Michigan public school on or after September 4, 2012, this is your opportunity to choose a retirement plan that fits your needs. Enclosed you will find resources from the Office of Retirement Services and your employer to help you make your decision, including:

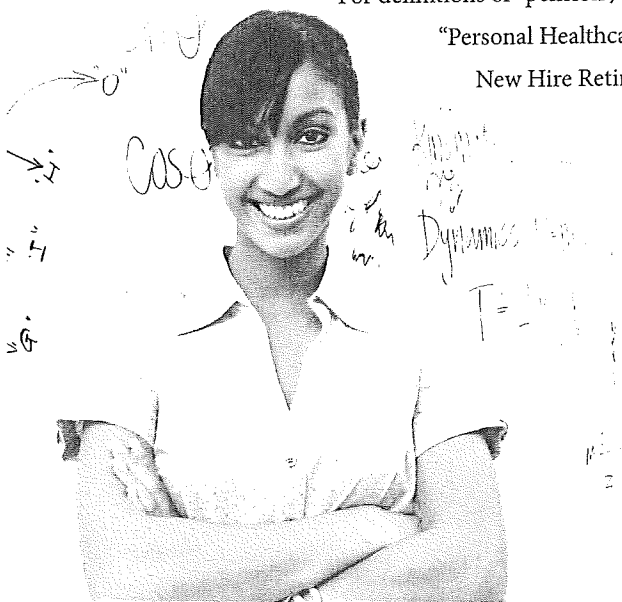
- access to the New Hire Retirement Plan Election Guide
- an overview of your plan options
- the New Hire Retirement Plan Election form

Review the online guide carefully. Talk about your plan options with the people in your life who would be affected by your decision. You may want to consult with a tax or financial advisor.

Don't miss the deadline. Return your completed election form to your payroll officer no later than 75 days from your first payroll end date. If you do not meet the deadline, you will remain enrolled in the Pension Plus plan. Once you submit your election form or the deadline passes, you cannot change your retirement plan.

Are you unsure about what a "pension" is?

For definitions of "pension", "defined contribution plan," "Personal Healthcare Fund" and more, see the New Hire Retirement Plan Election Guide at **PickMiPlan.org**.



Two retirement plans: the choice is yours

The two plans have some features in common including the Personal Healthcare Fund and the opportunity to invest in the State of Michigan 401(k) and 457 Plans. But there are distinct differences, too. Get to know each plan and pick the one that best fits your future retirement needs.

Pension Plus plan

This plan offers two types of retirement plans in one: it pairs a **Pension Component** with a **Savings Component**.

The **Pension Component** guarantees you regular payments over your lifetime once you meet age and service requirements.

Retirement income from the **Savings Component** will depend on contributions to your tax-deferred retirement investment account and investment performance. You choose how to invest the money in the account.

On the day you begin public school employment, you are automatically enrolled in the Pension Plus plan to get you started saving for your retirement right away. It's up to you whether to stay in this plan or switch to the Defined Contribution plan.

Defined Contribution plan

The Defined Contribution plan enrolls you in a tax-deferred retirement investment account. Retirement income will depend on contributions to the plan and investment performance. You choose how to invest the money in the account.

Which plan features matter most to you?

Here are six features to help you think about what you want from your retirement plan. Learn about all plan features in the New Hire Retirement Plan Election Guide at **PickMiPlan.org** before making your decision.

You must act soon!

Tear out, complete and return the election form to your payroll officer. Your decision is due no later than 75 days from your first payroll end date. Once you submit your election, your retirement plan election cannot be changed.

	Pension Plus plan	Defined Contribution plan
Income when you retire	After reaching age and service requirements, you would receive a guaranteed monthly benefit for life plus the additional retirement income you accumulate in your retirement investment account. You can decide how much and when to withdraw money from your retirement account, following IRS rules.	You would receive retirement income based on your contributions to the plan and investment earnings. There's no guaranteed benefit, and retirement income ends when the account is depleted. You can decide how much and when to withdraw the money from your retirement investment account, following IRS rules.
The people who depend on you	You would have the opportunity to provide a lifetime monthly benefit for an eligible survivor after your death. Beneficiaries would also receive your retirement investment account balance upon your death.	You would have the opportunity to name individuals as your beneficiaries to receive your retirement investment account balance upon your death.
If you become disabled	You would receive a pension benefit if you become totally and permanently disabled and unable to perform duties for which you are trained, educated or experienced. Your eligibility depends on if your disability was incurred while at work or outside of work. You would also have access to your employee contributions and any related earnings in your retirement investment account and Personal Healthcare Fund, along with any vested employer contributions and related earnings.	You would have access to your employee contributions and any related earnings in your retirement investment account and Personal Healthcare Fund, along with any vested employer contributions and related earnings.
Investment return and risk	Your pension payments would not be affected by the market's ups and downs or the risk of low returns on investments. But you would have the opportunity to use investment strategies to potentially build additional retirement income using the money you and your employer contribute to your retirement investment account.	Your retirement investment account would be affected by market fluctuations. You would invest the money you and your employer contribute to potentially build the value of your retirement account balance.
The money you put in	You would contribute toward both your future pension and your retirement investment account. **Pension Component:** You would make a mandatory contribution (graded, up to 6.4% of your pay), to your pension account. These contributions can be returned to you if you leave public school employment. **Savings Component:** You're automatically enrolled at a 4 percent contribution rate to your retirement investment account which allows you to receive your employer's full matching contributions to your retirement plan and Personal Healthcare Fund. You can make changes to your retirement investment account contributions at any time.	You would automatically be enrolled at an 8 percent contribution rate to your retirement investment account which allows you to receive your employer's full matching contributions to your retirement plan and Personal Healthcare Fund. You can make changes to your retirement investment account contributions at any time.
The money your employer puts in	**Pension Component:** Your employer makes contributions to help fund member benefits. **Savings Component:** Starting your first day on the job, you automatically began contributing 4 percent of your paycheck to your retirement investment account, which is made up of your Personal Healthcare Fund and your retirement savings. This automatic enrollment earns you your full employer match. For every dollar you contribute, up to 2 percent of your wages, you will receive an equal matching contribution to your account from your employer. This is directed to your Personal Healthcare Fund. For the next 2 percent of your wages that you contribute, your employer's matching contribution will be half of what you contributed, up to 1 percent of your wages. This, plus any additional contributions you make, is directed to your retirement savings.	Starting your first day on the job, you automatically began contributing 8 percent of your paycheck to your retirement investment account, which is made up of your Personal Healthcare Fund and your retirement savings. This automatic enrollment earns you your full employer match. For every dollar you contribute, up to 2 percent of your wages, you will receive an equal matching contribution to your account from your employer. This is directed to your Personal Healthcare Fund. For the next 6 percent of your wages that you contribute, your employer's matching contribution will be half of what you contributed, up to 3 percent of your wages. This, plus any additional contributions you make, is directed to your retirement savings.

Frequently Asked Questions

What are the steps I need to take?

1. Review all information carefully, including in the New Hire Retirement Plan Election Guide at **PickMiPlan.org**.
2. Complete and return the form to your payroll officer before the deadline. Make a copy for yourself.

Who can I talk to about my choices?

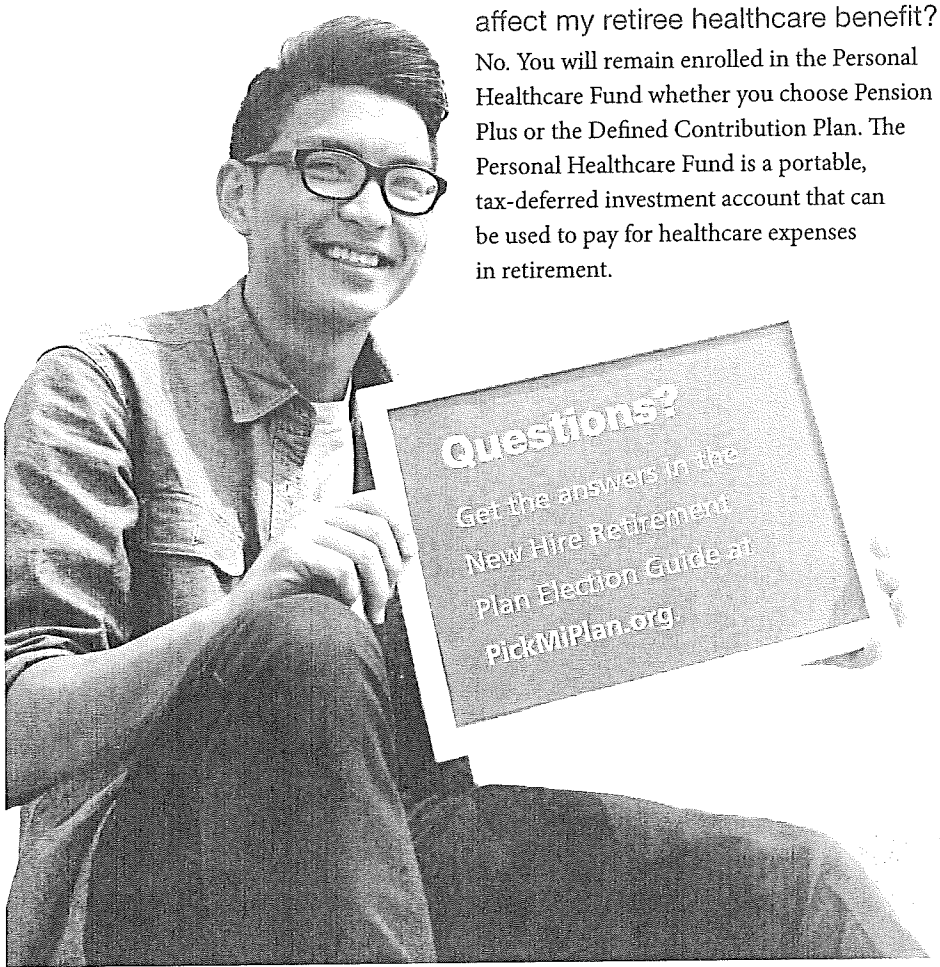
If you have questions after reviewing the New Hire Retirement Plan Election Guide, you can call us toll free. However, we cannot advise you on which retirement plan is right for you. Consider consulting a tax or financial advisor about your personal situation.

Call **1-800-381-5111** or log into miAccount at **www.michigan.gov/orsmiaccount** and use the secure Message Board for information about the Pension Plus pension account.

Call **1-800-748-6128** for information about the Pension Plus retirement investment account, the Defined Contribution plan and the Personal Healthcare Fund.

Does my choice of a retirement plan affect my retiree healthcare benefit?

No. You will remain enrolled in the Personal Healthcare Fund whether you choose Pension Plus or the Defined Contribution Plan. The Personal Healthcare Fund is a portable, tax-deferred investment account that can be used to pay for healthcare expenses in retirement.



Does my employer match my contributions to either plan?

Yes, your employer will match a portion of your contributions to either plan's retirement investment account. Your employer will match, dollar for dollar, your first 2 percent contribution to the Personal Healthcare Fund.

Are the investment options the same for the Pension Plus retirement investment account and the Defined Contribution plan?

Yes.

What type of account is the retirement investment account?

Your contributions to the retirement investment account in both the Pension Plus plan and the Defined Contribution plan, including the Personal Healthcare Fund, are invested in a 457 plan. Your employer's matching contributions are invested in a 401(k) plan.

What is the deadline for returning the form?

75 days from your first payroll end date.

Who can tell me what my first payroll end date was?

Ask your employer to confirm the date.

What happens if I don't do anything by the deadline?

You will remain a member of the Pension Plus plan.

What happens if I change my mind?

You cannot change retirement plans once you submit your election form or the deadline passes.

OFFICE of RETIREMENT SERVICES
ORS

3038629.G.P

Department of Technology, Management, & Budget
Office of Retirement Services
www.michigan.gov/ors (800) 381-5111
P.O. Box 30171
Lansing, MI 48909-7671

New Hire Retirement Plan Election

Michigan Public School Employees' Retirement System

If you first worked for a Michigan public school on or after September 4, 2012, you have 75 calendar days from your first payroll date (the last day of the first payroll period reported to ORS) to make your retirement plan election. If you do not make an election, you will remain a member of the Pension Plus plan.

Section I: Personal Information (Please print.)

MEMBER NAME (LAST, FIRST, M.I.)		LAST FOUR OF SSN XXX-XX-
MAILING ADDRESS		EMPLOYER (REPORTING UNIT NAME)
CITY, STATE, ZIP	PHONE: HOME OR CELL ( )	REPORTING UNIT NUMBER
EMAIL ADDRESS	WORK PHONE ( )	FIRST PAYROLL DATE

Tear or cut out this form along the dotted line.

Section II: Retirement Plan Selection

Please read the information included with this form and the New Hire Retirement Plan Election Guide at PickMiPlan.org carefully before choosing your retirement plan. Your retirement plan election is irrevocable. Regardless of your retirement plan election, you are also enrolled in the Personal Healthcare Fund retiree healthcare benefit.

☐ **Option 1: Defined Contribution plan.** I voluntarily choose to not become a member in the Pension Plus plan and to become a participant in the Defined Contribution plan, which provides a 50 percent employer match (not to exceed 3 percent of salary) on voluntary employee contributions of up to 6 percent of salary to a retirement investment account. I understand that retroactive to my first day worked, I will be automatically enrolled for a 6 percent employee contribution to my account in the State of Michigan 457 plan, which qualifies me for a 3 percent employer match paid into my account in the State of Michigan 401(k) plan. I understand that previous employer and employee contributions will be reconciled and deposited to the Defined Contribution plan.

☐ **Option 2: Pension Plus plan.** I voluntarily choose to become a member of the Pension Plus plan. I understand that the Pension Plus plan is a hybrid plan that contains a Pension Component with a mandatory employee contribution (graded, up to 6.4 percent of salary) and a Savings Component that provides an employer match of 50 percent (not to exceed 1 percent of salary) on voluntary employee contributions of up to 2 percent of salary to a retirement investment account. I understand that starting my first day worked, I will be automatically enrolled for a 2 percent employee contribution to my account in the State of Michigan 457 plan, which qualifies me for a 1 percent employer match paid into my account in the State of Michigan 401(k) plan.

Section III: Plan Selection Approval (Signature required.)

I acknowledge that my election is based on my individual circumstances. I understand that this election is based on current federal and state law, which takes precedence over any contrary information contained in this election form, and that those federal and state laws may change in the future and have an impact on the election I have made. I understand that each option has pluses and minuses for my situation. I further understand that I may change the automatic enrollmen for either retirement investment account and elect a different contribution percentage, on a prospective basis only. With these understandings, I voluntarily agree to this election.

MEMBER'S SIGNATURE	DATE

New Employee: Return this completed and signed form to your payroll officer as soon as possible but no later than 75 calendar days from your first payroll date (the last day of the first payroll period reported to ORS).

Employer: Report the new employee's retirement plan election to ORS as instructed in the Reporting Instruction Manual, chapter 7.11.00.01 – Reporting Employees New to the MPSERS System. Keep a copy of the completed election form for your records. Please do not send a copy to ORS.

R0940C (Rev. 7/2015)
Authority: 1980 PA 300, as amended

Lincoln Financial Group®

The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616
toll free (800) 423-2765 Fax (877) 573-6177
www.LFG.com

BENEFICIARY DESIGNATION FORM

Employer: Bloomfield Hills School District

Policy Number: 000010179188 Group ID#: _____

State: Michigan Insured's Name: _____

Certificate Number: _____

BENEFICIARY DESIGNATION

Primary Designation: _____

Address: _____

Relationship to Insured: _____

SSN: _____

Contingent Beneficiary: _____

Address: _____

Relationship to Insured: _____

SSN: _____

Note: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet to reflect this.

Insured's Signature: _____ Date Signed: _____