**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 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 are 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. By signing this agreement, I acknowledge and agree that **unless I provide appropriate direct deposit information to Bloomfield Hills Schools, any wages or earnings paid to me will be deposited on a pay card** and that a paper check will not be issued. I acknowledge my responsibility to retain a copy of this document.

Name (PLEASE PRINT)_____

Address_____City_____

State_____Zip_____Building/Department_____

Phone number __ __ __ - __ __ __ - __ __ __ __ _____
Employee Signature (***Required***)

**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

# 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

# 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:* ***Educated Choices*** Employment Transaction Form

| | | | |
|---|---|---|---|
| **Type of Employment Transaction** | ☐ New Hire ☐ Rehire ☐ Unpaid LOA ☐ Paid LOA ☐ Union Code Change<br>☐ Voluntary Termination ☐ Involuntary Termination ☐ Retirement<br>☐ 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**<br>**User Name:** _____<br>**Work Email Address:**_____<br>**Check Location:**_____<br>**Term Log:**_____<br>**Port Done:**_____<br>**Sungard Done:**_____ | ☐ Administrative: **A D** ___ ___<br>☐ Interpreter: **H I** ___ ___/ Intervener<br>☐ FT ☐ PT<br>☐ Teacher: **I N** ___ ___<br>☐ **< 75%** ☐ **75 – 99%** ☐ **FT**<br>☐ Parapro: **P P** _____/ Job Coach<br>☐ 5 hours<br>☐ Office Personnel: **C L** ___ ___<br>☐ Instruct. Assist.: **W L** ___ ___<br>☐ Aux Service: **A S** ___ ___ | ☐ Unaffiliated A: __ ___ ___ ___<br>☐ FT ☐ PT ☐ Technician<br>☐ Unaffiliated B: **U A** ___ ___<br>☐ Unaffiliated C: **U A** ___ ___<br>Nurse 2<br>☐ Unaffiliated E: **U A** ___ ___<br>☐ Unaffiliated F: **U A** ___ ___<br>DC/PS/LK/VH 10mos 12mos | |
| **Home Street Address** | | | |
| **City, State, Zip** | | | |
| **Home Phone Number** | ( ) | | |
| **Flex Sheet Done:**_____ | **Personal Email Address:**_____<br>For benefit confirmation statements | | |

*Date Entered to PS 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**
**7273 Wing Lake Rd, Bloomfield Hills, 48301**
**248-341-5406 fax: 248-341-5449**
**LSummers@Bloomfield.org**

# PRE-EMPLOYMENT CONSENT FOR CRIMINAL CONVICTION HISTORY CHECK

I am an applicant for an assignment with Bloomfield Hills Schools. I understand that I have been conditionally offered a position as a contract employee for the Bloomfield Hills Schools subject to a criminal conviction history check and/or fingerprinting.

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.***

RI-088A (02/2017)
MICHIGAN STATE POLICE
Criminal Justice Information Center

**AUTHORITY:** MCL 28.242
**COMPLIANCE:** Voluntary; however, failure to complete this Agreement will result in denial of request.

# MICHIGAN WAIVER AGREEMENT AND STATEMENT FOR SCHOOLS

## An Individual Applicant's Request for a Fingerprint-Based Criminal History Record Information (CHRI) Background Check Result for a Qualified Entity in Accordance with the Michigan School Volunteer & Employee Criminal History Program

Pursuant to the National Child Protection Act (NCPA) of 1993, as amended by the Volunteers for Children Act (VCA), this form should be completed and signed by every current or prospective employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity (i.e. school or management company) under these laws.

I hereby authorize (**enter name of Qualified Entity**) Bloomfield Hills Schools, to receive the results of my state and federal fingerprint-based CHRI background check result for the purpose of evaluating and determining my fitness to have responsibility for the safety and well-being of children or individuals with disabilities. Prior to submitting my fingerprints to the Michigan State Police to conduct a CHRI background check, I will complete, sign, and return this form and a Livescan Fingerprint Background Check Request form (RI-030). I understand the Qualified Entity will retain all required documentation for a period of time no less than prescribed by state or federal laws. By signing this Michigan Waiver Agreement and Statement, it is my intent to authorize the dissemination of any state and national CHRI that may pertain to me to the Qualified Entity with which I am, or am seeking to be, employed or to serve as a volunteer, pursuant to the NCPA VCA.

I understand that until the criminal history background check is completed, the Qualified Entity may choose to deny me unsupervised access to children or individuals with disabilities. I further understand that upon request the Qualified Entity will provide me a copy of the CHRI background results, if any, and that I am entitled to challenge the accuracy and completeness of any information contained in such results. I may obtain a prompt determination as to the validity of my challenge before the Qualified Entity makes a final decision about my status; as an employee, volunteer, contractor, or subcontractor.

| Printed/Typed Name | | | Date of Birth |
|---|---|---|---|
| Address | City | State: Michiga | ZIP Code |

What is your current or prospective status (check **one**)?
☐ Employee ☐ Volunteer ☐ Contractor/Vendor

Have you ever been convicted of a crime?
☐ Yes ☐ No

If yes, please provide a description of the crime and the particulars of the conviction.

I understand that I may be asked to assist with obtaining any and all official disposition documentation regarding my conviction.

If you are an employee, prospective employee, or a volunteer of a public school academy, do you authorize release of your CHRI results to another qualified entity (i.e. school or management company) for a like purpose? If yes, indicate the name of the other qualified entity below.
☐ Yes ☐ No **Not applicable to Bloomfield Hills Schools**

Name of Other Qualified Entity
**Not applicable to Bloomfield Hills Schools**

| Signature | Date Signed |
|---|---|
| | |

**ORIGINAL - MUST BE RETAINED BY QUALIFIED ENTITY**

# 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.**

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

Human Resources,
Payroll & Benefits

Booth Center
7273 Wing Lake Road
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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.<br><br>Injuries where an employee must be admitted to a hospital must be reported to the Benefits Coordinator (248)341-5431 or the Director 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.<br><br>1st 28 DAYS<br><br>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 Director 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

Booth Center
7273 Wing Lake Road
Bloomfield Hills, MI 48301

t: 248.341.5430
f: 248.341.5449
www.bloomfield.org

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 Director 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.**

**MICHIGAN OFFICE OF RETIREMENT SERVICES**
P.O. Box 30171 · Lansing, MI 48909-7671 www.michigan.gov/ors 800-381-5111
517-322-5103

# Your Retirement Plan Election

**Michigan Public School Employees' Retirement System**

As a new Michigan public school employee, 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 in the Pension Plus plan.

| MEMBER'S NAME (LAST, FIRST, M.I.) | LAST FOUR OF SSN<br>XXX-XX- | EMPLOYER (REPORTING UNIT NAME) |
|---|---|---|
| MAILING ADDRESS | DAYTIME TELEPHONE<br>- - | REPORTING UNIT NUMBER |
| CITY, STATE, ZIP CODE | WORK TELEPHONE<br>- - | FIRST PAYROLL DATE |

## Section I – Retirement Plan Selection

Carefully read the information included with this form and the Retirement Plan Election Guide at **PickMiPlan.org** 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 (DC) plan**. I voluntarily choose to not become a member in the Pension Plus plan and to become a participant in the Defined Contribution (DC) plan, which currently 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 the 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 State of Michigan 457 Plan, which qualifies me for a 3 percent employer match paid into my State of Michigan 401(k) Plan. I understand that previous employer and employee contributions to the Pension Plus plan will be reconciled and deposited to the DC plan.

On October 1, 2017, my employer will begin contributing an additional 4 percent to my 401(k) Plan, regardless of how much I contribute to my 457 Plan. On February 1, 2018, the employer match toward my retirement savings will change to 100 percent of my contributions to my 457 Plan, up to 3 percent of my wages. This is in addition to the 4 percent mandatory contribution.

☐ **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 retirement plan that contains a Pension Component with a mandatory employee contribution (starting at 3 percent of my pay and increases incrementally up to 6.4 percent based on my fiscal year earnings) 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 State of Michigan 457 Plan, which qualifies me for a 1 percent employer match paid into my State of Michigan 401(k) Plan.

Tear or cut out this form along the dotted line.

## Section II – 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 enrollment 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.

Department of Technology, Management & Budget
R0940C (Rev. 7/2017) Authority: 1980 PA 300, as amended

# Your Retirement Plan Election

## Michigan Public School Employees' Retirement System

# Get ready to make your retirement plan election

As a new Michigan public school employee, you have a decision to make for your future retirement plan. Enclosed you will find resources to help you make your decision, including:

- access to the online Retirement Plan Election Guide
- an overview of your plan options
- the *Your Retirement Plan Election (R0940C)* 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 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 with help from Voya Financial.®

# 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 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 investment 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.<br>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. 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. | You have the opportunity to take advantage of market fluctuations by the type and timing of your investments. However, investment returns are not guaranteed and your account could lose value.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.<br>**Pension Component:** You would make a mandatory contribution (starting at 3 percent of your pay and increases incrementally up to 6.4 percent based on your fiscal year earnings), to your pension account. These contributions can be returned to you if you leave public school employment.<br>**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 or fund selections 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 or fund selections at any time. |
| The money your employer puts in | **Pension Component:** Your employer makes contributions to help fund member benefits.<br>**Savings Component:** 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.<br>To receive the maximum match, you will need to contribute 4 percent and you will receive 3 percent from your employer. | 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.<br>To receive the maximum match, you will need to contribute 8 percent and you will receive 5 percent from your employer.<br>On October 1, 2017, your employer will begin contributing an additional 4 percent to your retirement investment account, regardless of how much you contribute. On February 1, 2018, the employer match toward your retirement savings will change to 100 percent of your contributions up to 3 percent of your wages. This is in addition to the 4 percent mandatory contribution. |

# Frequently Asked Questions

## Who is ORS?

ORS is an award-winning retirement organization driven to empower our customers for a successful today and a secure tomorrow. We administer the statewide retirement plans for Michigan public school employees, state employees, State Police, judges, and the Michigan National Guard. We partner with Voya Financial® to offer low-cost, high-performance plans for all our members. The teams at ORS and Voya are here to answer your questions and support you on your journey to retirement.

## What are the steps I need to take?

1. Review all information carefully, including in the Retirement Plan Election Guide at **PickMiPlan.org**.
2. Complete and return the Retirement Plan Election 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 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.

Visit **PickMiPlan.org** for more information about the Pension Plus retirement investment account, the Defined Contribution plan and the Personal Healthcare Fund or call **1-800-748-6128**.

## 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 (in which your employer matches your contribution dollar-for-dollar) 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.

## 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?

The deadline is 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.

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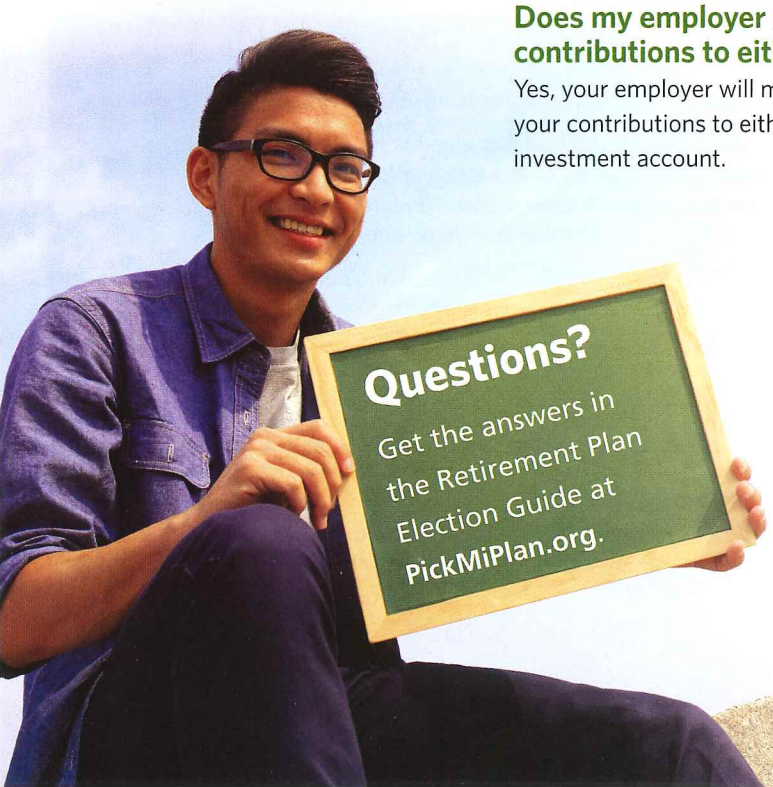
*This content summarizes plan provisions under PA 300 of 1980, as amended. Current laws, rates, and factors are subject to change. Should there be discrepancies between this publication and the actual law, the provisions of the law govern.*




MICHIGAN OFFICE OF RETIREMENT SERVICES
*Big Plans. Small Steps.*

CN0307-31800-0419D 3038629.G.P

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: _____