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 ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

FOR BENEFIT ENROLLMENT PURPOSES

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) _____

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
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	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

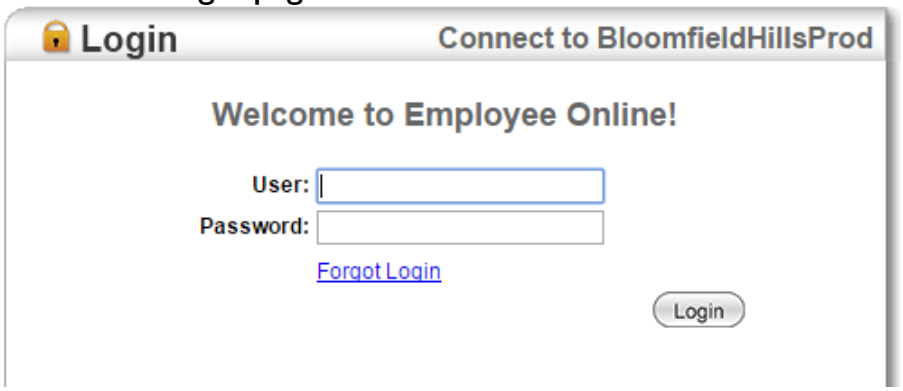
E-VOUCHER INFORMATION
VIEW PAYCHECK ON-LINE FROM ANYWHERE

Name: _____

Employee ID number: _____

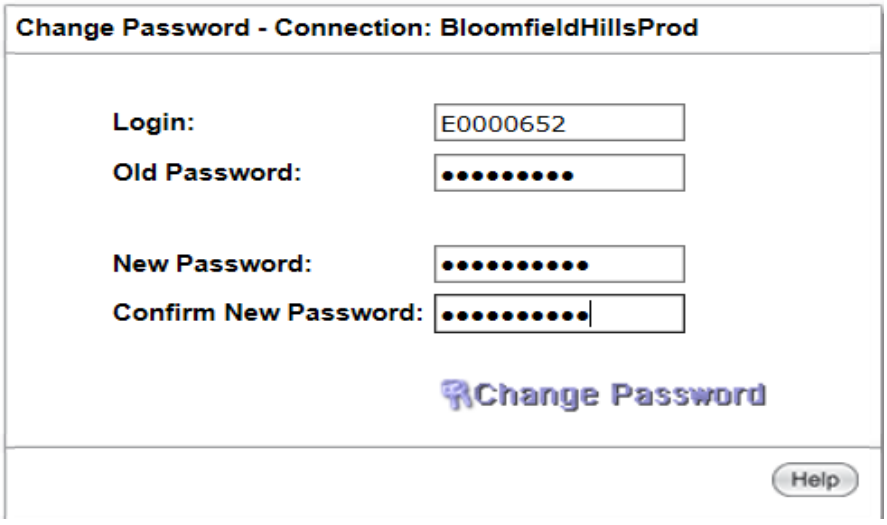
Step 1: Go to https://bloomfield.mipeer.org/
A link to this site is available on the BHS website

Step 2: Once on the log in page:

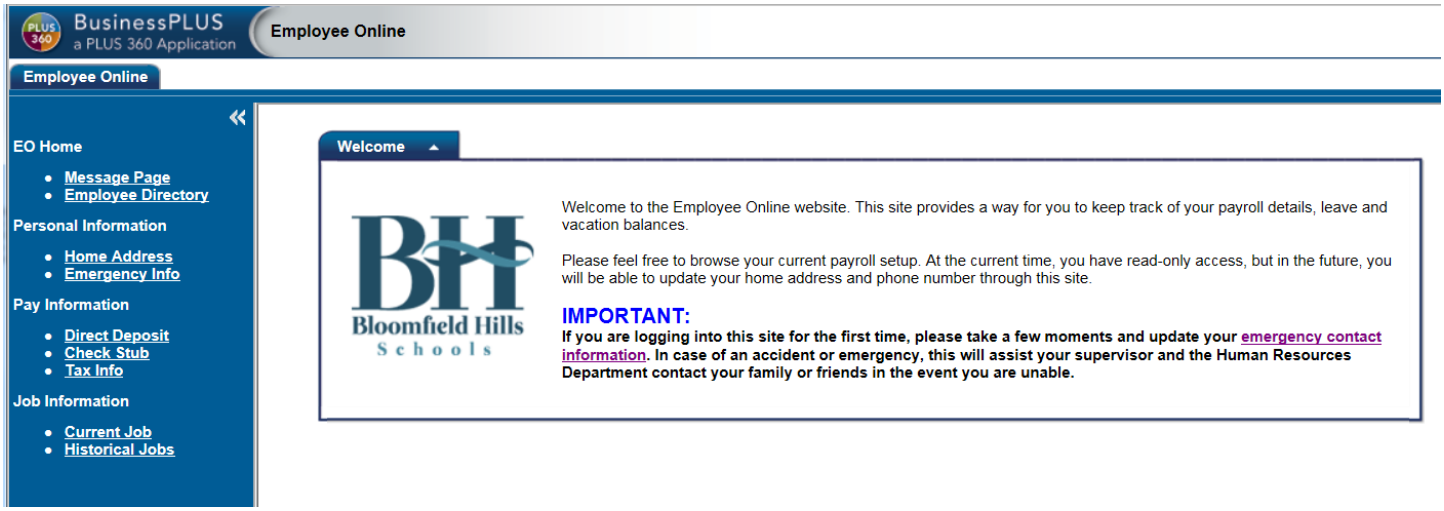


Enter your new employee ID number in the user name box. Your temporary password is your nine-digit Social Security Number (no dashes).

Step 3: Once logged in, you will be prompted to change your password:



You will then be directed to your home page, where you can click on the links on the left-hand side of the screen to access your personal information, including check stub details, current tax withholding and direct deposit information, as well as an employee directory.



You are encouraged to enter your Emergency Info, as this will aid your building/department secretary and principal/supervisor in the event of an emergency and your family or other designated individual(s) need to be contacted.

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.

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

FOR ALL: SUBSTITUTES

Completion of on-line training course: All substitute staff 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.

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 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.

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 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:_____

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** _____

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Coordinator at sdare@bloomfield.org or 248-341-5431

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

PART B: Information About Health Coverage Offered by Your Employer

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

Bloomfield Hills School District	(EIN): 38-6003046	
7273 Wing Lake Road	248-341-5431	
Bloomfield Hills	MI	48301

Who can we contact at this job? Sarah Dare or Karen Healy	
Phone number: 248-341-5431 or 248-341-5432	Email address: sdare@bloomfield.org or khealy@bloomfield.org

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

- As your employer, we offer a health plan to: Teachers, Administrators, Interpreters, Interveners, Clerical, Program Aides, Bus Aides, Instructional Assistants, ParaEducators, Job Coaches, AFSCME, and Technicians.
- We also offer coverage to eligible dependents. Eligible dependents are an employee's son, daughter, stepson, stepdaughter, adopted child, child placed for adoption or foster child, up to their 26th birthday
- We offer a medical plan that meets the minimum value standard, and the cost of this coverage is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Government announces delays

On July 2, 2013, the federal government announced that there will be a one-year delay in requiring employer groups with 50 or more full-time equivalents to provide health coverage to their employees or receive a penalty.

Further, the IRS is making the coverage reporting requirements that apply to any provider of minimum essential coverage and that apply to applicable large employers voluntary in 2014 with intent to make them mandatory in 2015. The remaining ACA provisions are still applicable to coverage that is offered.

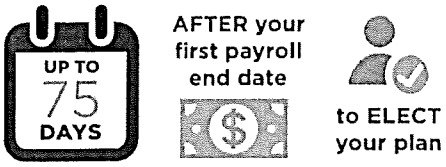
[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

MICHIGAN OFFICE OF RETIREMENT SERVICES
Big Plans. Small Steps.

YOUR RETIREMENT PLAN ELECTION

Employees who first worked on or after February 1, 2018

Your retirement journey begins today with an important first step—choosing your plan. The plan you choose will be your retirement plan throughout your entire career as a Michigan public school employee.



Choose between the **Pension Plus 2 plan** or the **Defined Contribution (DC) plan** within 75 days of your first payroll end date. If you make no election you'll become a participant in the DC plan.

YOUR NEXT STEPS

STEP 1

READ about your retirement benefit options at **PickMiPlan.org** and talk about your plan options with the people in your life affected by your decision.

STEP 2

RECEIVE a welcome letter containing your Member ID from the Office of Retirement Services.

STEP 3

ELECT your retirement plan anytime within the 75-day window by logging in to miAccount at **www.michigan.gov/orsmiaccount**. You'll need your Member ID to register.

Control Your Future

You have a short time to elect which plan is right for you, so be sure you don't miss the deadline. Once you submit your election or the deadline passes, your retirement plan election can't be changed. If the deadline passes, you'll be enrolled automatically in the DC plan.

R0615C

- *Marital & family issues*
- *Addictions*
- *Emotional problems*
- *Legal & financial concerns*
- *Careers*
- *Relationships*
- *Aging parents*
- *Stress, anxiety & depression*
- *Life enrichment techniques*

HelpNet

...for life's safe landings!

If you are worried about your family, personal life - or work, call HelpNet - your free personal employee assistance program!

For more information, or to make an appointment call:

1 (800) 969-6162

or

1 (269) 660-3900

Free help is just a call away - 24/7!

Life is a balancing act.
Use a very good 'net.'

HelpNet

Visit our website!

www.helpneteap.com

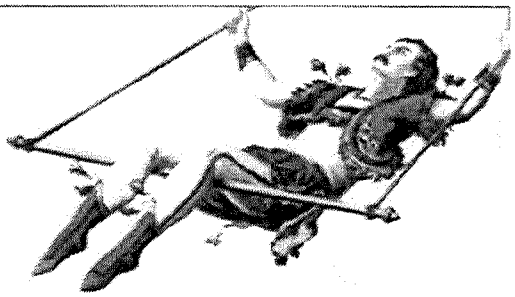
Life is a balancing act.

Use a very good 'net.'

HelpNet

Your personal employee assistance program!

HelpNet *is here for you and your family!*



Your employer has contracted with HelpNet to provide personal counseling to you and your household members. Our counselors are all master's level professionals with extensive experience in dealing with:

- *Marital & family issues*
- *Addictions*
- *Emotional problems*
- *Legal & financial concerns*
- *Careers*
- *Relationships*
- *Aging parents*
- *Stress, anxiety & depression*
- *Life enrichment techniques*

There is no cost to you or your family at HelpNet - and it's confidential!*

**HelpNet strictly adheres to all state and federal guidelines and regulations pertaining to patient confidentiality. If a contracting employer seeks information, we provide only statistics - no names or diagnoses are ever given without written permission from the patient. The only exception to that is by a court order, if there is a possibility that the patient may harm him or herself or be injured by another, or when child abuse or neglect is suspected.*

Just call us!

At HelpNet, we understand that problems don't always wait for regular 9 a.m. to 5 p.m. workday hours. That's why we are on-call 24 hours a day, 7 days a week, 365 days a year!

When you contact us, we will offer you an appointment *within 72 business hours of your call* - but if you are in crisis or in an emergency situation, you may request to speak to a counselor *right away!*

Call anytime!
24 hours a day - 365 days a year!
1-800-969-6162
Corporate Office

HelpNet offers:

Assessment

Your counselor will talk to you about your concerns and together you will decide the primary issues that need to be resolved. Then we'll offer...

Brief Counseling

If caught in the early stages, many problems can be handled right in the HelpNet office in just a few sessions. These 'brief counseling sessions' have been prepaid by your employer as a part of the overall Employee Assistance Program package. There is no cost to you!

A Community Referral

Some problems require more time - or are outside of our scope of services. In the event this happens,we will guide you to an affordable community professional with a good reputation for helping other people in your situation. We'll explain your health benefits package provided by your employer and any co-pay or out-of-pocket expenses you may incur.