UNIVERSITY OF OREGON Business Affairs Office

Clear Form

Employee Information Form

Please return this form to your hiring department by fax or U.S. Mail.

Section 1. To be completed by employee

Employee Name *(As listed on Social Security Card.)*

Last _____

First _____

Middle _____

Preferred First Name _____

SSN _____ **UO ID #** _____ (if known)

Date of Birth _____

Gender: ☐ Male ☐ Female

Oregon Retirement Plans: I am/or was a member of

☐ PERS ☐ ORP

Race/Ethnicity (completion of this section is optional)

1. Are you Hispanic or Latino? ☐ Yes ☐ No

2. Select one or more of the following races:

☐ Asian

☐ American Indian or Native Alaskan

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander

☐ White

3. **Racial or ethnic subgroup:** _____

Citizenship

☐ U.S. Citizen

☐ U.S. Resident Alien

☐ Foreign National (Non-Resident Alien)

Country of Residence: _____

Mailing Address

Street _____

City _____ State _____

Zip _____ Nation _____

Home Phone _____

Employee Signature _____ **Date:** _____

Section 2. To be completed by department *(After completion of Section 1 and 2, send to Payroll Office)*

Employee Class _____ ☐ New Hire ☐ Rehire

Monthly Appt % _____ Start Date _____

If applicable:

Employee is transferring from _____
OUS Institution / State Agency

Employee will be employed part-time at _____ (OUS institution)

Campus Address / Phone Numbers

Rm No. Bldg _____

Zip Plus 4 _____

Campus Phone _____

☐ ***Check box if Proximity card required* for bldg access?**

Department Name and Check Delivery

Department Name _____

Department Org _____

Earnings Statement Org _____
(if other than hiring dept)

☐ **Direct Deposit** *(complete paper form or enroll via DuckWeb)*

☐ with Paperless Earnings Statement Option

☐ **Pick-up check at Payroll Office**

Authorization

_____
Payroll Administrator's Name (Printed)

_____
Payroll Administrator's Signature

Email Address _____

Phone Number _____

Date Signed _____

Clear Form

Instructions

UNIVERSITY OF OREGON Business Affairs Office

Payroll Request Form

Job Change Reason _____

Identification

Name _____ (Last) _____ (First) _____ (Middle) UO ID _____ Position _____ Suffix ____

Department _____ Time Entry Org _____ E Class _____

Job Detail

Effective Date _____ **Type:** ☐ Primary ☐ Secondary ☐ Overload **Annual Basis:** ☐ 9 month ☐ 12 month

Job End Date _____

Title _____ (30 Char. Abbreviations)

Appt % (Actual FTE) _____ Hourly Rate $ _____

Job Location: (Outside Oregon) Monthly Salary $ _____

City _____ Appt. Salary $ _____

State ____ Country _____ Base Rate $ _____

☐ **Unclassified**
- ☐ Regular
- ☐ Adjunct
- ☐ Visiting

☐ **Classified**

Type _____

Range _____

Step _____

GTF ☐

Type _____

Grade _____

	Appt %	Monthly $
F		
W		
S		
U		

Tuition Code _____

Grad School Use:
- ☐ GTF Auth. Release
- ☐ GTF Tuition
- ☐ Department Copy
- ☐ Other: _____

Labor Distribution (Please use a PAW for additional lines)

	Index	Fund	Org	Acct	Pgm	Activity	Monthly $	%
1								
2								
3								
4								
5								
Total								

Employee Leave

Begin Date _____ End Date _____

Reason _____

Employee Separation

Date _____ Reason _____

Remarks

Employee's Supervisor

Last Name _____ First Name _____

UO ID _____ Position _____ Suffix ____

Department Contact	Authorization	Print	Sign	Phone	Date
Name	Principal Investigator				
Date	Dept Head				
Phone	Dean/Dir.				
	Appt. Auth.				

Form W-4 (2018)

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

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

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

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

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

General Instructions

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

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

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

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

---

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

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

Employee's Withholding Allowance Certificate

► Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074
2018

1 Your first name and middle initial	Last name	2 **Your social security number**

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

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

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

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

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

IRS Form W-4 Employee's Withholding Allowance Certificate (Required**)**

W-4 Overview

Completing this IRS form is a requirement for every new employee. The W-4 form determines how much tax will be withheld from each paycheck. A yearly renewal of the W-4 is not required unless a change in law makes it mandatory.

Note: Do not complete the worksheet on the W-4. It only applies to U.S. citizens, residents, or foreign nationals who have met the substantial presence test.

Instructions for Completing the W-4

On line 3 of the W-4, you must select the "Single" status, or the box entitled, "Married, but withhold at higher Single rate."

On line 5, you have the option of claiming "0" or "1" allowance. If you claim "0", more tax will be withheld from your paycheck.

Exceptions to line 5 restrictions:

- Residents of Canada, Mexico and South Korea may claim more than one allowance, if certain conditions are met.
- Students from India may claim an allowance for an accompanying spouse and dependent children who are U.S. citizens or residents, if certain conditions are met.
- Nationals of American Samoa and the Northern Mariana Islands may also claim allowances for dependents

On line 6, above the dotted line, write in NRA (for Nonresident) to denote your international status.

On line 7, you may not claim exempt status. (However, you may qualify to claim exemption from U.S. taxes based on a tax treaty. Please refer to the tax treaty section above for completion of appropriate forms.)

For additional tax information, see IRS Publication 519 U.S. Guide for Aliens.

Employment Eligibility Verification

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

Clear Form

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

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

Refer to the instructions for more information about acceptable receipts.

UNIVERSITY OF OREGON Business Affairs Office

Clear Form

Direct Deposit Authorization

(Campus mail to Payroll or Student Loans: US Mail to University of Oregon Business Affairs PO Box 3237 Eugene, OR 97403-0237)
(Please do not email private banking information)

☐ ***Start*** ☐ ***Stop*** ☐ ***Reactivate*** ☐ ***Change***

UO ID: _____ **Name:** _____ (Last) _____ (First) _____ (Middle)

Phone: _____ **UO Email:** _____ (UO email address)

Check One: ☐ **Payroll Only** ☐ **A/P Only** (Travel, reimbursements, grant advances, non-athletic stipends) ☐ **Both**

_____ (Name of Bank or Credit Union) _____ (Account Number) ☐ **Checking** ☐ **Savings**

Note: We are unable to offer the option of investment banks, money market accounts or foreign banks for direct deposit.

Optional Distributions for Payroll Deposits:

Fixed Amount	Name of Bank or Credit Union	Account Number	
$ _____	_____	_____	☐ Checking ☐ Savings
$ _____	_____	_____	☐ Checking ☐ Savings
$ _____	_____	_____	☐ Checking ☐ Savings

I authorize the University of Oregon to make the payments indicated above via direct deposit to my account(s) in the financial institution(s) named. I authorize the financial institution(s) to accept any credit entries to the above account(s) initiated by the University of Oregon. If funds to which I am not entitled are deposited to my account, I authorize the University of Oregon to direct the financial institution(s) to return said funds. I acknowledge that this direct deposit authorization must comply with Oregon and U.S. law.

I understand that three weeks may pass before this authorization takes effect. I understand that the University needs up to three business days to make the transfer to my account(s) after funds become available. I understand that it is my responsibility to verify that payments have been credited to my account(s) and that the University of Oregon assumes no liability for overdrafts for any reason. I understand that in the event my financial institution is not able to deposit any transfer into my account due to any action I take, the University cannot issue the funds to me until the funds are returned to the University by my financial institution.

I understand that this authorization will override any previous authorization and will remain in effect until a) revoked by my written request; or b) six months after the termination of my last appointment at the University; or c) six months after my last student registration.

☐ I would like to select the "paperless" option and view my earning statement each month on DuckWeb.

Will this money ultimately be routed to a foreign bank account?

☐ Yes, this deposit will ultimately be routed to a bank outside the US (not common).

☐ No, this deposit is going only to the bank I already designated above.

Note: If the destination of your direct deposit payment changes, please login to DuckWeb and update your direct deposit record.

Signature _____ Date _____

Attach voided check(s) or document(s) from your bank that provide routing and account numbers.

Deposit slips and ATM receipts are NOT acceptable.

For questions please call Payroll (541) 346-3151.

Veteran Classification and Self-Identification

This employer is a federal contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA) which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

- A **"disabled veteran"** is one of the following:
  - a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
  - a person who was discharged or released from active duty because of a service-connected disability.
- A "**recently separated veteran**" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "**active duty wartime or campaign badge veteran**" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "**Armed forces service medal veteran**" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA-the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at 1-866-4-USA-DOL.

Name: _____ UO Start Date: _____ Department: _____

☐ **I identify as one or more of the classifications of protected veterans listed.**
NOTE: If the Date of Discharge is within the past three years, and this option is selected, then you are selecting a classification as a "recently separated veteran"

Date of Discharge MM/DD/YYYY ☐

- ☐ Disabled Veteran
- ☐ Active wartime or campaign badge veteran
- ☐ Armed forces service medal veteran

☐ **I am a protected veteran, but I choose not to self-identify the classification to which I belong**
☐ **I am not a protected veteran**
☐ **I am not a veteran**

Reasonable Accommodation Notice

If you are a disabled veteran it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations. This information will assist us in making reasonable accommodations for your disability.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

Please print and complete all Self-Identification forms and return via campus mail in a sealed envelope marked "Confidential" to the Office of Affirmative Action & Equal Opportunity. This form is available in alternative formats by contacting the Office of Affirmative Action & Equal Opportunity, as noted below.

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ YES, I HAVE A DISABILITY (or previously had a disability)

☐ NO, I DON'T HAVE A DISABILITY

☐ I DON'T WISH TO ANSWER

_____ _____

Your Name Today's Date

UO Start Date: _____ Department: _____

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

Please print and complete all Self-Identification forms and return via campus mail in a sealed envelope marked "Confidential" to the Office of Affirmative Action & Equal Opportunity. This form is available in alternative formats by contacting the Office of Affirmative Action & Equal Opportunity, as noted below.

Office of Affirmative Action and Equal Opportunity, 677 East 12th Avenue, Suite 452, 5221 University of Oregon, Eugene OR 97403-5221
Office (541) 346-3123 · FAX (541) 346-4168

SOCIAL SECURITY ADMINISTRATION

NOTICE TO THIRD PARTY OF SOCIAL SECURITY NUMBER ASSIGNMENTS

PART A

IMPORTANT: THIS INFORMATION IS FOR YOUR USE IN PREPARING WAGE OR TAX REPORTS OR FOR COMPLETION OF YOUR RECORDS

FROM: Social Security Administration
Attn: Jerry Rygg
2504 Oakmont Way
Eugene, OR 97401

TO: Payroll Office
P.O. Box 3237
University of Oregon
Eugene, OR 97403-0237

A social security number has been assigned and a social security card mailed to the following person(s) who requested we notify you directly of the number.

APPLICANT	NUMBER

SSA REPRESENTATIVE TITLE DATE

PART B

Last Name: First Name:

I authorize the Social Security Administration to release information about me to University of Oregon for the purposes of tax reporting. The information to be released will include name and Social Security number. This consent is in effect for six months, or until such time as I withdraw my authorization.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____

Date: _____ Relationship: Employee

Form **SSA-7028** (2-1993) EF (12-2001)

Clear Form

University of Oregon
FOREIGN NATIONAL DATA REQUEST FORM

The information requested on this form is used to determine your U.S. tax withholding status. You must complete this form (1) **before beginning employment**, (2) **if your visa status changes**, and (3) **at the beginning of each calendar year**. *If you are not currently working, and do not plan to work in the next year you are not required to complete and turn in this paperwork.*

PLEASE ATTACH A COPY, FRONT AND BACK, OF YOUR MOST RECENT DOCUMENTS: I-94, I-20, DS-2019, or EAC (Employment Authorization Card)

PART 1 – PERSONAL INFORMATION AND RESIDENCY INFORMATION

1. Last Name First Middle	**2**. UO ID
3. Street Address (U.S.)	**4**. Work phone number
5. City State Zip Code	**6**. UO Department
7. E-mail Address	**8**. Personal phone number
9. **First** time you entered USA for any purpose since 1985 (Month/Day/Year)	
10. Country of Citizenship	
11. Country of Permanent Residence (if different from question 10)	

PART 2 – SUBSTANTIAL PRESENCE TEST – DETERMINATION OF RESIDENCE STATUS FOR TAX WITHHOLDING

INSTRUCTIONS: List **ALL** days of presence in the U.S. for **ANY** calendar year going back to **January 1, 1985** using the chart below and on page 2. A "calendar year" refers to the period January 1 to December 31. The information requested on this form is used to determine your U.S. tax withholding status and treaty eligibility.

SUBSTANTIAL PRESENCE TEST DATA (CURRENT YEAR IN USA):

In the chart below, include **ALL** days you expect to be present in the United States (at **ANY** school or location within the United States) for the current calendar year:

Calendar Year	Purpose: (for example teacher, researcher, or student). List all dates for mid-year changes (month/day/year).	Visa Type (F-1, J-1, etc.)	Number of days **expected** to be present in the U.S. beginning from Jan 1st
2018			

PART 2 (CONT.) – SUBSTANTIAL PRESENCE TEST DATA FOR ALL PREVIOUS YEARS IN USA:

In the chart below, include **ALL** days you were present in the United States (at **ANY** school or location within the United States) during any calendar year going back to **January 1, 1985**:

Calendar Year	Purpose: (for example teacher, researcher, or student). List all dates for mid-year changes (month/day/year).	Visa Type (F-1, J-1, etc.)	Number of days **actually** present in the U.S. during the year.
1985	**INCLUDE ALL DAYS PRESENT IN THE USA SINCE 1985.**		

PART 3 – CERTIFICATION

If the country of your permanent residency has a tax treaty benefit, do you wish to start or continue claiming treaty benefits? ****** Yes ☐ No ☐

****** If you claim treaty benefits and:

If you are a **Non-Resident Alien (NRA)** for U.S. tax purposes, you will need to complete a new **Form 8233** for each calendar year you are claiming the tax treaty benefit; or

If you are a **Resident** for U.S. tax purposes, you will need to have a **Form W-9** on file with the U of O.

I certify that to the best of my knowledge and belief all the information I have provided is true, correct, and complete. I acknowledge that if I have claimed a tax treaty benefit, the UO has the right to deny treaty benefits if eligibility cannot be clearly determined.

Signature: _____ **Date:** _____

Form **8233**

(Rev. March 2009)

Department of the Treasury
Internal Revenue Service

Exemption From Withholding on Compensation for Independent (and Certain Dependent) Personal Services of a Nonresident Alien Individual

► **See separate instructions.**

Clear Form

OMB No. 1545-0795

Who Should Use This Form? **Note:** *For definitions of terms used in this section and detailed instructions on required withholding forms for each type of income, see* ***Definitions*** *on pages 1 and 2 of the instructions.*	**IF** you are a nonresident alien individual who is receiving . . .	**THEN,** if you are the beneficial owner of that income, use this form to claim . . .
	Compensation for independent personal services performed in the United States	A tax treaty withholding exemption (Independent personal services, Business profits) for part or all of that compensation and/or to claim the daily personal exemption amount.
	Compensation for dependent personal services performed in the United States	A tax treaty withholding exemption for part or all of that compensation. **Note:** ***Do not*** *use Form 8233 to claim the daily personal exemption amount.*
	Noncompensatory scholarship or fellowship income **and** personal services income **from the same withholding agent**	A tax treaty withholding exemption for part or all of **both** types of income.
DO NOT Use This Form. . .	**IF** you are a beneficial owner who is . . .	**INSTEAD,** use . . .
	Receiving compensation for dependent personal services performed in the United States **and** you are **not** claiming a tax treaty withholding exemption for that compensation	Form W-4 (See page 2 of the Instructions for Form 8233 for how to complete Form W-4.)
	Receiving noncompensatory scholarship or fellowship income **and** you are **not** receiving any personal services income **from the same withholding agent**	Form W-8BEN or, if elected by the withholding agent, Form W-4 for the noncompensatory scholarship or fellowship income
	Claiming only foreign status or treaty benefits with respect to income that is **not** compensation for personal services	Form W-8BEN

This exemption is applicable for compensation for calendar year 2018 , or other tax year beginning _____ and ending _____ .

Part I Identification of Beneficial Owner (See instructions.)

1 Name of individual who is the beneficial owner	**2** U.S. taxpayer identifying number	**3** Foreign tax identifying number, if any (optional)

4 Permanent residence address (street, apt. or suite no., or rural route). **Do not use a P.O. box.**

City or town, state or province. Include postal code where appropriate.	Country (do not abbreviate)

5 Address in the United States (street, apt. or suite no., or rural route). **Do not use a P.O. box.**

City or town, state, and ZIP code

Note: *Citizens of Canada or Mexico are not required to complete lines 7a and 7b.*

6 U.S. visa type	**7a** Country issuing passport	**7b** Passport number
8 Date of entry into the United States	**9a** Current nonimmigrant status	**9b** Date your current nonimmigrant status expires

10 If you are a foreign student, trainee, professor/teacher, or researcher, check this box . . . . . ► ☑

Caution: *See the* ***line 10 instructions*** *for the required additional statement you must attach.*

Part II Claim for Tax Treaty Withholding Exemption and/or Personal Exemption Amount

11 Compensation for independent (and certain dependent) personal services:

a Description of personal services you are providing

b Total compensation you expect to be paid for these services in this calendar or tax year $

12 If compensation is exempt from withholding based on a tax treaty benefit, provide:

a Tax treaty **and treaty article** on which you are basing exemption from withholding

Article number ( ) of the U.S./( ) tax treaty.

b Total compensation listed on line 11b above that is exempt from tax under this treaty $

c Country of permanent residence

Note: *Do not complete lines 13a through 13c unless you also received compensation for personal services* ***from the same withholding agent.***

13 Noncompensatory scholarship or fellowship income:

a Amount $

b Tax treaty **and treaty article** on which you are basing exemption from withholding

c Total income listed on line 13a above that is exempt from tax under this treaty $

14 Sufficient facts to justify the exemption from withholding claimed on line 12 and/or line 13 (see instructions)

Note: *Lines 15 through 18 are to be completed only for certain independent personal services (see instructions).*

15 Number of personal exemptions claimed ▶ N/A	**16** How many days will you perform services in the United States during this tax year? ▶ N/A

17 Daily personal exemption amount claimed (see instructions) ▶

18 Total personal exemption amount claimed. Multiply line 16 by line 17 ▶ 0.00

Part III Certification

Under penalties of perjury, I declare that I have examined the information on this form and to the best of my knowledge and belief it is true, correct, and complete. I further certify under penalties of perjury that:

- I am the beneficial owner (or am authorized to sign for the beneficial owner) of all the income to which this form relates.
- The beneficial owner is not a U.S. person.
- The beneficial owner is a resident of the treaty country listed on line 12a and/or 13b above within the meaning of the income tax treaty between the United States and that country.

Furthermore, I authorize this form to be provided to any withholding agent that has control, receipt, or custody of the income of which I am the beneficial owner or any withholding agent that can disburse or make payments of the income of which I am the beneficial owner.

Sign Here ▶ Signature of beneficial owner (or individual authorized to sign for beneficial owner) Date

Part IV Withholding Agent Acceptance and Certification

Name	Employer identification number
University of Oregon	46-4727800

Address (number and street) (Include apt. or suite no. or P.O. box, if applicable.)

P.O. Box 3237

City, state, and ZIP code	Telephone number
Eugene, OR 97403-0237	541-346-3151

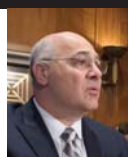
Under penalties of perjury, I certify that I have examined this form and any accompanying statements, that I am satisfied that an exemption from withholding is warranted, and that I do not know or have reason to know that the nonresident alien individual is not entitled to the exemption or that the nonresident alien's eligibility for the exemption cannot be readily determined.

Signature of withholding agent ▶ Date ▶

BUREAU OF LABOR AND INDUSTRIES

Oregon FAMILY LEAVE ACT

Brad Avakian, Commissioner



NOTICE TO EMPLOYERS AND EMPLOYEES

The Oregon Family Leave Act (OFLA) requires employers of 25 or more employees to provide eligible workers with protected leave to care for themselves or family members in cases of death, illness, injury, childbirth, adoption and foster placement. ORS 659A.150-659A.186

When can an Employee take Family Leave?

Employees can take family leave for the following reasons:

- **Parental Leave** during the year following the birth of a child or adoption or foster placement of a child under 18, or a child 18 or older if incapable of self-care because of a mental or physical disability. Parental leave includes leave to effectuate the legal process required for foster placement or adoption.
- **Serious health condition leave** for the employee's own serious health condition, or to care for a spouse, same-gender domestic partner, custodial parent, non-custodial parent, adoptive parent, foster parent, biological parent, step parent, parent in law, parent of same-gender domestic partner, grandparent, grandchild, a person whom the employee is or was a relationship of in loco parentis, biological, adopted, foster or step child of an employee or the child of an employee's same-gender domestic partner.
- **Pregnancy disability leave** (a form of serious health condition leave) taken by a female employee for an incapacity related to pregnancy or childbirth, occurring before or after the birth of the child, or for prenatal care.
- **Sick child leave** taken to care for an employee's child with an illness or injury that requires home care but is not a serious health condition.
- **Bereavement leave** to deal with the death of a family member.
- **Oregon Military Family Leave** is taken by the spouse or same gender domestic partner of a service member who has been called to active duty or notified of an impending call to active duty or is on leave from active duty during a period of military conflict.

Who is Eligible?

To be eligible for leave, workers must be employed for the 180 day calendar period immediately preceding the leave and have worked at least an average of 25 hours per week during the 180-day period.

Exception 1: For parental leave, workers are eligible after being employed for 180 calendar days, without regard to the number of hours worked.

Exception 2: For Oregon Military Family Leave, workers are eligible if they have worked at least an average of 20 hours per week, without regard to the duration of employment.

Exception 3: For compensable Workers Compensation injuries, for certain Workers Compensation injuries involving denied and then accepted claims and for certain accepted claims involving more than one employer.

Exception 4: When an employee is caring for a family member with a serious health condition and the same family member dies, the employee need not requalify with the 25 hour per week average to be eligible for bereavement leave.

How much Leave can an Employee take?

- Employees are generally entitled to a maximum of 12 weeks of family leave within the employer's 12-month leave year.
- A woman using pregnancy disability leave is entitled to 12 additional weeks of leave in the same leave year for any qualifying OFLA purpose.
- A man or woman using a full 12 weeks of parental leave is entitled to take up to 12 additional weeks for the purpose of sick child leave.
- Employees are entitled to 2 weeks of bereavement leave to be taken within 60 days of the notice of the death of a covered family member.
- A spouse or same gender domestic partner of a service member is entitled to a total of 14 days of leave per deployment after the military spouse has been notified of an impending call or order to active duty and before deployment and when the military spouse is on leave from deployment.

What Notice is Required?

Employees may be required to give 30 days notice in advance of leave, unless the leave is taken for an emergency. Employers may require that notice is given in writing. In an emergency, employees must give verbal notice within 24 hours of starting a leave.

Is Family Leave paid or unpaid? Benefits?

- Although Family Leave is unpaid, employees are entitled to use any accrued paid vacation, sick or other paid leave.
- Employees are entitled to group health insurance benefits during family leave as if they continued working.

How is an Employee's job Protected?

Employers must return employees to their former jobs or to equivalent jobs if the former position no longer exists. However, employees on OFLA leave are still subject to nondiscriminatory employment actions such as layoff or discipline that would have been taken without regard to the employee's leave.

FOR ADDITIONAL INFORMATION:

Employer Assistance . . .971-673-0824
Portland 971-673-0761
Eugene 541-686-7623
Salem 503-378-3292

www.oregon.gov/BOLI

BOLI
Civil Rights Division
800 NE Oregon, #1045
Portland, OR 97232

Employees who have been denied available leave, disciplined or retaliated against for requesting or taking leave, or have been denied reinstatement to the same or equivalent position when they returned from leave, may file a complaint with BOLI's Civil Rights Division.

This is a summary of laws relating to Oregon Family Leave Act. It is not a complete text of the law.

January 2016

THIS INFORMATION MUST BE POSTED IN A CONSPICUOUS LOCATION

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

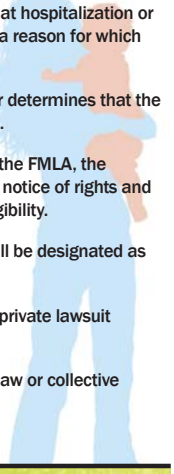
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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 University of Oregon Benefits Office, 541-346-3159.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
University of Oregon	42-4727800
5. Employer address	**6. Employer phone number**
5210 University of Oregon	541-346-3159

7. City	8. State	9. ZIP code
Eugene	OR	97403

10. Who can we contact about employee health coverage at this job?	
Kathryn Daniel, Benefits Coordinator	
11. Phone number (if different from above)	**12. Email address**
541-346-2964	kdaniel@uoregon.edu

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ⊡ Some employees. Eligible employees are:

    Classified, Unclassified academic and professional employees in appointments of at least .50 FTE for 90 days or longer.
    Graduate Teaching Fellows and Students

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouse; Domestic Partner; an employee's, spouse's or domestic partner's qualifying Dependent Children (son, daughter, stepson, stepdaughter, adopted child or child placed for adoption, foster child or other legally placed child), eligible grandchild, adult child up to age 26, disabled dependent children.
  - ☐ We do not offer coverage.

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

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

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