UNIVERSITY OF OREGON | Business Affairs

Clear Form

Employee Information Form

This form should **not** be used for MyTrack hires.
Please return this form to your hiring department.

Section 1. To be completed by employee

Employee Name (As listed on Social Security Card)

Last Name _____ SSN _____

First Name _____ UO ID _____

Middle _____ Date of Birth _____

Preferred First Name _____ Added to UKG _____

Recovery Email _____

Mailing Address

Street _____ Apt. _____ Zip _____ Nation _____

City _____ State _____ Phone _____

Employee Signature _____ Date _____

Section 2 – To be completed by department

Employee Type _____

Start Date _____

Department Name _____

Department Org _____

Campus Address

Room No. Bldg _____

Zip Plus 4 _____

Campus Phone _____

Authorization

_____ Date _____
Department Admin Signature

_____ Email Address _____
Department Admin Name (Printed)

Phone Number _____

After completion, send to Payroll Office.

See https://ba.uoregon.edu/payroll/payroll-document-submission for submission options.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

(c) ☐ **Single** or **Married filing separately** Non-Resident Aliens are limited to Single or Married Filing seperately

☐ **Married filing jointly** or **Qualifying surviving spouse**

☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Non-Resident Aliens Do Not Complete Steps 2-4

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . NRA **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Notice 1392

(Rev. January 2020)

Department of the Treasury
Internal Revenue Service

Supplemental Form W-4 Instructions for Nonresident Aliens

Nonresident aliens must follow special instructions when completing Form W-4, Employee's Withholding Certificate, for compensation paid to such individuals as employees performing dependent personal services in the United States. Compensation for dependent personal services includes amounts paid as wages, salaries, fees, bonuses, commissions, compensatory scholarships, fellowship income, and similar designations for amounts paid to an employee.

Getting tax forms and publications. Go to *IRS.gov/Forms-Instructions* to view, download, or print all of the forms and publications you may need. You can also download and view popular tax publications and instructions on mobile devices as an eBook at no charge. Or, you can go to *IRS.gov/OrderForms* to place an order and have forms mailed to you within 10 business days. Also, you can call 800-829-3676 to place your order.

Are you a nonresident alien? If so, these special instructions apply to you. Resident aliens should follow the instructions on Form W-4.

If you are an alien individual (that is, an individual who is not a U.S. citizen), specific rules apply to determine if you are a resident alien or a nonresident alien for federal income tax purposes. Generally, you are a resident alien if you meet either the “green card test,” or the “substantial presence test,” for the calendar year. Any alien individual not meeting either test is generally a nonresident alien. Additionally, a dual-resident alien who applies the so-called “tie-breaker” rules contained within the Resident (or Residence or Fiscal Residence) article of an applicable U.S. income tax treaty in favor of the other Contracting State is treated as a nonresident alien. See Pub. 519, U.S. Tax Guide for Aliens, for more information on the green card test, the substantial presence test, and the first-year choice.

What compensation is subject to withholding and requires a Form W-4?

Compensation paid to a nonresident alien for performing personal services as an employee in the United States is subject to graduated withholding. Compensation for personal services also includes amounts paid as a scholarship or fellowship grant to the extent it represents payment for past, present, or future services performed as an employee in the United States. Nonresident aliens must complete Form W-4 using the modified instructions provided later, so that employers can withhold the correct amount of federal income tax from compensation paid for personal services performed in the United States. This Notice modifies the instructions to Form W-4 to take into account the restriction on a nonresident alien's filing status, the restriction on claiming the standard deduction, and the restriction on claiming tax credits and deductions for certain Nonresident aliens.

Are there any exceptions to this withholding?

Yes. Nonresident aliens may be exempt from wage withholding on the following amounts.

- Compensation paid to employees of foreign employers if such pay is not more than $3,000 and the employee is temporarily present in the United States for not more than a total of 90 days during the tax year.
- Compensation paid to regular crew members of a foreign vessel.
- Compensation paid to residents of Canada or Mexico engaged in transportation-related employment.
- Certain compensation paid to residents of American Samoa, Puerto Rico, or the U.S. Virgin Islands.
- Compensation paid to foreign agricultural workers temporarily admitted into the United States on H-2A visas.

See Pub. 519 to see if you qualify for one of these exemptions.

Nonresident aliens may be exempt from wage withholding on part or all of their compensation for dependent personal services under an income tax treaty. If you are claiming a tax treaty withholding exemption, do not complete Form W-4. Instead, complete Form 8233, Exemption from Withholding on Compensation for Independent (and Certain Dependent) Personal Services of a Nonresident Alien Individual, and give it to each withholding agent from whom amounts will be received.

Even if you submit Form 8233, the withholding agent may have to withhold tax from your income because the factors on which the treaty exemption is based may not be determinable until after the close of the tax year. In this case, you must file Form 1040-NR, U.S. Nonresident Alien Income Tax Return (or Form 1040-NR-EZ, U.S. Income Tax Return for Certain Nonresident Aliens With No Dependents, if you qualify), to recover any overwithheld tax and to provide the IRS with proof that you are entitled to the treaty exemption. See Form 8233 and the Instructions for Form 8233, Pub. 901, U.S. Tax Treaties, and Pub. 519 for more information on treaty benefits.

Am I required to file a U.S. tax return even if I am a nonresident alien?

Yes. Nonresident aliens who perform personal services in the United States are considered to be engaged in a trade or business in the United States and generally are required to file Form 1040-NR (or Form 1040-NR-EZ). Also, you will need to file Form 1040-NR (or Form 1040-NR-EZ) to claim a refund of any overwithheld taxes. See the Instructions for Form 1040-NR, or the Instructions for Form 1040-NR-EZ, for more information.

Nonresident aliens who are bona fide residents of U.S. possessions should consult Pub. 570, for information on whether compensation is subject to wage withholding in the United States.

Will my withholding amounts be different from withholding for my U.S. coworkers?

Yes. Nonresident aliens cannot claim the standard deduction. The benefits of the standard deduction are included in the existing wage withholding tables published in Pub. 15-T, Federal Income Tax Withholding Methods.

Because nonresident aliens may not claim the standard deduction, employers are instructed to withhold an additional amount from a nonresident alien's wages. For the specific amounts to be added to wages before application of the wage tables, see Pub. 15-T.

Note. A special rule applies to nonresident alien students from India and business apprentices from India who are eligible for the benefits of Article 21(2) of the United States-India income tax treaty. Employers are not required to withhold an additional amount for the standard deduction from the wages of these individuals, as they may be entitled to claim the standard deduction. See Pub. 15-T and Pub. 519 for more information.

What are the special Form W-4 instructions?

Nonresident aliens should pay particular attention to the following lines when completing Form W-4.

Step 1(b): Personal Information. You are required to enter a social security number (SSN) on Step 1(b) of Form W-4. If you do not have an SSN, contact the Social Security Administration (SSA) to find out if you are eligible for one.

You can visit any SSA office or call the SSA at 800-772-1213. For the deaf or hard-of-hearing, call 800-325-0778 (TTY/TTD number).

For more information, go to *www.ssa.gov/ssnumber*.

Note. You cannot enter an individual taxpayer identification number (ITIN) in Step 1(b) of Form W-4.

Step 1(c): Personal Information. Check the Single or Married filing separately box regardless of your actual marital status.

Step 2: Multiple Jobs or Spouse Works. Do not complete this section unless you have more than one job at the same time. Do not account for your spouse's job because nonresident aliens may not file jointly.

If you have more than one job, you may complete Step 2(b) or Step 2(c).

If you chose Step 2(b), complete the Step 2(b) Multiple Jobs Worksheet for **only one** job and write "nonresident alien" or "NRA" below Step 4(c) for **only one** job.

If you have only two jobs, you may choose Step 2(c), check the box on **both** Forms W-4, and write "NRA" or "nonresident alien" below Step 4(c) for the Form W-4 for the highest paying job. Do not write "nonresident alien" or "NRA" below Step 4(c) for the other job.

Nonresident aliens should not use the Tax Withholding Estimator.

Multiple withholding agents. If you are completing Form W-4 for more than one withholding agent (for example, you have more than one employer), complete Steps 3-4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3: Claim Dependents. Only certain nonresident aliens should use Step 3. Nonresident aliens from Canada, Mexico, South Korea, or India may be able to claim the child tax credit or the credit for other dependents. See Pub. 519 and Pub. 972 for more information.

Nonresident aliens are generally not entitled to education credits. See Pub. 519 for more information.

Add the total credits that you may claim and enter the total in Step 3.

Step 4. Optional

Step 4(a). If you want tax withheld for other income this year that won't have withholding and the income is taxable in the United States, enter the amount of other income here. Do not include any income from any jobs or self-employment. See Pub. 519 for more information.

Step 4(b). Nonresident alien itemized deductions and adjustments to income may be limited. See Pub. 519 for more information. If you expect to claim itemized deductions and/or adjustments to income (such as the student loan interest deduction), add your itemized deductions and adjustments to income and enter the amount in Step 4(b).

Step 4(c). Write "nonresident alien" or "NRA" in the space below Step 4(c). If you would like to have an additional amount withheld, enter the amount in Step 4(c).

Exempt from withholding. Do not claim that you are exempt from withholding in the space below Step 4(c) of Form W-4 (even if you meet both of the conditions to claim exemption from withholding listed in the instructions to the Form W-4).

2025 Form OR-W-4

Page 1 of 1, 150-101-402 (Rev. 08-08-24, ver. 01)

Oregon Department of Revenue

19612501010000

Office use only

Oregon Withholding Statement and Exemption Certificate

First name	Initial	Last name	Social Security number (SSN)	☐ Redetermination

Address	City	State	ZIP code

Note: Your eligibility to claim a certain number of allowances or an exemption from withholding may be subject to review by the Oregon Department of Revenue. Your employer may be required to send a copy of this form to the department for review.

1. **Select one:** ☐ Single ☐ Married ☐ Married, but withhold at the higher single rate.
   Note: Select "Single" if you're married but legally separated or your spouse is a non-U.S. citizen without permanent resident status.

2. **Allowances.** Total number of allowances you're claiming on line **A4, B15,** or **C5.**
   See worksheets in the instructions. If you skip the worksheets and aren't exempt, **enter 0** ..... 2.

3. **Additional amount,** if any, you want withheld from each paycheck ..... 3.

4. **Exemption from withholding.** I certify my wages are exempt from withholding and I meet the conditions for exemption as stated on page 2 of the instructions. Complete **both** lines below:
   - Enter your exemption code. (See instructions) ..... 4a.
   - Write "Exempt" ..... 4b.

Sign here. Under penalty of false swearing, I declare the information provided is true, correct, and complete.

Employee signature (This form isn't valid unless signed.)	Date

Employer use only.

Employer name	Federal employer identification number (FEIN)		

Employer address	City	State	ZIP code

—Submit this form to your employer—

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.)

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
University of Oregon	**720 E 13th Ave., Eugene, OR, 97403**

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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, sex, 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, sex, 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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: 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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central** The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial *(if any)* from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,

Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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
2025			

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.
2024			
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. September 2018)

Department of the Treasury
Internal Revenue Service

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

▶ **Go to *www.irs.gov/Form8233* for instructions and the latest information.** ▶ **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*** in 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.
	Compensation for dependent personal services performed in the United States	A tax treaty withholding exemption for part or all of that compensation.
	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 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 2025, 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 identification number	**3** Foreign tax identification number, if any

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

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 on which you are basing exemption from withholding _____

b Treaty article on which you are basing exemption from withholding _____

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

d Country of residence

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

13 Noncompensatory scholarship or fellowship income:

a Amount $ _____

b Tax treaty on which you are basing exemption from withholding _____

c Treaty article on which you are basing exemption from withholding _____

d 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) _____

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, or was a resident of the treaty country listed on line 12a and/or 13b above at the time of, or immediately prior to, entry into the United States, as required by the treaty.

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**

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

City, state, and ZIP code	Telephone number

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 ▶

OREGON FAMILY LEAVE

You can take time off to take care of yourself or close family members under the Oregon Family Leave Act (OFLA).

- **This time is protected, but often unpaid unless you have vacation, sick, or other paid leave available.** Paid family leave will be available in 2023.
- To be eligible, you must have worked an average of 25 hours per week for 180 days - just 180 days for parental leave. Separation from employment or removal from the schedule for up to 180 days does not count against eligibility. During a public health emergency, you are eligible for all types of OFLA leave after working for at least 30 days prior at an average of at least 25 hours per week. Your employer must have at least 25 employees.
- You can take up to a total of 12 weeks of time off per year for any of these reasons.
  - » **Parental leave** for either parent to take time off for the birth, adoption, or foster placement of a child. If you use all 12 weeks, you can take up to 12 more weeks for sick child leave.
  - » **Serious health condition** of your own, or to care for a family member.
  - » **Pregnancy disability leave** before or after birth of child or for prenatal care. You can take up to 12 weeks of this in addition to 12 weeks for any reason listed here.
  - » **Military family leave** up to 14 days if your spouse is a service member who has been called to active duty or is on leave from active duty.
  - » **Sick child leave** for your child with an illness, injury or condition that requires home care but is not serious, or to care for a child whose school or place of care is closed because of a public health emergency.
  - » **Bereavement leave** for up to 2 weeks after the death of a family member.
- Your employer must keep giving you the same health insurance benefits as when you are working. When you come back you must be returned to your former job or a similar position if your old job no longer exists.

CONTACT US

If your employer isn't following the law or something feels wrong, give us a call. The Bureau of Labor and Industries is here to enforce these laws and protect you.

Call: 971-245-3844
Email: BOLI_help@boli.oregon.gov
Web: oregon.gov/boli
Se habla español.

OREGON BUREAU OF LABOR & INDUSTRIES
OREGON LAWS Protect You At Work
July 2022 - June 2023

Oregon Paid Family and Medical Leave (OR PFML)

Employee Notice of Benefits Available Under ORS 657B

PEBB employers electing Equivalent Plan coverage through The Standard

PEBB employers who have elected equivalent (private) plan coverage have engaged Standard Insurance Company (The Standard) to administer your OR PFML benefits through a state approved equivalent (private) plan. Benefits administered by The Standard's plan will be equal to or greater than benefits provided through the state-administered Paid Leave Oregon program, and will never cost employees more than participation under the state program.

Who is eligible for OR PFML Benefits?

Each employee who has Oregon wages may qualify for OR PFML. While on OR PFML, employees are paid a percentage of their wages. Benefit amounts depend on what an employee earned before their leave begins (or in the prior year if the benefit amount would be greater).

As of September 2023, paid benefits are available to eligible employees up to a combined 12 weeks per Benefit Year:

- to bond following the birth, adoption or foster placement of the employee's child within the first 12 months of birth or placement;
- to care for the employee's own serious health condition;
- to care for a family member's serious health condition;
- for safe leave related to the employee, or employee's minor child or dependent experiencing sexual assault, domestic violence, harassment or stalking

Up to an additional 2 weeks are available for limitations related to pregnancy, childbirth or a related medical condition, including but not limited to lactation, for total leave not to exceed 14 weeks per Benefit Year.

Who pays for Oregon paid family and medical leave benefits?

Starting on January 1, 2023, employees and employers contribute to the cost of the program through payroll taxes. Employers with approved Equivalent Plans may choose alternate funding scenarios. This will be communicated to you by your employer.

When do I need to tell my employer about taking leave?

If your leave is foreseeable, you are required to give notice to your employer at least 30 days before starting paid family, medical or safe leave. If you do not give the required notice, your first weekly benefit may be reduced.

How do I apply for OR PFML?

As of September 2023, you can apply for paid famly and medical leave with The Standard by calling 800.242.1888, on Standard.com, or by requesting a paper application from your employer. If your application is denied, you can appeal the decision to The Standard and/or the Oregon Employment Department.

What are my rights?

If you are eligible for paid family and medical leave, your employer cannot prevent you from taking it. Your job is protected while you take OR PFML leave if you have worked for your employer for at least 90 consecutive calendar days. You will not lose your pension rights while on paid family and medical leave and your employer must continue to provide you the same health benefits as when you are working.

How is my information protected?

Any health information related to family, medical or safe leave that you choose to share with your employer is confidential and can only be released with your permission, unless the release is required by law.

What if I have questions about my rights?

It is unlawful for your employer to discriminate or retaliate against you because you asked about or claimed paid family and medical leave benefits. If your employer is not following the law, you have the right to bring a civil suit in court or to file a complaint with the Oregon Bureau of Labor & Industries (BOLI). You can file a complaint with BOLI online, via phone or email:

Web: www.oregon.gov/boli
Call: 971-245-3844
Email: help@boli.oregon.gov

Learn more about Paid Leave Oregon

web: paidleave.oregon.gov
Call: 833-854-0166

Paid Leave Oregon

State of Oregon Employment Department

Standard Insurance Company
1100 SW Sixth Avenue, Portland, OR, 97204 I standard.com

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.

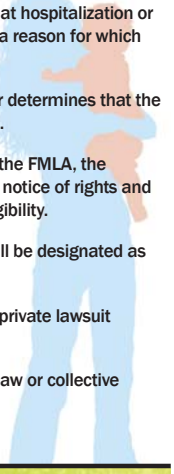
*Special "hours of service" requirements apply to airline flight crew employees.

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

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

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	46-4727800
5. Employer address	6. Employer phone number
677 E. 12th Ave, Suite 400	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?	
Anne Willis	
11. Phone number (if different from above)	12. Email address amwillis@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 and Unclassified academic and administrative employees in appointments of at least .50 FTE for 90 days or longer. (UO) Graduate Teaching Fellows (GTF) in appointments of .20 FTE or greater. Coverage available through the Graduate Teaching Fellows Federation (GTFF) office, 541-344-0832. May include group insurance through collective bargaining agreements and coverage for student workers, if any, who have health insurance (not health center access) through their university, or other campus-provided arrangements that qualify as a health plan.
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse; Domestic Partner; and 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 place child), eligible grandchild, adult child up to age 26, disables dependent child. (UO) GTF dependent coverage available through GTFF office
  - ☐ We do not offer coverage.

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

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

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

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

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

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

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

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 40.39
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☑ Monthly ☐ Quarterly ☐ Yearly

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

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

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

Workplace Accommodations Notice

The University of Oregon is an equal opportunity employer and does not discriminate on the basis of race, religion, color, sex, age, national origin, disability, veteran status, sexual orientation, gender identity, gender expression or any other classification protected by law.

The University of Oregon will make reasonable accommodations for known physical or mental disabilities of an applicant or employee as well as known limitations related to pregnancy, childbirth or a related medical condition, such as lactation, unless the accommodation would cause an undue hardship. Among other possibilities, reasonable accommodations could include:

- Acquisition or modification of equipment or devices;
- More frequent or longer break periods or periodic rest;
- Assistance with manual labor; or
- Modification of work schedules or job assignments.

Employees and job applicants have a right to be free from unlawful discrimination and retaliation

For this reason, the University of Oregon **will not**:

- Deny employment opportunities on the basis of a need for reasonable accommodation
- Deny reasonable accommodation for known limitations, unless the accommodation would cause an undue hardship.
- Take an adverse employment action, discriminate or retaliate because the applicant or employee has inquired about, requested or used a reasonable accommodation.
- Require an applicant or an employee to accept an accommodation that is unnecessary.
- Require an employee to take family leave or any other leave, if the employer can make reasonable accommodation instead.

To request an accommodation or to discuss concerns or questions about this notice, please contact the ADA Coordinator, at 541-346-2985 or workplaceada@uoregon.edu.