Town of Merrimac
New Employee Form
(Full-Time)

Employee #: _____ **Name: _____**

Address: _____ **Department: _____(_____)**

_____ **Position: _____**

Phone: (_____) _____- _____ **Date of Employment: _____/_____/_____**

SSN: _____-_____-_____ **Date of Birth: _____/_____/_____**

Marital Status: _____ **Emergency Contact: _____**

Rate/Hour: $_____ Weekly Hours: _____ **Emergency Phone: (_____) _____- _____**

Please complete the attached forms:

- **W-4 Employee Withholding Allowance Certificate:**
  The I.R.S. requires us to obtain your name and social security number exactly as they appear on your Social Security Card. Please show your Social Security Card for verification.
- **I-9 U.S. Department of Justice - Employment Eligibility Verification:**
  This form verifies your identity and employment authorization to work in the United States. Instructions are included with the form along with the Lists of Acceptable Documents. Original documents are required.
- **SSA 1945:** Acknowledgement that position is not covered by Social Security.
- **Essex Regional Retirement Board:** Make sure to fill out completely and return with required documents. You **must** provide a copy of your birth certificate for enrollment. **Note:** If you chose **"Option D"** on the beneficiary selection page, you **must** furnish a copy of the beneficiary's birth certificate. If the beneficiary is your spouse, you **must** also provide a copy of the marriage certificate.
- **Health Benefits:** For health, dental, and vision insurance options, please visit https://townofmerrimac.com/employee-resources/
  - Complete **Health Insurance Responsibility Disclosure Form** if you decline to participate in the health insurance plan.
- **Boston Mutual Life Insurance (OPTIONAL):** $10,000 Life and Accidental Death and Dismemberment insurance is available.
- **Boston Life Insurance Co. Authorization to Obtain Information for Underwriting:**
  If you elect to have Life with AD&D insurance, we must obtain your authorization for an investigative consumer report.
- **Refusal of Insurance:** This form must be completed if you elect not to sign up for Life and AD&D.
- **Salary Redirection Agreement:** This form must be completed if you elect to have your insurance deducted on a pretax basis.
- **Summary of the Conflict-of-Interest Law for Municipal Employees and Online Ethics Training:** The website is https://www.mass.gov/how-to/complete-the-conflict-of-interest-law-education-requirements Print and return certificate.
- **Pre-employment Physical and Screening:** Must be completed and received by payroll dept. PRIOR to start date.
- Please schedule at your convenience with ConvenientMD-clinic locations attached.
- **Direct Deposit:** Your paycheck will be deposited directly into the bank account(s) of your choice. Please provide a voided check.
- **Paperless Pay Stubs:** Provide your email address to select this option_____
- **Deferred Compensation Plan and Supplemental Insurance (OPTIONAL):** For SMART plan and AFLAC benefit information, please visit https://townofmerrimac.com/employee-resources/ for information.

By signing below, employee agrees that they have received a copy of the "Personnel Policies and Procedures." Which is available online at https://townofmerrimac.com/employee-resources/

_____ _____/_____/_____

Employee Signature Date

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

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**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*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount of tax withheld will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 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. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4.

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe when you file your tax return.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Instructions for Form I-9, Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 07/31/2026

Anti-Discrimination Notice: Employers must allow all employees to choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information entered in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or **Supplement B, Reverification and Rehire**. Employees do NOT need to prove their citizenship, immigration status, or national origin when establishing their employment authorization for Form I-9 or E-Verify. Requesting such proof or any specific document from employees based on their citizenship, immigration status, or national origin, may be illegal. Similarly, discriminating against employees in hiring, firing, recruitment, or referral for a fee, based on citizenship, immigration status, or national origin may be illegal. Employers should not reject acceptable documentation due to a future expiration date. For more information on how to avoid discrimination or how to report it, contact the Immigrant and Employee Rights Section in the Department of Justice's Civil Rights Division at **www.justice.gov/ier**.

Purpose of Form I-9

Employers and employees must complete their respective sections of Form I-9. The form is used to document verification of the identity and employment authorization of each new employee (both U.S. citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document the verification of the identity and employment authorization of each new employee (both U.S. citizen and noncitizen) hired after November 27, 2011.

Definitions

Employee: A person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term "employee" does not include individuals who do not receive any form of remuneration (e.g., volunteers), independent contractors, or those engaged in certain casual domestic employment.

Employer: A person or entity, including an agent or anyone acting directly or indirectly in the interest thereof, who engages the services or labor of an employee to be performed in the United States for wages or other remuneration. This includes recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Authorized Representative: Any person an employer designates to complete and sign Form I-9 on the employer's behalf. Employers are liable for any statutory and regulatory violations made in connection with the form or the verification process, including any violations committed by any individual designated to act on the employer's behalf.

Preparer and/or Translator: Any individual who helps the employee complete or translates **Section 1** for the employee.

General Instructions

Form I-9 consists of:

- **Section 1**: Employee Information and Attestation
- **Section 2**: Employer Review and Verification
- Lists of Acceptable Documents
- Supplement A, Preparer and/or Translator Certification for Section 1
- Supplement B, Reverification and Rehire (formerly Section 3)

EMPLOYEES

Employees must complete and sign **Section 1** of Form I-9 no later than the first day of employment (i.e., the date the employee begins performing labor or services in the United States in return for wages or other remuneration). Employees may complete **Section 1** before the first day of employment, but cannot complete the form before acceptance of an offer of employment.

EMPLOYERS

Employers in the United States, except Puerto Rico, must complete the English-language version of Form I-9. Only employers located in Puerto Rico may complete the Spanish-language version of Form I-9 instead of the English-language version. Any employer may use the Spanish-language form and instructions as a translation tool.

All employers must:

- Make the instructions for Form I-9 and Lists of Acceptable Documents available to the employee when completing the Form I-9 and when requesting that the employee present documentation to complete Supplement B, Reverification and Rehire. See page 5 for more information.
- Ensure that the employee completes **Section 1**.
- Complete **Section 2** within three business days after the employee's first day of employment. If you hire an individual for less than three business days, complete **Section 2** no later than the first day of employment.
- Complete Supplement B, Reverification and Rehire when applicable.
- Leave a field blank if it does not apply and allow employees to leave fields blank in **Section 1**, where appropriate.
- Retain completed forms. You are not required to retain or store the page(s) containing the Lists of Acceptable Documents or the instructions for Form I-9. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Additional guidance about how to complete Form I-9 may be found in the **Handbook for Employers: Guidance for Completing Form I-9 (M-274) and on I-9 Central.**

Section 1. Employee Information and Attestation

Step 1: Employee completes Section 1 no later than the first day of employment.

- All employees must provide their current legal name, complete address, and date of birth. If other fields do not apply, leave them blank.
- When completing the name fields, enter your current legal name and any last names you previously used, including any hyphens or punctuation. If you only have one name, enter it in the Last Name field and then enter "Unknown" in the First Name field.
- Providing your 9-digit Social Security number in the Social Security number field is voluntary, unless your employer participates in E-Verify. See page 5 for instructions related to E-Verify. Do not enter an Individual Taxpayer Identification Number (ITIN) as your Social Security number.

Step 2: Attest to your citizenship or immigration status.

You must select one box to attest to your citizenship or immigration status.

1. **A citizen of the United States.**
2. **A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant.

   Conditional residents should select this status. Asylees and refugees should NOT select this status; they should instead select "A noncitizen authorized to work." If you select "lawful permanent resident," enter your 7- to 9-digit USCIS Number (A-Number) in the space provided.

4. **A noncitizen (other than Item Numbers 2. and 3. above) authorized to work:** An individual who has authorization to work but is not a U.S. citizen, noncitizen national, or lawful permanent resident.

   If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the documentation evidencing your employment authorization. If your employment authorization documentation has been automatically extended by the issuing authority, enter the expiration date of the automatic extension in this space.

   - Refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other noncitizens authorized to work whose employment authorization does not have an expiration date, should enter N/A in the Expiration Date field.

   Employees who select "a noncitizen authorized to work" must enter **one** of the following to complete **Section 1**:

   (1) USCIS Number/A-Number (7 to 9 digits);

   (2) Form I-94 Admission Number (11 digits); or

   (3) Foreign Passport Number and the Country of Issuance

   Your employer may not ask for documentation to verify the information you entered in **Section 1**.

Step 3: Sign and enter the date you signed Section 1. Do NOT back-date this field.

Step 4: Preparer and/or translator completes a Preparer and/or Translator Certification, if applicable.

If a preparer and/or translator assists an employee in completing Section 1, that person must complete a Certification area on Supplement A, Preparer and/or Translator Certification for Section 1, located on Page 3 of Form I-9. There is no limit to the number of preparers and/or translators an employee may use. Each preparer and/or translator must complete and sign a separate Certification area. Employers must ensure that they retain any additional pages with the employee's completed Form I-9. If the employee does not use a preparer or translator, employers are not required to provide or retain Supplement A.

Step 5: Present Form I-9 Documentation

Within three business days after your first day of employment, you, the employee, must present to your employer original, acceptable, and unexpired documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before the Thursday of that week. However, if you were hired to work for less than three business days, you must present documentation no later than the first day of employment.

Choose which documentation to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which documentation you may present from the Lists of Acceptable Documents. You may present either: 1.) one selection from List A or 2.) a combination of one selection from List B and one selection from List C. In certain cases, you may also present an acceptable receipt for List A, B, or C documents. For more information on receipts, refer to the M-274.

- List A documentations show both identity and employment authorization. Some documentation must be presented together to be considered acceptable List A documentation. If you present acceptable List A documentation, you should not be asked to present List B and List C documentation.

- List B documentation shows identity only and List C documentation shows employment authorization only. If you present acceptable List B and List C documentation, you should not be asked to present List A documentation. Guidance is available in the M-274 if you are under the age of 18 or have a disability (special placement) and cannot provide List B documentation.

Your employer must physically examine the documentation you present to complete Form I-9, or examine them consistent with an alternative procedure authorized by the Secretary of DHS. If your documentation reasonably appears to be genuine and to relate to you, your employer must accept the documentation. If your documentation does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documentation. Your employer may choose to make copies of your documentation, but must return the original(s) to you. Your employer may not ask for documentation to verify the information you entered in **Section 1**.

Section 2. Employer or Authorized Representative Review and Verification

Before completing **Section 2**, you, the employer, should review **Section 1**. If you find any errors or missing information in **Section 1.**, the employee must correct the error, and then initial and date the correction.

You may designate an authorized representative to act on your behalf to complete **Section 2**.

You or your authorized representative must complete **Section 2** by physically examining evidence of the employee's identity and employment authorization within three business days after the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete **Section 2** on or before the Thursday of that week. However, if the individual will work for less than three business days, **Section 2** must be completed no later than the first day of employment.

Step 1: Enter information from the documentation the employee presents.

You, the employer or authorized representative, must either physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, the original, acceptable, and unexpired documentation the employee presents from the Lists of Acceptable Documents to complete the applicable document fields in **Section 2**. You cannot specify which documentation an employee may present from these Lists of Acceptable Documents. A document is acceptable if it reasonably appears to be genuine and to relate to the person presenting it. Photocopies, except for certified copies of birth certificates, are not acceptable for Form I-9. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

You may use common abbreviations for states, document titles, or issuing authorities, such as: "DL" for driver's license, and "SSA" for Social Security Administration. Refer to the M-274 for abbreviation suggestions.

List A documentation shows both identity and employment authorization.

- Enter the required information from the List A documentation in the first set of document entry fields in the List A column. Some List A documentation consists of a combination of documents that must be presented together to be considered acceptable List A documentation. If the employee presents a combination of documents for List A, use the second and third sets of document entry fields in the List A column. Use the Additional Information space, as necessary, for additional documents. When entering document information in this space, ensure you record all available document information, such as the document title, issuing authority, document number and expiration date.
- If an employee presents acceptable List A documentation, do not ask the employee to present List B and List C documentation.

List B documentation shows identity only, and List C documentation shows employment authorization only.

- If an employee presents acceptable List B and List C documentation, enter the required information from the documentation under each corresponding column and do not ask the employee to present List A documentation.
- If an employee under the age of 18 or with disabilities (special placement) cannot provide List B documentation, see the M-274 for guidance.

In certain cases, the employee may present an acceptable receipt for List A, B, or C documentation. For more information on receipts, refer to the Lists of Acceptable Documents and the M-274.

Photocopies

- You may make photocopies of the documentation examined but must return the original documentation to the employee.
- You must retain any photocopies you make with Form I-9 in case of an inspection by DHS, the Department of Labor, or the Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section.

Step 2: Enter additional information, if necessary.

Use the Additional Information field to record any additional information required to complete **Section 2**, or any updates that are necessary once **Section 2** is complete. Initial and date each additional notation. See the M-274 for more information. Such notations include, but are not limited to:

- Those required by DHS, such as extensions of employment authorization or a document's expiration date.
- Replacement document information if a receipt was previously presented.
- Additional documentation that may be presented by certain nonimmigrant employees.

You may also enter optional information, such as termination dates, form retention dates, and E-Verify case numbers, if applicable.

Step 3: Select the box in the Additional Information area if you used an alternate procedure for document examination authorized by the Secretary of DHS.

You must select this box if you used an alternative procedure authorized by DHS to examine the documents. You may refer to the M-274 for guidance on implementing alternative procedures for document examination approved by the Secretary of DHS.

Step 4: Complete the employer certification.

Employers or their authorized representatives, if applicable, must complete all applicable fields in this area, and sign and date where indicated.

Reverification and Rehire

To reverify an employee's work authorization or document an employee's rehire, use Supplement B, Reverification and Rehire (formerly Section 3). Employers need only complete and retain the supplement page when employment authorization reverification is required. Employers may choose to document a rehire on the supplement as well. Enter the employee's name at the top of each supplement page you use. In the New Name field, record any change the employee reports at the time of reverification or rehire. Use a new section of the supplement for each instance of a reverification or rehire, sign and date that section when completed, and attach it to the employee's completed Form I-9. Use additional supplement pages as necessary. Use the Additional Information fields if the employee's documentation presented for reverification requires future updates.

Reverifications

When reverification is required, you must reverify the employee by the earlier of the employment authorization expiration date stated in Section 1 (if any), or the expiration date of the List A or List C employment authorization documentation recorded in Section 2. Employers should complete any subsequent reverifications, if required, by the expiration date of the List A or List C documentation entered during the employee's most recent reverification.

For reverification, employees must present acceptable documentation from either List A or List C showing their continuing authorization to work in the United States. You must allow employees to choose which acceptable documentation to present for reverification. Employees are not required to show the same type of document they presented previously. Enter the documentation information in the appropriate fields provided.

You should not reverify the employment authorization of U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551) or other employment authorization documentation that is not subject to reverification (such as an unrestricted Social Security card). Reverification does not apply to List B documentation. Reverification may not apply to certain noncitizens. See the M-274 for more information about when reverification may not be required.

Rehires

If you rehire an employee within three years from the date the employee's Form I-9 was first completed, you may complete the supplement and attach it to the employee's previously completed Form I-9. If the employee remains employment-authorized, as indicated on the previously completed Form I-9, record the date of rehire and any name changes. If the employee's employment authorization or List A or C documents have expired, you must reverify the employee as described above.

Alternatively, you may complete a new Form I-9 for rehired employees. You must complete a new Form I-9 for any employee you rehired more than three years after you originally completed a Form I-9 for that employee.

E-Verify Employers

E-Verify uses Form I-9 information to confirm employees' employment eligibility. For more information, go to **www.e-verify.gov** or contact us at **www.e-verify.gov/contact-us**.

For employees of employers who participate in E-Verify:

- You must provide your Social Security number in the Social Security number field in **Section 1**.
  - If you have applied for, but have not yet received, your Social Security number, you should leave the field blank until you receive the number. Update this field once you receive it, and initial and date the notation.
  - If you can present acceptable identity and employment authorization documentation to complete Form I-9, you may begin working while waiting to receive your Social Security number.
- Providing your email address and telephone number in **Section 1** will allow you to receive notifications associated with your E-Verify case.
- If you present a List B document to your employer, it must contain a photograph.

For E-Verify employers:

- Ensure employees enter their Social Security number in **Section 1**.
- You must only accept List B documentation that contains a photograph. This applies to individuals under the age of 18 and individuals with disabilities.
- You must retain photocopies of certain documentation.

What is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any other government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the "**DHS Privacy Notice**" below.

USCIS Forms and Information

Employers may photocopy or print blank Forms I-9. To ensure you are using the latest version of this form and corresponding instructions, visit the USCIS website at **www.uscis.gov/i-9**. You may order paper forms at **www.uscis.gov/forms/forms-by-mail** or by contacting the USCIS Contact Center at **1-800-375-5283** or **1-800-767-1833** (TTY).

For additional guidance about Form I-9, employers and employees should refer to the **Handbook for Employers: Guidance for Completing Form I-9 (M-274)** or USCIS' Form I-9 website at **www.uscis.gov/i-9-central**.

You can obtain information about Form I-9 by e-mailing USCIS at **I-9Central@uscis.dhs.gov**. Employers may call **1-888-464-4218** or **1-877-875-6028** (TTY). Employees may call the USCIS employee hotline at **1-888-897-7781** or **1-877-875-6028** (TTY).

Retaining Completed Forms I-9

An employer must retain Form I-9, including any supplement pages, on which the employee and employer (or authorized representative) entered data, as well as any photocopies made of the documentation the employee presented, for as long as the employee works for the employer. When employment ends, the employer must retain the individual's Form I-9 and all attachments for one year from the date employment ends, or three years after the first day of employment, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is three years after the first day of employment.

Completed Forms I-9 and all accompanying documents should be stored in a safe and secure location. Employers should ensure that the information employees provide on Form I-9 is used only as stated in the DHS Privacy Notice below.

Form I-9 may be generated, signed, and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR section 274a.2. Employers creating, modifying, or storing Form I-9 electronically are encouraged to review these and any other relevant standards for electronic signature, and the indexing, security, and documentation of electronic Form I-9 data.

Penalties

Employers may be subject to penalties if Form I-9 is not properly completed or for employment discrimination occurring during the employment eligibility verification process. See 8 U.S.C. section 1324a and section 1324b, 8 CFR section 274a.10 and 28 CFR Part 44. Individuals may also be prosecuted for knowingly and willfully entering false information, or for presenting fraudulent documentation, to complete Form I-9.

Employees: By signing **Section 1** of this form, employees attest under penalty of perjury (28 U.S.C. section 1746) that the information they provided, along with the citizenship or immigration status they select, and all information and documentation they provide to their employer, is true and correct, and they are aware that they may face penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties or removal proceedings, and may adversely affect an employee's ability to seek future immigration benefits.

Employers: By signing **Sections 2** and **3**, as applicable, employers attest under penalty of perjury (28 U.S.C. section 1746) that they have physically examined the documentation presented by the employee, that the documentation reasonably appears to be genuine and to relate to the employee named, that to the best of their knowledge the employee is authorized to work in the United States, that the information they enter in **Section 2** is complete, true, and correct to the best of their knowledge, and that they are aware that they may face civil or criminal penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing Form I-9.

DHS Privacy Notice

AUTHORITIES: The information requested on this form, and the associated documents, are collected under the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 U.S.C. 1324a).

PURPOSE: The primary purpose for providing the requested information on this form is for employers to verify the identity and employment authorization of their employees. Consistent with the requirements of the Immigration Reform and Control Act of 1986, employers use the Form I-9 to document the verification of the identity and employment authorization for new employees to prevent the unlawful hiring, or recruiting or referring for a fee, of individuals who are not authorized to work in the United States. This form is completed by both the employer and the employee and is ultimately retained by the employer.

DISCLOSURE: The information employees provide is voluntary. However, failure to provide the requested information, and acceptable documentation evidencing identity and authorization to work in the United States, may result in termination of employment. Failure of the employer to ensure proper completion of this form may result in the imposition of civil or criminal penalties against the employer. In addition, knowingly employing individuals who are not authorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an individual to work in the United States. The employer must retain this completed form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section. DHS may also share this information, as appropriate, for law enforcement purposes or in the interest of national security.

Paperwork Reduction Act Notice

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 34 minutes per response, when completing the form manually, and 25 minutes per response when using a computer to aid in completion of the form, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Office of Policy and Strategy, Regulatory Coordination Division, 5900 Capital Gateway Drive, Mail Stop Number 2140, Camp Springs, MD 20588-0009; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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. A noncitizen (other than **Item Numbers 2.** and **3.** above) 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)					
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)					

Additional Information

☐ 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
Town of Merrimac	4 School St., Merrimac MA 01860

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, 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 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.
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		

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 07/31/2026

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 07/31/2026

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.

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name: _____

Employee ID#: _____

Employer Name: _____

Employer ID#: _____

Your earnings from this job are not covered under Social Security (i.e., you will not pay Social Security taxes). This means that you will not earn credits for Social Security retirement or disability benefits in this job. If you retire or become disabled, and you are eligible for a Social Security benefit based on other work, your earnings from this job will not be used to compute your Social Security benefit. In addition, we will not consider these non-covered earnings for the future potential calculation of survivor benefits based on your earnings. Your earnings from this job are subject to Medicare taxes and will count for purposes of the Medicare program. For information on how you may qualify for Social Security benefits, visit www.ssa.gov.

For More Information

Social Security publications and additional information are available at www.ssa.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778 or contact your local Social Security office.

I certify that I have received Form SSA-1945 and understand that my earnings from this job are not covered under Social Security and will not be used to determine eligibility to or the amount of my potential future Social Security Benefits.

Signature of Employee: _____

Date: _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

The Social Security Protection Act of 2004, Pub. L. No. 108-203, Section 419 requires State and local government employers to provide a statement to employees hired January 1, 2005, or later in a job not covered under Social Security. Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers must use to meet the requirements of the law.

While the earlier version of the SSA-1945 discussed the effect of the Windfall Elimination Provision and/or Government Pension Offset on an employee's potential future benefits, the Social Security Fairness Act (SSFA) of 2023 enacted on January 5, 2025, eliminated the reduction of Social Security benefits under the Windfall Elimination Provision and/or Government Pension Offset for individuals entitled to certain pensions from work not covered by Social Security, starting January 2024. However, this did not remove the requirement for State and local government employers to provide a statement to employees hired January 1, 2005, or later in jobs not covered under Social Security. This version of SSA-1945 explains to an employee that non-covered earnings will not be used to determine eligibility to or calculate the amount of potential future benefits.

Employers must:

- Get the employee's signature on the form
- Give the signed statement and information page to the employee prior to the start of employment
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

A fillable, downloadable version of the SSA-1945 is available online at the Social Security website, www.ssa.gov/online/ssa-1945.pdf.

ESSEX REGIONAL RETIREMENT:

Your pension contributions are made through a payroll deduction. If you became a member after July 1, 1996 to present your contribution rate is 9%. Additionally, you also must contribute 2% of your annual pensionable income earned over $30,000.

- New Members **must** provide a copy of their birth certificate.
- If new member is a Veteran, he/she **must** provide a copy of Military Discharge.
- Beneficiary Form must be completed and signed by a witness **that is NOT a beneficiary**. Note that it is acceptable for the official administering the enrollment form at the time of hire witness the Beneficiary Selection Form.
- If you choose "Option D" on the beneficiary page, you **must** furnish a copy of the beneficiary's birth certificate or there may be a suspension of compensation.
- If you choose "Option D" and the beneficiary is your current or former spouse, you **must** provide a copy of your marriage certificate.

For questions regarding beneficiary benefit options, please contact Essex Regional Retirement Board at 978-739-9151 or 800-224-4804.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
New Member Enrollment

Form Last Revised: February, 2020

The *New Member Enrollment* Form allows a newly hired employee to apply for membership in a public retirement system. The form must be completed by any new employee regardless of his or her past employment with any governmental entity. Certain information on this form must be provided by the Payroll/Personnel Department and verified by the retirement board.

A new member must also complete the *Beneficiary Selection Form for Refund of Accumulated Deductions* and, if applicable, the *Beneficiary Selection Form (Option D)*.

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	Essex Regional Retirement System		
Address:	491 Maple St. Suite 202		
City/Town:	Danvers	**Zip Code:**	01923-4025
Telephone:	978-739-9151	**Fax:**	

Employee Information

Employee Last Name:		**First Name:.**		**M.I.:**	
Social Security # (Entire #):		**Phone #:**		**Sex:**	
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Birth/Former Name *(if different)*			**Email:**		
Date of Birth*:		**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced***			
Spouse's Name:		**Spouse's DOB:**		**# of Children:**	

Your Retirement Board will request a copy of birth records, military discharge papers and other pertinent data.
***If Divorced and you have a Qualified Domestic Relations Order (QDRO), please attach a copy.**

Current/Prior Retirement System Membership

List prior or current public retirement system membership:

Are you retired from any other Massachusetts public retirement system? ☐ **YES** ☐ **NO**

Were you ever a member of any other Massachusetts public retirement system? ☐ **YES** ☐ **NO**

List prior or current public retirement system membership:

SYSTEM	DATES OF MEMBERSHIP From:	To:	ARE YOUR FUNDS STILL ON DEPOSIT?	
			☐ YES	☐ NO
			☐ YES	☐ NO
			☐ YES	☐ NO

If you wish to purchase past creditable service, please ask your Retirement Board about your options.

Did you ever work for or do you currently work for the Commonwealth or one of its political subdivisions for which you were not/are not a contributing member of a a retirement system? ☐ **YES** ☐ **NO**

Member Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Other Public Employment in Massachusetts

List prior or current public employment in Massachusetts or one of its political subdivisions (Non-membership):

EMPLOYER	DATES OF EMPLOYMENT	
	From:	To:

Veteran Status

Are you a veteran? ☐ YES ☐ NO

If **YES**, please enter dates of service and attach a copy of your military discharge papers, Forms DD-214, DD-215, DD-256, NGB 22, or NGB 22A.

DATES OF ACTIVE SERVICE	
From:	To:

I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and to deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular interest as provided by law, will be returned to me upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor benefits **OR** a refund of my accumulated total deductions as allowed by law.

I sign this application under the penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

Applicant's Signature:

Print Employee's Name:

Employee's Signature: **Date:**

Member Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Payroll/Personnel Department

To be completed by Payroll/Personnel Department and verified by Retirement Board:

Check base rate to be deducted for retirement:

☐ 5% ☐ 7% ☐ 8% ☐ 9% ☐ Additional 2%

If 5%, 7%, or 8%, state reason:

Current Rate of Regular Compensation per Pay Period: $

Employment Status (Check ALL that apply):

☐ Permanent ☐ Temporary ☐ Full-time ☐ Part-time ☐ 50% ☐ 75% ☐ Other:

Agency/Dept: **Title/Position:**

Starting Date of Present Position:

Authorized Signature: **Date:**

Print Name:

Retirement Board

To be completed by Retirement Board:

Membership Date: **Annual Regular Compensation:** $

% to be Deducted **Current Group Classification:**

The member should also complete the *Beneficiary Selection Form (Refund)* or if applicable, the *Beneficiary Selection Form (Option D)*.

ESSEX REGIONAL RETIREMENT SYSTEM

491 Maple Street, Suite 202, Danvers MA 01923
Telephone: 978-739-9151
Email: info@essexrrs.org
www.essexregional.com

Charles E. Kostro
Executive Director

Board Members:
Susan J. Yaskell, Chair
Vincent R. Malgeri, Vice Chair
Tracy A. Blais
Kevin A. Merz
Donald C. Cudmore

HIPAA Authorization for Release of Limited Medical Information

(Pre-Employment Physical Examination)

Member/Employee Name: _____

Date of Birth: _____

1. Authorization

I hereby authorize the physician, medical provider, clinic, hospital, or other health care provider that conducted my **pre-employment physical examination**, and/or my employer who is in possession of this documentation in connection with my employment with _____ (the "Employer") to disclose a copy of the report of that examination to:

Essex Regional Retirement Board
491 Maple Street, Suite 202
Danvers, MA 01923

This authorization is intended to permit the Retirement Board to obtain documentation of the **pre-employment physical examination conducted at the time I was hired for the position that requires my membership in the Essex Regional Retirement System.**

---

2. Information Authorized for Disclosure

This authorization applies **only to the report of my pre-employment physical examination**, including:

- Physician's examination report (medical and psychological)
- Medical history taken in connection with the examination
- Findings and conclusions relating to my physical condition at the time of hire
- Any forms or certifications completed for employment purposes

This authorization does NOT authorize the release of:

- General medical records unrelated to the pre-employment examination
- Psychotherapy notes
- Records of treatment unrelated to the employment physical
- HIV/AIDS test results or other specially protected information unless specifically required by law

3. Purpose of Disclosure

The purpose of this disclosure is to allow the Retirement Board to:

- Administer benefits and obligations under **Massachusetts General Laws Chapter 32**
- Evaluate future claims for disability retirement or other benefits if necessary.

4. Voluntary Authorization

I understand that this authorization is **voluntary**, but failure to authorize disclosure may delay or prevent the Retirement Board from obtaining documentation required to administer retirement benefits, in particular those involving statutory presumptions that require a retirement system member have passed a pre-employment physical which did not reveal evidence of the condition for which I am later seeking a disability retirement.

5. Right to Revoke

I understand that I may **revoke this authorization at any time** by submitting written notice to the Retirement Board, except to the extent that action has already been taken in reliance on this authorization.

6. Expiration

Unless revoked in writing, this authorization shall remain in full force and effect while I continue to be a retirement system member.

7. Redisclosure

I understand that information disclosed pursuant to this authorization may be **subject to redisclosure by the Retirement Board** as required by law in the administration of retirement benefits, but the documentation provided through this authorization will not be otherwise disclosed or produced without my express written consent or an order of a court with competent jurisdiction.

8. Copy of Authorization

I understand that I am entitled to receive a copy of this authorization.

Signature of Employee/Member: _____

Printed Name: _____

Date: _____

Essex Regional Retirement System

BENEFICIARY OPTIONS WHILE STILL A MEMBER

A member has options from which to choose in order to provide benefits to your survivors if you should pass prior to retirement. But you must complete a beneficiary form and submit it to the retirement system in order for your wishes to be followed. During your membership in the retirement system, you may change your beneficiary selection at any time by filing a new form.

If a member wishes to have a lump sum paid to a designated beneficiary or beneficiaries, they must complete the Beneficiary Selection Form. If the member has not designated an Option D beneficiary, the member's accumulated deductions will be paid in a lump sum to the beneficiary or beneficiaries based on the allocations provided on the Beneficiary Selection Form.

If a member wishes to have a monthly retirement benefit paid out to their beneficiary, they must fill out the Choice of Option D Beneficiary Form. Option D provides a monthly benefit that a beneficiary would have received under Option C had the member retired on the date of death. If the member is under age 55, the member's age is "bumped up" to age 55 under Option D. (For members joining after April 2, 2012, the age is "bumped up" to 60.) A member can designate an Option D beneficiary at any time. Only a spouse, former spouse who has not remarried, child, mother, father, brother or sister is eligible to be designated as an Option D beneficiary.

The Option D beneficiary must receive the survivor benefit allowance.

If a member does not make an Option D designation, the member's spouse can still elect to receive the Option D allowance, or can request a return of the member's accumulated retirement deductions, provided that the member must have completed at least two years of creditable service; the member and spouse must have been married for at least one year; the member and spouse must have been living together at the time of death; and if the member and spouse were not living together at the time of death, the Board must find that they were living apart for justifiable cause.

The rights of a eligible surviving spouse will always supersede any other person nominated as the Option D beneficiary. The eligible spouse will have 90 days from the date of notification from the retirement board to elect the Option D benefit.

The selection of Option D beneficiary has a serious and lasting legal implications and we strongly recommend members speak with an ERRS retirement counselor when determining which beneficiary option to select. Our retirement counselors can be reached during regular office hours, which are Monday through Friday from 8:30 a.m. to 4:30 p.m., and the phone number is (978) 739-9151.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Beneficiary Selection Form for Refund of Accumulated Deductions
(If Member Dies Before Retirement)
Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Form Last Revised: February, 2020

The *Beneficiary Selection Form for Refund of Accumulated Deductions* allows a member to select a beneficiary or beneficiaries to receive payment of accumulated deductions and other payments due a member if the member dies before retirement, as described at Massachusetts General Laws, Chapter 32, Section 11(2)(c).

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you have designated an eligible beneficiary who is alive at the time of your death on the *Beneficiary Selection Form for Option D*, then the money in your annuity account will not be disbursed to anyone in a one-time lump-sum payment, even if you have designated them on this form.
- Any person or entity may be designated as your Refund of Accumulated Deductions beneficiary under Section 11(2)(c). You may designate multiple beneficiaries and must indicate the percentage of the annuity account that you wish each beneficiary to receive. The percentages must total 100%.
- Your selection of a beneficiary on this form also may be superseded by an eligible spouse under the provisions of Option D.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Section 11(2)(c) form with your retirement board, it will supersede any and all prior Section 11(2)(c) forms filed previously by you.
- When you sign this form, it should be witnessed by a disinterested party.
- This form becomes void upon your retirement.

Beneficiary Selection Form for Refund of Accumulated Deductions
(If Member Dies Before Retirement)
Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	Essex Regional Retirement Board Essex Regional Retirement System		
Address:	491 Maple St. Building 201 491 Maple St. Suite 202		
City/Town:	Danvers Danvers	**Zip Code:**	01923 01923-4025
Telephone:	(978) 739-9151 (978) 739-9151	**Fax:**	(978) 750-0745

Member's Information:

Member's Last Name	Member's First Name	Social Security # (last four)
		***-**-____ ____ ____ ____

Street Address:					
City/Town:		**State:**		**Zip Code:**	
Email:					
Phone:					

Choice of Beneficiary or Beneficiaries to Receive a Refund of Accumulated Total Deductions at Member's Death:

- Any person or entity may be a beneficiary under Massachusetts General Laws, Chapter 32, Section 11(2)(c). Give complete name and address of each beneficiary on the next page.

I, (Print Name) _____, a member of the _____ Retirement System hereby request the Retirement Board to pay any sum referred to in Massachusetts General Laws, Chapter 32, Section 11(2)(c) due at my death to the following beneficiary or beneficiaries in the proportions designated on the next pages.

Member Last Name: ______ **First Name:** ______ **SSN:** ***-**-__ __ __ __

PRIMARY LUMP-SUM BENEFICIARY(IES)

Do NOT name any one person or entity as a beneficiary more than ONCE in this section.

Primary Lump-Sum Beneficiary Information:

				% of Benefit**
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
				0%

*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.
**Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficaries.

CONTINGENT LUMP-SUM BENEFICIARY(IES)

In the event that none of the named primary lump-sum beneficiary(ies) above, are alive, or, if an organization, still operating, as of your death.

Contingent Lump-Sum Beneficiary Information:

				% of Benefit**
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
Full Name: (First, MI, Last):		**SSN/EIN*:**		
Relationship to You:	**Phone:**	**Date of Birth:**		
Address:				
				0%

*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.
**Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficaries.

Beneficiary Selection Form for Refund of Accumulated Deductions

Member Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

I understand that my selection may be superseded if I die with an eligible beneficiary under Option D.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement, this form becomes void.

The types of payments covered under Massachusetts General Laws, Chapter 32, Section 11(2)(c) include:

- The one-time payment of the accumulated deductions credited to a member's account in the annuity savings fund at the date of death when the member's death occurs prior to his/her retirement.
- Any amounts payable to a member at his or her death.

Member's Signature:

Print Name:

Signature: **Date:**

To Be Completed By Witness (should be disinterested party):

Name (Print):

Street Address:

City/Town: **State:** **Zip Code:**

Signature: **Date:**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction

Beneficiary Selection Form - Option D (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 12(2)(d)

Form Last Revised: February, 2020

The *Beneficiary Selection Form - Option D* allows a member to select an eligible beneficiary to receive an allowance if the member dies before retirement. This is the Member Survivor allowance described at Massachusetts General Laws, Chapter 32, Section 12(2)(d) ("Option D").

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you designate an eligible beneficiary on this form, and that beneficiary is living at the time of your death, the money in your annuity account will not be disbursed to anyone in a one-time, lump-sum payment, even if you have named them to receive such money on your *Beneficiary Selection Form for Refund of Accumulated Deductions*.
- You may name only one person as the Option D beneficiary. That one person may be your spouse, your former spouse who is not remarried at the time of your death, your child, your father, your mother, your sister or your brother.
- If you select a beneficiary other than the spouse to whom you are married at the time of your death, your selection on this form may be superseded by the eligible spouse under the provisions of Option D if you die before retirement.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Option D form with your retirement board, it will supersede any and all prior Option D forms previously filed by you.
- When you sign this form, it should be witnessed by a disinterested party.
- To cancel an Option D beneficiary designation prior to retirement, your written notice must be filed with the retirement board.
- This form becomes void upon your retirement.

Beneficiary Selection Form - Option D (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 12(2)(d)

Form Last Revised: July, 2019

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	Essex Regional Retirement Board		
Address:	491 Maple Street, Building 200		
City/Town:	Danvers	**Zip Code:**	01923
Telephone:	(978) 739-9151	**Fax:**	(978) 750-0745

Member's Information:

Member's Last Name	**Member's First Name**	**Social Security # (last four)**
		***-**-____ ____ ____ ____

Street Address:					
City/Town:		**State:**		**Zip Code:**	
Email:					
Phone:					

Choice of Option D Beneficiary

I, (Print Name) _____ , a member of the _____ Retirement System, hereby nominate the beneficiary listed below, under the provisions of Massachusetts General Laws, Chapter 32, Section 12(2)(d) to receive from the retirement system a benefit equal to the Option C retirement allowance which would otherwise have been payable to me, in the event that I die before being retired.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement this form becomes void.

I understand that this choice of Option D Beneficiary can be superceded if, at my death, I have at least two years of creditable service and leave a spouse to whom I have been married for over one year and with whom I am living on the date of my death, or if living apart, doing so for justifiable cause as determined by the Retirement Board.

Beneficiary

This person is my:

☐ Parent ☐ Sibling ☐ Unmarried Former Spouse*

☐ Spouse* ☐ Child

Name of Eligible Beneficiary:					
Beneficiary's Date of Birth: *(attach birth record)*		**Beneficiary's Social Security #:**			
Beneficiary's Street Address:					
City/Town:		**State:**		**Zip Code:**	

*If beneficiary is your spouse or former spouse, a copy of your marriage certificate is required

Member's Signature:

Print Name:			
Signature:		**Date:**	

To Be Completed By Witness (should be disinterested party):

Print Name:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Signature:		**Date:**			

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy

Employee Health Insurance Responsibility Disclosure Form

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at < www.mahealthconnector.org >.

Employer

Employers: please complete this section. See reverse side for instructions.

Employer Name: Town of Merrimac **FEIN:** 046-001-219

Employer D/B/A:

Employer Address: 4 School Street

City | State | ZIP Code: Merrimac, MA 01860

1. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes ☐ No ☐
2. Did you offer employer sponsored health insurance to this employee? Yes ☐ No ☐
3. If you offered sponsored insurance to this employee, what is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee? (If did not offer sponsored insurance, leave blank.) $

Employee

Employees: please complete this section. See reverse side for instructions.

Employee First Name **Middle Initial**

Employee Last Name **Suffix** (e.g., Sr., Jr.)

1. Did you accept your employer sponsored health insurance? Yes ☐ No ☐ None Offered ☐
2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase health insurance? Yes ☐ No ☐ None Offered ☐
3. Do you have other health insurance? Yes ☐ No ☐

Employee Affidavit

I hereby affirm, under penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

Employee Signature **Date (MM/DD/YY)**

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Department of Revenue as required by state regulation 114.5 CMR 18.00.

Instructions

Employer Information

Employer Name
Employers must enter the company's legal name.

FEIN
The employer must enter the Federal Employer Identification Number.

D/B/A
The employer must enter the company's trade name "Doing Business As" here, if applicable.

Employer Address
The employer must enter the business address including city, state, and ZIP Code.

Question 1
The employer must indicate either Yes or No (check box).

Question 2
The employer must indicate either Yes or No (check box).

Question 3
The employer must report the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee, if the employer offers a sponsored health plan (i.e. the employer offers to pay for a portion of the premium).

Employee Information

Employee First Name
The employee or employer must enter the employee's first name.

Employee Last Name
The employee or employer must enter the employee's last name.

Question 1
The employee must indicate Yes, No, or None Offered if health insurance is not offered (check box).

Question 2
The employee must indicate Yes, No, or None Offered if a "Section 125 Cafeteria Plan" is not offered (check box).

Question 3
The employee must indicate Yes or No (check box).

Employee Signature
The employee must sign and date the Employee Health Insurance Responsibility Disclosure (HIRD) form.

Note to Employer Regarding Employee Signature
If the employee refuses to sign and date the form, the refusal should be noted in writing and signed by the authorized company representative (e.g., the owner, supervisor or manager, chief executive officer, etc.).

Alternate Versions of This Form

Employers may recreate their own version of the Employee Health Insurance Responsibility Disclosure (HIRD) form. However, all information must be included, with the same wording and order, and the sequence and numbering of the Questions must be exactly as it appears on the version provided by the Commonwealth of Massachusetts.

EMPLOYER CAFETERIA PLAN
SALARY REDIRECTION/REDUCTION AGREEMENT

EMPLOYER: TOWN OF MERRIMAC

EMPLOYER'S TAX ID NUMBER: 04 - 6001219

AFFILIATE'S NAME/LOCATION: _____

AFFILIATE'S TAX ID NUMBER: _____ - _____

CAFETERIA PLAN YEAR: FY ___/___/___ – ___/___/___

(CHECK ONE) ☐ OPEN ENROLLMENT OR ☐ NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE: ___/___/___

SOCIAL SECURITY NO.: _____ DATE OF BIRTH: ___/___/___ PHONE: (___)_____

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

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: _____

No. of Payroll Cycles in Plan Year: _____ Date of First Deduction: ___/___/___ Payroll Mode: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution will be deducted from my paycheck by my employer or a third-party payroll administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to employer-provided, nonelective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Cafeteria Plan as elected in the Pre-Tax column below. Any previous election and Salary Redirection Agreement under the Cafeteria Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/ contribution amounts hereunder shall evidence acceptance of this agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage	_____	_____	Specified Health Event Insurance	_____	_____
Dental Insurance	_____	_____	Short-Term Disability Insurance	_____	_____
Vision Insurance	_____	_____	Long-Term Disability Insurance	_____	_____
Cancer Insurance	_____	_____	Hospital Confinement Indemnity Insurance	_____	_____
Hospital Intensive Care Insurance	_____	_____	Personal Sickness Indemnity Insurance	_____	_____
Accident Insurance	_____	_____	Health Savings Account (HSA) §223	_____	_____
Group Term Life Insurance (if family, must be after-tax)	_____	_____	Other accident or health plan(s) under Section 106 of the Internal Revenue Service Code	_____	_____
			List: _____		

Required acknowledgment to participate in Cafeteria Plan:

I certify that the features and benefits under the Cafeteria Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Cafeteria Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Cafeteria Plan.

INITIAL

WAIVER OF PRE-TAX BENEFITS UNDER THE CAFETERIA PLAN:

I elect to waive all pre-tax benefits under the Cafeteria Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

INITIAL

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____

IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE FLEXIBLE BENEFITS PLAN

I understand and agree to the following:

- **Restrictions on Election Changes:** On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a change in status occurs (as defined under the plan and the Internal Revenue Code), and the change is caused by and consistent with the change in status.

- **Commencement of Coverage and Status of Prior Elections:** Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop, or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue.

- **Use of Personal Information:** In addition to and without limiting in any way the rights my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status, and health and dependent child care information) as is reasonably required to administer the plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure, or release of such information so long as the information is used in furtherance of plan administration, or to detect or prevent fraud or misrepresentation.

- **Effect of Pre-Tax Contributions on Benefits Payments:** Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverages may be funded on an after-tax basis to preserve the excludability of policy benefits.

- **PLAN DOCUMENT CONTROLS:** I verify that I have received a summary of the tax rules, operational guidelines, and procedures for use with the Cafeteria Plan. I understand that the plan document will control notwithstanding any contrary oral representation by any person.

BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

2518-1 — Group Number-Division Number

Town of Merrimac — Employer/Policyholder

Dept. ID

Employee Name *(Last, First, Middle)*

Social Security Number

Home Address *(Street, City, State, Zip)*

( ) Telephone #

Gender *(M/F)* | Occupation or Job Title | Date of Birth | Age

PAYROLL TYPE: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Annual Earnings: $

Average Hours Worked | Date of Hire | or Date of Full Time Employment if different | Effective Date | State | Class | Rate Basis

Spouse *(Last, First, Middle)* | Gender *(M/F)* | Date of Birth | Age | No. of Dependents

LIFE - DISABILITY

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

BASIC	YES	NO	Insurance Amount
LIFE	❑	❑	$
AD&D	❑	❑	$
DEPENDENT LIFE:			
SPOUSE	❑	❑	$
CHILD(REN)	❑	❑	$
SHORT TERM DISABILITY	❑	❑	$
LONG TERM DISABILITY	❑	❑	$
❑ OTHER *(Please specify coverage & amt.)*			

VOLUNTARY	YES	NO	Insurance Amount
LIFE	❑	❑	$
AD&D	❑	❑	$
DEPENDENT LIFE:			
SPOUSE LIFE AND AD&D	❑	❑	$
CHILD(REN)	❑	❑	$
SHORT TERM DISABILITY	❑	❑	$
LONG TERM DISABILITY	❑	❑	$
❑ OTHER *(Please specify coverage & amt.)*			

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS: ***(Attach Additional Beneficiaries on a signed and dated separate sheet)***

Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit
Contingent Beneficiary(ies):						

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

Please complete as much beneficiary information as you can provide.

SIGNATURE

REFUSAL OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer *(or the Association with whom I am affiliated)* and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

❑ All Coverages ❑ Life & AD&D ❑ Dependent Coverage ❑ Short Term Disability ❑ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

EMPLOYEE SIGNATURE REQUIRED

I apply for the insurance for which I am now eligible *(or for which I may become eligible)* under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. *I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

NOTICE: READ BEFORE SIGNING ENROLLMENT FORM

BOSTON MUTUAL LIFE INSURANCE COMPANY REQUIRED FRAUD NOTICES

For use with Application Forms

STANDARD NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to California residents:

For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Residents:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to DC Residents:

Warning: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by an applicant.

Notice to Florida Residents:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Maine Residents:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefit.

Notice to New Jersey Residents:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oklahoma Residents:

Any person who knowingly and with intent to injure, defraud or deceive any insurers, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Residents:

Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Notice to Puerto Rico:

Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years, if mitigating circumstances prevail, it may be reduced to a minimum of two (2) years.

Notice to Vermont:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to criminal and civil penalties.

Notice to Virginia Residents:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Notice to Washington:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. The penalties include imprisonment, fines, and denial of insurance benefits.

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing,** at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient _____

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient _____

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____ , the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured _____ Date _____

BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x 700**

Please refer to your Administration Kit for enrollment and mailing instructions

REFUSAL OF INSURANCE

Employee Name *(Last, First, Middle)*	Employer/Policyholder	Group No.

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer (or the Association with whom I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

☐ All Coverages ☐ Life & AD&D ☐ Dependent Coverage ☐ STD ☐ LTD ☐ Dental ☐ Vision

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company. If I desire to participate in the dental program at a later date, additional benefit type waiting periods may apply.

Signature of Employee _____ SSN # _____

Signature of Witness _____ Date _____

Treatment Form

convenientMD

EMPLOYER & EMPLOYEE INFORMATION

EMPLOYER: Town of Merrimac

EMPLOYEE / APPLICANT:

AUTHORIZED BY: Carol McLeod **EXPIRATION DATE:**

SERVICES REQUIRED:

BREATH ALCOHOL TYPE

Non-Federal (Non-DOT) ☐

DRUG TESTING TYPE

5 Panel Rapid (With **BLANK LabCorp** Non-DOT Chain of Custody) ☒

BREATH ALCOHOL REASON FOR TEST

Post-Accident ☐
Reasonable Suspicion / For Cause ☐

DRUG TESTING REASON FOR TEST

Pre-Employment ☒
Post-Accident ☐
Reasonable Suspicion / For Cause ☐

EXAMINATIONS & TESTING

Pre-Employment Physical ☒
Pre-Employment DOT Physical ☐
Re-Certification DOT Physical ☐

WORK INJURY TREATMENT

Work Injury Treatment ☐

RESULTS

ConvenientMD Staff: Please verify account protocol on the Occupational Health Directory

Date of Service: **Patient ID:**

Clinic Location:

	Pending/ CCF Sent out	Pass/ Negative	
5 Panel Rapid Drug Screen	☐	☐	_____ (Initials)

When results are negative attach DocuTAP Printout*
If sent out for further testing, attach COC EMPLOYER COPY *

STOP **If requested and not completed, select reason below:**
☐ Outside of hours ☐ Unable to provide sample ☐ Other _____

	Pass	Fail	
Non-DOT Breath Alcohol	☐	☐	_____ (Initials)

Attach Employer Copy of ATF Form*

STOP **If requested and not completed, specify reason below:**
☐ Other _____

	Pending	Pass	Fail	
Pre-Employment Physical	☐	☐	☐	_____ (Initials)
Pre-Employment DOT Physical	☐	☐	☐	_____ (Initials)
Re-Certification DOT Physical	☐	☐	☐	_____ (Initials)

Attach DOT Medical Card*

Comments

Please see the attached Treatment Form. *Please review the allocated hours for Physicals & Drug Screens.*

Patients must arrive to our ConvenientMD Clinics and identify themselves as an occupational health visit. When sending an employee, please have them identify themselves as an employee of Town of Merrimac. This will allow our team to identify the correct protocol we have in place and send to you the relevant documentation after the visit is completed. **For Workers Compensation Visits - Treatment Form is not required.**

Treatment Forms Instructions

Please fill out this form for any employee visiting our clinic for the above services. For Drug Screen Tests & Breath Alcohol Testing, always make sure you select the **TYPE** and the **REASON** for testing.

Please ask your employee to bring the completed form with them to present to our team at the time of service.

You can also send all treatment forms to the following email occhealth@convenientmd.com. Please indicate in the subject of the email employee name and company name (for example: Jon Smith Treatment Form/ Town of Merrimac). Our team uses this form to confirm that the services were authorized and identify your customized protocols for the services requested. **We highly recommend emailing a copy of the treatment form directly to your employee/applicant as well.** This way, if from any reason our front desk is not able to locate the treatment form, your employee/applicant has a copy to provide us at the time of service.

EXPIRATION DATE: Please enter a date in the event you would like to limit the time frame for when the employees/applicants can complete the requested services. The date you enter would be the last day for the employee to complete the services, otherwise the form will expire. If you do not wish to limit the employees/applicants enter N/A or leave blank.

DOT Physical Availability

Please click here to review daily availability for DOT Certified Provider for this month. This information will be updated on a monthly basis. Please keep in mind that if there are an unexpected absence, there may be changes to the schedule. We recommend calling the clinic prior to the employees arrival to verify that a certified provider is scheduled for that day.

ONLINE CHECK-IN

In an effort to enhance our patient experience and improve work flow, we have implemented an Online Check-in capability on our website for all ConvenientMD locations. Scheduling and queuing is a key area we are focusing on to improve patient access and throughput.

When you log on to our website or visit our locations page you will see the ability to reserve your spot before heading to the clinic up to two days in advance at most locations. This is not an appointment but rather a reserved check-in time that allows you to get in line in advance of arriving at the clinic. Once you select the visit reason (work-related injury, employer request, etc.) that *most closely* aligns with your visit, dates and times will appear that you can choose from. You will be required to provide patient/employee information to reserve your spot online. For your convenience, you will receive updates and reminder text messages about your employer related visit once you're in the queue.

ConvenientMD will continue to see patients and employees on a walk-in basis for pre-employment visits with the rollout of the reserve your spot online functionality. In the event there is a wait time at the time of service, we will do our best to accommodate these visits and fit them in to the schedule within 48 hours.

Thank you for trusting ConvenientMD for the care of your employees. If you have any questions please feel free to reach out to Employer Services at EmployerServices@ConvenientMD.com or (603) 766-5913.

Thank you,

Jessica Dyer
Employer Services Supervisor
P: (603) 766-5913
F: (603) 766-5912
jdyer@convenientmd.com

ConvenientMD Urgent Care **Clinic Locations**

Updated 07/31/2024

New Hampshire

Bedford	3 Nashua Road	P 603-472-6700	F 603-472-6701
Belmont	77 Daniel Webster Highway	P 603-737-0550	F 603-737-8331
Concord	8 Loudon Road	P 603-226-9000	F 603-226-2268
Dover	14 Webb Place	P 603-742-7900	F 603-343-4749
Exeter/Stratham	1 Portsmouth Avenue	P 603-772-3600	F 603-772-3601
Keene	351 Winchester Street	P 603-352-3406	F 603-352-3416
Littleton	551 Meadow Street	P 603-761-3660	F 603-761-7791
Londonderry	42 Nashua Road	P 603-413-6800	F 603-413-6803
Manchester	738 Hooksett Road	P 603-384-3900	F 603-384-3912
Merrimack	2 Dobson Way	P 603-471-6069	F 603-471-6068
Nashua	565 Amherst Street	P 603-578-3347	F 603-578-3387
Plaistow	49 Plaistow Road	P 603-371-3229	F 603-371-3239
Portsmouth	599 Lafayette Road	P 603-942-7900	F 603-630-1009
Windham	125 Indian Rock Road	P 603-890-6330	F 603-458-7626

Maine

Auburn	590 Center Street	P 207-955-5565	F 207-955-5567
Augusta	4 Whitten Road	P 207-466-2400	F 207-466-2402
Bangor	543 Broadway	P 207-922-1300	F 207-217-6742
Belfast	18 Belmont Ave	P 207-607-5270	F 207-607-5271
Brunswick	193 Bath Road	P 207 424-2272	F 207-424-2268
Ellsworth	235 High Street	P 207-412-5200	F 207-412-5201
Portland	191 Marginal Way	P 207-517-3838	F 207-517-3820
Saco	506 Main Street	P 207-571-7991	F 207-571-7990
Sanford	1420 Main Street	P 207-850-5744	F 207-850-5729
Westbrook	950 Main Street	P 207-517-3800	F 207-517-3818

ConvenientMD Urgent Care **Clinic Locations**

Updated 07/31/2024

Massachusetts

Bellingham	245 Hartford Avenue	P 774-295-4355	F 774-295-4880
Burlington	181 Cambridge Street	P 781-730-0045	F 781-552-4842
Brockton *coming soon!*			
Dedham	983 Providence Highway	P 781-819-6400	F 339-234-6921
Falmouth	40 Davis Straits	P 774-255-3010	F 508-388-2312
Framingham	236 Cochituate Road	P 774-244-3227	F 774-244-4916
Leominster	20 Commercial Rd, Suite 2	P 978-798-6896	F 978-798-6897
Ludlow	471 Center Street	P 413-625-3500	F 413-625-3655
Newburyport	35 Storey Avenue	P 978-225-6607	F 978-225-6609
North Andover	419 B Andover Street	P 978-620-5048	F 978-620-5073
Peabody	210 Andover Street	P 978-488-3234	F 978-488-3235
Pembroke	296 Old Oak Street	P 339-244-3033	F 339-244-3005
Pittsfield	999 Dalton Avenue	P 413-242-6577	F 413-242-6637
Plainville	86 Taunton Street	P 508-928-5211	F 508-928-5212
Plymouth	140 Samoset Street	P 508-209-5362	F 508-209-5393
Quincy	479 Washington Street	P 857-529-5220	F 857-529-5422
Saugus	156 Main Street	P 339-674-0978	F 339-674-0914
Sutton	15 Pleasant Valley Rd	P 508-426-9005	F 508-426-8966
Westborough	139 Turnpike Road	P 508-882-7300	F 508-882-7312
Weymouth	987 Main Street	P 781-927-3000	F 781-277-3009
Worcester	70 Gold Star Blvd, Suite 100	P 508-426-9002	F 508-426-9070

Pregnant Workers Fairness Act

On July 27, 2017, "An Act Establishing the Massachusetts Pregnant Workers Fairness Act" was signed into law. The Act prohibits workplace and hiring discrimination related to pregnancy, childbirth, or a related condition, including, but not limited to, lactation or the need to express breast milk for a nursing child. The law further requires employers to provide reasonable accommodations in the workplace for expectant and new mothers. It is the [City/Town]'s policy to comply with the provisions of the Pregnant Workers Fairness Act, including the provision of reasonable accommodations when appropriate.

Under the Act, Town of Merrimac employees have a right to be free from discrimination based upon pregnancy or a condition related to pregnancy. The Town of Merrimac shall not take any adverse action against an employee on the basis of pregnancy or related medical condition, or for requesting or using an accommodation for pregnancy or related medical condition.

Examples of adverse actions include: denying employment opportunities based on pregnancy or related conditions; requiring an employee who is pregnant or has a pregnancy related medical condition to accept an accommodation that the employee chooses not to accept; requiring an employee to take leave if other reasonable accommodation can be provided without undue hardship; making pre-employment inquiry of a job applicant related to pregnancy, childbirth, or a related condition; and, when the need for a reasonable accommodation ceases, failing to reinstate the employee to the original employment status or to an equivalent position with equivalent pay and accumulated seniority, retirement, fringe benefits and other applicable service credits.

Reasonable Accommodations:

An employee working for the Town of Merrimac has a right to reasonable accommodation with respect to pregnancy and/or any condition resulting from pregnancy, so that the employee may perform the essential functions of the job, unless the requested accommodation will cause an undue hardship on the Town of Merrimac.

These accommodations can include, for example: frequent or longer paid or unpaid breaks; time off to recover from childbirth or complications from pregnancy, with or without pay; acquisition or modification of equipment or seating; temporary transfer to a less strenuous or hazardous position; job restructuring and/or modified work schedule; light duty and/or assistance with manual labor; and private non-bathroom space for expressing breast milk.

The Town of Merrimac may request documentation from the employee's health care provider(s) about the need for a reasonable accommodation, except in the cases of requests for: more frequent restroom, food or water breaks; seating; limits on lifting more than 20 pounds; and private non-bathroom space for expressing breast milk.

Contact Carol McLeod with questions about, or requests for reasonable accommodation under, the Pregnant Workers Fairness Act.

PLEASE PRINT CLEARLY OR TYPE AND PROVIDE VOIDED CHECK FOR CHECKING ACCOUNT

TOWN OF MERRIMAC

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

To enroll in Direct Deposit, simply fill out his form and give it to your Payroll Department. Attach a voided check for each checking account. If depositing to a savings account, ask your bank to give you the routing/transit number for your account. (It isn't always the same as the number on your deposit slip.) This will ensure that you are paid correctly.

Employee Name _____

ACCOUNT INFORMATION

1. Bank Name/City/State: _____
   Routing/Transit # _ _ _ _ _ _ _ _ _ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

2. Bank Name/City/State: _____
   Routing/Transit # _ _ _ _ _ _ _ _ _ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

3. Bank Name/City/State: _____
   Routing/Transit # _ _ _ _ _ _ _ _ _ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

4. Bank Name/City/State: _____
   Routing/Transit # _ _ _ _ _ _ _ _ _ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

5. Bank Name/City/State: _____
   Routing/Transit # _ _ _ _ _ _ _ _ _ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

I hereby authorize the Town of Merrimac to deposit any amounts owed me by initiating credit entries to my accounts indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by the Town of Merrimac to my accounts. In the event that the Town of Merrimac deposits funds erroneously into my account, I authorize the Town of Merrimac to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until the Town of Merrimac and Bank have received written notice from me of its termination in such manner as to afford the Town of Merrimac and Bank reasonable opportunity to act on it.

EMPLOYEE SIGNATURE: _____ DATE: ___/___/_____