Mountain View School District Personnel File Checklist
Full-time Professional Employee

Name of Employee _____

Address _____

_____ Township_____

SS Number _____Date of Birth _____ Telephone_____

Required for Employment

1. Pennsylvania Standard Application returned and signed _____
2. Resume _____
3. Pennsylvania Certification *(must be original to be copied) _____
4. College/University Transcripts – Official _____
5. Recommendations for Employment _____
6. Interview Records/Data _____
7. Pennsylvania State Request for Criminal Record Check https://epatch.state.pa.us *(must be original to be copied) (Act 34) _____
8. PA Child Abuse History Clearance *(must be original to be copied) (Act 151) https://www.compass.state.pa.us/cwis/public/home _____
9. FBI Federal Criminal History Record – https://uenroll.identogo.com; code 1KG6XN *(must be original to be copied) (Act 114) _____
10. Arrest/Conviction Report (Act 24) _____
11. Employment Eligibility Verification (Form I-9) _____
12. W-4 Form _____
13. Letter of Appointment by Board of Education _____
14. Temporary Professional Employee Contract or Professional Employee Contract _____
15. Health Record with Proof of Tuberculosis Tine Test within the last 3 months _____
16. Loyalty Oath _____
17. Verification of Prior Substitute/Temporary Professional/ Professional Employment _____
18. Verification of Unused Sick Leave Days for Transfer _____
19. Health Insurance Application _____
20. Dental Insurance Application _____
21. Group Life Insurance Enrollment Application _____
22. Direct Deposit Authorization Information _____
23. Payroll Deduction Authorization Information _____
24. Notice of Election for Annualized Salary _____
25. One Time Notice for Buy-Back Benefit _____
26. Local Earned Income Tax (Act 32) _____
27. Acceptable Use for Computer and Internet Access _____
28. MVR Form (Need Copy of Car Insurance Coverage) _____
29. Act 126 Certificate http://www.socialwork.pitt.edu/researchtraining/child-welfare-education-research-programs/act-31-line-training _____
30. 403 Universal Availability Document _____
31. Act 168 _____
32. Act 29 PSER'S Form _____
33. Aflac _____
34. Vision Form _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

▶**START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization

List A	List B	List C
Document Title	Document Title	Document Title
Issuing Authority	Issuing Authority	Issuing Authority
Document Number	Document Number	Document Number
Expiration Date *(if any) (mm/dd/yyyy)*	Expiration Date *(if any) (mm/dd/yyyy)*	Expiration Date *(if any) (mm/dd/yyyy)*
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any) (mm/dd/yyyy)*		
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any) (mm/dd/yyyy)*		

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

H511.340 (8/2011)

Position _____

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH

SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name | First | MI | Sex | Date of Birth

Social Security Number | Home Telephone | Work Telephone

Mailing Address | Street | City | State | Zip

Usual Source of Medical Care | Physician's Name | Address | Telephone

Emergency Contact – Name | Relationship | Address | Telephone

II. Immunization History

VACCINE	Enter Month, Day, and Year Each Immunization was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus*	1.	2.	3.	4.	5.
Hepatitis B	1.	2.	3.		
Measles, Mumps, Rubella	1.	2.			
Other _____	1.	Other _____		1.	

* Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DtaP, DT, or Td

III. Required Tuberculosis Test Results (as per Regulations of the Department of Health

DATE APPLIED	ARM	METHOD	ANTIGEN	MANUFACTURER	SIGNATURE
DATE READ	**RESULTS (mm)**		**SIGNATURE**		

For previously known/new positive reactors: _____

Chest X-ray: Date: _____ Results: _____
(Attach a copy of the report.)

Other: Date: _____ Results: _____
(Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE:

_____

_____

_____

IV. Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain:
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

V. Report of Physical Examination (✓)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches) _____				
Weight (pounds) _____				
Pulse _____				
Blood Pressure _____				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: R_____L_____				
Eyes – Color Vision				
Ears – Hearing (dB) R_____L_____				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc...				
Lungs – Adventitous Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her work role? If so, specify _____

_____ Physician Name (Print)

_____ Signature of Examiner

_____ Date

_____ Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

_____ Signature of Employee

_____ Date

School District of ..... County	LOYALTY OATH	Pursuant to Act No. 463, Approved December 22, 1951 as amended, May 2, 1967

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF ..... } SS:

I, ... do solemnly swear (or affirm) that I will support, obey and defend the Constitution of the United States and the Constitution of this Commonwealth, and that I will discharge the duties of .....with fidelity.
"State Employee," "teacher," etc.

And I do further swear (or affirm) that I am not knowingly a member with the specific intent to further the aims of any organization that advocates the overthrow of the government of the United States or of this Commonwealth, by force or violence or other unconstitutional means, or seeking by force or violence to deny other persons their rights under the Constitution of the United States or of this Commonwealth.

And I do further swear (or affirm) that I will not knowingly become a member with the specific intent to further the aims of such organization during the period that I am an employe of the

....
Commonwealth of Pennsylvania or Political Subdivision Thereof

Taken, sworn and subscribed
before me, this ..... day of
.....A. D. .....
.....
SEAL .....

.....

* * * * * * * * * * *

NOTE: The foregoing oath shall be administered by any person duly authorized by law to administer oaths. Any person failing or refusing to execute this oath shall be discharged immediately by the proper appointing authority. Notice is hereby given that this oath is subject to the penalties of perjury, a felony: To wit, a fine not exceeding three thousand dollars ($3000), or imprisonment by separate or solitary confinement at labor not exceeding seven (7) years, or both, and disqualification forever from being a witness in any matter in controversy.

Form No. 02. Printed by Kurtz Bros., Clearfield, Pa.

Guardian The Guardian Life Insurance Company of America

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: MOUNTAIN VIEW SCHOOL DISTRICT	Group Plan Number: 00563214	Benefits Effective:_____
PLEASE CHECK APPROPRIATE BOX Initial Enrollment	Add Employee/Dependents	Drop/Refuse Coverage Information Change

Class: PROFESSIONAL STAFF Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

About You: First, MI, Last Name:	Employer Provided Identification: _____	Social Security Number ___-___-___ Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address	City	State	Zip

Gender: M F Date of Birth (mm-dd-yy):___-___-___

Phone (indicate primary): Home (___)___-___
Work (___)___-___
Mobile (___)___-___

Email Address (indicate primary) Home _____ Work _____

Are you married or do you have a partner? Yes No Date of marriage/union:___-___-___
Do you have children or other dependents? Yes No Placement date of adopted child:___-___-___

About Your Job: Job Title:

Work Status: Active Retired Cobra/State Continuation Hours worked per week: _____	Date of full time hire: ___-___-___	Annual Salary: $_____

Drop Coverage:

Drop Employee Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: ___-___-___
Termination of Employment Retirement
Last Day Worked: ___-___-___
Other Event: _____
Date of Event: ___-___-___

Coverage Being Dropped:

Basic Life
Long Term Disability

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

Covered under another insurance plan
Other _____
(additional information may be required)

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Apr 09, 2022

Guardian The Guardian Life Insurance Company of America

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: MOUNTAIN VIEW SCHOOL DISTRICT	Group Plan Number: 00563214	Benefits Effective:_____
PLEASE CHECK APPROPRIATE BOX Initial Enrollment	Add Employee/Dependents	Drop/Refuse Coverage Information Change

Class: PROFESSIONAL STAFF Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

About You:

First, MI, Last Name:

Employer Provided Identification: _____

Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Social Security Number must be provided if enrolling for Life Coverage, Short Term Disability Coverage and/or Long Term Disability Coverage.

Address	City	State	Zip

Gender: M F Date of Birth (mm-dd-yy): ___ - ___ - ___

Phone (indicate primary): Home (___) ___ - ___
Work (___) ___ - ___
Mobile (___) ___ - ___

Email Address (indicate primary) Home _____ Work _____

Are you married or do you have a partner? Yes No Date of marriage/union: ___ - ___ - ___
Do you have children or other dependents? Yes No Placement date of adopted child: ___ - ___ - ___

About Your Job: Job Title:

Work Status: Active Retired Cobra/State Continuation Hours worked per week: _____	Date of full time hire: ___ - ___ - ___	Annual Salary: $_____

Drop Coverage:

Drop Employee Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: ___ - ___ - ___

Termination of Employment Retirement

Last Day Worked: ___ - ___ - ___

Other Event: _____

Date of Event: ___ - ___ - ___

Coverage Being Dropped:

Basic Life

Long Term Disability

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

Covered under another insurance plan

Other _____

(additional information may be required)

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Apr 09, 2022

Basic Life Coverage:

Benefit reductions apply. Please see plan administrator.

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Policy Amount
Employee Only
☑ $40,000
The Guarantee Issue Amount is $40,000.

* If Employee is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name:_____ **Social Security Number:**___-___-_____ %___

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Name:_____ **Social Security Number:**___-___-_____ %___

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Contingent Beneficiary:_____ **Social Security Number:** ___-___-_____

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Please contact your employer for any record of or changes to your beneficiary information.

Spouse and dependent child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:
Name: _____ **Social Security Number (or FEIN/TIN # if a corporate entity):** ___-___-_____
Date of Birth (mm-dd-yyyy) (if an individual): ____-____-____
Address/City/State/Zip: _____
Phone: ( ) -

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $_____

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

Long-Term Disability (LTD) Coverage:

The amount of LTD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you.

Monthly Benefit
☑ 60% of salary to a maximum of $2,000

Guardian Group Plan Number: **00563214**

Please print employee name:

Signature

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.

I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.

I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.

I hereby apply for the group benefit(s) that I have chosen above.

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

I consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice.

I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

SIGNATURE OF SPOUSE (IF APPLYING FOR LIFE INSURANCE) X _____ **DATE** _____ Enrollment Kit 00563214, 0003, EN

SIGNATURE OF DEPENDENT CHILD (IF AGE 18 OR OVER AND APPLYING FOR LIFE INSURANCE) X _____ **DATE** _____

SIGNATURE OF DEPENDENT CHILD (IF AGE 18 OR OVER AND APPLYING FOR LIFE INSURANCE) X _____ **DATE** _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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

Colorado: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

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

District of Columbia: WARNING: It is a crime to provide false or misleading information to an 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 the applicant.

Florida: 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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

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

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

Oregon: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material thereto, may be committing a fraudulent act, and may be subject to civil penalties or denial of insurance benefits.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

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

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

Pennsylvania: 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.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Enrollment / Change / Delete Form

Expert Solutions. Exceptional Service.

Please Note: Incomplete information may delay processing of this form (please print-black ink only).

GROUP ADMINISTRATOR: Please return completed forms to: VBA at Elig@vbaplans.com (Confirmation will be sent by VBA when this form has been processed).

This section to be completed by the Group Administrator:

Date: _____ Group#/Name: **#4529 / Mountain View School District** Subgroup (if applicable):

Administrator: _____ Phone #: _____ Ext: _____

Effective Date of Change: _____ Enrollment Status: _____ Active _____ Cobra

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Employee Information Transaction Type: _____Add _____Change _____Delete

Social Security Number: _____ Date of Birth: _____ Gender: _____

Employee Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

First Name, Middle Initial, Last Name Action Codes: (A)dd (C)hange (D)elete

SPOUSE:		SSN#	DOB:	GENDER	ACTION:
CHILD 1:		SSN#	DOB:	GENDER	ACTION:
CHILD 2:		SSN#	DOB:	GENDER	ACTION:
CHILD 3:		SSN#	DOB:	GENDER	ACTION:
CHILD 4:		SSN#	DOB:	GENDER	ACTION:
CHILD 5:		SSN#	DOB:	GENDER	ACTION:

Special Dependent Information -- To be used to designate Full-Time Student or Handicapped Dependent

Child Name _____ Handicapped _____

Child Name _____ School _____

Child Name _____ School _____

I agree to all terms and conditions of the VBA Vision Plan and corresponding payroll deductions (if applicable).

Employee Signature: _____ **Date:** _____

SCHEDULE OF VISION BENEFITS

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Routine Exam Once every 12 months	Covered 100%	Up to $ 40
- AND -		
Lenses Once every 12 months Single Vision Bifocal Blended Bifocals Progressive Trifocal Lenticular Polycarbonate (under age 19) 1 Year Scratch Protection	Standard Glass or Plastic Covered 100% 100% 100% Controlled Cost 100% 100% 100% 100%	 Up to $ 40 Up to $ 60 Up to $ 60 Up to $ 80 Up to $ 80 Up to $ 120 N/A N/A
Frame Once every 24 months	Covered 100% if within the plan's wholesale allowance	Up to $ 50
- OR -		
Contact Lenses Once every 12 months Elective Contact Lenses* Elective Contact Lens Fit Fee Medically Necessary (requires prior authorization from VBA)	 Up to $ 150 15% Discount 100% In lieu of all other materials/services	 Up to $ 150 N/A Up to $ 450 In lieu of all other materials/services
Lasik Surgery (Once every 8 years)	N/A	Up to $ 125

* The contact allowances can be applied to contact lens fits and/or contact lens materials and there is no guarantee that these amounts will be sufficient to cover the full cost of said fits and/or materials.

NOTE: Utilization of both participating and non-participating providers in the same benefit period may reduce or eliminate coverage for services and materials depending upon reimbursement or provider payment amounts. Contact VBA's member services department for more information.

400 Lydia Street • Suite 300 • Carnegie, PA 15106 • 1-800-432-4966 • www.vbaplans.com

vba

Mountain View School District - #4529

VBA maintains a network of more than 18,000 participating optometrists, ophthalmologists and retail locations nationwide to provide professional vision care for those covered under this plan.

HOW YOUR VISION PROGRAM WORKS

Select a **VBA** participating provider in your area. When scheduling an appointment, please notify the **VBA** participating provider that your vision coverage is administered by **VBA**. A list of participating providers is available on our website at vbaplans.com. The provider selected will contact **VBA** to verify eligibility via online system and will process services received electronically.

To verify your benefit eligibility prior to visiting your eye care provider, please visit our website at vbaplans.com or contact one of **VBA**'s exceptional customer care representatives toll-free at 1-800-432-4966.

Eligibility (from the last date of service)

Exam: Once every 12 months

And:

Lenses: Once every 12 months
Frames: Once every 24 months

Or:

Contact Lenses: Once every 12 months

Member Services
To verify eligibility/dependent age, locate a participating provider or to receive answers to all your vision care related inquiries, please contact one of **VBA**'s exceptional member services representatives at 1-800-432-4966/option 5.

VBA Vision makes using your benefits simple and easy.

Step 1

Go to **www.vbaplans.com**, log in to your account then click on "Am I Eligible."

Step 2

If you are eligible, click on "Find A Doctor" at the top of the page. From there you can fill in your zip code and find a doctor close to you.

Step 3

Go to your appointment and let your doctor know that you have a VBA Vision plan. During your appointment, your doctor will give you an exam, order your materials, make sure your lenses are made correctly, and dispense your prescription.

Step 4

Relax—we've got you covered! VBA Vision will pay your doctor for covered exams, lenses, and frames.

If your doctor is not within the VBA network, requesting reimbursement is simple.

To request reimbursement for services provided by an out-of-network provider, go to **www.vbaplans.com**, download and complete a reimbursement form, attach all receipts and mail or fax to the address below.

This sheet is for information only and does not guarantee benefits.

400 Lydia Street, Suite 300
Carnegie, PA 15106
1-800-432-4966
Fax: 412-881-4898
www.vbaplans.com

With VBA, your benefits extend beyond typical coverage.

VBA partners with several other companies that provide services to better your health and wellness.

LASIK OFFERS

LASIK surgery reshapes the cornea of your eye, redirecting the light angle as it enters the eye to refocus correctly on your retina. With this surgery, your dependence on glasses and contact lenses diminishes significantly.

TLC Laser Eye Centers®

Receive a free consultation and 10% off a LASIK procedure from TLC Laser Eye Centers.

TLC Laser Eye Centers offer the most advanced LASIK procedures including Bladeless and Custom LASIK. TLC has performed over two million procedures, and provides enhancement procedures free of charge if necessary. Learn more at www.TLCVision.com.

QualSight® LASIK

Save 40-50% off LASIK procedures from QualSight, including flexible payment plans as low as $53/mth.

QualSight provides a managed Laser Vision Correction program through a national, credentialed network of the nation's most experienced surgeons, who have collectively performed more than 6.5 million procedures. QualSight has more than 900 locations nationwide, serving over 75 million members. Learn more at www.qualsight.com or call 877-437-6105.

HEARING OFFERS

Along with your vision, VBA understands the importance of your auditory health.

Beltone
Helping the world hear better

Receive a free hearing screening and 20% off all Beltone hearing aids, including free loss, stolen or damage protection.

For over 70 years, Beltone remains the most trusted brand for quality hearing products and care among adults aged 50 and older. We're devoted to giving patients the best listening experience, at over 1500 locations nationwide. Learn more at www.Beltone.com.

To take advantage of any of these offers, contact an exceptional customer care representative today.

400 Lydia Street, Suite 300
Carnegie, PA 15106
1-800-432-4966
www.vbaplans.com

vba

Vision Benefits of America
Notice of Privacy Practices

NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice outlines the ways in which Vision Benefits of America (VBA) may use and disclose protected health information about you. Protected health information (PHI) is health information that identifies a patient and relates to a patient's mental or physical condition, medical treatment, or payment for medical treatment.

We at VBA take great care to properly handle any personal health information about you and to maintain your privacy. This Notice is required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Notice describes how VBA protects the confidentiality of your health care information in our possession. Some examples of personal health information include your name, address, telephone and/or fax number, e-mail address, social security number or other identification number, date of birth, date of vision benefit services, enrollment and other claims records. VBA receives, uses and/or discloses your personal health information to administer your vision benefit plan as permitted or required by law. Any other disclosure of your personal health information without your authorization is strictly prohibited.

VBA must follow the privacy practices described in this Notice and also comply with any more stringent requirements under federal or state law. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these privacy practices the first time you become a VBA member. We must follow the privacy practices described in this Notice as long as it is in effect. This Notice is effective as of September 1st, 2016, and will remain in effect unless we replace it. We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for medical information we already have about you as well as any information we receive in the future. Any change to this Notice will be posted on our website. The revised Notice will contain its effective date on the first page. <u>You may request a copy of this Notice at any time. You may contact VBA's Privacy Department with any questions or concerns regarding our privacy policies. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.</u>

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Disclosures required by HIPAA

(i) *Disclosures to the Secretary of the U.S. Department of Health and Human Services* -- We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule

(ii) *Disclosures to You* -- We are required to disclose to you most of your protected health information that is in a "designated record set" (defined by HIPAA Privacy Rule) when you request access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about your vision care benefits. We are also required to provide, upon your request, an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment and health care operations.

Permitted Uses and Disclosures

Under HIPAA, VBA is permitted to use and disclose your personal health information for certain purposes without your prior authorization. These permitted uses and disclosures include:

(i) Disclosure to you; and

(ii) Disclosures for treatment, payment, or health care operations.

a. For example:

I. **Treatment** - We may use and disclose your personal health information to determine eligibility for vision benefit services and/or materials, or to coordinate vision benefit coverage.

II. **Payment** - We may use and disclose your personal health information to bill you or your plan sponsor.

III. **Health Care Operations** - We may use and disclose your personal health information to review the quality of care provided by our network providers.

VBA uses administrative, technical, and physical safeguards to maintain the privacy of your personal health information, and we are required by law to limit the use and disclosure of your personal health information to the minimum amount necessary.

Uses and Disclosures of Personal Health Information to Other Entities

VBA may disclose your personal health information to other covered entities, business associates, or other individuals (as permitted by HIPAA) who assist us in administering our programs and delivering services to our members. These parties are required by law to sign a contract with VBA agreeing to protect the confidentiality of your personal health information.

(i) <u>Business Associates</u> -- In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services. To perform these services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) <u>Plan Sponsors</u> -- If your vision benefit program is sponsored by your employer or another party, VBA may disclose your personal health information in certain instances to permit the plan sponsor to perform plan administration functions. We will make such disclosures to the plan sponsor only if the plan sponsor has certified that it has put into place plan provisions requiring the sponsor to keep the health information protected. We may also disclose "summary health information" (defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor. For example, a plan sponsor may contact us regarding members' questions or concerns regarding claims, benefits, services, coverage, etc. The plan sponsor may use this information to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

(iii) <u>Health Care Providers</u> - VBA may disclose your personal health information to participating vision care providers. These providers are required to implement their own privacy policies and procedures that comply with applicable federal and state laws.

Other Permitted Disclosures of Personal Health Information

Under HIPAA, VBA is permitted to use and disclose your personal health information without your prior authorization under the following conditions:

- When required by law;
- For public health activities;
- Disclosures about victims of abuse, neglect or domestic violence;
- Health oversight activities;
- Judicial and administrative proceedings (e.g. in response to court order or subpoena);
- Law enforcement, organ donation, or research purposes;
- Uses and disclosures about decedents;
- To avert a serious threat to health or safety;
- For specialized government functions (e.g. military and veterans' activities);
- Regarding workers' compensation;
- For underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

Uses and Disclosures Requiring You to Have an Opportunity to Agree or Object

Unless you object, VBA may disclose your protected health information to a family member, close friend, or other person you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

UNITED CONCORDIA
America's Premier Dental Insurer

DENTAL ENROLLMENT FORM

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please complete the applicable "Type of Activity" change(s) in Section A along with the identification number and employee name in Section B and Section C for dependent changes.

SECTION A: GENERAL INFORMATION

Effective Date (mm/dd/yyyy) ____/____/____

1. TYPE OF PROGRAM

- ☐ FFS
  (Indemnity, Active PPO, Passive PPO - Please Specify)
  - ☐ Concordia Access
  - ☐ Concordia Choice
  - ☒ Concordia Flex
  - ☐ Concordia Preferred
  - ☐ Concordia Select
  - ☐ Other _____
- ☐ DHMO (Please Specify)
  - ☐ Concordia Plus
  - ☐ Other _____

2. TYPE OF ACTIVITY

- ☐ New Enrollment
- ☐ Cancel Coverage
  - ☐ Cancel All Coverage (Employee & All Dependents)
  - ☐ Cancel Dependent(s) Only (List dependents to be cancelled)
- ☐ Change (Please Specify)
  - ☐ Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - ☐ Change Address
  - ☐ Reinstate Coverage
  - ☐ Change Name
  - ☐ Change Group Number
  - ☐ Change Provider
  - ☐ COBRA
  - ☐ Other _____

SECTION E: FOR EMPLOYER USE ONLY

EMPLOYER INFORMATION
Employer Name

Group Number 85 7302

Sub Group 0 00

UCCI Payroll Location

SECTION B: EMPLOYEE INFORMATION - Please print clearly to expedite your request.

1. Identification Number (For example, Social Security Number)	2. Original Employment Date (mm/dd/yyyy)		
	____/____/____		
3. Employee Name (Last, First, Middle Initial)	4. Date of Birth	5. Sex	6. Provider Number (DHMO Only)
7. Home Address	City	State	Zip Code

SECTION C: DEPENDENT INFORMATION

Please list the added/cancelled dependents in this section. For more than five dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time students age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

1. Identification Number (For example, Social Security Number)	2. Type	3. Last Name	4. First Name	5. MI	6. Sex	7. Date of Birth	8. Provider Number (DHMO Only)
	Spouse/Domestic Partner						
	Dependent (A)						
	Dependent (B)						
	Dependent (C)						
	Dependent (D)						
	Dependent (E)						

SECTION D: OTHER DENTAL COVERAGE

Do you or your dependent(s) have other Group Dental Coverage? Yes ☐ No ☐
If your answer is yes, please complete the following information:

Policy Holder	Insurance Company	Policy/Identification Number	Effective Date (mm/dd/yyyy)
			____/____/____

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance 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.

Employee Signature _____ Date _____

Employer Signature _____ Phone Number _____ Date _____

PROGRAM AVAILABILITY

- Products are not available in any state where prohibited by law or where United Concordia does not have regulatory approval.
- Domestic partner coverage is not permitted in Idaho.

STATE MANDATED PROVISIONS

CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FL: 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.

AZ, GA, KY, NE & NH: All statements made by a Policyholder or by any Insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.

KS: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

LA: 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 is guilty of a crime and may be subject to fines and confinement in prison.

NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NY: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OR: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

OR: Contestability is limited to two years as stated in the Group Policy.

TN: 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 and denial of insurance benefits.

UT: Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the Rules of (the American Arbitration Association or other recognized arbitrator), a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction.

VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

UNITED CONCORDIA OPERATES AS A WHOLLY OWNED SUBSIDIARY UNDER THE NAME LISTED BELOW IN THE FOLLOWING STATES:

- United Concordia Dental Corporation of Alabama – AL
- United Concordia Dental Plans, Inc. – MD, NJ
- United Concordia Dental Plans of California, Inc. – CA
- United Concordia Dental Plans of Delaware, Inc. – DE, DC
- United Concordia Dental Plans of Florida, Inc. – FL
- United Concordia Dental Plans of Kentucky, Inc. – KY
- United Concordia Dental Plans of the Midwest, Inc. – MI, MO, OH
- United Concordia Dental Plans of Pennsylvania, Inc. – PA
- United Concordia Dental Plans of Texas, Inc. – TX
- United Concordia Insurance Company – AK, AR, AZ, CA, CO, CT, FL, GA, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY
- United Concordia Life and Health Insurance Company – DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York – NY

HIGHMARK.
120 Fifth Avenue
Pittsburgh PA 15222-3099

WAIVER OF INSURANCE COVERAGE

A. APPLICANT INFORMATION (Please Print):

Employee Name: _____

Date of Birth: _____ SS #: _____

Employer Name: _____ Hire Date: _____

B. OTHER INSURANCE INFORMATION:

I elect to waive health care coverage offered by my employer through Highmark Blue Cross Blue Shield. I currently:

- ☐ Do not have health coverage under any health plan.
- ☐ Do have health coverage through (please complete the following information):

CONTRACT HOLDER NAME

_____

NAME OF HEALTH CARE PLAN/INSURER

_____

GROUP NUMBER SUBSCRIBER ID NUMBER

_____

RELATIONSHIP OF CONTRACT HOLDER TO YOU

_____

☐ I decline coverage for the following individuals. Please check (✓) types of coverage being waived for each individual.

	LAST NAME	FIRST NAME	MI	COVERAGE WAIVED: MEDICAL	DRUG	VISION	DENTAL
EMPLOYEE							
SPOUSE							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							

C. VALIDATION/AUTHORIZATION STATEMENT:

☐ I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

SPECIAL ENROLLMENT RIGHTS:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Employee Signature _____ Date _____

Employees and Employers: Please retain copies of this form for your records.

HIGHMARK.
120 Fifth Avenue
Pittsburgh PA 15222-3099

WAIVER OF INSURANCE COVERAGE

A. APPLICANT INFORMATION (Please Print):

Employee Name: _____

Date of Birth: _____ SS #: _____

Employer Name: _____ Hire Date: _____

B. OTHER INSURANCE INFORMATION:

I elect to waive health care coverage offered by my employer through Highmark Blue Cross Blue Shield. I currently:

- ☐ Do not have health coverage under any health plan.
- ☐ Do have health coverage through (please complete the following information):

CONTRACT HOLDER NAME

_____

NAME OF HEALTH CARE PLAN/INSURER

_____

GROUP NUMBER SUBSCRIBER ID NUMBER

_____

RELATIONSHIP OF CONTRACT HOLDER TO YOU

_____

☐ I decline coverage for the following individuals. Please check (✓) types of coverage being waived for each individual.

	LAST NAME	FIRST NAME	MI	COVERAGE WAIVED: MEDICAL	DRUG	VISION	DENTAL
EMPLOYEE							
SPOUSE							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							

C. VALIDATION/AUTHORIZATION STATEMENT:

☐ I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

SPECIAL ENROLLMENT RIGHTS:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Employee Signature _____ Date _____

Employees and Employers: Please retain copies of this form for your records.

Discrimination Is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Please note that your plan sponsor – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un Iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រកាសចងចាំ ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នង កាតសម្គាល់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bino'dęę' (TTY: 711) jį' hodiilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711).

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुछन्। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

HIGHMARK.

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK. DO NOT USE PENCIL OR HIGHLIGHTER.

☐ **ENROLLING**
(Complete sections I, II, IV, and V)

☐ **WAIVING**
(Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name	Group Number	Payroll Location

First Name	MI	Last Name	Social Security Number *(If no SS#, write N/A)*

Address

City	State	Zip	County	Home/Cell Phone

Marital Status *(Please check one)*:
☐ Single/Widowed ☐ Married
☐ Divorced

Enrollment Status
☐ Active Employee ☐ COBRA Continuant Start Date ___/___/___
☐ Rehired Employee ☐ HIPAA Life Event
(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)

Full-Time Hire (or Rehire) Date *(Month/Day/Year)*	Hours Worked Per Week	Job Title
/ /		

Gender	Date of Birth *(Month/Day/Year)*	Age	Product Selection(s)
☐ Male ☐ Female	/ /		☐ Medical Product Name: _____ ☐ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		☐ Yes ☐ No

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
			☐ Spouse ☐ Domestic Partner†

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	☐ Male ☐ Female	/ /	

Product Selection(s):
☐ Medical ☐ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		☐ Yes ☐ No

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.

†If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child
			☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	☐ Male ☐ Female	/ /	

Product Selection(s):	Dependent Status If Age 26 or Older
☐ Medical ☐ Vision ☐ Dental	☐ Disabled ☐ Act 4**

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		☐ Yes ☐ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ☐ Male ☐ Female	Date of Birth *(Month/Day/Year)* / / Age
Product Selection(s): ☐ Medical ☐ Vision ☐ Dental			Dependent Status if Age 26 or Older ☐ Disabled ☐ Act 4**
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ☐ Yes ☐ No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ☐ Male ☐ Female	Date of Birth *(Month/Day/Year)* / / Age
Product Selection(s): ☐ Medical ☐ Vision ☐ Dental			Dependent Status If Age 26 or Older ☐ Disabled ☐ Act 4**
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ☐ Yes ☐ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

III WAIVER OF COVERAGE (Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- ☐ For myself
- ☐ For family members ONLY:
- ☐ For myself and ALL family members
- ☐ For the following family members:

_____

REASON FOR DECLINING MEDICAL COVERAGE:

- ☐ Insured under spouse. Please provide spouse's employer and insurance carrier names:

_____

- ☐ Other:

_____

VISION

I HEREBY DECLINE VISION COVERAGE:

- ☐ For myself
- ☐ For family members ONLY
- ☐ For myself and ALL family members
- ☐ For the following family members:

_____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- ☐ For myself
- ☐ For family members ONLY
- ☐ For myself and ALL family members
- ☐ For the following family members:

_____

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage for myself and/or my dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

_____ _____

Employee/Contract Holder Signature Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date	Name of Policyholder
		/ /	

Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status
/ /			☐ Active ☐ Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

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.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an existing group, please fax/send Enrollment/Waiver Forms to one of the following addresses:

Fax (800) 290-3301

https://www.enrollmentandbilling@highmark.com

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

To find more information about our benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefits determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on the back of your Member ID card to request these free services (TTY/TDD users may call 711).

Mountain View School District

Direct Deposit Authorization Form

By completing this form you are authorizing Mountain View School District to direct deposit your paycheck on payday to the below named bank(s). To ensure that the deposits are made accurately, please follow the instructions below:

1) Complete your name and social security number,

2) Enter the name of your bank or credit union. You may deposit your check into multiple bank accounts. Please be sure to verify with your bank or credit union that they participate in ACH for direct deposit,

3) Submit a voided check or statement from your bank,

4) Sign the form,

5) Return the form to the Payroll Office, Attention: Donna Keslo.

Name_____ SS #_____

1). Bank or Credit Union_____ Amount or % to Deposit_____

Routing #_____Account #_____Savings_____Checking_____

---

2). Bank or Credit Union_____ Amount or % to Deposit_____

Routing #_____Account #_____Savings_____Checking_____

---

3). Bank or Credit Union_____ Amount or % to Deposit_____

Routing #_____Account #_____Savings_____Checking_____

Employee Signature_____ Date_____

Office Use Only

Date Received_____

Entered In System_____

Signature_____

MOUNTAIN VIEW SCHOOL DISTRICT
11748 State Route 106
Kingsley, Pa. 18826

NOTICE OF ELECTION FOR ANNUALIZED SALARY

To: Professional Employees

From: Dr. Michael S. Elia, Superintendent

Subject: IRS Section 409A Election

This is to notify the Mountain View School District that I have elected – beginning with the 2023-2024 school year – to have the salary for the approximately 10-month period (184 days) during which I actually perform services paid out over a 12-month period.

Select One:

_____ Twenty-six (26) nearly equal payments paid bi-weekly on Thursday's beginning in the month of September.

_____ Twenty-six (26) nearly equal payments paid bi-weekly on Thursdays, with a final single lump sum payment in June encompassing all remaining payments due for June, July, and August.

This notice is irrevocable for any particular school year, and may not be changed or withdrawn after the beginning of the school year in which I am working. This notice will be effective for all years following the 2023-2024 school year, unless I choose to change my election.

This notice shall have no effect if not submitted prior to the time I begin working for the 2023-2024 school year.

In the event a separation from service occurs before the end of the 12-month period, I will be entitled to an additional payment for the amount I have actually earned from the beginning of the 12-month period until the date of my separation from service, but which has not yet been paid. This additional payment will be included in my final paycheck. For this purpose, "separation from service" shall have the same meaning as that term is defined in section 1.409A-1(h) of the Treasury Regulations.

_____	_____	_____
Printed Name	Signature	Date

MOUNTAIN VIEW SCHOOL DISTRICT

KINGSLEY, PENNSYLVANIA 18826-9778

Elementary School Office (570) 434-2181
Fax (570) 434-2755
High School Office (570) 434-2501
Fax (570) 434-9582
Superintendent/Business Office (570) 434-2180
Fax (570) 434-2404

To: All Professional Staff

From: Dr. Michael Hill, Superintendent

Subject: *One Time Notice for Buy-Back Benefit*

This one-time notice for the voluntary buyback or the mandatory buyback is provided under the MVEA Collective Bargaining Agreement (CBA) provisions. The referenced section of the CBA has been included for your perusal. All professional employees covered by the CBA are to complete the form, sign, and return it to the business office prior to the April 1st deadline. This notice is for the 23-24 fiscal year beginning July 1, 2023. Each employee must select even if you are currently on the voluntary or mandatory buyback or currently not eligible for either buyback.

Article IX, INSURANCE PROTECTION, Section 5, Benefits Waiver, pages 12, 13, & 14.
Deadline for Notification
The District shall issue a one-time enrollment letter to all professional employees no later than March 1, 2024. The employee will indicate by April 1st whether he/she is taking a voluntary or mandatory buyback and the form of such payment (payroll check, deposit to employee's 403b or IRS 125 plan). The status indicated in this letter shall remain in effect until the employee chooses to change his/her status. Any change to the status indicated in the initial letter must be indicated in writing by the employee no later than April 1st of the year prior to change in status. All new employees shall be given the one-time letter upon being hired.

In special cases where unforeseen circumstances result in an employee becoming eligible for either the mandatory buyback or the voluntary buyback after the April 1st deadline, he/she shall immediately notify the president of the Association in order that his/her specific case may be reviewed by the Board of Education.

****

_____ Yes _____ No Are you taking the voluntary or the mandatory buyback for the health insurance benefits? If "No" sign, date, and return this form to the business office.

If "Yes" which one are you taking?
_____ Mandatory – Spouse working for the school district.
_____ Voluntary – Proof of other insurance must be attached.
Which "...form of payment..." do you desire?
_____ Payroll Check
_____ Deposit to Employee's 403B
_____ Deposit to Employee's IRS 125 Plan.

_____
Printed Name

_____ _____
Signature Date

A COMMUNITY'S COMMITMENT TO EXCELLENCE

CLGS-32-6 (6-13)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change. Use the Address Search Application at www.newPA.com/Act32 to determine PSD codes, EIT rates and tax collector contact information.

EMPLOYEE INFORMATION – RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS (No PO Box, RD or RR)			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION – EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com/Act32

Mountain View School District
Acceptable Use Policy Agreement For
Computer and Internet Access

READ CAREFULLY, COMPLETE AND RETURN TO THE SUPERINTENDENT'S OFFICE TO THE ATTENTION OF BARBARA MAXON BY _____

USER
I will abide by the Mountain View School District Acceptable Use Policy #815. I further understand that any violation of the regulations are in fact unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked and school disciplinary action and/or other appropriate legal action may be taken.

User Name (please print) _____

User Signature_____ Date ___/___/___

CC: Personnel File

Dear Employee,

At the request of our Property and Casualty Insurance carrier we must begin to check the driving records of persons driving Mountain View School District vehicles. This process will be completed through the Pennsylvania Department of Transportation (PennDot).

Should you have any questions regarding this policy, or concerns about your driving record, please see your immediate supervisor.

By signing below you authorize Mountain View School District permission to obtain and review your driving record from PA Department of Transportation via a MVR Request.

_____ _____

Name Date

Driver's License Number_____ Expiration Date_____

Dr. Michael S. Elia
Superintendent of Schools

Mrs. Barbara Maxon
Human Resource Coordinator/
Assistant to the Superintendent

MOUNTAIN VIEW SCHOOL DISTRICT
Superintendent / Business Office
11748 State Route 106, Kingsley, PA 18826-6941
Phone (570) 434-2180 Fax (570) 434-2404

Mrs. Donna Keslo
Business Manager

Mrs. Alicia Chidester
Coordinator of Payroll / Transportation
Accounts Payable

Mrs. Jessica Worden
Administrative Assistant

Acknowledgement Receipt of 403(b) Information

I _____, acknowledge receipt of the Summary of Mountain View School District's 403(b) Tax-Sheltered Account Program and the Salary Reduction Agreement information forms.

Signature of Employee_____ Date_____

Signature of Business Manager _____ Date_____

The Mountain View School District is an equal opportunity educational institution and will not discriminate on the basis of race, color, age, creed, religion, gender, sexual orientation, ancestry, national origin or handicap/disability in its activities, programs or employment practices as required by Title VI, Title IX, Section 504, and Age Discrimination Act. Director of Special Services can be reached at (570) 434-2180 ext. 437.

Salary Reduction Agreement for 403(b) Programs

ALL EMPLOYEES, WITHOUT EXCEPTION, ARE ELIGIBLE TO PARTICIPATE IN THE 403(B) PROGRAMS

Part 1. Employee Information:

Name:_____ SS#: _____

Address:

_____

Part 2. Agreement

The above-named Employee elects to become a participant of the_____(Employer Name) 403(b) and/or 457 Plan(s) and agrees to be bound by all the terms and conditions of the plan. By executing this agreement employee authorizes the employer to reduce his or her compensation and have that amount contributed as an elective deferral and/or as a salary reduction contribution to the Roth 403(b) option if permitted in the plan, on his or her behalf into the annuity or custodial accounts as selected by the employee. It is intended that the requirements of all applicable state or federal income tax rules and regulations (Applicable Law) will be met. The Employee understands and agrees to the following:

1) this Salary Reduction Agreement is legally binding and irrevocable with respect to amounts paid or available while this agreement is in effect.
2) this Salary Reduction Agreement may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new Salary Reduction Agreement is submitted; and
3) this Salary Reduction Agreement may be changed with respect to amounts not yet paid or available in accordance with the Employer's administrative procedures
4) the Employer will stop reductions at such time as the reduction will exceed the Employee's statutory limits under Section 402(g) or the limitation of Section 415 of the Internal Revenue Code in any given calendar year.

Employee is responsible for providing the necessary information at the time of initial enrollment and later if there are any changes in any information necessary or advisable for the employer to administer the plan. Employee is responsible for determining that the salary reduction amount does not exceed the limits set forth in applicable law and for selecting annuities or custodial accounts. Furthermore, Employee agrees to indemnify and hold Employer harmless against any and all actions, claims and demands whatsoever that may arise from the purchase of annuities or custodial accounts. Employee acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account described herein. Employee agrees Employer shall have no liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the annuity and/or custodial account. Nothing herein shall affect the terms of employment between Employer and Employee. This agreement supersedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

Employee is responsible for setting up and signing the legal documents to establish an annuity contract or custodial account. However, in certain group annuity contracts, the Employer is required to establish the contract.

Employee is responsible for naming a death beneficiary under annuity contracts or custodial accounts. Employee acknowledges that this is normally done at the time the contract or account is established and reviewed periodically.

Employee is responsible for all distributions and any other transactions with vendor. All rights under contracts or accounts are enforceable solely by Employee, Employee beneficiary or Employee's authorized representative. Employee must deal directly with the vendor to make loans, transfers, apply for hardship distributions, begin regular distributions, or any other transactions.

Part 3. Representation by Employee for Calendar Year_____:

A. Participation in other employer plans: (you must check only one)

_____I *do not* and will not have any other elective deferrals, voluntary salary reduction contributions, or non-elective contributions with any other employer.

_____I *do* participate in another employer's 403(b), 401(k), SIMPLE IRA/401(k), or Salary Reduction SEP. The following information pertains to all of my other employers for the current calendar year: Includible Earnings $_____; Elective Deferrals and/or salary reduction contributions to a Roth 403(b) or Roth 401(k) plan $_____; Non-elective Contributions $_____.

B. I have not received a Hardship Distribution from a plan of this Employer within the last six months. I further agree to provide notification to the employer prior to initiating a request if I plan to elect a hardship distribution during the term of this agreement.

C. Maximum Elective Deferral or Roth 401(k)/403(b)/457(b) salary reduction contribution: (you must check only one)

_____ My elective deferral/salary reduction contribution does not exceed the Basic Limit (the lesser of my includible compensation or $22,500).

_____ My elective deferral exceeds the Basic Limit due to the additional Age 50 Catch-up of $7,500.

Part 4. Voluntary Salary Reduction Information: (Check all that apply)

☐ Initiate new salary reduction	Please complete Part 5.
☐ Change salary reduction	This is notification to change the amount of my elective deferral to the new amount listed in Part 5.
☐ Change Funding Vehicle Vendor	This is notification to change my Funding Vehicle – Complete Part 5.
☐ Discontinue salary reduction	Please discontinue my elective deferral to the following Funding Vehicle: _____.

Implementation Date (next available pay on or after): _____.

Part 5. Funding Vehicle & Amount of Pre-Tax Elective Deferrals:

	Contribution Per Pay Period (Select one) *	Funding Vehicles (Annuity Contracts or Custodial Accounts)
1.	☐_____% or ☐ $ _____	
2.	☐_____% or ☐ $ _____	
3.	☐_____% or ☐ $ _____	

Part 5a. Funding Vehicle & Amount of After-Tax Salary Reduction Contributions to the Roth 403(b):

	Amount Per Pay (Select one) *	Funding Vehicles (Annuity Contracts or Custodial Accounts)
1.	☐_____% or ☐ $ _____	
2.	☐_____% or ☐ $ _____	
3.	☐_____% or ☐ $ _____	

* NOTE: Any employee who works variable hours or who does not have a regular bi-weekly paycheck must select "% of pay."

Part 6. Employee Signature

I certify that I have read this complete agreement and provided the information necessary for the employer to administer the plan and that my salary reductions will not exceed the elective deferral or contribution limits as determined by Applicable Law. I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the annuity or custodial account established by me under the Program are enforceable solely by my beneficiary, my authorized representative or me.

I understand that certain information about my 403(b) account is necessary to properly maintain and administer my account under the 403(b) plan. I authorize the holder of that information to make it available to the plan sponsor, the administrator of the plan and/or their representative(s) so long as the information is used exclusively for purposes of complying with legal and regulatory requirements and proper administration of the plan and my account there under.

I am aware that if I select Vanguard Funds as my investment provider, plan administration expenses will be deducted from my account on a monthly basis. This fee, $24.00 annually, may be changed in the future subject to prior notification to me of such change.

Employee Signature:_____ Date: _____

Part 7. Representative Signature

Signature:_____Company Name:_____Date: _____

Part 8. Employer Signature

Employer hereby agrees to this Salary Reduction Agreement:

Employer Signature:_____ Title:_____ Date: _____

A Summary of Mountain View School District's

2023 - 403(b) Tax-Sheltered Account Program

Prepared by: Kades-Margolis

Mountain View School District offers our eligible employees the opportunity to save for retirement by participating in a 403(b) Tax- Sheltered Account (TSA) Plan. All employees, except for private contractors, appointed/elected trustees and/or school board members and student workers, are eligible to participate in the 403(b) Plan immediately upon employment. You can participate in this plan by making pre-tax contributions. The 403(b) TSA Plan is a valuable retirement savings option.This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) TSA Plan offered.

What is a 403(b) Tax-Sheltered Account?

403(b) Tax-Sheltered Account (TSA) is a section of the IRS Code that permits the establishment of 403(b) TSAs for school employees to supplement their retirement income. A 403(b) TSA allows you to voluntarily set aside money from each paycheck to be put into a tax-deferred account. It's called an "elective deferral"; you notify the payroll office that you wish ("elective") to have funds taken out of your pay ("deferral") and contributed to your 403(b) TSA. You may begin your contribution, change the amount of your contribution, or stop your contribution at any time. The funds withheld from your paycheck are then invested with a 403(b) provider that you choose from our list of approved companies. You control how your funds are invested by consulting with a representative from the investment provider you select.

How much can you contribute to your 403(b) TSA?

The maximum amount you can contribute for the current calendar year is $22,500. Everyone can contribute up to $22,500 or 100% of salary if you make less than $22,500. Beginning on January 1 of the year you turn 50, you may contribute an additional $7,500 each year. If you are able and desire to contribute more than the maximum, see if the district offers a 457(b) Deferred Compensation program. If a 457(b) Plan is available, you may be allowed to contribute similar amounts to that tax-sheltered program.

When can I get my money out of my 403(b) TSA?

In addition to loans and hardship distributions, a 403(b) plan may allow employees to take money out of the plan when they reach age 59 ½, have a severance from employment in the year they turn age 55 or after, become disabled, or die. In most cases, any withdrawals made from a 403(b) account are taxable in full as ordinary income. Most withdrawals are subject to 10% additional tax if before age 59½.

Why should you participate in a 403(b) TSA program?

First: It reduces your current income taxes. It is the first tax shelter that nearly every tax professional recommends.

Second: It provides for tax-deferred growth. Instead of paying income taxes on your bank interest earnings, all your contributions, and the earnings on those contributions, are tax deferred until you take out the money. That will usually be after retirement when you will most likely be in a lower tax bracket.

Third: It supplements other retirement benefits, like your personal savings, Social Security, and the PA Public School Employees Retirement System (PSERS). Who knows if any of us will get all the Social Security we are entitled to, given the budget shortfall of Social Security and Medicare? And even though PSERS is one of the best retirement systems, you still will have to live on the amount of that check from PSERS for the rest of your life. Many of today's employees will live longer retired than they worked. It is not uncommon for people to live to their late 80s, 90s or even 100. Considering future scientific and medical advances, that PSERS check may have to last you 30 years or more. You need to supplement it with your 403(b) TSA, which should reflect any economic growth during your career and retirement years.

Who is administering the district's 403(b) TSA Program?

The district has chosen U.S. OMNI & TSACG Compliance Services, Inc. as the Third-Party Administrator (TPA) because of their experience and reliability. They employ a full-service flexible technology platform that provides secure Internet access by both employers and employees. You can get immediate answers to your questions regarding all contributions and transaction processing requests, as well as access all necessary forms on their website www.tsacg.com. (NOTE: The TPA charges no fees to employees. There may be fees associated with your investment that your investment provider and/or investment fund may charge.)

Optional Provisions Included in Mountain View School District's 403(b) TSA Plan

Eligibility

All employees, except for private contractors, appointed/elected trustees and/or school board members and student workers, are eligible to participate in the 403(b) Plan immediately upon employment. Employees may make voluntary elective deferrals to the 403(b) TSA Plan. Participants are always fully vested in their contributions and earnings.

Exchanges

Our 403(b) TSA Plan does permit exchanges. An "exchange" is defined by the IRS as moving your 403(b) TSA from one of our approved investment providers to another of our approved investment providers. Under IRS 403(b) TSA regulations, you may only invest your 403(b) TSA funds with the district's approved investment providers if you are employed by our district.

Transfers

Our 403(b) TSA Plan does permit transfers, both into our plan and out of our plan. A "transfer" is defined by the IRS as moving your 403(b) TSA from one employer's 403(b) TSA Plan to another employer's 403(b) TSA Plan when you change employment. If you have a 403(b) TSA with a previous employer, and that employer's 403(b) TSA Plan permits transfers out of their 403(b) TSA Plan, you may transfer the account with the previous employer to our 403(b) TSA Plan. However, you must transfer the account to one of our districts' approved investment providers. If you leave employment with our district, you may transfer your account to a subsequent employer's 403(b) TSA (if that employer's 403(b) TSA Plan allows for incoming transfers) or you may roll over your account (see below).

Rollovers

As required by IRS regulations, our 403(b) TSA Plan does permit rollovers. A "rollover" is defined by the IRS as moving your 403(b) TSA upon the occurrence of a "distributable event" (age 59 ½, death, disability, separation from service, etc.). Once you leave employment with our district, (or upon another distributable event) you are permitted to roll over your 403(b) TSA to any other IRS permitted account, such as an IRA.

Loans

Our 403(b) TSA Plan does permit you to borrow funds from your 403(B) TSA; however, you need to check with your investment provider to determine if your investment provider permits loans. Loans are subject to IRS regulations and prior to taking a loan, participants should consult a tax advisor.

Financial Hardship Distributions

Our 403(b) TSA Plan does permit you to apply for a Hardship Distribution from your 403(B) TSA. Hardship Distributions are subject to IRS regulations and to be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must verify and provide evidence that the distribution is being taken for specific reasons.

Roth 403(b)

Our 403(b) TSA Plan does permit you to contribute to a Roth 403(b). Like a Roth IRA, Roth 403(b) contributions do not tax shelter current income; they are funded with after-tax dollars. One advantage of a Roth is the earnings grow tax free; there are no taxes on withdrawals from a Roth 403(b) if all the Roth and 403(b) rules are followed. The maximum annual contribution for a Roth 403(b) is combined with the traditional 403(b) TSA; for the current calendar year, $22,500 and $7,500 for the age 50 catch-up. For example: If you are under 50 years of age, you could contribute $12,500 to a traditional 403(b) TSA and up to $10,000 to a Roth 403(b). Withdrawals of your contribution and earnings can be made tax free. (Reached age 59 ½ and Account has been held for at least five years) Contact one of the approved investment providers for more information about the Roth 403(b). Roth 403(b) contributions are subject to IRS regulations.

Authorized Investment Providers for This 403(b) TSA Plan

	Contacts	Phone
AMERIPRISE FINANCIAL	N/A	800-862-7919
EQUITABLE	N/A	800-628-6673
INVESCO OPPENHEIMER FUNDS	N/A	800-959-4246
KADES-MARGOLIS CORPORATION	Scott Skammer	800-433-1828 X 262
LINCOLN INVESTMENT PLANNING, LLC	N/A	800-242-1421
METLIFE INSURANCE CO	N/A	800-560-5001
SECURITY BENEFIT GROUP	Scott Skammer	800-433-1828 X 262
VANGUARD INVESTMENTS	N/A	800-569-4903

COMMONWEALTH OF PENNSYLVANIA
SEXUAL MISCONDUCT/ABUSE DISCLOSURE RELEASE
(under Act 168 of 2014)

(Hiring school entity or independent contractor submits this form to ALL current employer(s) and to former employer(s) that were school entities and/or where the applicant had direct contact with children)

To:

Name of Current or Former Employer:		☐ No applicable employment
Street Address:		
City, State, Zip:		
Telephone Number:	Fax Number:	Email:
Contact Person:		Title:

The named applicant is under consideration for a position with our entity. The Pennsylvania General Assembly has determined that additional safeguards are necessary in the hiring of school employees to ensure the safety of the Commonwealth's students. The individual whose name appears below has reported previous employment with your entity. We request you provide the information requested in SECTION 2 of this form within **20 calendar days** as required by Act 168 of 2014.

SECTION 1: APPLICANT CERTIFICATION AND RELEASE (TO BE COMPLETED BY THE APPLICANT EVEN IF THE APPLICANT HAS NO CURRENT OR PRIOR EMPLOYMENT TO DISCLOSE)

Applicant's Name (First, Middle, Last):	
Any former names by which the Applicant has been identified:	
DOB:	
Last 4 digits of Applicant's Social Security Number:	PPID (if applicable):
Approximate dates of employment with the entity listed above:	
Position(s) held with the entity:	

Pursuant to Act 168, an employer, school entity, administrator, and/or independent contractor that provides information or records about a current or former employee or applicant shall be immune from criminal liability under the CPSL, the Educator Discipline Act, and from civil liability for the disclosure of the information, unless the information or records provided were knowingly false. Such immunity shall be in addition to and not in limitation of any other immunity provided by law or any absolute or conditional privileges applicable to such disclosure by the virtue of the circumstances of the applicant's consent thereto. Under Act 168, the willful failure to respond to or provide the information and records as requested may result in civil penalties and/or professional discipline, where applicable.

Have you (Applicant) ever:

Yes ◯ No ◯ Been the subject of an abuse or sexual misconduct investigation by any employer, state licensing agency, law enforcement agency or child protective services agency (unless the investigation resulted in a finding that the allegations were false)?

Yes ◯ No ◯ Been disciplined, discharged, non-renewed, asked to resign from employment, resigned from or otherwise separated from employment while allegations of abuse or sexual misconduct were pending or under investigation or due to adjudication or findings of abuse or sexual misconduct?

Yes ◯ No ◯ Had a license, professional license or certificate suspended, surrendered or revoked while allegations of abuse or sexual misconduct were pending or under investigation or due to an adjudication or findings of abuse or sexual misconduct?

By signing this form, I certify under penalty of law that the statements made in this form are correct, complete, and true to the best of my knowledge. I understand that false statements herein, including, without limitation, any willful failure to disclose the information required, shall subject me to criminal prosecution under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and to discipline up to, and including, termination or denial of employment, and may subject me to civil penalties and disciplinary action under the Educator Discipline Act. I also hereby authorize the above-named employer to release to the entity listed on page 3, the information requested in SECTION 2 of this form and any related records. I hereby release, waive, and discharge the above-named employer from any and all liability of any kind that may arise from such disclosure or release of records. I understand that third party vendors may be used to process this Act 168 pre-employment history review.

Signature of Applicant _____ Date _____

SECTION 2: CURRENT/FORMER EMPLOYER VERIFICATION (TO BE COMPLETED BY THE APPLICANT'S CURRENT EMPLOYER(S) AND ALL FORMER EMPLOYERS THAT WERE SCHOOL ENTITIES AND/OR WHERE THE APPLICANT HAD DIRECT CONTACT WITH CHILDREN)

Dates of employment of Applicant: _____ Contact telephone #: _____

To the best of your knowledge, has Applicant ever:

Yes ◯ No ◯ Been the subject of an abuse or sexual misconduct investigation by any employer, state licensing agency, law enforcement agency or child protective services agency (unless the investigation resulted in a finding that the allegations were false)?

Yes ◯ No ◯ Been disciplined, discharged, non-renewed, asked to resign from employment, resigned from or otherwise separated from employment while allegations of abuse or sexual misconduct were pending or under investigation or due to adjudication or findings of abuse or sexual misconduct?

Yes ◯ No ◯ Had a license, professional license or certificate suspended, surrendered or revoked while allegations of abuse or sexual misconduct were pending or under investigation or due to an adjudication or findings of abuse or sexual misconduct?

☐ No records or other evidence currently exists regarding the above questions. I have no knowledge of information pertaining to the applicant that would disqualify the applicant from employment.

Former Employer Representative Signature and Title _____ Date _____

Return all completed information to:

School Entity/Independent Contractor: Mountain View School Dist. / Barbara Maxon, HR Coord.	
Address: 11748 State Route 106	Phone: 570-434-8413
City: Kingsley State: PA Zip: 18826	Fax: 570434-2404 Email: bmaxon@MVSD.net
Contact Person: Barbara Maxon	Title: HR Coordinator

Date Form Received: _____ Received by: _____

COMMONWEALTH OF PENNSYLVANIA
SEXUAL MISCONDUCT/ABUSE DISCLOSURE RELEASE
(Pursuant to Act 168 of 2014)

Instructions

This standardized form has been developed by the Pennsylvania Department of Education, pursuant to Act 168 of 2014, to be used by school entities and independent contractors of school entities and by applicants who would be employed by or in a school entity in a position involving direct contact with children to satisfy the Act's requirement of providing information related to abuse or sexual misconduct. As required by Act 168, in addition to fulfilling the requirements under section 111 of the School Code and the Child Protective Services Law ("CPSL"), an applicant who would be employed by or in a school entity in a position having direct contact with children, must provide the information requested in SECTION 1 of this form and complete a written authorization that consents to and authorizes the disclosure by the applicant's current and former employers of the information requested in SECTION 2 of this form. The applicant shall complete one form for the applicant's current employer(s) and one for each of the applicant's former employers that were school entities or where the applicant was employed in a position having direct contact with children (therefore, the applicant may have to complete more than one form). Upon completion by the applicant, the hiring school entity or independent contractor shall submit the form to the applicant's current and former employers to complete SECTION 2. **A school entity or independent contractor may not hire an applicant who does not provide the required information for a position involving direct contact with children.**

Relevant Definitions:

Direct Contact with Children is defined as: "the possibility of care, supervision, guidance or control of children or routine interaction with children."

Sexual Misconduct is defined as: "any act, including, but not limited to, any verbal, nonverbal, written or electronic communication or physical activity, directed toward or with a child or a student regardless of the age of the child or student that is designated to establish a romantic or sexual relationship with the child or student. Such acts include, but are not limited to: (1) sexual or romantic invitation; (2) dating or soliciting dates; (3) engaging in sexualized or romantic dialogue; (4) making sexually suggestive comments; (5) self-disclosure or physical exposure of a sexual, romantic or erotic nature; or (6) any sexual, indecent, romantic or erotic contact with the child or student."

Abuse is defined as "conduct that falls under the purview and reporting requirements of the CPSL, 23 Pa.C.S. Ch. 63, is directed toward or against a child or a student, regardless of the age of the child or student."

Please Note

A prospective employer that receives any requested information regarding an applicant may use the information for the purpose of evaluating the applicant's fitness to be hired or for continued employment and shall report the information as appropriate to the Department of Education, a state licensing agency, law enforcement agency, child protective services agency, another school entity or to a prospective employer.

If the prospective employer decides to further consider an applicant after receiving an affirmative response to any of the questions listed in SECTIONS 1 and 2 of this form, the prospective employer shall request that former employers responding affirmatively to the questions provide additional information about the matters disclosed and include any related records. The **Commonwealth of Pennsylvania Sexual Misconduct/Abuse Disclosure Information Request** can be used to request this follow-up information. Former employers shall provide the additional information and records within 60 calendar days of the prospective employer's request.

The completed form and any information or records received shall not be considered public records for the purposes of the Act of February 14, 2008 (P.L. 6, No. 3) known as the "Right to Know Law."

The Department of Education shall have jurisdiction to determine willful violations of Act 168 and may, following a hearing, assess a civil penalty not to exceed $10,000. School entities shall be barred from entering into a contract with an independent contractor who is found to have willfully violated the provisions of Act 168.

Mountain View School District
Business Office

Act 29 Classification

This form must be completed and signed before any payroll can be processed.

Under Act 29, all public school districts are required to track employees and their wages, according to the employee classification defined by the hire date. All employees are Existing or New as defined herein.

Existing
Employees hired by the Mountain View School District before July 1, 1994, OR employees hired by the Mountain View School District after June 30, 1994, who had been employed by another public school entity within the Commonwealth before July 1, 1994 classification is defined regardless of whether the employee was a member of the Public School Employees' Retirement System.

New
Employees hired by the Mountain View School District after June 30, 1994, who have NOT been employed by another public school entity within the Commonwealth before July 1, 1994.

In both instances, employed means to receive compensation.

Once an employee is classified as a new employee, the person will always be classified as a new employee for Social Security and Retirement.

Due to this law, we require that you answer the following questions:

Have you ever received a paycheck from a school district in Pennsylvania prior to July 1, 1994? (This would include any type of work such as permanent, part-time, substitute, custodial, etc.)

◯ Yes ◯ No

Were you ever a member of the Public School Employees' Retirement System (PSERS)?

◯ Yes, enrollment date: _____ ◯ No

Are you a retiree drawing a benefit from PSERS?

◯ Yes ◯ No

Name (Please Print): _____

Signature: _____ Date: _____