OFFICE OF THE TOWN
TREASURER/COLLECTOR

Megan Crosby
Treasurer/Collector
Tel: 508-378-1604/1602
Fax: 508-378-4803

175 Central Street
P.O. Box 386
E. Bridgewater, MA 02333
mcrosby@eastbridgewaterma.gov

Congratulations on your new position and welcome to the Town of East Bridgewater!

Enclosed you will find information required to be completed for employment and voluntary benefits available to you, if eligible.

Please review and complete all items listed in the enclosed **New Hire Checklist**.

Voluntary benefits include health insurance, dental insurance, life insurance, medical and dependent flexible spending accounts, short-term and long-term disability and deferred compensation plans. Your new employment status allows you to enroll now. If you choose not to enroll now, you must wait until the next open enrollment period. Please refer to the **Schedule of Employee Benefits and Deductions** for a detailed description of each benefit available.

The following documents will be required to complete the new hire process:

- Driver's License or Passport
- Social Security Card
- MTRS Members (School) - Completed enrollment form, Certification #, and Date.
- PCR Members (Town/School – Non-MTRS) – birth certificate
- Additional Information is required to waive or enroll in **group health and dental insurance plans** – please refer to the enrollment forms included in this packet.

Upon review and completion of the enclosed information, please remit all information to the Treasurer's Office located at Town Hall.

Please note that compensation of wages will not be paid until the necessary information is provided.

If you should have any questions, feel free to contact the Treasurer's Office.

I certify that I have received the **New Hire Checklist and supporting documentation**. I understand that all forms must be completed and submitted (in person) with positive identification to the Treasurer's office on or before my date of hire/first day I report to work.

New Employee Signature	Town/School Admin Signature	Date

New Hire Checklist

The following forms are included in this packet:

- Schedule of Employee Benefits & Deductions
- Marketplace Notice for State & Municipal Employees
- FMLA (Family Medical Leave Act) Information Sheet
- Health Insurance Waiting/Hiatus Period Stipend memo
- Summary of the Conflict of Interest Law – Complete and remit to the Town Clerk
- State of MA – Mandatory Education Requirements/Ethics Reform Bill – Complete and remit to the Town Clerk

ALL employees MUST complete the following forms and return to the Treasurer's Office:

_____ Signed Acknowledgement of Receipt – Conflict of Interest Law – Remit to TOWN CLERK
_____ Ethics Exam Certificate print out – See attached sheet for website – Remit to TOWN CLERK
_____ I-9 Form
_____ Copy of Social Security Card
_____ Copy of Driver's License
_____ Copy of Birth Certificate (if contributing to Plymouth County Retirement)
_____ W-4 Form (Federal Income Tax withholding Form)
_____ M-4 (State Income Tax withholding Form)
_____ Direct Deposit & Electronic Delivery of Payroll Advice (required for school employees)
A voided check or letter from financial institution is required to confirm all accounts
_____ Plymouth County Retirement New Member Enrollment
_____ Social Security Statement Sheet
_____ Pre-Tax Deduction Form
_____ Acknowledgement form for GIC Eligible Employees
_____ *Health Insurance enrollment form or **Waiver - if waived, need copy of current health card**
_____ *Dental Insurance enrollment form or **Waiver**
_____ *Flexible Spending Account Information Sheet & enrollment form
_____ *Life Insurance enrollment form or **Refusal of Insurance section (bottom of form) if waiving**

***Newly hired employees have TEN (10) days from their start date to sign up for benefits**

ALL employees need to enroll in ONE of the following retirement options and complete the corresponding enrollment form:

1. _____ Plymouth County Retirement
2. _____ Massachusetts Teachers' Retirement System (MTRS) Certificate
3. _____ OBRA Enrollment Form & Information Sheet

Are you retired from another retirement system? YES or NO
If yes, please indicate retirement system._____

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Schedule of Employee Benefits and Deductions

Mandatory Benefits/Deductions

Plymouth County Retirement (PCR) - PRE-TAX
In lieu of Social Security, eligible Town employees are required to enroll with PCR. Eligible Town employees must have permanent, regular hours of employment with the Town.

For persons who become members on or after April 2, 2012, the contribution rate is 9% of regular compensation plus an additional 2% of regular compensation in excess of $30,000.

Retirement guides are available on the PCR website:
https://www.mass.gov/files/documents/2016/07/vj/retirement-guide-post-2012.pdf

Massachusetts Teachers' Retirement System (MTRS) - PRE-TAX
In lieu of Social Security, eligible public school teachers and administrators are required to enroll with MTRS. Please contact the Superintendent's office to determine eligibility and contribution rates. The Superintendent's office will remit the necessary information to the Treasurer/Collector's office to authorize the deduction.

For persons who become members on or after April 2, 2012 the contribution rate is 11% of regular compensation.

Additional information is available on the MTRS website:
http://www.mass.gov/mtrs/

Omnibus Budget Reconciliation Act (OBRA) - PRE-TAX
Town employees not eligible to participate in PCR or MTRS must enroll in an OBRA plan with Nationwide Retirement Solutions in lieu of social security. The contribution rate is 7.5%.

Ethics Exam
Regular Town employees are required to complete an ethics exam. Please see the Town Clerk for exam instructions.

Optional Benefits/Deductions

Direct Deposit
All employees may elect to have all or a portion of their pay deposited directly to their financial institution (s). A maximum of four bank accounts is allowed.

Health Insurance - PRE-TAX
The Town is a member of the Group Insurance Commission (GIC). Permanent employees who work **at least 18.75 hours per week** are eligible to enroll.

- Enrollment applications must be received within 10 days of hire.
- GIC benefits begin on the first day of the month following 60 days or two full calendar months of employment, whichever comes first.
- Refer to the rate sheet for a list of plans and cost.
- Additional information can also be accessed on the GIC website: http://www.mass.gov/anf/employee-insurance-and-retirement-benefits/oversight-agencies/gic/

Dental Insurance - PRE-TAX
The Town offers dental insurance to permanent employees who work **at least 20 hours per week**. Altus Dental is the current carrier – see rate sheet for plan cost.

Flexible Spending Accounts – PRE-TAX
Permanent employees who work **at least 20 hours per week** are eligible to enroll in the Town's flexible spending accounts. We currently offer Medical and Dependent Care flexible spending accounts. Enrollment forms should be forwarded directly to Cafeteria Plan Advisors, Inc. Additional information and forms can be access through their website: www.cpa125.com.

Life Insurance
Permanent employees who work **at least 20 hours per week** are eligible to enroll in the Town's group life insurance plan with the Boston Mutual Life Insurance Company. The Town pays 50% of the cost. Additional voluntary life and accidental death & dismemberment may also be purchased. To initiate enrollment indicate on enrollment application. Employees have thirty days from date of hire to enroll in the Town's group life insurance plan. This is the only opportunity to enroll in the plan.

Colonial Life
Permanent employees who work **at least 20 hours per week** are eligible to purchase various disability/insurance policies. To enroll contact the Town's Representative – **Barbara Wolfreys @ 781.982.4332**

AFLAC
Permanent employees who work **at least 20 hours per week** are eligible to purchase disability, accident and cancer protection insurance with AFLAC. Accident & cancer coverage are pre-tax benefits. To enroll contact the Town's Representative - **Brad Lytle @ 781.588.3555**

Union Dues
Union Dues will be deducted once we receive an authorization to withdraw. Please contact your Union Representative to complete the required documentation.

IRC 457(b) Deferred Compensation Plans - PRE-TAX
Permanent employees of the Town who work **at least 20 hours per week** are eligible to enroll in the Town's deferred compensation plan offered with Nationwide Retirement Solutions. To enroll contact the Town's Representative – Michael Hackleman 614-435-8366 hacklm2@nationwide.com

IRC 403(b) Tax-Sheltered Annuity Plans - PRE-TAX
Permanent employees of the **public school system** who work **at least 20 hours per week** are eligible to enroll in the Town's tax-sheltered annuity plan. Contact one of our vendors listed on the next page.

U.S. Wage and Hour Division
(Revised 2012)

Fact Sheet #28: The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. This fact sheet provides general information about which employers are covered by the FMLA, when employees are eligible and entitled to take FMLA leave, and what rules apply when employees take FMLA leave.

COVERED EMPLOYERS

The FMLA only applies to employers that meet certain criteria. A **covered employer** is a:

- Private-sector employer, with 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including a joint employer or successor in interest to a covered employer;
- Public agency, including a local, state, or Federal government agency, regardless of the number of employees it employs; or
- Public or private elementary or secondary school, regardless of the number of employees it employs.

ELIGIBLE EMPLOYEES

Only eligible employees are entitled to take FMLA leave. An **eligible employee** is one who:

- Works for a *covered employer*;
- Has worked for the employer for at least *12 months*;
- Has at least *1,250 hours* of service for the employer during the 12 month period immediately preceding the leave*; and
- Works at a location where the employer has at least *50 employees within 75 miles*.

* Special hours of service eligibility requirements apply to airline flight crew employees. *See* Fact Sheet 28J: Special Rules for Airline Flight Crew Employees under the Family and Medical Leave Act.

The 12 months of employment do not have to be consecutive. That means any time previously worked for the same employer (including seasonal work) could, in most cases, be used to meet the 12-month requirement. If the employee has a break in service that lasted seven years or more, the time worked prior to the break will not count *unless* the break is due to service covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), or there is a written agreement, including a collective bargaining agreement, outlining the employer's intention to rehire the employee after the break in service. *See* "FMLA Special Rules for Returning Reservists".

LEAVE ENTITLEMENT

Eligible employees may take up to **12 workweeks** of leave in a 12-month period for one or more of the following reasons:

- The birth of a son or daughter or placement of a son or daughter with the employee for adoption or foster care;
- To care for a spouse, son, daughter, or parent who has a serious health condition;
- For a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
- For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.

An eligible employee may also take up to **26 workweeks** of leave during a "single 12-month period" to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember. The "single 12-month period" for military caregiver leave is different from the 12-month period used for other FMLA leave reasons. *See* Fact Sheets 28F: Qualifying Reasons under the FMLA and 28M: The Military Family Leave Provisions under the FMLA.

Under some circumstances, employees may take FMLA leave on an intermittent or reduced schedule basis. That means an employee may take leave in separate blocks of time or by reducing the time he or she works each day or week for a single qualifying reason. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operations. If FMLA leave is for the birth, adoption, or foster placement of a child, use of intermittent or reduced schedule leave requires the employer's approval.

Under certain conditions, employees may choose, or employers may require employees, to "substitute" (run concurrently) accrued paid leave, such as sick or vacation leave, to cover some or all of the FMLA leave period. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

NOTICE

Employees must comply with their employer's usual and customary requirements for requesting leave and provide enough information for their employer to reasonably determine whether the FMLA may apply to the leave request. Employees generally must request leave 30 days in advance when the need for leave is foreseeable. When the need for leave is foreseeable less than 30 days in advance or is unforeseeable, employees must provide notice as soon as possible and practicable under the circumstances.

When an employee seeks leave for a FMLA-qualifying reason for the first time, the employee need not expressly assert FMLA rights or even mention the FMLA. If an employee later requests additional leave for the same qualifying condition, the employee must specifically reference either the qualifying reason for leave or the need for FMLA leave. *See* Fact Sheet 28E: Employee Notice Requirements under the FMLA .

Covered employers must:

(1) Post a notice explaining rights and responsibilities under the FMLA. Covered employers may be subject to a civil money penalty for willful failure to post. For current penalty amounts, see www.dol.gov/whd/fmla/applicable_laws.htm;

(2) Include information about the FMLA in their employee handbooks or provide information to new employees upon hire;

(3) When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA-qualifying reason, provide the employee with notice concerning his or her eligibility for FMLA leave and his or her rights and responsibilities under the FMLA; and

(4) Notify employees whether leave is designated as FMLA leave and the amount of leave that will be deducted from the employee's FMLA entitlement.

See Fact Sheet 28D: Employer Notice Requirements under the FMLA.

CERTIFICATION

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition. *See* Fact Sheet 28G: Certification of a Serious Health Condition under the FMLA. For information on certification requirements for military family leave, *See* Fact Sheet 28M(c): Qualifying Exigency Leave under the FMLA; Fact Sheet 28M(a): Military Caregiver Leave for a Current Servicemember under the FMLA; and Fact Sheet 28M(b): Military Caregiver Leave for a Veteran under the FMLA.

JOB RESTORATION AND HEALTH BENEFITS

Upon return from FMLA leave, an employee must be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot be counted against the employee under a "no-fault" attendance policy. Employers are also required to continue group health insurance coverage for an employee on FMLA leave under the same terms and conditions as if the employee had not taken leave. *See* Fact Sheet 28A: Employee Protections under the Family and Medical Leave Act .

OTHER PROVISIONS

Special rules apply to employees of local education agencies. Generally, these rules apply to intermittent or reduced schedule FMLA leave or the taking of FMLA leave near the end of a school term.

Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under the FLSA regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the "salary basis" requirements for FLSA's exemption extends only to an eligible employee's use of FMLA leave.

ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any

proceeding, related to the FMLA. *See* Fact Sheet 77B: Protections for Individuals under the FMLA . The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE
TTY: 1-866-487-9243
Contact Us

TOWN OF EAST BRIDGEWATERFAMILY AND MEDICAL LEAVE POLICY

Family and Medical Leave is an unpaid employee leave of absence. The Family and Medical Leave policy is integrated and included with Sick Leave, Vacation, or other paid leave policies.

ELIGIBILITY

Employees may have their absence designated as Family and Medical Leave under the Family and Medical Leave Act if they are absent for five (5) or more consecutive work days, or seven (7) or more calendar days. An employee will be eligible for Family and Medical Leave if (1) the employee has worked for the Town of East Bridgewater for at least 12 months, and (2) the employee has worked for at least 1,250 hours during the 12 months before the leave. In some circumstances, employees who do not meet these conditions may be eligible to take an eight-week leave for the purpose of giving birth to or adopting a child (as determined under the Parental Leave Policy). Employee rights under the Family and Medical Leave Act are also described on the attached informational sheet.

TYPES OF FAMILY AND MEDICAL LEAVE

Employees may qualify for Family and Medical Leave for any of the following reasons:

- the birth, adoption or foster care placement of a child, and for the care of that child (leave must be completed within 12 months of the child's birth, adoption or foster care placement);
- to care for a seriously ill or injured spouse, parent, or child under age 18 (or child 18 years old or older who is incapable of self-care);
- because of an illness or injury that makes the employee unable to perform his or her job.

The injury or illness must be a "serious health condition." A "serious health condition" means any illness, injury or impairment that involves one or more of the following:

- inpatient hospitalization;
- continuing treatment by a health care provider due to incapacity caused by a health condition that lasts for more than three days and requires health care visits or continuing treatment;
- pregnancy or prenatal care;
- a chronic, serious health condition that requires periodic visits for health care; or
- a permanent or long-term condition requiring medical supervision.

NOTICE AND SCHEDULING OF LEAVE

An employee who plans to take leave because of planned medical treatment must make an effort to schedule the treatment to reduce the disruption to the Town of East Bridgewater subject to the health care provider's approval. In general, an employee should consult with his or her supervisor to explore alternatives. At least 30 days' written notice of the leave should be given to the Department Head whenever possible. If an employee cannot give the full amount of advance notice, he or she should give as much notice as possible under the circumstances. If an employee fails to provide notice or to comply with any obligations set out in this policy, his or her request for leave may be denied or the conditions of that leave may be modified. In addition, he or she will be subject to appropriate discipline up to and including discharge.

CONFIRMATION OF LEAVE

Employees requiring leave must provide the Town of East Bridgewater with the reason for the requested leave so that the Town of East Bridgewater can determine if the employee qualifies for leave. After an employee gives notice of his or her intent to take a Family and Medical Leave, the Department Head will give the employee a memorandum confirming receipt of the notice of the leave, which sets forth some of the basic procedures and responsibilities of both the employee and the Town of East Bridgewater. This memo is considered part of this Policy. It will inform you of whether the leave has been approved, denied, or conditionally approved pending medical certification.

Employees requesting a leave for personal or family medical reasons are generally required to provide medical certification. Under most circumstances, medical certification must be provided within 15 calendar days. Further medical verification may be required during the leave, depending on the circumstances. Moreover, employees on leave may be contacted periodically for updates concerning their status and intent to return to work. Employees are expected to respond fully to such requests for updates.

LENGTH OF LEAVE AND RESTORATION RIGHTS

In general, an employee is entitled to a maximum of 12 weeks of Family and Medical Leave during any 12-month period. The 12-month period is a rolling period, measured backward from the date an employee last used any leave under this policy. Thus, any leave taken will be deducted from the employee's annual Family and Medical Leave entitlement.

At the end of a Family and Medical Leave, the Town of East Bridgewater will have the right to return the employee to his or her last position before the leave or to an equivalent position. While on unpaid Family and Medical Leave, employees do not accrue additional vacation, sick leave or personal time. However, the employee will not lose any benefit rights to the extent that those rights accrued before the leave period.

An employee will not be entitled to more favorable employment terms as a result of taking Family and Medical Leave. Thus, the employee will be subject to any pay or benefit reductions or other adverse actions, including layoff that he or she would have experienced if he or she had not been on a Family and Medical Leave.

INTERMITTENT OR REDUCED WORK SCHEDULE LEAVE

Unless otherwise approved by the appropriate Department Head a child care leave must be taken at one time, whereas a medical leave may be taken through either a reduced working schedule or on an intermittent basis if such an arrangement is certified to be medically necessary. Where an employee takes leave on a reduced work schedule or intermittent basis, the Town of East Bridgewater may transfer the employee temporarily to an available alternative position with equivalent pay and benefits if the alternative position better accommodates the recurring periods of medical leave.

SPECIAL RULE APPLICABLE TO SPOUSES WHO ARE BOTH EMPLOYED BY THE TOWN OF EAST BRIDGEWATER

If the Town employs both spouses, the total birth, adoption and child care leave to which both will be entitled will be 12 weeks in any 12-month period.

CERTIFICATION BEFORE RETURN

Before an employee may return from a personal medical leave that has continued for at least five calendar days, the employee's health care provider may be required to certify that the employee is able to resume his or her job. This practice is consistent with personnel bylaws and collective bargaining unit Sick Leave Policies.

COORDINATION WITH AVAILABLE PAID LEAVE TIME

Family and Medical Leave is unpaid leave, except to the extent that an employee is eligible for paid leave for unused sick, vacation, or personal time. Where an employee is eligible for leave under these policies, the Town of East Bridgewater will provide the paid leave to run concurrently with, not in addition to, the Family and Medical Leave.

MAINTENANCE OF HEALTH BENEFITS

During a Family and Medical Leave, the Town of East Bridgewater will continue the employee's medical, dental and life insurance coverage, provided that the employee pays the regular employee share of such coverage on a timely basis. During any paid leave, the employee share of the premiums will be deducted from the employee's pay. During the unpaid portion of a Family and Medical Leave, the employee will be required to pay the employee share, either prior to commencing unpaid leave, or through a special billing arrangement while on unpaid leave. The Treasurer/Collector Office should be contacted by the employee prior to going on unpaid leave to make the appropriate payment arrangements. If any payment due is more than 30 days late, the Town of East Bridgewater may cease providing the benefits until the employee returns to work. Also, if the employee does not return to work, and the employee's failure to return to work is not due to the continuation, recurrence or onset of a serious health condition, the Town of East Bridgewater is entitled to recover the premium(s) that it paid for maintaining the employee's health coverage.

This policy was adopted by the Board of Selectmen at their Monday, April 24, 2017 meeting.

John Margie, Chairman

David Sheedy, Vice Chairman

William Dowling, Clerk

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Overview of Health Insurance Marketplaces

THIS NOTICE IS REQUIRED BY THE NATIONAL HEALTH REFORM LAW (ALSO KNOWN AS THE AFFORDABLE CARE ACT OR ACA)

This notice is meant to help you understand health insurance Marketplaces, which were set up to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. Your employer is required by law (§ 1512 of the ACA, which creates 29 U.S.C. 218b) to provide you the information contained in this notice. You may or may not qualify for subsidized health insurance through the Health Connector. If you are offered coverage by your employer that is considered "affordable" and meets a "minimum value" standard according to federal definitions (see below), you most likely will not qualify for the subsidized coverage offered through the Health Connector described in this notice. However, it may still be helpful for you to read and understand the information included here. Please ask your employer for more information if you have questions.

Overview:

As a result of the Affordable Care Act (ACA), there is an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting **MAhealthconnector.org.**

What is the Massachusetts Health Connector?

The Health Connector is our state's health insurance Marketplace. It helps individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state's leading health and dental insurance companies. Some individuals and families may also qualify for a federal tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This tax credit is enabled by §36B of the Internal Revenue Code.

The next open enrollment for individuals and families to buy health insurance coverage through the Health Connector is scheduled to begin on November 1, 2018, and run through January 23, 2019. Individuals and families who experience a qualifying event can shop outside of open enrollment periods. You can find out more by visiting **MAhealthconnector.org** or calling **1-877 MA ENROLL** (1-877-623-6765).

Continued on next page »»

Employees that live outside of Massachusetts can visit healthcare.gov to find out about Marketplaces in their region.

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **MAhealthconnector.org** or calling **1-877 MA ENROLL** (1-877-623-6765).

Does access to employer-sponsored coverage affect my eligibility for help paying for coverage through the Health Connector?

An offer of health coverage from your employer could affect your eligibility for subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for subsidies through the Health Connector if:

- Your employer does not offer coverage to you, ***or***
- Your employer does offer you coverage, ***but***:
  - Your employer's offer of coverage for just you (not including other family members) would require you to spend more than the following percentage(s) of your household income:

Is your employer's individual health insurance coverage affordable?	
Coverage for **2018**	**9.56%** of household income
Coverage for **2019**	**9.86%** of household income

or

  - The coverage your employer provides does not meet the "minimum value" standard set by federal law (which says that the plan offered has to cover at least 60 percent of total allowed costs).

If you have coverage through your employer but are interested in shopping through the Health Connector, be sure to check with your employer on the rules around how and when you can disenroll from your employer's group coverage. If you purchase a health plan through the Health Connector instead of accepting health coverage offered by your employer, please note that you will lose the employer contribution (if any) for your health insurance. Also, the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes.

Please note: You can find the most up to date percentages used to calculate affordability here: **www.mahealthconnector.org/esi-affordability-calculator.**

Continued on next page »»

Employees that live outside of Massachusetts can visit healthcare.gov to find out about Marketplaces in their region.

EMPLOYER-SPONSORED HEALTH COVERAGE

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

Does this employer offer employer-sponsored health insurance coverage that is affordable and meets a minimum value standard (according to federal standards) to at least some of its employees? Note: *Whether a plan meets "minimum value" can be found on the plan's Summary of Benefits and Coverage (SBC).*

Check one: Yes No

***If yes,* and if the employee receiving this notice qualifies for such benefits, they can find out more by contacting:** _____
(may be an HR contact, a resource, or an appendix to this document)

***If no,* or if employee receiving notice does not qualify for such benefits,** the Health Connector can help employees evaluate coverage options, cost and eligibility. Please visit **MAhealthconnector.org** for more information, including an online application for health insurance coverage.

Employees that live outside of Massachusetts can visit healthcare.gov to find out about Marketplaces in their region.

OFFICE OF TOWN CLERK

175 Central Street, P.O. Box 387
East Bridgewater, Massachusetts 02333-0387

SUSAN GILLPATRICK
Town Clerk

As annually required by the State Ethics Commission, I am providing you with information regarding the MA Conflict of Interest Summary/State Ethics.

Every year ALL municipal employees, board/committee members and vendors must be provided with the Summary of the Conflict-of-Interest Law. In addition, please note that every 2 years ALL municipal employees, board/committee members and vendors must complete an online training program. MA State Ethics has recently released a new program, and this program will track compliance moving forward.

Municipal employees *(anyone performing services for the town or holding a municipal position, whether paid or unpaid, elected officials, volunteers, and consultants, An employee of a private firm can also be a municipal employee, if the private firm has a contract with the town and the employee is a "key employee" under the contract),* will need to create an account to access the Commission's learning management system in order to complete the new conflict of interest law training program and acknowledge receipt of the summary of the conflict of interest law. These requirements can be completed on any computer or mobile device. Completion of these mandatory training and education requirements will be automatically recorded.

With the new State reporting system, there is no need for anyone to print out their certificate unless they want to keep a copy for themselves - my office does not need a printed copy.

Please use this link to access the training: https://massethicstraining.skillburst.com/User/index.php

Because this is a state requirement, please help our office to comply with this mandate by making sure you complete in a timely manner. As the local administrator for East Bridgewater, I will be able to go into the program and see monitor compliance. After 30 days, reminders will be sent as needed.

Michele Doll

Assistant Town Clerk
508-378-1606

OFFICE OF TOWN CLERK
175 Central Street, P.O. Box 387
East Bridgewater, Massachusetts 02333-0387

ACKNOWLEDGEMENT OF RECEIPT OF MA CONFLICT OF INTEREST AND STATE ETHICS LETTER

I, _____,
(Print Name)

an employee at _____,
(Name of Department or School)

Hereby acknowledge that I received the letter explaining the State Ethics Commission's learning management system which I will need to create an account for.

PLEASE PROVIDE YOUR CONTACT INFORMATION & JOB TITLE

Phone Number: _____

Email: _____

Position Title: _____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

First Day of Employment (mm/dd/yyyy):

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

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

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

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Town of East Bridgewater 175 Central St. East Bridgewater, MA 02333		04-6001137

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

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

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

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

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

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

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

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

FORM M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 11/19

Print full name ..... Social Security no. .....

Print home address..... City..... State..... Zip .....

Employee:
File this form with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:
Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" .....
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C..... .....
3. Write the number of your qualified dependents. See Instruction D..... .....
4. Add the number of exemptions which you have claimed above and write the total..... ☐
5. Additional withholding per pay period under agreement with employer $_____

A. ☐ Check if you will file as head of household on your tax return.

B. ☐ Check if you are blind. C. ☐ Check if spouse is blind and not subject to withholding.

D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed $8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date..... Signed .....

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. The more exemptions you claim on this certificate, the less tax withheld from your employer. If you claim more exemptions than you are entitled to, civil and criminal penalties may be imposed. However, you may claim a smaller number of exemptions without penalty. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income. Underwithholding may result in owing additional taxes to the Commonwealth at the end of the year.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholdingg exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a spouse, write "4" in line 2. Entering "4" makes a withholding system adjustment for the $4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

OFFICE OF THE TOWN
TREASURER/COLLECTOR

I hereby authorize the Town of East Bridgewater (The Employer) to initiate credit entries to my checking and/or savings account(s) indicated below and the Depository(s) named below to credit the same to such account(s):

Account Information: *(a voided check or direct deposit form is required for all new accounts)*

☐ Add ☐ Change 1. Bank Name:_____
Routing #:_____ Account #:_____
☐ Checking ☐ Savings Deposit Amount: $_____or ☐Net Pay

☐ Add ☐ Change 2. Bank Name:_____
Routing #:_____ Account #:_____
☐ Checking ☐ Savings Deposit Amount: $_____

☐ Add ☐ Change 3. Bank Name:_____
Routing #:_____ Account #:_____
☐ Checking ☐ Savings Deposit Amount: $_____

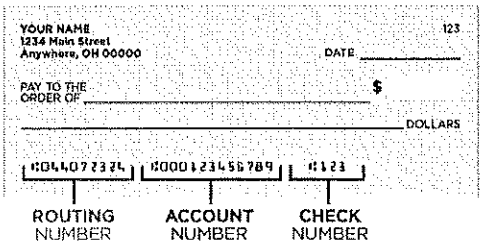
☐ Add ☐ Change 4. Bank Name:_____
Routing #:_____ Account #:_____
☐ Checking ☐ Savings Deposit Amount: $_____

☐ Remove account ending in (last 4 numbers)_____

This authority is to remain in force and effect until the Town of East Bridgewater has received written notification from me of its termination in such time and in such manner as to afford the Town of East Bridgewater to act on it.

Name:_____ Date:_____
(Please print)

Signature:_____ Employee #_____



OFFICE OF THE TOWN
TREASURER/COLLECTOR

Megan Crosby
Treasurer/Collector
Tel: 508-378-1604/1602
Fax: 508-378-4803

175 Central Street
P.O. Box 386
E. Bridgewater, MA 02333
mcrosby@eastbridgewaterma.gov

Consent Form for Electronic Delivery of Payroll Advices

You are contractually required to enroll in the electronic delivery of Payroll Advices of Direct Deposits. They will be sent via email as an attachment encrypted with a password that you specify.

You may complete a new consent form at any time to make changes to your email address or password.

A computer with email access and a program (such as the free Adobe Reader) that can open PDF files are required to access, print and retina the statements.

Name:_____ Employee#:_____

Email Address:_____
MUST BE A PERSONAL EMAIL ADDRESS; DO NOT USE TOWN/SCHOOL ISSUED EMAIL ADDRESSES

Signature:_____ Date:_____

(After password is entered into the system, please detach and shred this portion)

Password:_____
PASSWORDS ARE CASE SENSITIVE
(Maximum of 30 letters, numbers and special characters)

Plymouth County Retirement Association
60 Industrial Park Road
Plymouth, MA 02360
Phone number (508) 830 - 1803 * Fax number (508) 830 - 1875

NEW MEMBER ENROLLMENT FORM

Section 1 – Member Information (To be completed by member)

Name_____ SSN_____-_____-_____
(First) (Middle) (Last)

Birth Name (if different)_____ Date of Birth_____/_____/_____

Address_____

City_____ State_____ Zip_____

Home Phone(_____)_____ - _____ Cell Phone(_____)_____ - _____

E-mail Address_____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed * Gender ◯ Male ◯ Female

Spouse's name_____ Spouse's Date of Birth_____/_____/_____

Veteran Status: ◯ No ◯ Yes (If yes, please include a copy of your DD-214)

Governmental Entity_____EAST BRIDGEWATER_____ Agency/Department_____
(Town/School District/Housing Authority)

THE PCRA will be unable to process this form without a copy of your birth certificate

Section 2 – Past Governmental Entity (To be completed by member – if applicable)

Any previous or concurrent employment with the Commonwealth of Massachusetts, County or City/Town?

◯ No ◯ Yes (if yes, please provide history below)

Retirement System	Start Date	End Date	Was a refund taken?
_____	____/____/_____	____/____/_____	◯ No ◯ Yes
_____	____/____/_____	____/____/_____	◯ No ◯ Yes
_____	____/____/_____	____/____/_____	◯ No ◯ Yes

If you wish to reinstate/purchase a previous refund, please complete and submit a **Refund Buyback Form** to this Board.

Are you currently or have you received a retirement allowance from another public retirement system?
◯ No ◯ Yes

I certify the above statements are true and correct to the best of my knowledge and under the penalties of perjury and hereby accept membership with the Plymouth County Retirement System.

Member's Signature_____ **Date**_____

Plymouth County Retirement Association
60 Industrial Park Road, Suite 234
Plymouth, MA 02360
Phone number (508) 830 - 1803 * Fax number (508) 830 - 1875

Section 3 – Payroll Information (To be completed by payroll)

Title/Position_____ Start Date____/____/_____

Date First Deduction applies to(if different from Start Date)____/____/_____ ◯ New ◯ Transfer

Contribution Rate ◯ 5% ◯ 7% ◯ 8% ◯ 9% ☐ Additional 2%

Service Status(check all that apply) ☐ Full-Time _____% Part-Time ☐ Temp/Sub ☐ Other

Hours of Employment Per Week_____ * Collective Bargaining Agreement: ◯ Yes ◯ No

Rate of Regular Compensation_____ Per_____ Group_____ to be completed by PCRA

***As of August 25, 2016, at least 20 hours per week is required to be a member of the Plymouth County Retirement Association**

Payroll Signature_____ **Date**_____

Plymouth County Retirement Association
60 Industrial Park Road
Plymouth, MA 02360
Phone number (508) 830 - 1803 * Fax number (508) 830 - 1875

ACTIVE MEMBER BENEFICIARY FORM

Section 1 – Member Information

Name _____ SS# XXX – XX – _____

Address _____

City _____ State _____ Zip Code _____

Home Phone(_____)_____-_____ Cell Phone(_____)_____-_____

E-mail _____ Unit _____

BE SURE TO CAREFULLY READ WHAT EACH BENEFICIARY OPTION PROVIDES BEFORE SELECTING.

Member-Survivor(Option D) Beneficiary – Only one person may be named as a Member-Survivor(Option D) beneficiary. It is limited to a spouse, former spouse not remarried, parent, sibling or child. The beneficiary would receive a monthly survivor allowance equal to the amount you would have received if you had retired under Option C on the date of your passing.

Section 2 – Member-Survivor(Option D) Beneficiary Information

Name _____

Address _____

Relationship _____ * Date of Birth ____/____/____ SS# ____-____-____

***limited to spouse, former spouse who has not remarried, parent, sibling or child**

AND / OR

Lump-Sum Beneficiary – You may name one or more Lump-Sum beneficiaries. **There is no restriction on whom the Lump-Sum beneficiary(ies) can be, with the lone exception that it cannot be the same as a Member-Survivor(Option D) beneficiary, if you listed one above.** A Lump-Sum beneficiary would receive a one-time payment of your entire account balance or the percentage allocated to if you name more than one. **If you name both a Member-Survivor(Option D) and a Lump-Sum beneficiary(ies), the Member-Survivor(Option D) beneficiary would receive the entire benefit.**

Section 3 – Lump-Sum Beneficiary Information

1)Name _____ **Percentage** _____ **%**

Address _____

Relationship _____ Date of Birth ____/____/____ SS# ____-____-____

2)Name _____ **Percentage** _____ **%**

Address _____

Relationship _____ Date of Birth ____/____/____ SS# ____-____-____

3)Name _____ **Percentage** _____ **%**

Address _____

Relationship _____ Date of Birth ____/____/____ SS# ____-____-____

The total sum of all the percentages above must equal 100%

Please be advised that pursuant to Massachusetts law, a surviving spouse may supersede a nominated beneficiary and be awarded any benefits as a result of your passing. If you have any questions, please contact the PCRA.

Member's Signature _____ **Date** ____/____/____

Witness' Signature _____ **Date** ____/____/____

Witness' Name (Print) _____

Active Member Beneficiary Form Instructions

Introduction:

Please complete this **Active Member Beneficiary Form** only if you are an active member currently contributing to the Plymouth County Retirement Association (PCRA) or are an inactive member, but still have contributions in the system.

As an active or inactive member of the PCRA, you should always have a beneficiary on file. In order to name or update your beneficiary(ies), all you would need to do is to complete a new **Active Member Beneficiary Form**. You may do this at any time before you retire. These allocations become void upon your retirement.

Having a beneficiary(ies) on file allows you to designate who should specifically receive any allowance if you should pass away before you retire. The allowance that is paid out will depend on what type of beneficiary that you name, though any selection that you make may be superseded by an eligible spouse (provided that you have been married for at least one year, you have two years of creditable service and have been living with at the time of passing). If you are an inactive member at the time of your passing, then your spouse will not supersede your named beneficiary(ies). If you do not have either a beneficiary on file, an eligible spouse or dependent children, a lump-sum payment will be made to your Estate.

Beneficiary Types:

There are two types of beneficiaries that you can name, a **Member-Survivor(Option D)** and a **Lump-Sum**. While you can name both types of beneficiaries, you cannot name the same person as both. Additionally, if you do name both types of beneficiaries, in the event of your passing, the Member-Survivor(Option D) beneficiary will receive the entire benefit. As previously noted, an eligible spouse may supersede any beneficiary named, unless you are an inactive member at the time of passing.

The two types of Beneficiary are as follows:

Member-Survivor(Option D) – This beneficiary would receive a monthly survivor allowance equal to the amount that you would have received if you had retired under Option C on the date of your passing. Only one person may be named as a Member-Survivor(Option D) beneficiary. It is limited to spouse, former spouse not remarried, parent, sibling or child.

If a spouse is to receive an Member-Survivor(Option D) benefit and the member was an active member at the time of passing and there are dependent children, an additional monthly payment of $120 for the oldest child and $90 for each additional child is available.

Lump-Sum – This beneficiary(ies) would receive a one-time payment of your entire account balance or the percentage allocated to if you name more than one. Any person(s) or entity(ies), such as an Estate or charity, may be named as a Lump-Sum beneficiary and there is no limit to how many you are allowed to name. If you need more space for additional beneficiaries, please print additional copies of the **Active Member Beneficiary Form** and indicate how many pages submitted.

Before you submit your **Active Member Beneficiary Form**, as a reminder:

- You may name both a Member-Survivor(Option D) beneficiary and a Lump-Sum beneficiary. If you do, the Member-Survivor beneficiary will receive the benefits in case of your passing.
- You are not allowed to name the same person as both a Member-Survivor(Option D) and Lump-Sum beneficiary
- An eligible spouse may supersede any beneficiary listed unless you are an inactive member.
- You may change your beneficiary(ies) at any time by completing a new **Active Member Beneficiary Form.**
- Your beneficiary(ies) named will become void when you retire.

If you have any further questions about naming a beneficiary as an active or inactive member, please feel free to contact the Plymouth County Retirement Association at (508) 830 – 1803.

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

Employee Name _____ **Employee ID#** _____

Employer Name Town of East Bridgewater **Employer ID#** 04-6001137

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

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

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

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

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

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

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

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Emergency Contact Form

Name: _____ **Dept:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

E-Mail Address: _____

Please list the names and telephone numbers of two individuals you would like us to contact:

EMERGENCY CONTACT #1:

Name: _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Work Phone #: _____ **Cell Phone #:** _____

EMERGENCY CONTACT #2:

Name: _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Work Phone #: _____ **Cell Phone #:** _____

Do you give us permission to transport you to the nearest medical facility should you incur serious illness or injury during normal working hours? ☐ **YES** ☐ **NO**

If yes, please indicate the name and contact telephone number of the physician or health care provider that you would like us to contact:

Name: _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Work Phone #: _____ **Cell Phone #:** _____

OFFICE OF THE TOWN

TREASURER/COLLECTOR

Medical Insurance Pre-Tax Deduction Authorization Form

I, _____, hereby authorize and request the Town
(*please print Name*)
Treasurer to deduct all Medical Insurance Premiums from my pay on a pre-tax basis effective immediately and until further notice.

Signed: _____

Print Name: _____

Soc. Sec. #: _____

Address: _____

Town/St/Zip: _____

Date: _____

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Municipal Employee Acknowledgement Form For GIC Eligible Employees

You are responsible for familiarizing yourself with your benefit options and making your elections within 10 days of the date of hire:

- Health Insurance Options
- Summary of Benefits and Coverage

Your signature is required on this form before your municipality can process your benefit elections. Please sign, date and return this form to your GIC Coordinator after you have reviewed the *Benefit Decision Guide*.

I hereby acknowledge that I have reviewed the most recent GIC *Benefit Decision Guide* and understand my benefit options before I made my benefit elections. I understand that if I enroll in GIC health insurance, my premiums will be deducted on a pretax basis unless I elect post tax benefits. I understand if I enroll in a GIC health plan, I can't change my health plan until the next Annual Enrollment period.

Name: _____
(Please print)

Signature: _____

Date: _____

Employee: Return this signed form to your GIC Coordinator/Benefits Office with your benefit elections.
GIC Coordinator: Give employee copy of this form and retain original signed form in employee's personnel file. Do not send to the GIC.

OFFICE OF THE TOWN
TREASURER/COLLECTOR

Megan Crosby
Treasurer/Collector
Tel: 508-378-1604/1602
Fax: 508-378-4803

175 Central Street
P.O. Box 386
E. Bridgewater, MA 02333
mcrosby@eastbridgewaterma.gov

Health Insurance Waiting/Hiatus Period Stipend

New employees of the Town who are eligible to enroll in Health insurance must enroll within 10 calendar days of the first date of employment. GIC health insurance benefits begin on the first day of the month following sixty (60) days or two (2) full calendar months of employment, whichever is less. The period between the date of employment and the effective date of coverage is referred to as the "Waiting/Hiatus Period".

During the "Waiting/Hiatus Period" the Town shall pay a stipend to those newly hired employees who have notified the Town within 10 calendar days of employment that they have chosen to enroll in health insurance through the GIC. The amount of the Waiting/Hiatus Period Stipend will be equal to the employer's portion, up to a maximum of 70%, of the premium cost for whichever plan the employee has chosen to enroll. The stipend will be paid after the Waiting/Hiatus Period has ended.

To receive the Stipend, the employee must show proof of other health insurance coverage during the Waiting/Hiatus Period (e.g. COBRA or other alternative health insurance plan). The employee must also show proof of payment (canceled check, bank statement, etc.) and all paperwork must be submitted to the Treasurer/Collector's office no later than the first day of health insurance coverage through the Town of East Bridgewater.

Newly enrolled employees/subscribers who cancel their GIC coverage within sixty (60) days of the effective date of the GIC coverage shall return the Waiting/Hiatus Period Stipend in its entirety to the Town.

EXAMPLE #1	Month 1	Month 2	
Other Health Insurance	$ 1,200.00	$ 1,200.00	$ 2,400.00
Harvard Pilgrim Quality Family Employers Portion	$ 1,447.72	$ 1,447.72	$ 2,895.44
Stipend			**$ 2,400.00**

EXAMPLE #2	Month 1	Month 2	
Other Health Insurance	$ 1,800.00	$ 1,800.00	$ 3,600.00
Harvard Pilgrim Quality Family Employers Portion	$ 1,447.72	$ 1,447.72	$ 2,895.44
Stipend			**$ 2,895.44**

OFFICE OF THE TREASURER/COLLECTOR

TOWN OF EAST BRIDGEWATER

Megan Crosby
Treasurer/Collector

www.eastbridgewaterma.gov
175 CENTRAL STREET
EAST BRIDGEWATER, MASSACHUSETTS 02333-1912

Telephone: 508-378-1600 X1020
Facsimile: 508-378-4803

If you are enrolling in health insurance, please complete the following:

First Name:_____

Last Name:_____

Email(personal):_____

Date of Birth:_____

We will send you an electronic link, followed by an email letting you know it was sent. The GIC link may end up in your spam if you do not receive it please reply back to our email to let us know.

When adding a spouse or dependents the GIC requires a copy of a marriage certificate and birth certificates for each child. The documents should be attached to the electronic form.

Any questions please call 508-378-1604.

Town of East Bridgewater
Insurance Rates - Employee and NON-MEDICARE Retiree/Survivor
Effective July 1, 2023

Health Product	Product Type	Coverage Type	Full Cost Premium	Employee Share	Employee Monthly Share	Payroll Deductions: TOWN Employee Weekly Share (48 Pays)	Payroll Deductions: School Employee Bi-weekly Share (24 Pays)	Payroll Deductions: School Employee School Year Share (21 Pays)
Harvard Pilgrim Access America	PPO	Individual	$ 1,180.40	50%	$ 590.20	$ 147.55	$ 295.10	$ 337.26
Harvard Pilgrim Access America	PPO	Family	$ 2,629.04	50%	$ 1,314.52	$ 328.63	$ 657.26	$ 751.15
Harvard Pilgrim Explorer	POS	Individual	$ 976.42	40%	$ 390.57	$ 97.64	$ 195.28	$ 223.18
Harvard Pilgrim Explorer	POS	Family	$ 2,412.86	40%	$ 965.14	$ 241.29	$ 482.57	$ 551.51
Harvard Pilgrim Quality	HMO	Individual	$ 721.33	30%	$ 216.40	$ 54.10	$ 108.20	$ 123.66
Harvard Pilgrim Quality	HMO	Family	$ 1,829.24	30%	$ 548.77	$ 137.19	$ 274.39	$ 313.58
Mass General Brigham Health Plan Complete (FKA Allways)	HMO	Individual	$ 892.50	30%	$ 267.75	$ 66.94	$ 133.88	$ 153.00
Mass General Brigham Health Plan Complete (FKA Allways)	HMO	Family	$ 2,352.42	30%	$ 705.73	$ 176.43	$ 352.86	$ 403.27
Unicare Total Choice	Indemnity	Individual	$ 1,348.43	50%	$ 674.22	$ 168.55	$ 337.11	$ 385.27
Unicare Total Choice	Indemnity	Family	$ 2,983.18	50%	$ 1,491.59	$ 372.90	$ 745.80	$ 852.34
UniCare State Indemnity Plan/Community Choice	PPO-Type	Individual	$ 676.74	40%	$ 270.70	$ 67.67	$ 135.35	$ 154.68
UniCare State Indemnity Plan/Community Choice	PPO-Type	Family	$ 1,669.16	40%	$ 667.66	$ 166.92	$ 333.83	$ 381.52
UniCare State Indemnity Plan/PLUS	PPO-Type	Individual	$ 883.99	40%	$ 353.60	$ 88.40	$ 176.80	$ 202.05
UniCare State Indemnity Plan/PLUS	PPO-Type	Family	$ 2,097.98	40%	$ 839.19	$ 209.80	$ 419.60	$ 479.54
Altus Dental	Dental	Individual	$ 43.09	50%	$ 21.55	$ 5.39	$ 10.77	$ 12.31
Altus Dental	Dental	Family	$ 112.34	50%	$ 56.17	$ 14.04	$ 28.09	$ 32.10
Boston Mutual	Life		$ 5.95	50%	$ 2.98	$ 0.74	$ 1.49	$ 1.70

***All rate questions should be directed to the Treasurer's Office ~ Call (508) 378-1604 ***

altus dental™

Altus Dental Insurance Company, Inc.

Benefit Highlights

Plus Plan

Welcome to Altus Dental

This overview highlights your dental benefits and explains how your Plus plan works. We look forward to providing you and covered family members with dental insurance. When your coverage begins, we will send you an ID card.

Register at altusdental.com to learn more about your benefits and choose to receive paperless communications from us through your secure and convenient online account.

How to Contact Us

ONLINE

You can access your account information online 24 hours a day, 7 days a week at www.altusdental.com.

INFOLINE

1.877.223.0588

Our automated telephone information system is available 24 hours a day, 7 days a week.

CUSTOMER SERVICE

1.877.223.0588

Our customer service representatives are available Monday – Thursday 8 am to 7 pm and Friday 8 am to 5 pm, ET.

TOWN OF EAST BRIDGEWATER

Group #: 6130-0001

The annual maximum is: $1500 per member per calendar year
The annual deductible is: $50 per individual /$150 per family
The maximum lifetime cap is: Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0% (exempt from annual maximum)

- Two oral exams per calendar year
- Two cleanings per calendar year
- One set of bitewing x-rays per calendar year
- One complete x-ray series or panoramic film every 36 months
- Single x-rays as required
- Fluoride treatment for children under age 19 twice per calendar year
- Sealants for children under age 16, once per unrestored permanent molar every 36 months

Plan pays 100%; Member Coinsurance 0%

- Space maintainers for lost deciduous (baby) teeth, replacement limited to once every 60 months

Plan pays 80%; Member Coinsurance 20%

- Palliative treatment (minor procedures necessary to relive acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on all teeth.
- Extractions and other routine oral surgery not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for complex surgical procedures
- Root canal therapy
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges
- Rebasing or relining of partial or complete dentures; once every 60 months
- Periodontal maintenance following active therapy – two per year
- Root planing and scaling once per quadrant every 24 months
- Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered)
- Gingivectomies once per site every 24 months
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per tooth every 60 months

Plan pays 50%; Member Coinsurance 50% Deductible Applies

- Surgical placement of endosteal implant and abutment; replacement limited to once every 60 months
- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months
- Bridges, build ups, posts and cores, crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months

Orthodontics:

Plan pays 100%; Member Coinsurance 0%

- Braces and related services for dependent children under the age of 23

Lifetime Maximum (orthodontics only): $1000

Dependent Coverage – Dependent children are covered up until the end of the month that they turn age 26.

How Your Plan Works

Receiving care from a participating network dentist will save you money. To make sure you get the maximum out of your dental plan, it's important to know how your plan works.

The Altus Dental network includes many dentists in your area. We are the largest Preferred Provider Organization (PPO) in the state. We also offer access to dentists nationwide through the CONNECTION Dental network. All of our network dentists pass our rigorous credentialing process.

How to Find a Dentist

Choose from Altus Dental's extensive network of dentists. With a continually expanding list of participating dentists, you're sure to find one that's right for you.

Visit altusdental.com to use our online Find a Dentist tool. You can see if your current dentist participates with us or look for a new dentist by searching by name, location or specialty. If your card displays the CONNECTION Dental logo, you have access to a national network of dentists and specialists. Enter your address or other criteria important to you (extended hours, languages spoken, etc.), and our tool will return a list of dentists that meet your needs — as well as maps and driving directions.

Thanks for choosing Altus Dental – we look forward to providing you and any covered family members with quality dental benefits.

Maximize your coverage with participating dentists

In-network care

When you receive care from a participating dentist, your out-of-pocket costs will be less. That's because the dentist has agreed to accept the allowance as full payment, minus any coinsurance and applicable deductibles, which means no "balance billing." Participating dentists also handle paperwork and inquiries directly with us.

Out-of-network care

You have the freedom to see a dentist who does not belong to our network. However, when you go to a non-participating dentist, it will usually cost you more money. That's because non-participating dentists expect you to pay for any difference between the amount Altus Dental allows and the amount the dentist charges.

You may also have to file the claim yourself and be reimbursed by Altus Dental.

Members Online

When you register at altusdental.com, you can log in to see your benefits, eligibility and claims information whenever it's convenient for you. And, you can choose to receive paperless communications from us through your secure and convenient online account. Visit www.altusdental.com today!

Claims and correspondence should be sent to:
Altus Dental
P.O. Box 1557
Providence, RI 02901-1557

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Altus Dental Insurance Co. does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.
Português (Portuguese): ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

altus dental™

Altus Dental Insurance Company, Inc.

Register today at altusdental.com

Taking good care of your teeth and gums is an important part of keeping your whole body healthy.

When you register at altusdental.com, you can take charge of your oral health and:

- Register for paperless communications
- See if your dentist participates or locate a new one
- Understand the costs of dental care in your area
- See how you've used your dental benefits this year
- Learn more about your Altus Dental plan
- Get tips to keep your smile healthy

Registering at our site is easy. Follow these steps:

1. Go to altusdental.com to register
2. Under "Log In To Your Account," click on "Click Here to Register"
3. Click on "Member with Coverage"
4. Enter the subscriber's information

Once you've registered, we'll occasionally send you e-mails with information and quick tips that make it easy to have a healthy smile.

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Altus Vision™ in partnership with VSP® Vision Care

Benefits Summary: Altus Vision™ - 150 Plus

Benefit	Description	Copay
In-Network Coverage with VSP Choice Network: 45,000 Preferred Providers | 117,000 Access Points		
WELLVISION® EXAM		
Exams 1 exam every 12 months	• Comprehensive eye exam to ensure overall visual wellness	$10
PRESCRIPTION GLASSES		
Frames 1 pair every 12 months	• $150 allowance for wide selection of frames • 20% savings on amount over allowance. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied • Frame allowance backed by a wholesale guarantee, meaning VSP fully covers more frames than retail allowance plans • Allowance may differ at Costco® Optical, however it is of equivalent value. Costco® Optical allowance of $80 is equivalent to $150 frame allowance at VSP doctor locations and participating retail chains	$25
Lenses 1 pair every 12 months	• Single vision, lined bifocal, lined trifocal, and lenticular lenses	
Covered Lens Enhancements	• Impact-resistant lenses for children • Standard Progressive Lenses	$0
CONTACT LENSES (instead of glasses)		
Contacts Every 12 months	• $150 allowance for contacts	$0
	• Contact lens fitting and evaluation	Up to $60
VALUE-ADDED PROGRAMS		
VSP Essential Medical Eye Care Program	• Exams and services to treat immediate issues like pink eye and sudden changes in vision • Treatment options to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more • Members with diabetes who do not have diabetic eye disease receive full retinal screening at no cost. Members with diabetic eye disease, glaucoma, and age-related macular degeneration (AMD) receive additional exams and services with $20 copay. Limitations and coordination with medical coverage may apply. Ask your VSP network doctor for details	

Extra Savings	
Additional Lens Enhancements	• Average savings of 30% on enhancements including tints, UV protection, scratch-resistant coating, anti-glare coating and more • Discount rate for Premium Progressive Lenses: $95-$105; Custom Progressive Lenses: $150-$175
Featured Frames	• Extra $20 allowance on featured brands like bebe®, Calvin Klein, Flexon®, Lacoste, Nike, and more. Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Not applicable at Costco® Optical. Ask your VSP network doctor for more details
Additional Glasses and Sunglasses	• 20% savings on additional prescription or non-prescription glasses and/or sunglasses from any VSP provider within 12 months of last WellVision Exam
Laser Vision Correction	• Average 15%-20% savings. See VSP.com for more information
TruHearing®[1]	• Save up to 60% on the latest brand-name hearing aids. Visit TruHearing.com/VSP or call 877.396.7194 for more information

Monthly Rates			
Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
$6.50	$13.00	$13.65	$18.85

See reverse side for more information.

altus dental™

Town of East Bridgewater
Altus Vision 150+
Effective July 1, 2023

Vision	Employee Monthly Share	TOWN Employee Weekly Share (48 Pays)	School Employee Bi-weekly Share (24 Pays)	School Employee School Year Share (21 Pays)
Employee Only	$ 6.50	$ 1.63	$ 3.25	$ 3.71
Employee & Spouse	$ 13.00	$ 3.25	$ 6.50	$ 7.43
Employee & Child(ren)	$ 13.65	$ 3.41	$ 6.83	$ 7.80
Family	$ 18.85	$ 4.71	$ 9.43	$ 10.77

***All rate questions should be directed to the Treasurer's Office
Call (508) 378-1604 ***

altusdental™ Altus Vision™ ENROLLMENT FORM

Altus Dental Insurance Company, Inc.
PO Box 1557
Providence, RI 02901-1557
877-223-0588

GROUP INFORMATION *To be completed by Human Resources or Benefit Administrator.*			
Employer / Group Name			Group No.
Dental Division No.	Vision Division No.	Date of Hire	Location No. (if applicable)

I. SUBSCRIBER INFORMATION

Subscriber Name (First, Last)		Date of Birth (MM/DD/YYYY)	Social Security / I.D. #	
Street Address / P.O. Box No.	Apt. No.	City	State	Zip
Preferred Mobile Number		Preferred Email		

II. ENROLLMENT INFORMATION

Effective Date of Action (MM/DD/YYYY)

TYPE OF COVERAGE *Check all that apply.* ☐ Dental ☐ Vision

QUALIFYING EVENT
☐ Open Enrollment ☐ New Hire/Re-hire ☐ Marriage ☐ Divorce ☐ Birth or Adoption ☐ Workers' Compensation ☐ Return from Leave of Absence ☐ Loss of Coverage ☐ Full-Time/Part-Time Status ☐ Death of a Member

ACTION CODE *Check one.*

ADDITIONS
☐ New Subscriber
☐ Add Dependent to Family
☐ Reinstatement

TERMINATION
☐ Remove Subscriber
☐ Remove Dependent *List name in Section III*

STATUS CHANGE
☐ Name / Address Change
☐ Transfer from Division #_____ to #_____
☐ Change Type of Coverage

COBRA
☐ Reinstatement of Subscriber
☐ Addition of Dependent Prior ID # _____

III. DEPENDENT INFORMATION

First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Enroll In: Dental	Enroll In: Vision
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. If my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ Date _____ Benefits Administrator Authorization _____ Date _____

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Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

Sign up NOW for the 2023–2024 Plan Year!

Flexible Spending Benefits

Town of East Bridgewater

One of the Few Gifts the IRS Gives!

Discover the benefit that SAVES YOU MONEY. This perk allows you to set aside a portion of your pay—*BEFORE TAXES*—to cover out-of-pocket expenses in these categories:

- **HEALTH CARE.*** Eligible expenses and services include: non-cosmetic medical, dental, and vision care services; prescription medications; over-the-counter 'medicines' (not vitamins or supplements); orthodontics, prescription eyeglasses, contact lenses, laser eye surgery; mental health services; alternative health therapies (e.g. chiropractic, acupuncture), and *MORE!*

  Max. Annual Health Care Election: $3,050.

  Who's Covered? You, your legal spouse, and your dependents as defined by the Internal Revenue Service, including those claimed on your tax return and adult children under age 26.

  Benefit Cards. For employer plans that offer the benefit card, new Health Care FSA enrollees will receive **2 cards** that can be used at most medical facilities, dental offices, optical shops, and pharmacies to pay for eligible expenses. ***Keep your cards!*** They will reload each plan year that you enroll.

  Rollover Option. Health Care FSA balances—***up to $610***—will roll over to the next plan year as long as you re-enroll for that new plan year. Funds roll over after the prior plan year's 90-day run-out deadline. (Note: The rollover max. for the 2022-2023 plan year is $570; re-enrollment is required.)

  HSA Ineligibility. If you or your spouse have a Health Savings Account ('HSA'), you are NOT ELIGIBLE to participate in the Health Care FSA plan.

Make Your Money Go UP TO 30% Further! depending on your tax status

- **DEPENDENT CARE.**** For qualified **childcare** expenses for dependent children under age 13, elderly dependents, and dependents with special needs. Eligible expenses include daycare, pre-school, before/after school care, day camp, elder daycare.

  Max. Annual Dep. Care Election: $5,000. per family

Enroll by 5/3/2023
for the
7/1/2023 – 6/30/2024
Plan Year

Already in the FSA Plan?

Re-enrollment is NOT automatic!

▶**Re-enroll** via your online account portal—*not the mobile app!* Go to ***cpaemployee.lh1ondemand.com*** and log-in on the LEFT side of the sign-in screen. On your account home-page, click the blue *Enroll/Re-enroll* button and follow the steps to enroll for the new plan year; be sure to click *Submit* at the end of the process. (Printing or saving your enrollment confirmation is recommended.)

▶***New to the FSA Plan?*** Complete the *"Authorization for Pre-Tax Payroll Reduction"* form and send it to **Cafeteria Plan Advisors** via e-mail (info@cpa125.com) or fax (781-848-8477) by the deadline shown above.

Track Your Account and File Claims 24/7!

Log in to your **employee portal** via our website (www.CPA125.com), or use our **app**: ***CPA Flex Mobile.***

The annual FSA administrative fee is paid by your employer, so you save even more!

* Not all Health Care expenses are FSA-eligible, such as: cosmetic procedures or products (e.g. Botox, teeth whitening, veneers, etc.), couples/family counseling, general health/wellness expenses (e.g. toothbrushes, toothpastes, non-prescription sunglasses, gym dues, etc.), and federally non-permissible products. Some healthcare-related expenses, such as medical equipment and some services, may require a physician's Letter of Medical Necessity in order to be FSA-eligible. Visit *https://fsastore.com/CPAEligibility* for more info. on specific products and services.

** Overnight camp and school tuition for kindergarten and above are not FSA-eligible; day camp is eligible when utilized as a form of childcare in order for the parent(s)/guardian(s) to be able to work; extra-curricular and enrichment programs/activities that aren't daycare/childcare-based are not eligible; money paid to a childcare provider who doesn't report it as income on their taxes is not FSA-eligible.

Flexible Spending Plans administered by...

CAFETERIA PLAN ADVISORS | 120 LONGWATER DR., SUITE 102, NORWELL, MA 02061 | **www.CPA125.com**
TEL.: 781.848.9848 | **FAX:** 781.848.8477 | **E-MAIL:** INFO@CPA125.COM

CAFETERIA PLAN ADVISORS
120 Longwater Dr., Ste. 102
Norwell, MA 02061
Tel.: 781-848-9848

Authorization for Pre-Tax Payroll Reduction

Open Enrollment is April 5 to May 3, 2023.

*** Enroll/Re-enroll deadline is 5/3/2023. Late enrollments not accepted. ***

INSTRUCTIONS: **If Already in Plan:** ***Re-enrollment is NOT automatic!*** To enroll for the new plan year via your online account portal, go to **cpaemployee.lh1ondemand.com**—***not the app.*** Log-in on the *left* side of the sign-in screen. Once on your account homepage, click the blue *ENROLL/RE-ENROLL* button and follow the steps to enroll; click *Submit* at the end. (We recommend printing or saving your enrollment confirmation.)

New Enrollees: Complete & return this form **to CPA** via **e-mail** (info@cpa125.com) or **fax** (781-848-8477).

❶ Personal Information:

Participant Name: _____ **Employer:** **East Bridgewater**

Mailing Address: _____ **Plan Year:** **7/1/2023 to 6/30/2024**
(Expenses must be incurred between these dates)

City/Town, State, ZIP: _____ **SSN:** _____ **DOB:** _____

☐ personal
E-Mail: _____ **Daytime Phone:** _____ ☐ work

❷ I work for *(check one):* ☐ Town ☐ Schools → I am paid *(check one):* ☐ Weekly 48 ☐ Bi-weekly 24 (year-round) ☐ Bi-weekly 21

❸ Flexible Spending Account (FSA) Benefit Selections:

☐ **Health Care FSA Election: $_____ for the plan year** for employee, legal spouse, and eligible dependents' qualified medical, dental, vision expenses. *Benefit card included.*

Max. Annual Election: $3,050.

Rollover Option: Any unspent Health Care balance—***up to $610***—will roll over to the next plan year if you re-enroll for the next plan year. (Note: The rollover maximum for the 2022-2023 plan year is $570; re-enrollment is required for funds to roll over.)

Ineligibility Note: You are NOT eligible for this plan if you or your spouse have a Health Savings Account ("HSA").

☐ **Dependent Care FSA Election: $_____ for the plan year** for qualified **childcare** expenses of eligible dependents under age 13, and elderly or special needs dependents requiring day care.

Max. Annual Election: $5,000. per family

Claim-based reimbursement benefit from accrued funds; no benefit card. Participants must submit claim(s) each plan year to receive accrued funds.

See Open Enrollment flyer for more plan information.

❹ Direct Deposit Info.

Direct deposit is our preferred method of expense reimbursement. Unless your banking info. is already on file with Cafeteria Plan Advisors, please set up direct deposit online via your account portal once you receive enrollment confirmation.

❺ Certification.

I hereby authorize a salary reduction agreement for the amount(s) shown above and understand that:

- Cafeteria Plan Advisors will hold these funds until eligible expenses are incurred and a claim is submitted. FSA expenses must be consistent with allowable deductions under Internal Revenue Service (IRS) Publication 969, and funds may be forfeited in accordance with the same publication if eligible balance isn't incurred and/or submitted for reimbursement by plan year deadline.
- All claims for the Plan Year must be submitted within ninety (90) days of the end of the Plan Year.
- Your Health Care FSA plan has a **Rollover option.** Eligible balances roll over to the next plan year when you re-enroll in the Health Care FSA for the new plan year and the rollover occurs after the current plan year's 90-day runout period ends.
- **This election cannot be revoked or changed** during the plan year unless the participant experiences a qualifying event as defined by the IRS.
- **Current participants must enroll each plan year; re-enrollment is not automatic.**
- **Health Care FSA cards,** if offered through your employer's plan, **will reload** at the start of each plan year when you re-enroll; keep until they expire.
- Additional certification for Dependent Care Plan Participants: I understand that the Dependent Care Reimbursement Plan Guidelines can be found at CPA125.com and I qualify to participate in the FSA Dependent Care plan. I agree to notify the plan administrator in writing within 30 days should I experience a change in need or no longer meet the IRS's eligibility criteria. Dependents must qualify under regulations set forth in IRC sections 152 and 129.
- **Tax advice:** It is suggested you consult with a tax advisor to determine your tax savings and/or limits on tax deductions.

➤ Signature: _____ **Date:** _____

A system-generated e-mail confirmation will be sent once your enrollment is processed.

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

FAMILY MATTERS. NO MATTER WHAT.®

Basic Life and Accidental Death & Dismemberment (AD&D) Benefit Summary

Designed for the Employees of

Town of East Bridgewater

ELIGIBILITY & BENEFIT FEATURES

Class 1: All Eligible Active Employees working a minimum of 20 hours per week

Basic Life and AD&D: **$5,000**

COST OF COVERAGE

The premium for your coverage is paid by you and your employer.

GUARANTEED ISSUE

No medical questions are required for amounts up to **$5,000** for first time applicants in their initial eligibility period.

REDUCTIONS IN BENEFITS

Your benefit amount does not reduce, even upon retirement.

* *All insurance benefits shall terminate upon the employee's termination of employment.*

ADDITIONAL FEATURES

Accidental Death & Dismemberment: Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. An additional death benefit is paid if death is the result of a covered accident.

Portability: If you leave your employer prior to age **60** , the coverage is portable for you, your spouse under age **60** and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or AD&D.

Conversion: Employees have 31 days from the date of termination to convert their basic life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or AD&D.

Waiver of Premium: If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Also Included: Education Benefit, Seat Belt Benefit, and Repatriation of Remains Benefit.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

FAMILY MATTERS. NO MATTER WHAT.®

Voluntary Term Life and Accidental Death & Dismemberment Benefit Summary (Issue Age Pricing)

Designed for the Employees of

Town of East Bridgewater

ELIGIBILITY & BENEFIT FEATURES

All eligible active employees working **20** or more hours per week, their spouse under age **70** , unmarried children ages 14 days to 19 years *(25 if a full time student),* and handicapped children over the age of 19 are eligible for coverage.

Dependent coverage is available only if the employee elects coverage. Dependents may not be insured if they are confined to a medical facility. If the employee is not actively at work on the effective date of coverage, the insurance will become effective on the date of the employee's return to active employment.

Employee coverage maximum of **$500,000** , sold in increments of **$10,000** . Coverage cannot exceed **5** times base annual salary.

Spouse coverage maximum of **$100,000** , sold in increments of **$5,000** . Coverage cannot exceed **50** % of employee coverage amount elected.

Child coverage: Age 14 days to 1 year: **$1,000**

Age 1 to 19 years: **$10,000** *(age 25 for full-time students)*

A spouse or child who is also an employee cannot be insured as a dependent. If both spouses are insured as employees of the same group, their children can be insured as dependents of one spouse only.

COST OF COVERAGE

The premium for your coverage is paid by you.

Issue Age pricing means that your rates (and your spouse's if applicable) do not change with age.

After the initial rate guarantee period, the employer is subject to an annual review and possible rate changes.

GUARANTEED ISSUE

No medical underwriting will be required unless you apply for coverage over the Guaranteed Issue amount, apply beyond the initial 31 day eligibility period, or have been previously declined coverage by Boston Mutual.

Guaranteed Issue Amounts

AGE	EMPLOYEE	SPOUSE
Under 60	$100,000	$30,000
60 - 69	$50,000	$20,000
70 & Over	$10,000	N/A

All life insurance coverage for dependent children is guaranteed issue if applied for during the initial 31 day eligibility period.

REDUCTIONS IN BENEFITS

Employee coverage reduces upon the attainment of age **70** and periodically thereafter in accordance with the following schedule:

to 65 % of the original benefit at age 70

to 50 % of the original benefit at age 75

to 25 % of the original benefit at age 80

Spouse coverage terminates upon the attainment of age **70** *. Dependent children coverage terminates upon notice that all dependent children are no longer eligible. All insurance benefits shall terminate upon the employee's retirement.*

see other side

ADDITIONAL FEATURES

Accidental Death & Dismemberment: The Voluntary Life Insurance benefit is doubled if death is the result of a covered accident. Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions.

Portability: If you leave your employer prior to age **60** , the coverage is portable for you, your spouse under age **60** and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or Group Voluntary AD&D.

Conversion: Employees have 31 days from the date of termination to convert the voluntary life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or Voluntary AD&D.

Waiver of Premium: If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Accelerated Death Benefit: This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary. To be eligible, the employee must have purchased at least $10,000 in voluntary life coverage.

Also Included: Education Benefit, Seat Belt Benefit, and Repatriation of Remains Benefit. These benefits pertain to the accidental death & dismemberment only.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: intentionally self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefits administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

Issue Age Life and AD&D Premiums*

Designed for the Employees of Town of East Bridgewater

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891-

FAMILY MATTERS. NO MATTER WHAT.®

Guaranteed Issue Amounts			
Age	18-59	60-69	70+
Employee	$100,000	$50,000	$10,000
Spouse	$30,000	$20,000	N/A

Employees may elect in increments of $10,000 to a maximum of the lesser of 5 times salary or $500,000.

Employee Monthly Premium** - Life and AD&D

Age	Monthly Rate per 1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
Under 20	$0.120	$1.20	$2.40	$3.60	$4.80	$6.00	$7.20	$8.40	$9.60	$10.80	$12.00
20-24	$0.120	$1.20	$2.40	$3.60	$4.80	$6.00	$7.20	$8.40	$9.60	$10.80	$12.00
25-29	$0.120	$1.20	$2.40	$3.60	$4.80	$6.00	$7.20	$8.40	$9.60	$10.80	$12.00
30-34	$0.120	$1.20	$2.40	$3.60	$4.80	$6.00	$7.20	$8.40	$9.60	$10.80	$12.00
35-39	$0.160	$1.60	$3.20	$4.80	$6.40	$8.00	$9.60	$11.20	$12.80	$14.40	$16.00
40-44	$0.240	$2.40	$4.80	$7.20	$9.60	$12.00	$14.40	$16.80	$19.20	$21.60	$24.00
45-49	$0.350	$3.50	$7.00	$10.50	$14.00	$17.50	$21.00	$24.50	$28.00	$31.50	$35.00
50-54	$0.560	$5.60	$11.20	$16.80	$22.40	$28.00	$33.60	$39.20	$44.80	$50.40	$56.00
55-59	$0.790	$7.90	$15.80	$23.70	$31.60	$39.50	$47.40	$55.30	$63.20	$71.10	$79.00
60-64	$1.330	$13.30	$26.60	$39.90	$53.20	$66.50	$79.80	$93.10	$106.40	$119.70	$133.00
65-69	$2.250	$22.50	$45.00	$67.50	$90.00	$112.50	$135.00	$157.50	$180.00	$202.50	$225.00
70-74	$3.970	$39.70	$79.40	$119.10	$158.80	$198.50	$238.20	$277.90	$317.60	$357.30	$397.00
75-79	$6.790	$67.90	$135.80	$203.70	$271.60	$339.50	$407.40	$475.30	$543.20	$611.10	$679.00
80+	$10.940	$109.40	$218.80	$328.20	$437.60	$547.00	$656.40	$765.80	$875.20	$984.60	$1,094.00

Age	Monthly Rate per 1,000	$110,000	$120,000	$130,000	$140,000	$150,000	$160,000	$170,000	$180,000	$190,000	$200,000
Under 20	$0.120	$13.20	$14.40	$15.60	$16.80	$18.00	$19.20	$20.40	$21.60	$22.80	$24.00
20-24	$0.120	$13.20	$14.40	$15.60	$16.80	$18.00	$19.20	$20.40	$21.60	$22.80	$24.00
25-29	$0.120	$13.20	$14.40	$15.60	$16.80	$18.00	$19.20	$20.40	$21.60	$22.80	$24.00
30-34	$0.120	$13.20	$14.40	$15.60	$16.80	$18.00	$19.20	$20.40	$21.60	$22.80	$24.00
35-39	$0.160	$17.60	$19.20	$20.80	$22.40	$24.00	$25.60	$27.20	$28.80	$30.40	$32.00
40-44	$0.240	$26.40	$28.80	$31.20	$33.60	$36.00	$38.40	$40.80	$43.20	$45.60	$48.00
45-49	$0.350	$38.50	$42.00	$45.50	$49.00	$52.50	$56.00	$59.50	$63.00	$66.50	$70.00
50-54	$0.560	$61.60	$67.20	$72.80	$78.40	$84.00	$89.60	$95.20	$100.80	$106.40	$112.00
55-59	$0.790	$86.90	$94.80	$102.70	$110.60	$118.50	$126.40	$134.30	$142.20	$150.10	$158.00
60-64	$1.330	$146.30	$159.60	$172.90	$186.20	$199.50	$212.80	$226.10	$239.40	$252.70	$266.00
65-69	$2.250	$247.50	$270.00	$292.50	$315.00	$337.50	$360.00	$382.50	$405.00	$427.50	$450.00
70-74	$3.970	$436.70	$476.40	$516.10	$555.80	$595.50	$635.20	$674.90	$714.60	$754.30	$794.00
75-79	$6.790	$746.90	$814.80	$882.70	$950.60	$1,018.50	$1,086.40	$1,154.30	$1,222.20	$1,290.10	$1,358.00
80+	$10.940	$1,203.40	$1,312.80	$1,422.20	$1,531.60	$1,641.00	$1,750.40	$1,859.80	$1,969.20	$2,078.60	$2,188.00

Dependent Child(ren) Coverage - Life Only - $1.90 per Family Unit. All Guaranteed Issue.
$1,000 - 14 days to 1 year
$10,000 - 1yr to 19yrs (25yrs if a Full-Time Student)
(The employee must be enrolled in the Voluntary Life Plan in order to enroll the Spouse and/or Children.)

*Issue Age Premiums - The premium for your coverage is paid by you. Issue Age pricing means that your rates (and your spouse's if applicable) do not change with age. After the initial rate guarantee period, the employer is subject to an annual review and possible rate changes.

Rates are effective as of the date shown above. Group life policies are underwritten by Boston Mutual Life Insurance Company under Policy form BML GRTP 4/99, subject to state availability. Product offerings may vary depending on state laws and regulations. Policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

***Premiums shown above are based on current monthly rates and may vary from billed premiums.*

413-13942-0419-MOEVTL11/17

Issue Age Life and AD&D Premiums*

Designed for the Employees of Town of East Bridgewater

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891-

FAMILY MATTERS. NO MATTER WHAT.®

Guaranteed Issue Amounts			
Age	18-59	60-69	70+
Employee	$100,000	$50,000	$10,000
Spouse	$30,000	$20,000	N/A

Employees may elect in increments of $10,000 to a maximum of the lesser of 5 times salary or $500,000.

Employee Monthly Premium** - Life and AD&D

Age	Monthly Rate per 1,000	$210,000	$220,000	$230,000	$240,000	$250,000	$260,000	$270,000	$280,000	$290,000	$300,000
Under 20	$0.120	$25.20	$26.40	$27.60	$28.80	$30.00	$31.20	$32.40	$33.60	$34.80	$36.00
20-24	$0.120	$25.20	$26.40	$27.60	$28.80	$30.00	$31.20	$32.40	$33.60	$34.80	$36.00
25-29	$0.120	$25.20	$26.40	$27.60	$28.80	$30.00	$31.20	$32.40	$33.60	$34.80	$36.00
30-34	$0.120	$25.20	$26.40	$27.60	$28.80	$30.00	$31.20	$32.40	$33.60	$34.80	$36.00
35-39	$0.160	$33.60	$35.20	$36.80	$38.40	$40.00	$41.60	$43.20	$44.80	$46.40	$48.00
40-44	$0.240	$50.40	$52.80	$55.20	$57.60	$60.00	$62.40	$64.80	$67.20	$69.60	$72.00
45-49	$0.350	$73.50	$77.00	$80.50	$84.00	$87.50	$91.00	$94.50	$98.00	$101.50	$105.00
50-54	$0.560	$117.60	$123.20	$128.80	$134.40	$140.00	$145.60	$151.20	$156.80	$162.40	$168.00
55-59	$0.790	$165.90	$173.80	$181.70	$189.60	$197.50	$205.40	$213.30	$221.20	$229.10	$237.00
60-64	$1.330	$279.30	$292.60	$305.90	$319.20	$332.50	$345.80	$359.10	$372.40	$385.70	$399.00
65-69	$2.250	$472.50	$495.00	$517.50	$540.00	$562.50	$585.00	$607.50	$630.00	$652.50	$675.00
70-74	$3.970	$833.70	$873.40	$913.10	$952.80	$992.50	$1,032.20	$1,071.90	$1,111.60	$1,151.30	$1,191.00
75-79	$6.790	$1,425.90	$1,493.80	$1,561.70	$1,629.60	$1,697.50	$1,765.40	$1,833.30	$1,901.20	$1,969.10	$2,037.00
80+	$10.940	$2,297.40	$2,406.80	$2,516.20	$2,625.60	$2,735.00	$2,844.40	$2,953.80	$3,063.20	$3,172.60	$3,282.00

Age	Monthly Rate per 1,000	$310,000	$320,000	$330,000	$340,000	$350,000	$360,000	$370,000	$380,000	$390,000	$400,000
Under 20	$0.120	$37.20	$38.40	$39.60	$40.80	$42.00	$43.20	$44.40	$45.60	$46.80	$48.00
20-24	$0.120	$37.20	$38.40	$39.60	$40.80	$42.00	$43.20	$44.40	$45.60	$46.80	$48.00
25-29	$0.120	$37.20	$38.40	$39.60	$40.80	$42.00	$43.20	$44.40	$45.60	$46.80	$48.00
30-34	$0.120	$37.20	$38.40	$39.60	$40.80	$42.00	$43.20	$44.40	$45.60	$46.80	$48.00
35-39	$0.160	$49.60	$51.20	$52.80	$54.40	$56.00	$57.60	$59.20	$60.80	$62.40	$64.00
40-44	$0.240	$74.40	$76.80	$79.20	$81.60	$84.00	$86.40	$88.80	$91.20	$93.60	$96.00
45-49	$0.350	$108.50	$112.00	$115.50	$119.00	$122.50	$126.00	$129.50	$133.00	$136.50	$140.00
50-54	$0.560	$173.60	$179.20	$184.80	$190.40	$196.00	$201.60	$207.20	$212.80	$218.40	$224.00
55-59	$0.790	$244.90	$252.80	$260.70	$268.60	$276.50	$284.40	$292.30	$300.20	$308.10	$316.00
60-64	$1.330	$412.30	$425.60	$438.90	$452.20	$465.50	$478.80	$492.10	$505.40	$518.70	$532.00
65-69	$2.250	$697.50	$720.00	$742.50	$765.00	$787.50	$810.00	$832.50	$855.00	$877.50	$900.00
70-74	$3.970	$1,230.70	$1,270.40	$1,310.10	$1,349.80	$1,389.50	$1,429.20	$1,468.90	$1,508.60	$1,548.30	$1,588.00
75-79	$6.790	$2,104.90	$2,172.80	$2,240.70	$2,308.60	$2,376.50	$2,444.40	$2,512.30	$2,580.20	$2,648.10	$2,716.00
80+	$10.940	$3,391.40	$3,500.80	$3,610.20	$3,719.60	$3,829.00	$3,938.40	$4,047.80	$4,157.20	$4,266.60	$4,376.00

Dependent Child(ren) Coverage - Life Only - $1.90 per Family Unit. All Guaranteed Issue.
$1,000 - 14 days to 1 year
$10,000 - 1yr to 19yrs (25yrs if a Full-Time Student)
(The employee must be enrolled in the Voluntary Life Plan in order to enroll the Spouse and/or Children.)

*Issue Age Premiums - The premium for your coverage is paid by you. Issue Age pricing means that your rates (and your spouse's if applicable) do not change with age. After the initial rate guarantee period, the employer is subject to an annual review and possible rate changes.

Rates are effective as of the date shown above. Group life policies are underwritten by Boston Mutual Life Insurance Company under Policy form BML GRTP 4/99, subject to state availability. Product offerings may vary depending on state laws and regulations. Policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

***Premiums shown above are based on current monthly rates and may vary from billed premiums.*

413-13942-0419-MOEVTL11/17

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

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

Town of East Bridgewater — Employer/Policyholder

School — Dept. ID

Employee Name *(Last, First, Middle)*

Social Security Number

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

( ) Telephone #

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

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

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

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

LIFE

You Must Have Basic Coverage to Elect Voluntary Coverage

BASIC:

Group # 1537 Div. 1

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$

You Must Have Voluntary Coverage to Elect Dependent Coverage

VOLUNTARY:

Group # 13942 Div.

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$
SPOUSE	❑	❑	$

DEPENDENT LIFE:

CHILD(REN)	❑	❑	$

BENEFICIARY

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: *(Total Percentage of Benefit must equal 100%)* **List Additional Beneficiaries on separate sheet**

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

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

SIGNATURE

ACCEPTANCE OF INSURANCE - *Employee Signature Required*

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

Signature of Employee _____ **Date** _____

REFUSAL OF INSURANCE

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

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

❑ Basic Life & AD&D ❑ Voluntary Life & AD&D ❑ Dependent Life

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

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

EQUITABLE

Facts about a 403(b) plan

Preparing for a comfortable retirement

A 403(b) is like a 401(k)

A 403(b) is a retirement plan designed specifically for educators that can supplement your pension and help you enjoy a more comfortable retirement. If you work in education (or for a research or nonprofit organization), you may be eligible for a 403(b) retirement plan available through your employer. No matter where you are in life, it can be a smart choice that may give you a level of confidence along your path to a fulfilling future.

How a 403(b) plan can help

- Every dollar counts. You can set your own goals and start saving whatever amount works for you. You have the flexibility to start or stop and increase or decrease your contributions up to the federal maximum, at any time.
- It's automatic. Because your savings are deducted right from your paycheck, you pay yourself first. That can make it easier to save. You can contribute with pretax dollars and, if your plan permits, Roth after-tax dollars.
- It's flexible. You select the investments you're most comfortable with — and change them when you want.
- Your money grows tax-deferred until you withdraw it from your account, which is typically when you're retired and in a lower tax bracket. One way to grow your investments more quickly is by reducing the amount of tax you pay along the way. Since your contributions, plus all of your earnings, stay invested for the future, your money grows faster than if it were in a taxable account.

The boost from pretax contributions

A 403(b) plan lets you save more than you could in a regular savings account or other taxable investment.

Here's how it works:

Let's say you can budget $1,000 to save each month. If that $1,000 is deducted from your paycheck pretax (and you're in the 24% tax bracket), you could actually increase the contribution to $1,315.78. Your take-home pay would still only be reduced by $1,000. There's no change to your budget, but there's an extra $315.78 available for potential earnings in your 403(b).

And if $1,000 per month is more than you can save right now? Remember that every dollar counts. Look at the difference that saving with pretax dollars means at any amount.

If you can budget:	The pretax equivalent would be:
$100	$131.57
$200	$328.94
$500	$657.89
$750	$986.84
$1,000	$1,315.78

The power of tax deferral

One of the other benefits of a 403(b) plan is that, once your money is in there, it can continue to grow tax-free.

Let's think about your $1,000 contribution again. If that $1,000 went straight into your bank account — or into a taxable investment — you'd owe $240 in taxes (again, assuming a 24% tax bracket), so only $760 of your $1,000 would be available for you to spend or save.

Instead, if you contribute to a 403(b) plan, straight from your paycheck, the full $1,000 — and any amount it earns — remains invested for the future.

Questions you may have

Q. Can I roll over a 403(b) from my previous job?

A. Yes, you can roll over funds from other retirement plans, including 401(k), 401(a), 457(b), IRA or SEP into your 403(b) (and roll funds from your 403(b) into other retirement plans, if your employer's plan allows).

Q. How much can I contribute?

A. Up to $19,500 per year or 100% of your compensation, whichever is lower.[1]

Q. Is there any way to contribute more?

A. If you're age 50 or older, you can also make "catch-up" contributions of up to $6,500 per year. And if you have 15 years of service or more with the same employer, you may be eligible to contribute and additional $3,000 per year, up to a maximum of $15,000.

Q. Once I start, do I have to keep contributing at the same rate?

A. No, you can stop or change contributions at any time, as long as your employer's plan allows.

Q. When can I access my money?

A. You can withdraw money with no penalty:

- Starting at age 59½ or at age 55 if you stop working; or
- Earlier if the need for the withdrawal is caused by death, disability or medical hardship that meets specific requirements.

You're required by regulation to take distributions starting at age 70½ or the year you stop working, whichever comes later.

Q. Can I borrow from my account sooner?

A. You can borrow a percentage of your account value if your employer's plan allows. You must repay the loan within 5 years, or within 10 years if the loan was used to buy your primary residence.

Putting it all together

Look for flexible investment options

A 403(b) is a long-term investment strategy. As your goals change over time, your retirement plan should evolve as well. Look for a well-rounded mix of investment options that allows you to make choices that match your own goals, needs and tolerance for risk at every stage of life.

Take advantage of a guiding hand

A common trait among top savers is that they get help from a financial professional and educational resources to guide smart choices and keep their plan on track as life evolves. It can lead to higher account balances and more confidence in your future. So take advantage of the personal attention, digital tools and 24-hour account access that your employer's plan offers.

Get smart about costs

Here are some questions you should ask — and your plan provider should have clear answers ready: What sales charges or administrative fees does the plan provider charge? Are they ever waived? When they report on performance of different investment options, are the numbers shown net of fees (or in other words, shown with the fees subtracted?

Retirement is about making the most of what you have to achieve the freedom to pursue your passions. Consider how a 403(b) can help you feel empowered to make choices for a meaningful life as you define it, while finding fulfillment in your day-to-day.

1 This limit is effective through December 31, 2020, and will be indexed in future years.

Please be advised that this document is not intended as legal or tax advice. Accordingly, any tax information provided in this document is not intended or written to be used, and cannot be used, by any taxpayer for the purpose of avoiding penalties that may be imposed on the taxpayer. The tax information was written to support the promotion or marketing of the transaction(s) or matter(s) addressed, and you should seek advice based on your particular circumstances from an independent tax advisor.

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Variable Annuities: • Are Not a Deposit of Any Bank • Are Not FDIC Insured • Are Not Insured by Any Federal Government Agency • Are Not Guaranteed by Any Bank or Savings Association • May Go Down in Value

Equitable Financial Life Insurance Company (NY, NY)

GE-131353 (12/19) (Exp. 1/21) | G717996 | Cat. #161405 (1/20)

EQUITABLE

Approved 403(b) Vendors:

Ameriprise Financial Services, Inc
Representative: Michael McIntyre
Phone: 781-356-2086

AXA Equitable
Representative: Susan Barber or Matthew Miller
Phone: 781-820-2184 or 508-680-4572

Security Benefit/LPL Financial
Representative: Michael Kelley
Phone: 781-934-2502

Health Insurance

Date Employment Begins	Deductions Begins	Coverage Begins
January 2 - February 1	March	April
February 2 - March 2	April	May
March 3 - April 2	May	June
April 3 - May 2	June	July
May 3 - June 2	July	August
June 3 - July 3	August	September
July 4 - August 2	September	October
August 3 - September 2	October	November
September 2 - October 2	November	Decemeber
October 3 - November 2	Decemebr	January
November 3 - December 3	January	February
December 4 - January 1	February	March

Dental and Life Insurance

Date Employment Begins	Deductions Begins	Coverage Begins
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August
July	August	September
August	September	October
September	October	November
October	November	Decemeber
November	Decemebr	January
Decemebr	January	February

OFFICE OF THE TOWN

TREASURER/COLLECTOR

Megan Crosby
Treasurer/Collector
Tel: 508-378-1604/1602
Fax: 508-378-4803

175 Central Street
P.O. Box 386
E. Bridgewater, MA 02333
mcrosby@eastbridgewaterma.gov

Date: _____

Subject: Group Insurance Waiver

Medical

☐ I waive my employer's group MEDICAL insurance coverage for myself and my eligible dependents (if any) Effective Date:_____

Dental

☐ I waive my employer's group DENTAL insurance coverage for myself and my eligible dependents (if any) Effective Date:_____

Reason for Waiver of Coverage – check all that apply

☐ I am covered as a spouse or dependent under another group MEDICAL plan.

☐ I am covered as a spouse or dependent under another group DENTAL plan.

☐ I am covered by Medicare, non-group, Veterans program or a secondary employer.

Employer name:_____

Insurance Company:_____

☐ I am not covered by another MEDICAL insurance and choose not to participate in my employer's group plan at this time.

Other(requires explanation)_____

I waive my and/or dependents' (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll in the future under the terms defined in the eligibility section of the subscriber certificate or benefit description.

Employee Signature:_____

Employee Name:_____

Date of Birth:_____

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

Employee Health Insurance Responsibility Disclosure Form

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

Employer

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

Employer Name: Town of East Bridgewater **FEIN:** 04-6001137

Employer D/B/A:

Employer Address: 175 Central Street

City | State | ZIP Code: East Bridgewater, MA 02333

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

Employee

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

Employee First Name **Middle Initial**

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

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

Employee Affidavit

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

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

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