NEW HIRE PACKET

This packet includes all of the information and forms required to complete your employment profile. Please complete the forms in this packet and return them to us, check them off of the list below as you complete them.

- Application For Employment ☐
- Employee Acknowledgment For Workers' Compensation Procedures ☐
- Employee Emergency Information ☐
- W-4 Form ☐
- Authorization for Direct Deposit ☐
- Acknowledgment of Receipt of Prohibition Against Discrimination, Harassment and Retaliation in the Workplace and Complaint Reporting Procedure ☐
- Employee Rights and Responsibilities: Nevada Workplace Safety Brochure ☐
- Notice to Employees Regarding the Nevada Pregnant Workers Fairness Act ☐
- I-9 Employment Eligibility Verification ☐
- New Health Insurance Marketplace Coverage Options and Your Health Coverage ☐
- COBRA Notice (20 or more employees) ☐
- Model General Notice of COBRA Continuation Coverage Rights ☐
- Acknowledgment of Receipt of Model General Notice of COBRA Continuation Coverage Rights ☐

APPLICATION FOR EMPLOYMENT

APLICACION PARA EMPLEO

Client Company: _____ Date: _____

Compañía del Cliente Fecha

PERSONAL INFORMATION

INFORMACION PERSONAL

Name _____ E-mail: _____

Nombre Last First Middle

Apellido Paterno Primer nombre Segundo Nombre

Present Address _____

Dirección Actual Street City State Zip

Calle Ciudad Estado Código Postal

Position Applying For _____ Main Telephone Number _____

Posición para la que esta Aplicando Numero de Telefono Principal

Company offers equal employment opportunities regardless of sex, age, race, color, religious creed, national origin, ancestry, medical status, medical condition, physical or mental disability, pregnancy or sexual orientation. Company

ofrece oportunidades de empleo para todos igual, sin importar sexo, edad, raza, color, religión, nacionalidad, ascendencia, estado medico, condición medica, inhabilidad física o mental, embarazo u orientación sexual.

Do you have a Driver's License? ☐ Yes ☐ No Issuing state. _____

Tienes Licencia para Manejar? Si No En que Estado la obtuviste?

Are you at least 18 years old? ☐ Yes ☐ No

Tienes por lo menos 18 años? Si No

If hired, can you provide written evidence that you are authorized to work in the U.S.? ☐ Yes ☐ No

Si es contratado, puede comprobar con papeles que esta autorizado a trabajar en USA? Si No

Are you able to perform the essential functions of the position for which you are applying either with or without reasonable accommodations? ☐ Yes ☐ No

Si No

Puede usted desempeñar las funciones esenciales para la posición en la cual estas aplicando, ya sea con o sin alojamiento razonable?

PLEASE REVIEW THE FOLLOWING BEFORE SIGNING THIS APPLICATION FOR EMPLOYMENT.

FAVOR DE REVISAR LO SIGUIENTE ANTES DE FIRMAR ESTA APLICACIÓN DE EMPLEO.

I authorize any representative of Company to investigate my background, including but not limited to, references, education and work history. I authorize the above and any other individual or entity that may possess information about my background to provide full disclosure without prior notice to me. I release all of the above from any and all liability for damage of any kind that may at any time result to me because of compliance with this authorization to release information.

Yo autorizo al representante de Company para investigar mis antecedentes, incluyendo pero no limitado a las referencias, educación e historial de trabajo. Yo autorizo lo arriba mencionado y cualquier otro individuo que posee información sobre mis antecedentes para que provee toda la información sin tenerme que avisar con anterioridad. Yo libero a todos lo mencionados anteriormente en el párrafo de arriba de cualquier o toda la responsabilidad por cualquier clase de danos que en cualquier momento pudiera resultarme a razón del cumplimiento de esta autorización que es la liberación de información.

I understand that any employment with Company is at will, and can be terminated at any time with or without cause.

Yo entiendo que cualquier empleo con Company es con mi consentimiento, y puede ser terminado en cualquier momento con o sin causa alguna.

I understand that any falsification of this or any Company document may result in failure to receive an offer or if hired, dismissal from employment. I understand that any offer may be conditional on the successful completion of medical or drug testing.

Yo entiendo que cualquier falsificación de este o cualquier otro documento con Company podrían dar como resultado a la falla de recibir una oferta de empleo o despido del empleo. Yo entiendo que cualquier oferta será condicional al completo y favorable resultado del examen medico de la prueba de drogas.

Signature of Applicant: _____ **Date:** _____

Firma del Solicitante **Fecha**

IMPORTANT: THIS SECTION MUST BE FULLY COMPLETED BY CLIENT TO BE PROCESSED (OFFICE USE ONLY)

IMPORTANTE: ESTA SECCION DEBERA SER COMPLETADA POR EL CLIENTE PARA QUE SE PROCESE

Date of Hire: _____ Job Position Title: _____ W/C Code: _____

Fecha de Contratación Titulo de la Posición Código de la Compensación de Trabajadores

Salary ☐ or Hourly ☐ Rate of Pay: _____ Full Time ☐ Part Time ☐ Exempt ☐ Non-exempt ☐

Salario Por Hora Pago Tiempo Completo Medio Tiempo Exento No- Exento

Social Security Number Department Location: _____

SSN# Departamento Ubicacion

FORMER EMPLOYERS

EMPLEOS ANTERIORES

List below the last three employers, starting with the most recent one first.

Lista debajo los últimos 3 empleos que tuviste, empezando con el más reciente primero.

Name of Present or Last Employer:____
Nombre del Presente o Ultimo Empleador

Address:____________________ City_______________ State__________ Zip__________
Direccion Ciudad Estado Código postal

Starting Date:_______________ Leaving Date:_______________ Job Title____________________
Fecha de Comienzo Fecha de Separación Titulo de trabajo

Name of Supervisor: __________ May we contact your Supervisor?: __________
Nombre del Supervisor Podemos contactar a su Supervisor?

Description of Work:____________________ Title:____________________ Phone:( )_______________
Descripción del Trabajo Titulo Numero telefónico

Reason for Leaving:____
Razón de la separación

Name of Present or Last Employer:____
Nombre del Presente o Ultimo Empleador

Address:____________________ City_______________ State__________ Zip__________
Direccion Ciudad Estado Código postal

Starting Date:_______________ Leaving Date:_______________ Job Title____________________
Fecha de Comienzo Fecha de Separación Titulo de trabajo

Name of Supervisor: __________ May we contact your Supervisor?: __________
Nombre del Supervisor Podemos contactar a su Supervisor?

Description of Work:____________________ Title:____________________ Phone:( )_______________
Descripción del Trabajo Titulo Numero telefónico

Reason for Leaving:____
Razón de la separación

Name of Present or Last Employer:____
Nombre del Presente o Ultimo Empleador

Address:____________________ City_______________ State__________ Zip__________
Direccion Ciudad Estado Código postal

Starting Date:_______________ Leaving Date:_______________ Job Title____________________
Fecha de Comienzo Fecha de Separación Titulo de trabajo

Name of Supervisor: __________ May we contact your Supervisor?: __________
Nombre del Supervisor Podemos contactar a su Supervisor?

Description of Work:____________________ Title:____________________ Phone:( )_______________
Descripción del Trabajo Titulo Numero telefónico

Reason for Leaving:____
Razón de la separación

References: Names of three persons you are not related to, whom you have known at least one year.

Referencias: Nombra a tres personas que no estén relacionados con usted y que los conozca por lo menos por un año.

NAME NOMBRE	PHONE NUMBER NUMERO DE TELEFONO	ADDRESS DIRECCION	BUSINESS NEGOCIO	YEARS ACQUAINTED AÑOS DE CONOCERSE

EMPLOYEE ACKNOWLEDGMENT FOR WORKERS' COMPENSATION PROCEDURES

RECONOCIMIENTO DEL EMPLEADO PARA LOS PROCEDIMIENTOS DE COMPENSACIÓN DE TRABAJADORES

Company is involved with a wide variety of Medical Providers for Workers' Compensation. This helps provide the most timely and suitable, quality medical care in the event of an injury on the job.

The following procedures must be followed for all work related injuries and illnesses.

1. Report promptly all work-related injuries to your supervisor. Your supervisor will direct you to the nearest authorized Occupational Medical Provider.
2. If it is a medical emergency, get medical care immediately, then notify your supervisor.
3. Complete a Workers' Compensation Injured Employee Packet within 24 hours of the time of the injury.
4. After treatment, you must bring back to your supervisor the paperwork given to you at the clinic. This will normally include the Doctor's Report with any Work Restrictions.
5. You may choose to inform your employer that you wish to pre-designate your personal medical doctor by filling out a pre-designation form. Please see your supervisor for this form.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury.

La Compañía está involucrada con una amplia variedad de proveedores médicos para la compensación de trabajadores. Esto ayuda a proporcionar la atención médica más oportuna y adecuada y de calidad en caso de una lesión en el trabajo.

Se deben seguir los siguientes procedimientos para todas las lesiones y enfermedades relacionadas con el trabajo.

1. Reporte puntualmente todos las lesiones relacionadas con el trabajo a su supervisor. Su supervisor lo dirigirá al proveedor médico ocupacional autorizado más cercano posible.
2. Si se trata de una emergencia médica, obtenga asistencia médica de inmediato, y después notifique a su supervisor.
3. Complete un paquete de Empleados Lesionados de Compensación a los Trabajadores dentro de las 24 horas del momento de la lesión.
4. Después del tratamiento, debé traer a su supervisor los documentos que le dieron en la clínica. Estos normalmente incluyen el Reporte del Doctor con las Restricciones del Trabajo.
5. Usted puede optar informar a su empleador que desea pre-designar a su doctor médico personal, llenando un formulario de pre-designación. Favor de preguntar a su supervisor por esta forma.

Por favor firme a continuación para indicar que usted ha leído y entendido los procedimientos a seguir en caso de una lesión.

____
Employee Name/Nombre del Empleado

____
Company Name/Nombre de la Compañía

____
Employee Signature/Firma del Empleado

____
Date/Fecha

Employee Information Sheet

Employee Information

Full Name: _____ Hire Date: _____ Pay Rate: _____

Company: _____ Title: _____ Salary or Hourly

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____

Social Security Number or Government ID: _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone: ( ) _____

Dependents Information: (For insurance purposes only)

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Emergency Contact Information

Full Name: _____

Address: _____

Primary Phone: ( ) _____ Cell Phone: ( ) _____

Relationship: _____

Full Name: _____

Address: _____

Primary Phone: ( ) _____ Cell Phone: ( ) _____

Relationship: _____

For HR USE ONLY:

Dept: _____ WC Job Code: _____ FLSA status: _____

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. 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.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B, Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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.

0MB No. 1545-0074

@25

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) D **Single** or **Married filing separately**
D **Married filing jointly** or **Qualifying surviving spouse**
D **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.)

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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** $

Step4 (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)

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

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

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

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

2. Expect to work only part of the year;

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

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

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

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

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

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

Specific Instructions

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

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

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

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c).** The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount 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 2025 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; or, you can use the online withholding estimator at *www.irs.gov/W4App.*

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 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 2025 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:
- $22,500 if you're head of household
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $15,000 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(1)(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 0MB 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	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

AUTHORIZATION FOR DIRECT DEPOSIT - EMPLOYEE FORM

This authorizes Company to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Account #1 Type (Check one) ○ Checking ○ Savings

Employee Bank Name

Percentage or Dollar Amount to be Deposited to This Account

Bank Routing # (ABA#)

Account #

Account #2 Type (Check one) ☐ Checking ☐ Savings

Employee Bank Name

Percentage or Dollar Amount to be Deposited to This Account

Bank Routing # (ABA#)

Account #

Please attach a voided check for each account here. Porfavor incluya una copia de un cheque anulado.

Signature

Date

Printed Name

Company Name

IMPORTANT: This document must be signed by employees requesting an automatic deposit of paychecks and retained on file by the employer. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

IMPORTANTE: Este documento debe ser firmado por los empleados que solicitan el depósito automático de cheques de pago y retenido en archivo del empleador. Los empleados deben adjuntar un cheque anulado para cada una de sus cuentas para ayudar a verificar su cuenta números y números de ruta bancaria.

Acknowledgement and Verification of Completion of Anti-Sexual-Harassment and Anti-Discrimination Policies Program

_____ _____ _____hereby state that I am an employee of
First Name MI Last Name

_____
Employer Name

By my signature below, I acknowledge and verify that I completed the Anti-Sexual-Harassment and Anti-Discrimination Training Program on _____.

The training included the following topics:

(1) Equal Employment Opportunity Policy;
(2) Anti-Discrimination and Anti-Harassment Policy;
(3) Enforcement of Company Policies;
(4) Documenting Violations of Company Policies; and
(5) Case Studies and Questions.

I understand that this form will be placed in my personnel file.

_____ _____
Employee Signature Date

Acknowledgement and Verification of Completion of Anti-Sexual-Harassment and Anti-Discrimination Policies Program

_____ _____ _____hereby state that I am an employee of
First Name MI Last Name

_____
Employer Name

By my signature below, I acknowledge and verify that I completed the Anti-Sexual-Harassment and Anti-Discrimination Training Program on _____.

The training included the following topics:

(1) Equal Employment Opportunity Policy;
(2) Anti-Discrimination and Anti-Harassment Policy;
(3) Enforcement of Company Policies;
(4) Documenting Violations of Company Policies; and
(5) Case Studies and Questions.

I understand that this form will be placed in my personnel file.

_____ _____
Employee Signature Date

Acknowledgement of Receipt of Prohibition Against Discrimination and Harassment in the Workplace, Prohibition Against Retaliation in the Workplace, and Complaint Reporting Procedure

I acknowledge that my employer has provided me with copies of the following policies/procedures:

1. Prohibition Against Discrimination and Harassment in the Workplace;
2. Prohibition Against Retaliation in the Workplace; and
3. Complaint Reporting Procedure.

I understand that it is my responsibility to read this information, familiarize myself with its contents, and to adhere to the standards stated therein.

I further understand that the guidelines and policies provided by my employer do not create an express or implied employment contract between my employer and me. I acknowledge that my employment with the employer is at will and that either my employer or I may terminate the employment relationship at any time with or without cause or notice.

_____
Employee Printed Name

_____ _____
Signature Date

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: Date:

Employee ID:
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- ☐ Yes, I have a disability, or have had one in the past
- ☐ No, I do not have a disability and have not had one in the past
- ☐ I do not want to answer

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

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: Date of Hire:

Voluntary Self-Identification of Veteran Status

Why are you being asked to complete this form?

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

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

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

2. If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

   ☐ I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED ABOVE

   ☐ I AM NOT A PROTECTED VETERAN

   ☐ I DON'T WISH TO ANSWER

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

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

_____ _____

Your Name Today’s Date

NEVADA WORKPLACE SAFETY

Stop and Learn Your Rights and Responsibilities

The Division of Industrial Relations of the Nevada Department of Business & Industry helps employers provide a safe and healthful workplace. This document explains the rights and responsibilities of both employers and employees in creating a safe working environment.

WORKPLACE SAFETY IS EVERYONE'S RESPONSIBILITY.

I have (check one) ___ read this document or ___ viewed the video, entitled " Nevada Workplace Safety: Your Rights and Responsibilities" and I understand my rights and responsibilities for safety in the workplace.

Employee Name (please print)_____ Date_____

Employee' s Signature_____

Place of Viewing Video_____

Employer' s Name (please print)_____

Employer' s Signature (or representative)_____

Note: This portion must be maintained in the employee' s personnel

Any employee who does not understand this document should contact his or her supervisor, employee representative or the Division of Industrial Relations of the Nevada Department of Business & Industry.

Las Vegas: (702) 486-9140

Reno: (775) 688-3730

Elko: (775) 778-3312

Toll-Free: (877) 472-3368

EMPLOYEE RIGHTS AND RESPONSIBILITIES

The Nevada Occupational Safety and Health Act was created to allow you to do your job in a safe and healthy workplace. But it is up to you to make sure that job safety works. Here are some tips to help you stay safe on the job.

Know and follow all safety rules set by:

- Your employer
- The Nevada Occupational Safety and Health Act
- State of Nevada Occupational and Health Administration (NVOSHA)

You can get copies of all Nevada safety and health standards from the Safety Consultation and Training Section of the Division of Industrial Relations or on the web at www.4safenv.state.nv.us. Also, your employer may be required to have a written workplace safety program.

If your employer requires personal protective equipment, such as hard hats, safety shoes, safety glasses, respirators, or hearing protection, you are responsible to wear and/or use the equipment.

If you do not know how to safely use tools, equipment or machinery, be sure to ask your supervisor.

If you see something that's unsafe,report it to your supervisor. That's part of your job. Give your employer a chance to fix the problem. If you think the unsafe condition still exists, it is your right to file a complaint with NVOSHA. The Division will not give your name to your employer.

There are laws that protect you if you are punished for filing a safety and health complaint. If you feel you have been treated unfairly for making a safety and health complaint, you have 30 days from the date of the punishment to file a discrimination complaint with NVOSHA.

Whistle Blower Hotline – (702) 486-9097

Most on-the-job injuries are covered by Workers' Compensation Insurance. From cuts and bruises to serious accidents, coverage begins the first minute you're on the job.

It is your responsibility to report any on-the-job injury or occupational disease immediately to your supervisor or foreman using the "Notice of Injury or Occupational Disease" C-1 Form. You have 7 days from the date of injury or knowledge of the occupational disease to turn in the completed C-1 Form to your employer. If you seek medical treatment for a work-related injury you must complete a "Claim for Compensation" C-4 Form at the emergency room or medical provider's office to initiate a claim for workers compensation.

But remember, filing a false claim will result not only in a loss of benefits, but could mean costly fines and/or jail time.

If there is a dangerous situation at work and an employee, with no reasonable alternative, refuses in good faith to expose themselves to a dangerous condition, they would be protected from subsequent retaliation. The condition must be of such a nature that a reasonable person would conclude that there is a real danger of death or serious harm and that there is not enough time to contact NVOSHA and for NVOSHA to inspect. Where possible, the employee must have also sought from the employer, and been unable to obtain, a correction of the condition.

During a NVOSHA inspection, you have the right to talk privately with the inspector and take part in meetings with the inspector before and after the inspection. You are encouraged to point out hazards, describe injuries and illnesses from these hazards, discuss past worker complaints and inform the inspector of working conditions that are not normal during the inspection. If after the inspection citations are proposed to the employer, the employer is required to post the citations where employees can see them.

SCATS Form IE, 0-302 (Rev.07/18) All previous forms obsolete.

EMPLOYER RIGHTS AND RESPONSIBILITIES

The Safety Consultation and Training Section (SCATS) was created to assist employers in complying with Nevada laws which govern occupational safety and health. They are available to provide a workplace hazard assessment. This service can assist employers in minimizing on-the-job hazards, and is provided at no charge. The Division also offers no cost safety training and informational programs for Nevada employers.

A Nevada employer with 11 or more employees must establish a written workplace safety program. A safety committee is required if you have more than 25 employees or if an employer's employees are engaged in the manufacturing of explosives.

You must maintain a workplace that is free from unsafe conditions.

As an employer you are responsible for complying with all Nevada safety and health standards and regulations found in the:

+ Nevada Occupational Safety and Health Act
+ Occupational Safety and Health Standards and Regulations

Copies of all occupational safety and health standards and regulations are available from the Division of Industrial Relations (SCATS and NVOSHA) or on the web at www.4safenv.state.nv.us.

You are also responsible for ensuring that your employees comply with these same rules, standards and regulations. You must select someone to administer and enforce occupational safety and health programs in your workplace.

Before assigning an employee to a job, you must provide proper training in a language and format that is understandable to each employee:

+ Safe use of equipment and machinery
+ Personal protective gear
+ Hazard recognition
+ Emergency procedures
+ Hazardous chemicals and substances found at the jobsite or in the workplace

You must also inform all employees of the safety rules, regulations and standards which apply to their respective duties.

It is your responsibility to maintain accurate accident, injury and safety records and reports. These files must be made available, upon request, to the affected employee and representatives of NVOSHA.

The Nevada Safety and Health Poster, provided by the Division of Industrial Relations, must be posted in a prominent place on the job site.

Any accident or motor vehicle crash occurring in the course of employment which results in the inpatient hospitalization of one or more employees, the amputation of a part of an employee's body or an employee's loss of an eye must be reported by the employer orally to the nearest office of NV OSHA within 24 hours hours after the time that the accident or crash is reported to any agent or employee of the employer.

Any accident or motor vehicle crash occurring in the course of employment which is fatal to one or more employees must be reported by the employer orally to the nearest office of NV OSHA within 8 hours after the time that the accident or crash is reported to any agent or employee of the employer.

Nevada employers are required to secure and maintain workers' compensation insurance unless excluded by Nevada Revised Statute (NRS). There are few exceptions to this requirement. In the event of an injury or at the onset of an occupational disease, the employer must provide the C-1 Form, "Notice of Injury or Occupational Disease - Incident Report" to the injured worker. The employer is also responsible for filing an "Employer's Report of Injury" (C-3 Form) within six working days with your insurer after the receipt of a "Claim for Compensation" (C-4 Form) from a physician or chiropractor.

Additional employer responsibilities:

+ Perform tests such as air sampling and noise monitoring.
+ Prevent employee exposure to harmful substances to include chemicals, lead, asbestos, and sharps.
+ Provide hearing exams, medical testing, fall protection, machine guarding, cave-in and confined space safety equipment and protection, respirators, personal protective equipment, etc., as required by NVOSHA and OSHA standards.

The law requires that employers shall provide newly-hired employees with a copy of this document or with a video setting forth the rights and responsibilities of employers and employees to promote safety in the workplace.

Employers shall keep a signed copy of the attached receipt in the employee's personnel file to show he or she has been made aware of these rights and responsibilities.

ADDITIONAL INFORMATION

If you require further information or would like to obtain copies of safety and health standards, videos of this pamphlet in English and Spanish or more copies of the pamphlet, contact the following:

State of Nevada Department of Business & Industry, Division of Industrial Relations, Safety Consultation and Training Section

Southern Nevada
3360 W. Sahara Avenue
Suite 100
Las Vegas, NV 89102
(702) 486-9140
Fax: (702) 486-8711

Northern/Central Nevada
4600 Kietzke Lane
Suite E-144
Reno, NV 89502
(775) 688-3730
Fax: (775) 688-1478

Northeastern Nevada
350 West Silver Street
Suite 210
Elko, NV 89801
(775) 778-3312
Fax: (775) 778-3412

Or Call, Toll-Free
1 (877) 4SAFENV (472-3368)
www.4safenv.state.nv.us

State of Nevada Department of Business & Industry, Division of Industrial Relations NVOSHA

Southern Nevada
3360 W. Sahara Avenue
Suite 200
Las Vegas, NV 89102
(702) 486-9020
Fax: (702) 486-8714

Northern Nevada
4600 Kietzke Lane
Suite F-153
Reno, NV 89502
(775) 688-3700
Fax: (775) 688-1378

A video of this information is available in English and Spanish through the Division of Industrial Relations, Safety Consultation and Training Section.

LA SEGURIDAD EN EL LUGAR DE TRABAJO EN NEVADA

Pare y Aprenda Sus Derechos y Responsabilidades

La División de Relaciones Industriales del Departamento de Nevada de Negocios e Industria ayuda a los empleadores a proveer un lugar de trabajo seguro e higiénico. Este documento explica los derechos y las responsabilidades de empleadores y trabajadores para crear un ambiente laboral seguro.

DERECHOS Y RESPONSABILIDADES DEL TRABAJADOR

La Ley de Seguridad Ocupacional y de Salud de Nevada fue creada para permitirle hacer su trabajo en un lugar seguro e higiénico. Pero de usted depende asegurarse que la seguridad en el trabajo funcione. Los siguientes son unos consejos para ayudarle a mantenerse seguro en el trabajo.

Conozca y cumpla todos los reglamentos de seguridad establecidos por:

+ Su empleador
+ La Ley de Seguridad Ocupacional y de Salud de Nevada
+ La Administración de Seguridad Ocupacional y de Salud del Estado de Nevada (NVOSHA)

Usted puede obtener copias de todos los estándares de seguridad y salud de Nevada en el Departamento de la Sección de Consultoría y Entrenamiento de Seguridad de la División de Relaciones Industriales o en el sitio de Internet www.4safenv.state.nv.us. También, es posible que a su empleador se le requiera contar con un programa de seguridad en el trabajo por escrito.

Si su empleador requiere el uso de equipo de protección personal, tales como cascos de seguridad, zapatos de seguridad, anteojos de seguridad, respiradores, o protección auditiva, usted es responsable de portar y/o utilizar el equipo.

Si usted no sabe cómo usar las herramientas, el equipo o la maquinaria de manera segura, asegúrese de preguntarle a su supervisor.

Si usted ve algo que no es seguro, repórtelo a su supervisor. Eso es parte de su trabajo. Dele la oportunidad a su empleador de componer el problema. Si usted piensa que la condición insegura sigue existiendo, es su derecho presentar una queja ante la NVOSHA. La División no le proporcionará su nombre a su empleador.

Existen leyes que lo protegen si usted es castigado por presentar una queja de seguridad y salud. Si usted siente que lo han tratado injustamente por haber presentado una queja de seguridad y salud, usted tiene hasta 30 días después de la fecha del castigo para presentar una queja de discriminación con la NVOSHA.

Línea de Denuncias – (702) 486-9097

La mayoría de las lesiones que suceden en el trabajo son cubiertas por el Seguro de Compensación al Trabajador. Desde cortadas, moretones y accidentes serios, la cobertura comienza el primer minuto que usted está en el trabajo.

Es su responsabilidad reportar inmediatamente cualquier lesión que sucede en el trabajo a su supervisor o encargado utilizando la "Notificación de Lesión o Enfermedad Ocupacional" Formulario C-1. Usted tiene siete días de la fecha en que se lesiona o que sabe de una enfermedad ocupacional para entregar el formulario C-1 completo a su empleador. Si busca tratamiento médico para una lesión relacionada con el empleo usted debe llenar un "Reclamo para Compensación" Formulario C-4 en la sala de emergencia o en la oficina de su proveedor médico para comenzar el proceso de solicitud de compensación para trabajadores.

Pero recuerde, el presentar un reclamo falso no solo resultará en la pérdida de los beneficios, pero también podría significar multas costosas y/o tiempo en la cárcel.

Si existe una situación de peligro en el trabajo y el trabajador, sin alternativa razonable, se reúsa de buena fe a exponerse a una condición peligrosa, ellos serán protegidos de una represalia posterior. La condición deberá ser de tal naturaleza que una persona razonable podrá concluir que existe un peligro real de muerte o un daño serio y que no hay suficiente tiempo para contactar a NVOSHA y tiempo para que NVOSHA realice una inspección. De ser posible, el trabajador también debió haberle pedido a su empleador una corrección de la condición y no haberla obtenido.

Durante una inspección de NVOSHA, usted tiene el derecho de hablar en privado con el inspector y formar parte de las reuniones con el inspector antes y después de la inspección. Fomentamos que señale riesgos, que describa lesiones y enfermedades de estos riesgos, que comparta reclamos anteriores de trabadores y que informe al inspector sobre condiciones laborales que no son normales durante la inspección. Si se proponen citaciones al empleador después de la inspección, al empleador se le requerirá que coloque las citaciones donde los empleados las puedan ver.

SCATS Form IE, 0-302 (Rev.07/18) All previous forms obsolete.

LA SEGURIDAD EN EL TRABAJO ES RESPONSABILIDAD DE TODOS

Yo he (marque una) ___ leído este documento o ___ visto el video, titulado " La Seguridad en el Trabajo en Nevada: Sus Derechos y Responsabilidades" y yo entiendo mis derechos y responsabilidades sobre la seguridad en el lugar de

Nombre del Empleado (por favor escriba con letra de molde) _____ Fecha _____

Firma del Empleado _____

Lugar Donde Vio el Video _____

Nombre del Empleador (por favor escriba con letra de molde) _____

Firma del Empleador (o representante) _____

Nota: Esta porción deberá mantenerse en el archivo de recursos humanos del empleado

Cualquier empleado que no entienda este documento deberá contactar a su supervisor, a su representante de empleados o a la División de Relaciones Industriales del Departamento de Nevada de Negocios e Industria.

Las Vegas: (702) 486-9140
Reno: (775) 688-3730
Elko: (775) 778-3312
Toll-Free: (877) 472-3368

DERECHOS Y RESPONSABILIDADES DEL EMPLEADOR

La Sección de Consultoría y Entrenamiento (SCATS, por sus siglas en inglés) fue creada para ayudar a los empleadores a cumplir con las leyes de Nevada que gobiernan la seguridad ocupacional y la salud. Estas leyes están disponibles para proporcionar una valoración de riesgos en el lugar de trabajo. Este servicio puede ayudar a los empleadores a minimizar los riesgos en el lugar de trabajo, y se brinda sin costo alguno. La División también ofrece entrenamiento de seguridad y programas informativos para los empleadores de Nevada sin costo.

Un empleador de Nevada con 11 empleados o más deberá establecer un programa de seguridad del lugar de trabajo por escrito. Se requiere contar con un comité de seguridad si el empleador tiene más de 25 empleados o si los trabajadores del empleador están involucrados con la manufactura de explosivos.

Usted deberá mantener un lugar de trabajo libre de condiciones peligrosas.

Como empleador usted es responsable de cumplir con todos los estándares y reglamentos de seguridad y salud de Nevada que se encuentran en:

+ La Ley de Seguridad Ocupacional y de Salud de Nevada
+ Los Estándares y Reglamentos de Seguridad Ocupacional y de Salud

Copias de todos los estándares y reglamentos de seguridad ocupacional y salud se encuentran disponibles en la División de Relaciones Industriales (SCATS y NVOSHA) o en el sitio de Internet www.4safenv.state.nv.us.

Usted también es responsable de asegurarse que todos sus empleados cumplan con estas mismas normas, estándares y reglamentos. Usted deberá elegir a alguien que administre y haga cumplir los programas de seguridad ocupacional y salud en su lugar de trabajo.

Antes de asignar a un empleado para un trabajo, usted deberá proporcionar entrenamiento adecuado en un idioma y formato que cada empleado pueda entender:

+ El uso seguro de equipo y maquinaria
+ Equipo de protección personal
+ Reconocimiento de Riesgo
+ Procedimientos de Emergencia
+ Químicos peligrosos y sustancias encontradas en el lugar de la obra o en el lugar de trabajo

Usted también deberá informar a todos los empleados sobre las reglas de seguridad, reglamentos y estándares aplicables a sus respectivas responsabilidades.

Es su responsabilidad mantener registros y reportes precisos de accidentes y lesiones. Estos archivos deberán hacerse disponibles de ser solicitados, al empleado afectado y a los representantes de NVOSHA.

El Póster de Seguridad y Salud de Nevada, proporcionado por la División de Relaciones Industriales, deberá ser colocado en un lugar prominente en el lugar de trabajo.

Cualquier accidente o choque automovilístico que ocurre en el transcurso de empleo que resulta fatal para uno o más empleados deberá ser reportado oralmente por el empleador a la oficina de la División más cercana dentro de las 8 horas subsiguientes del tiempo que el accidente o el choque se reporto a cualquier agente o empleado del empleador.

Cualquier accidente o choque automovilístico que ocurre en el trascurso de empleo que resulta en la hospitalización de uno o más empleados, la amputación de una parte del cuerpo del empleado o en la pérdida de un ojo del empleado, deberá ser reportado oralmente por el empleador a la oficina de la División más cercana dentro de las 24 horas subsiguientes del tiempo que el accidente o el choque se reporto a cualquier agente o empleado del empleador.

Los empleadores de Nevada tienen requerido asegurar y mantener los seguros de compensación de los trabajadores a menos que sean excluidos por el Estatuto Revisado de Nevada (NRS). Hay algunas excepciones para este requisito. En caso de una lesión o de el comienzo de una enfermedad ocupacional, el empleador debe proporcionar el Formulario C-1, “Notificación de Lesión o Enfermedad Ocupacional – Reporte de un Incidente” al trabajador lesionado. El empleador también es responsable por llenar y entregar el “Reporte de Lesión del Empleador” (Formulario C-3) a la compañía aseguradora dentro de seis días después de recibir un “Reclamo para Compensación” (Formulario C-4) por parte de un médico o quiropráctico.

Responsabilidades Adicionales del Empleador:

+ Realizar pruebas tales, como muestras de aire y monitoreo de ruido.
+ Prevenir que los empleados estén expuestos a sustancias nocivas que incluyen químicos, plomo, amianto, y objetos filosos.
+ Proveer exámenes de audición, pruebas médicas, protección contra caídas, guardas en las maquinas, equipo y protección de seguridad para derrumbamiento de excavaciones y espacios encerrados, respiradores, equipo de protección personal, etc., tal y como lo requieren los estándares de NVOSHA y OSHA.

La ley requiere que los empleadores proporcionen a los trabajadores recién contratados con una copia de este documento o enseñarles un video con los derechos y responsabilidades de empleadores y trabajadores para promover la seguridad en el lugar de trabajo.

Los empleadores deberán conservar una copia firmada del recibo adjunto en el expediente personal del trabajador para mostrar que él o ella conocen estos derechos y responsabilidades.

INFORMACIÓN ADICIONAL

Si usted requiere de mayor información o quisiera obtener copias de los estándares de seguridad y salud, videos de este panfleto en inglés y español o más copias del panfleto, contacte a los siguientes:

La Sección de Consultoría de Seguridad y Entrenamiento de la División de Relaciones Industriales del Departamento de Negocios y División Industrial del Estado de Nevada

Sur de Nevada
3360 W. Sahara Avenue
Suite 100
Las Vegas, NV 89102
(702) 486-9140
Fax: (702) 486-8711

Norte/Centro de Nevada
4600 Kietzke Lane
Suite E-144
Reno, NV 89502
(775) 688-3730
Fax: (775) 688-1478

Noreste Nevada
350 West Silver Street
Suite 210
Elko, NV 89801
(775) 778-3312
Fax: (775) 778-3412

O Llame, Gratis
1 (877) 4SAFENV (472-3368)
www.4safenv.state.nv.us

Departamento de Negocios y División Industrial del Estado de Nevada de Relaciones Industriales NVOSHA

Sur de Nevada
3360 W. Sahara Avenue
Suite 200
Las Vegas, NV 89102
(702) 486-9020
Fax: (702) 486-8714

Norte de Nevada
4600 Kietzke Lane
Suite F-153
Reno, NV 89502
(775) 688-3700
Fax: (775) 688-1378

Un video de esta información está disponible en inglés y español a través de la División de Relaciones Industriales, de la Sección de Consultoría de Seguridad y Entrenamiento.

NEVADA PREGNANT WORKERS' FAIRNESS ACT

Pursuant to NRS 613.335 and sections 2 to 8, inclusive, of the Nevada Pregnant Workers' Fairness Act (effective October 1, 2017) employees have the right to be free from discriminatory or unlawful employment practices based on pregnancy, childbirth, or a related medical condition.

Under the Act, it is unlawful for employers to:

- Deny a reasonable accommodation to female employees and applicants, upon request, for a condition related to pregnancy, childbirth, or a related medical condition, unless an accommodation would impose an undue hardship on the business of the employer.
- Take adverse employment actions against a female employee because the employee requests or uses a reasonable accommodation.
- Deny an employment opportunity to a qualified female employee or applicant based on a need for a reasonable accommodation.
- Require a female employee or applicant to accept an accommodation that the employee or applicant did not request or chooses not to accept or to take leave from employment if an accommodation is available.

Under the act, an employer may:

Require a female employee to submit written medical certification from the employee's physician substantiating the need for an accommodation because of pregnancy, childbirth, or related medical conditions, and the specific accommodation recommended by the physician.

NERC
Nevada Equal Rights Commission

www.nvdetr.org

For further information regarding the Act, contact the Nevada Equal Rights Commission.

An equal opportunity employer/program.
Auxiliary aids and services are available upon request for individuals with disabilities
Relay 711 or 800.326.6868

1820 East Sahara Avenue
Suite 314
Las Vegas, NV 89104
Phone (702) 486-7161

1325 Corporate Blvd.
Room 115
Reno, NV 89502
Phone (775) 823-6690

LEY DE EQUIDAD DE TRABAJADORAS EMBARAZADAS DE NEVADA

De acuerdo a Estatuto Revisado de Nevada 613.335 y las secciones 2 a 8, incluido, de la Ley De Equidad De Trabajadoras Embarazadas De Nevada (a partir del 1 de octubre de 2017) las empleadas tienen el derecho de estar libres de prácticas discriminatorias o ilegales basadas en el embarazo, el parto, o una condición médica relacionada.

BAJO LA LEY, ES ILEGAL QUE LOS EMPLEADORES:

- Nieguen una acomodación razonable a las empleadas y a las solicitantes, a petición, para una condición relacionada con el embarazo, el parto, o una condición médica relacionada, a menos que una acomodación impondría una dificultad excesiva en el negocio del empleador.
- Tomar acciones adversas de empleo contra una empleada porque solicito o utiliza una acomodación razonable.
- Nieguen una oportunidad de empleo a una empleada o solicitante calificada basada en la necesidad de una acomodación razonable.
- Requieren que una empleada o solicitante acepte una acomodación que la empleada o solicitante no solicitó o eligió no aceptar o tomar una ausencia del empleo si hay una acomodación disponible.

BAJO LA LEY, UN EMPLEADOR PUEDE:

Requerir que la empleada someta una certificación médica escrita del médico de la empleada comprobando la necesidad de una acomodación debido al embarazo, el parto, o condiciones médicas relacionadas, y la acomodación específica recomendada por el médico.

NERC
Nevada Equal Rights Commission

www.nvdter.org

PARA MAS INFORMACIÓN SOBRE LA LEY, CONTACTE LA COMISIÓN DE IGUALDAD DE DERECHOS DE NEVADA.

Un empleador/programa de igualdad de oportunidades.
Ayudas auxiliares y servicios están disponibles a petición para las personas con discapacidades.
Relay 711 or 800.326.6868

1820 East Sahara Avenue
Suite 314
Las Vegas, NV 889104
Phone: 702.486.7161

1325 Corporate Blvd.
Room 115
Reno, NV 89502
Phone: 775.823.6690

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

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

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact at this job?		
11. Phone number (if different from above)	12. Email address	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Federal COBRA Procedure (20 or more employees)

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) was enacted by Congress to provide continuation health coverage to qualified beneficiaries who lose health coverage under a group insurance plan due to the occurrence of qualifying event. COBRA continuation health coverage applies to any employer that has employed 20 or more employees on at least 50 percent of working days during the preceding calendar year.

Important Note: Many states have enacted separate continuation coverage statutes that apply to employers with 2-19 employees. Additionally, some states have continuation coverage laws that may apply to employers regardless of size in certain situations. Therefore, if your business has 20 or more employees, you may be subject to both federal COBRA *and* state continuation coverage laws.

COBRA contains extensive notification requirements as well as payment and election procedures. The procedure described below is applicable in most circumstances but may not cover every possible situation. If you have questions or find yourself presented with unusual circumstances, please contact an employment law attorney or human resource professional.

Initial COBRA Notice to New Employees

Within 90 days of a new employee becoming subject to group-health plan coverage, plan administrators must notify, in writing, each covered employee and their spouse and/or dependents of the right to future continuation of coverage. A record of this notification should be retained with the company's group health plan records. The COBRA initial notification package should include:

- Initial COBRA Notification;
- Acknowledgement of Receipt of Initial COBRA Notice; and
- Copy of the plan's Summary Plan Description or the HMO's Explanation of Coverage (Contact your insurance broker for copies).

These forms may be provided to the employee in person or U.S. Mail. The executed Acknowledgement is your proof that the Notice was received. The administrator also has the responsibility to notify the employee's spouse. If a spouse's last known address is the same as that of the covered employee, a single notice sent to the covered employee is sufficient. If the spouse does not reside with the employee, however, a good faith effort must be made to provide notice to the spouse in a separate mailing via U.S. Postal Service with a Certificate of Mailing to the last known address. Notice sent to a spouse as a qualified beneficiary is sufficient as notice to all other qualified beneficiaries residing with the spouse. If the employer or plan administrator obtains a USPS Certificate of Mailing (file with company group health plan records), it is not necessary to obtain a signed Acknowledgement of Receipt.

Qualified Beneficiaries

A qualified beneficiary is any individual who, on the day before a qualifying event, is covered under an employer's group health plan as:

- A covered employee (including independent contractors, partners, and other non-employees who are covered by their health plan due to the services performed for the plan sponsor);
- The spouse of a covered employee; or
- The dependent child of a covered employee.

Qualifying Events

Qualifying events include the:

1. Death of a covered employee;
2. Voluntary or involuntary termination of an employee (unless the employee is terminated for "gross misconduct" – **see note below**);
3. Reduction of hours of a covered employee such that the employee is no longer eligible for the company health care plan;
4. Covered employee's entitlement to Medicare (a qualifying event for non-Medicare covered dependents);
5. Divorce or legal separation of the covered employee from his or her spouse;
6. Dependent child losing that status; or
7. Chapter 11 filing by an employer with covered retired employees who will lose coverage.

Important Note on Gross Misconduct: COBRA regulations are silent as to the definition of "gross misconduct." However, the courts have held that gross misconduct must rise to the level of criminal conduct, such as theft or assault. To avoid potential liability, please consult a qualified employment law attorney before denying COBRA to a terminated employee.

Maximum Length of COBRA Coverage

The maximum required duration of continuation coverage is as follows:

- 18 months, for employee termination or reduction of hours;
- 29 months, if the individual is disabled at the time of a qualifying event; and
- 36 months total if another qualifying event occurs during the initial 18 months of continuing coverage (qualified beneficiaries will get an additional 18 months for a max of 36 months of continuing coverage).

COBRA Election Notice

Some employers use a third-party administrator to notify and correspond with the qualified beneficiary. Other employers conduct COBRA administration in-house. If a plan administrator (PA) is used, the employer must notify the PA of Qualifying Events #1-4 and #7 (above) within 30 days of the event. Our Notice to Carrier of Qualifying Event form may be used for this purpose. The PA then has 14 days within which to notify all qualified beneficiaries of their rights under COBRA. If an employer self-administers COBRA, notice must be given to all qualified beneficiaries within 44 days of the qualifying event.

If the qualifying event is divorce, legal separation or the loss of dependent child status, a qualified beneficiary must notify the employer within 60 days of the event. Plans may deny COBRA coverage to qualified beneficiaries who fail to give notice within the 60-day period. In the event of divorce, legal separation, or loss of dependent child status, within 14 days

of notice of a qualifying event, whether the employer uses a PA or self-administers COBRA, qualified beneficiaries must be notified of their rights under COBRA.

To notify qualified beneficiaries of their rights under COBRA, the employer or PA should provide them with a packet containing the following documents:

- COBRA Continuation Coverage Election Notice;
- Acknowledgement of Receipt of Notification of COBRA Rights; and
- HIPAA Certificate of Group Health Coverage**.**

  Note: Although the employer has statutory responsibility to provide the HIPAA certificate, the insurance carrier usually sends it to the qualifying beneficiary automatically.

The employer or PA should send the above packet to each qualified beneficiary via first class U.S. Mail and should obtain a Certificate of Mailing from the USPS. Employers should retain copies of all COBRA forms sent and received (file with the company's group health plan records).

Employee Responsibilities

- An employee or other qualified beneficiary who wishes to elect continuation coverage must be given at least 60 days for the election. This period is measured from the later of the coverage loss date or the date the COBRA election notice is provided by the employer or plan administrator.
- A qualified beneficiary who elects COBRA must pay 100% of the monthly premiums. The employer or plan administrator may add an administration charge of up to 2% of the amount of the premium due, with the total COBRA expense being no more than 102% of the premium. The qualified beneficiary must make the first premium payment no later than 45 days from the date he or she mails the completed Continuation Coverage Election Notice. If the qualified beneficiary fails to mail the first premium payment within the 45-day window, his or her COBRA continuation rights may be terminated.
- After the initial payment is made, monthly premiums are due on the date established by the employer or other plan administrator. Failure to make timely payment of premiums would generally constitute grounds for termination of a qualified beneficiary's benefits. A grace period (minimum 30 days) must be provided for each payment.

COBRA Notification of Unavailability

If an employee or qualified beneficiary provides notice to the employer or plan administrator of a qualifying event, a second qualifying event, or of a Social Security Administration disability determination, and the employer or PA determines that one or more qualified beneficiary is not eligible for COBRA, the employer or PA must provide a notice of unavailability. For your convenience, you may use our "COBRA Notification of Unavailability" form. This notice must be provided within 14 days of receipt of the notice of the disqualifying event. This should be mailed first class and the employer or PA should obtain a certificate of mailing from the USPS. A record of this notification should be retained with the company's group health plan records.

Termination of COBRA

If a qualified beneficiary elects to participate in COBRA, and continuation coverage ends earlier than the maximum period of coverage applicable to the specific qualifying event (*e.g.,* the qualified beneficiary ceases to be eligible for COBRA or fails to make required premium payments within the grace period), the employer or plan administrator must notify (by first class mail with a certificate of mailing from the USPS), all affected qualified beneficiaries of the early termination. This notice should be provided as soon as practicable after the plan administrator has determined that continuation coverage will be terminated and must include the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage. For your convenience, you may use our "Notice of Termination of COBRA" form. This notice should be mailed first class and the employer or PA should obtain a certificate of mailing from the USPS. A record of this notification should be retained with the company's group health plan records.

Additional Information

- Employer's Guide to Group Health Continuation Coverage Under COBRA
- U.S. Department of Labor: Health Plans & Benefits: Continuation of Health Coverage - COBRA

The above information is a summary providing guidance on the key aspects of the law. Federal and state laws are more complex than presented here. This information is simplified for the sake of brevity and is not intended to be a substitute for legal advice. This information is provided with the understanding that (1) the author and publisher are not rendering legal advice and (2) this information is not a substitute for the advice of competent legal counsel. For more information, please contact a human resource professional or an employment law attorney.

Model COBRA Continuation Coverage General Notice Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do **not** need to include this instruction page with the model general notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) ("PRA"), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget ("OMB") control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0123.

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the "Plan"). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (the "Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

[If the Plan provides retiree health coverage, add the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events no later than 30 days after the qualifying event occurs:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- [add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;] ; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [or enter longer period permitted under the terms of the Plan] **after the qualifying event occurs. You must provide this notice to** : [Enter name of appropriate party] Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must and the time period for giving notice.]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program ("CHIP"), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]

Acknowledgment of Receipt of Model General Notice of COBRA Continuation Coverage Rights

I hereby acknowledge that I have received an Initial Notice of Rights to continue health plan coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

I understand that under federal law, the Company must offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the plan would otherwise end due to certain Qualifying Events. I further understand that I, my spouse or other family member has the responsibility to inform the Company or the Plan Administrator of divorce, legal separation or a child losing dependent status. Said notice must be within 60 days of the Qualifying Event.

_____ _____

Signature Date

_____ _____ _____

Last Name First Name M.I.

This form must be returned to: _____

Questions about your COBRA rights may be directed to _____

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If **you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility -**

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment **(HIPP)** Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA - Medicaid**
https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBi): https://www.mycohibi.com/ HIBi Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtp!recovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA - Medicaid and CHIP (Hawki)	**KANSAS - Medicaid**
https://dhs.iowa.govlime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 **HIPP** Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp **HIPP** Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 **HIPP** Phone: l-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program **(KI-HIPP)** Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: l-888-342-6207 (Medicaid hotline) or l-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_us Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: l-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone:573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vennont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/leam/premium-assistance/famis-select https://coverva.dmas. virginia.gov/leam/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (0MB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by 0MB under the PRA, and displays a currently valid 0MB control number, and the public is not required to respond to a collection of information unless it displays a currently valid 0MB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions oflaw, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid 0MB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the 0MB Control Number 1210-0137.

0MB Control Number 1210-0137 (expires 1/31/2026)

PAY TRANSPARENCY

NONDISCRIMINATION PROVISION

The contractor will not discharge or in any other manner discriminate against employees or applicants because they have inquired about, discussed, or disclosed their own pay or the pay of another employee or applicant. However, employees who have access to the compensation information of other employees or applicants as a part of their essential job functions cannot disclose the pay of other employees or applicants to individuals who do not otherwise have access to compensation information, unless the disclosure is (a) in response to a formal complaint or charge, (b) in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or (c) consistent with the contractor's legal duty to furnish information. 41 CFR 60-r.35(c)

If you believe that you have experienced discrimination contact OFCCP
1.800.397.6251 I TTY 1.877-889.5627 I www.dol.gov/ofccp

OFFICE OF FEDERAL CONTRACT COMPLIANCE PROGRAMS
OFCCP

200 CONSTITUTION AVENUE NW | WASHINGTON, DC 20210 | tel: 1-800-397-6251 | TTY: 1-877-889-56271 www.dol.gov/ofccp

EMPLOYEE HANDBOOK ACCESS ACKNOLEDGEMENT FORM

I _____ (print name), acknowledge that the Employee Handbook has been provided and is available to employees at anytime.

I understand that any violation of the Professional Conduct Guidelines may subject me to disciplinary action, up to including dismissal, as well as possible civil and criminal penalties.

_____

Employee Name (Print)

_____ _____

Employee Signature Date