

MISSISSIPPI DEPARTMENT OF EDUCATION EMPLOYEE PERSONNEL DATA FORM

Information listed below is necessary for the protection of you and your family. This will be a part of your permanent personnel file.

EMPLOYEE: _____ SSN: _____

DATE OF BIRTH: _____ HOME PHONE: _____

ADDRESS: _____

City State Zip

WORK PHONE: _____

NEXT OF KIN: _____
(Name)

RELATIONSHIP: _____

NEXT OF KIN (PLACE OF EMPLOYMENT): _____

CLOSEST RELATIVE OR NEIGHBOR NOT LIVING WITH YOU:

(Name)

(Relationship)

(Phone)

WHOM DO YOU WISH TO BE NOTIFIED IN CASE OF EMERGENCY:

NAME THREE:

PHONE NUMBER

RELATIONSHIP

1. _____

2. _____

3. _____

If you are employed with another organization, please complete the following information:

EMPLOYER: _____ PHONE: _____

ADDRESS: _____

City State Zip

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026**Step 1:****Enter
Personal
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

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

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

Step 2:**Multiple Jobs
or Spouse
Works**

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate ☐

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	(a) Multiply the number of qualifying children under age 17 by \$2,200	3(a) \$	
	(b) Multiply the number of other dependents by \$500	3(b) \$	
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here	3	\$
Step 4: Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a) \$	
	(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here	4(b) \$	
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c) \$	

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 <input type="checkbox"/>		
Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

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

Future Developments

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

Purpose of Form

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

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

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

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

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

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

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



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

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

Step 4.

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

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

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

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

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

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

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

- 2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____

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

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

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

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

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

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

1	Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.				
a	Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000	1a \$ _____			
b	Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	1b \$ _____			
c	Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000	1c \$ _____			
2	Add lines 1a, 1b, and 1c. Enter the result here	2 \$ _____			
3	Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):				
a	Enter \$6,000 if you are age 65 or older before the end of the year	3a \$ _____			
b	Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	3b \$ _____			
4	Add lines 3a and 3b. Enter the result here	4 \$ _____			
5	Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	5 \$ _____			
6	Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:				
a	Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income	6a \$ _____			
b	State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)	6b \$ _____			
c	Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	6c \$ _____			
d	Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income	6d \$ _____			
e	Other itemized deductions. Enter the amount for other itemized deductions	6e \$ _____			
7	Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	7 \$ _____			
8	Limitation on itemized deductions.				
a	Enter your total income	8a \$ _____			
b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	8b \$ _____			
9	Enter: <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="vertical-align: middle;"> <ul style="list-style-type: none"> • \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,600 if you're single or head of household • \$384,350 if you're married filing separately </td> <td style="font-size: 3em; vertical-align: middle; padding: 0 10px;">}</td> <td style="vertical-align: middle;">.</td> </tr> </table>	<ul style="list-style-type: none"> • \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,600 if you're single or head of household • \$384,350 if you're married filing separately 	}	9 \$ _____
<ul style="list-style-type: none"> • \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,600 if you're single or head of household • \$384,350 if you're married filing separately 	}			
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10 \$ _____			
11	Standard deduction.				
	Enter: <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="vertical-align: middle;"> <ul style="list-style-type: none"> • \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately </td> <td style="font-size: 3em; vertical-align: middle; padding: 0 10px;">}</td> <td style="vertical-align: middle;">.</td> </tr> </table>	<ul style="list-style-type: none"> • \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately 	}	11 \$ _____
<ul style="list-style-type: none"> • \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately 	}			
12	Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)	12 \$ _____			
13	Add lines 11 and 12. Enter the result here	13 \$ _____			
14	If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14 \$ _____			
15	Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	15 \$ _____			

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

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

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

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

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	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name _____ SSN _____

Employee's Residence _____

Number and Street _____ City or Town _____ State _____ Zip Code _____

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION			
	Marital Status	Personal Exemption Allowed	Amount Claimed
EMPLOYEE: File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	1. Single	<input type="checkbox"/> Enter \$6,000 as exemption ▶	\$
	2. Marital Status (Check One)	(a) <input type="checkbox"/> Spouse NOT employed: Enter \$12,000 . . . ▶	\$
		(b) <input type="checkbox"/> Spouse IS employed: Enter that part of \$12,000 claimed by you in multiples of \$500. See instructions 2(b) below. ▶	\$
	3. Head of Family	<input type="checkbox"/> Enter \$9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d) below ▶	\$
EMPLOYER: Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	4. Dependents Number Claimed <input type="text"/>	You may claim \$1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim \$1,500 for each dependent excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by \$1,500. Enter amount claimed... ▶	\$
	5. Age and blindness	• Age 65 or older <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Single • Blind <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Single Multiply the number of blocks checked by \$1,500. Enter the amount claimed ▶ * Note: No exemption allowed for age or blindness for dependents.	\$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5... ▶		\$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer ▶		\$
	8. If you meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write "Exempt" on line 8. You must attach a copy of the Federal Form DD-2038 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▶		

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ Date: _____

INSTRUCTIONS

- The personal exemptions allowed:**

(a) Single Individuals	\$6,000	(d) Dependents	\$1,500
(b) Married Individuals (Jointly)	\$12,000	(e) Age 65 and Over	\$1,500
(c) Head of family	\$9,500	(f) Blindness	\$1,500
- Claiming personal exemptions:**
 - Single Individuals enter \$6,000 on Line 1.
 - Married individuals are allowed a joint exemption of \$12,000.
If the spouse is not employed, enter \$12,000 on Line 2(a). If the spouse is employed, the exemption of \$12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of \$500. For example, the taxpayer may claim \$6,500 and the spouse claims \$5,500, or the taxpayer may claim \$8,000 and the spouse claims \$4,000. The total claimed by the taxpayer and spouse may not exceed \$12,000. Enter amount claimed by you on Line 2(b).
 - Head of Family
A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter \$9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).
 - An additional exemption of \$1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but should not include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.
 - An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the age of 65 before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.
 - An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both are blind. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by \$1,500 and enter amount of exemption claimed.
- Total Exemption Claimed:**
Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.
- A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.**
- PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION.**
- IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENEFIT OF EXEMPTION.**

To comply with the Military Spouse Residency Relief Act (PL 111-97) signed on November 11 2009.



Employment Eligibility Verification

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

USCIS

Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
		<input type="checkbox"/> 1. A citizen of the United States					
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
		<input type="checkbox"/> 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)		Additional Information							
Issuing Authority									
Document Number (if any)									
Expiration Date (if any)									
Document Title 3 (if any)									
Issuing Authority									
Document Number (if any)									
Expiration Date (if any)									
						<input type="checkbox"/> 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		LIST B	LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity AND	Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph	3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card	4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record	5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card	6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card	7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central . The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
		8. Native American tribal document	
		9. Driver's license issued by a Canadian government authority	
		For persons under age 18 who are unable to present a document listed above:	
		10. School record or report card	
		11. Clinic, doctor, or hospital record	
		12. Day-care or nursery school record	
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
<ul style="list-style-type: none">Receipt for a replacement of a lost, stolen, or damaged List A document.Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



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

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

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

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) 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 (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	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 (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	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 (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	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 (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code



Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) 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 (<i>if applicable</i>)		New Name (<i>if applicable</i>)	
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)	
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 (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)		New Name (<i>if applicable</i>)	
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)	
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 (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)		New Name (<i>if applicable</i>)	
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)	
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 (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

SELECTIVE SERVICE REGISTRATION
VERIFICATION FORM

The 1999 Mississippi Legislature adopted House Bill 1136, to be effective July 1, 1999. The bill provides that every male between the ages of eighteen (18) and twenty-six (26) who is required to register under the Federal Military Selective Service Act, 50 USCS App. 453, and seeking employment with the State of Mississippi, shall submit to the person, commission, board or agency to which his application is submitted, satisfactory documentation of his compliance with the draft registration requirements of the Military Selective Service Act.

Beginning July 1, 1999, every male between the ages of eighteen (18) and twenty-six (26) who is required to register under the Federal Military Selective Service Act, 50 USCS App. 453, and who is an employee of the state, shall not be promoted to any higher position of employment with the state until he submits to the person, commission, board or agency by which he is employed, satisfactory documentation of his compliance with the draft registration requirement of the Military Selective Service Act.

=====

CHECK (X) EITHER SECTION 1., SECTION 2. OR SECTION 3. AND COMPLETE THE INFORMATION AS REQUESTED. A SIGNATURE IS REQUIRED.

SECTION 1.

☐ I am between the ages of 18-26.

I, _____, attest to the fact that I have complied
(Print Name)
with the registration requirements of the Selective Service System.

SIGNATURE

SELECTIVE SERVICE
REGISTRATION NO.

DATE

=====

SECTION 2.

☐ I am between the ages of 18-26, but I attest to the fact that I am not required to register with Selective Service for the following reason: _____

PRINT NAME

SIGNATURE

DATE

=====

SECTION 3.

☐ I am NOT between the ages of 18-26.

PRINT NAME

SIGNATURE

DATE



Membership Application

Form 1 – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Member Information – Attach a copy of the member's Social Security card.

First Name: _____ MI: _____ Last Name: _____ Gender: ☐ M ☐ F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date mm/dd/ccyy: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

Have you previously served on active duty in the U.S. Armed Forces? If yes, attach Form(s) DD214 ☐ Yes ☐ No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? ☐ Yes ☐ No

2 Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. Select applicable plan.

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

3 Family Information – Use additional Membership Applications if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B, Beneficiary Designation, to officially designate any and all beneficiaries.

Marital Status – Select one. Add date for last three. ☐ Single ☐ Married ☐ Divorced ☐ Widowed Effective Date mm/dd/ccyy: _____

Spouse's Full Name	Social Security No.	Birth Date mm/dd/ccyy	Wedding Date mm/dd/ccyy	Gender
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

Dependent Child's Full Name – Up to age 19, or 23 if unmarried and a full-time student	Social Security No.	Birth Date mm/dd/ccyy	Relationship	Gender
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

4 Member Certification – If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

Member's Signature: _____ Date mm/dd/ccyy: _____

5 Employer Certification – This section must be completed by an authorized employer representative, not the member.

Member's Position Held/Job Title: _____ Member's Hire Date mm/dd/ccyy: _____

Member's Status: Elected Official: ☐ Yes ☐ No Fee Paid Official: ☐ Yes ☐ No Public Safety Employee: ☐ Yes ☐ No

Employer Name: _____ Employer No.: _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, Eligibility of Part-time Employees for State Retirement Annuity Service Credit, and PERS Board of Trustees Regulation 36, Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS).

Employer Representative's Signature: _____ Date mm/dd/ccyy: _____



Beneficiary Designation

Form 1B – Revised 08/30/2022

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

1 Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ ☐ Member ☐ Retiree

Social Security No.: _____ Birth Date mm/dd/ccyy: _____ Gender: ☐ M ☐ F

2 Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. Select applicable plan.

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

3 Beneficiary Information – Use additional Form 1B, Beneficiary Designation, to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary beneficiaries must equal 100 percent, and total secondary beneficiaries must equal 100 percent. Secondary beneficiaries will only receive payment if all listed primary beneficiaries are deceased.

Beneficiary Name	Social Security No.	Birth Date mm/dd/ccyy	Relationship	Beneficiary Percentage P=Primary, S=Secondary Use whole numbers	Gender
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> P <input type="checkbox"/> S _____ %	<input type="checkbox"/> M <input type="checkbox"/> F

4 Member/Retiree Certification – Check applicable acknowledgement then sign. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

☐ **Member** – I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).

☐ **Retiree** – I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date mm/dd/ccyy: _____

5 Employer Certification – This section must be completed by an authorized employer representative, not the member. Only complete for active members.

Employer Name: _____ Employer No.: _____ - _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

Employer Representative's Signature: _____ Date mm/dd/ccyy: _____

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
EFFECTIVE JANUARY 1, 2026

Legacy - Initially hired before 1/1/2006
Horizon - Initially hired on or after 1/1/2006

	LEGACY EMPLOYEES			
	<u>BASE</u>		<u>SELECT</u>	
	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
ACTIVE EMPLOYEE				
Employee*	\$513	\$0	\$533	\$20
Employee + Spouse	\$1,074	\$561	\$1,173	\$660
Employee + Spouse & Child(ren)	\$1,367	\$854	\$1,467	\$954
Employee + Child	\$659	\$146	\$759	\$246
Employee + Children	\$886	\$373	\$983	\$470

	HORIZON EMPLOYEES			
	<u>BASE</u>		<u>SELECT</u>	
	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	\$513	\$0	\$566	\$53
Employee + Spouse	\$1,074	\$561	\$1,205	\$692
Employee + Spouse & Child(ren)	\$1,367	\$854	\$1,499	\$986
Employee + Child	\$659	\$146	\$790	\$277
Employee + Children	\$886	\$373	\$1,015	\$502

*The State pays 100% of the employee's premium for Base Coverage. Active employees enrolling in Select Coverage must pay a portion of the employee premium.

	LEGACY RETIREES	
	<u>BASE</u>	<u>SELECT</u>
RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE		
Retiree	\$590	\$614
Retiree + Spouse (Non-Medicare)	\$1,235	\$1,349
Retiree + Spouse & Child(ren) (Non-Medicare)	\$1,571	\$1,686
Retiree + Child	\$758	\$839
Retiree + Children	\$1,017	\$1,063
Retiree + Spouse (Medicare)	N/A	\$864
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$1,089
RETIRED EMPLOYEE - MEDICARE ELIGIBLE	<u>BASE</u>	<u>SELECT</u>
Retiree	N/A	\$250
Retiree + Spouse (Non-Medicare)	N/A	\$985
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	\$1322
Retiree + Child	N/A	\$474
Retiree + Children	N/A	\$699
Retiree + Spouse (Medicare)	N/A	\$500
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$725

	HORIZON RETIREES	
	<u>BASE</u>	<u>SELECT</u>
Retiree	\$941	\$975
Retiree + Spouse (Non-Medicare)	\$1,887	\$2,010
Retiree + Spouse & Child(ren) (Non-Medicare)	\$2,109	\$2,234
Retiree + Child	\$1,109	\$1,200
Retiree + Children	\$1,368	\$1,425
Retiree + Spouse (Medicare)	N/A	\$1,225
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$1,450
	<u>BASE</u>	<u>SELECT</u>
Retiree	N/A	\$250
Retiree + Spouse (Non-Medicare)	N/A	\$1285
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	\$1509
Retiree + Child	N/A	\$474
Retiree + Children	N/A	\$699
Retiree + Spouse (Medicare)	N/A	\$500
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$725

	LEGACY	
	<u>BASE</u>	<u>SELECT</u>
COBRA		
Participant	\$522	\$545
Participant + Spouse	\$1,095	\$1,197
Participant + Spouse & Child(ren)	\$1,394	\$1,496
Participant + Child	\$672	\$774
Participant + Children	\$903	\$1,003
COBRA DISABILITY EXTENSION	<u>BASE</u>	<u>SELECT</u>
Participant	\$769	\$801
Participant + Spouse	\$1,611	\$1,760
Participant + Spouse & Child(ren)	\$2,051	\$2,201
Participant + Child	\$988	\$1,138
Participant + Children	\$1,329	\$1,476

	HORIZON	
	<u>BASE</u>	<u>SELECT</u>
Participant	\$522	\$577
Participant + Spouse	\$1,095	\$1,229
Participant + Spouse & Child(ren)	\$1,394	\$1,529
Participant + Child	\$672	\$806
Participant + Children	\$903	\$1,036
	<u>BASE</u>	<u>SELECT</u>
Participant	\$769	\$849
Participant + Spouse	\$1,611	\$1,808
Participant + Spouse & Child(ren)	\$2,051	\$2,249
Participant + Child	\$988	\$1,186
Participant + Children	\$1,329	\$1,524

**MISSISSIPPI'S STATE AND SCHOOL EMPLOYEES' HEALTH
INSURANCE PLAN APPLICATION FOR COVERAGE**

PLEASE PRINT Section A: Enrollee Information (all fields are required)		Employer Name	
Social Security Number	First Name	MI	Last Name
Home Address		City	State
Primary Telephone Number	Secondary Telephone Number	Personal Email Address	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement
Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? <input type="checkbox"/> No (Horizon) <input type="checkbox"/> Yes (Legacy) If <u>yes</u> , please list your most recent (pre-1/1/06) employer and dates of employment: _____ If married, is your spouse a Plan participant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Spouse Name and SSN: _____			

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

☐ I hereby apply to ADD, CONTINUE AND/OR CHANGE COVERAGE for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the *Plan Document*. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

☐ I hereby WAIVE COVERAGE in the State and School Employees' Health Insurance Plan. I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.

Enrollee Signature: _____ Date: _____

Section C: Coverage

Enrollee Type: <input type="checkbox"/> Employee - Legacy <input type="checkbox"/> Employee - Horizon <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse	Coverage Type: <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee + Spouse <input type="checkbox"/> Enrollee + Child <input type="checkbox"/> Enrollee + Children <input type="checkbox"/> Enrollee + Spouse & Child(ren)	Coverage Option: (Choose Only One) <input type="radio"/> Base <input type="radio"/> Select	Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Number: _____ <input type="checkbox"/> "A" Effective Date: _____ <input type="checkbox"/> "B" Effective Date: _____ Reason for Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability
Are you a tobacco user? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you interested in participating in the Plan's free cessation program? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? ☐ Yes ☐ No If yes, please provide the following:

Name of Individual Covered: 1. _____	2. _____	3. _____	4. _____
Policyholder's Name: _____	_____	_____	_____
Policyholder's Date of Birth: _____	_____	_____	_____
Policyholder's Insurance Effective Date: _____	_____	_____	_____
Policy Number: _____	_____	_____	_____
Policyholder's Employment Status: _____	_____	_____	_____
Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Insurance Company Name address & phone #: _____	_____	_____	_____
_____	_____	_____	_____
Coverage Type: _____	_____	_____	_____
<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:
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Section E: Dependents

Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security Number	Date of Birth (mm/dd/yyyy)	Address (if different from Enrollee)	Current Status
1.	Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female				Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled
3.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled
4.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? ☐ Yes ☐ No

If yes, please provide the following:

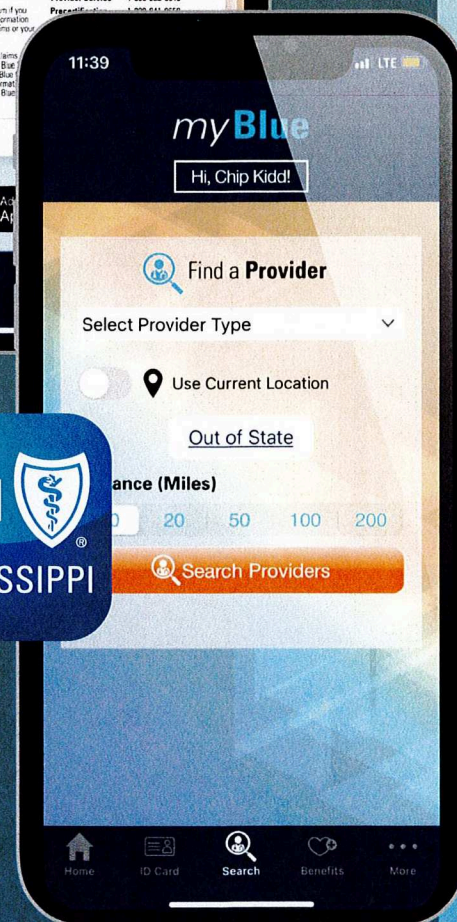
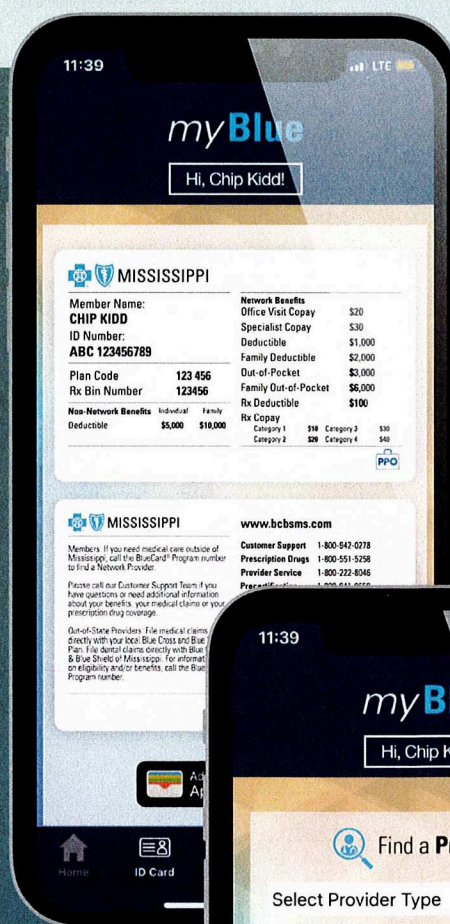
Name	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Section F: Change Information

<input type="checkbox"/> Add Enrollee: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Loss of Coverage due to Divorce <input type="checkbox"/> Other: _____ Requested Effective Date: _____							
<input type="checkbox"/> Add Dependent(s): <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other: _____ (List all dependents in Section E.) Qualifying Event/ Effective Date: _____							
<input type="checkbox"/> Change Coverage: <input type="checkbox"/> Base Coverage Select Coverage							
<input type="checkbox"/> Drop Dependent(s): <input type="checkbox"/> Divorce <input type="checkbox"/> Deceased <input type="checkbox"/> Other: _____ Provide information below for dependents to be dropped: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Name</th> <th style="width: 33%;">Social Security Number</th> <th style="width: 33%;">Requested Termination Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Name	Social Security Number	Requested Termination Date	_____	_____	_____
Name	Social Security Number	Requested Termination Date					
_____	_____	_____					
<u>Other Changes</u> (Explain): _____							
FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER: _____ New Legacy Employee, Requested Effective Date: _____ New Horizon Employee, Requested Effective Date: _____ Retiree, Requested Effective Date: _____ COBRA, Requested Effective Date: _____ Surviving Spouse, Requested Effective Date: _____ Change(s), Requested Effective Date: _____	ENTERED BY: _____ DATE: _____ VERIFIED BY: _____ DATE: _____						

Access your benefits 24/7 with *myBlue*!

- Instant access to your ID card.
- See your benefit details in real time.
- View claims as they are processed.
- View your latest health information.
- Search for lower cost Rx alternatives.
- Search for network providers and pharmacies, by specialty and location.
- View your EOBs.



Scan the QR code to download the *myBlue* mobile app from the Apple Store or Google Play.



State & School Employees' Life Insurance Plan
Active Employee Premiums Effective 1/1/23

Insurance Amount	Employee Premium	Employer Premium	Total Premium	Insurance Amount	Employee Premium	Employer Premium	Total Premium
\$30,000	\$3.00	\$3.00	\$6.00	\$66,000	\$6.60	\$6.60	\$13.20
\$31,000	\$3.10	\$3.10	\$6.20	\$67,000	\$6.70	\$6.70	\$13.40
\$32,000	\$3.20	\$3.20	\$6.40	\$68,000	\$6.80	\$6.80	\$13.60
\$33,000	\$3.30	\$3.30	\$6.60	\$69,000	\$6.90	\$6.90	\$13.80
\$34,000	\$3.40	\$3.40	\$6.80	\$70,000	\$7.00	\$7.00	\$14.00
\$35,000	\$3.50	\$3.50	\$7.00	\$71,000	\$7.10	\$7.10	\$14.20
\$36,000	\$3.60	\$3.60	\$7.20	\$72,000	\$7.20	\$7.20	\$14.40
\$37,000	\$3.70	\$3.70	\$7.40	\$73,000	\$7.30	\$7.30	\$14.60
\$38,000	\$3.80	\$3.80	\$7.60	\$74,000	\$7.40	\$7.40	\$14.80
\$39,000	\$3.90	\$3.90	\$7.80	\$75,000	\$7.50	\$7.50	\$15.00
\$40,000	\$4.00	\$4.00	\$8.00	\$76,000	\$7.60	\$7.60	\$15.20
\$41,000	\$4.10	\$4.10	\$8.20	\$77,000	\$7.70	\$7.70	\$15.40
\$42,000	\$4.20	\$4.20	\$8.40	\$78,000	\$7.80	\$7.80	\$15.60
\$43,000	\$4.30	\$4.30	\$8.60	\$79,000	\$7.90	\$7.90	\$15.80
\$44,000	\$4.40	\$4.40	\$8.80	\$80,000	\$8.00	\$8.00	\$16.00
\$45,000	\$4.50	\$4.50	\$9.00	\$81,000	\$8.10	\$8.10	\$16.20
\$46,000	\$4.60	\$4.60	\$9.20	\$82,000	\$8.20	\$8.20	\$16.40
\$47,000	\$4.70	\$4.70	\$9.40	\$83,000	\$8.30	\$8.30	\$16.60
\$48,000	\$4.80	\$4.80	\$9.60	\$84,000	\$8.40	\$8.40	\$16.80
\$49,000	\$4.90	\$4.90	\$9.80	\$85,000	\$8.50	\$8.50	\$17.00
\$50,000	\$5.00	\$5.00	\$10.00	\$86,000	\$8.60	\$8.60	\$17.20
\$51,000	\$5.10	\$5.10	\$10.20	\$87,000	\$8.70	\$8.70	\$17.40
\$52,000	\$5.20	\$5.20	\$10.40	\$88,000	\$8.80	\$8.80	\$17.60
\$53,000	\$5.30	\$5.30	\$10.60	\$89,000	\$8.90	\$8.90	\$17.80
\$54,000	\$5.40	\$5.40	\$10.80	\$90,000	\$9.00	\$9.00	\$18.00
\$55,000	\$5.50	\$5.50	\$11.00	\$91,000	\$9.10	\$9.10	\$18.20
\$56,000	\$5.60	\$5.60	\$11.20	\$92,000	\$9.20	\$9.20	\$18.40
\$57,000	\$5.70	\$5.70	\$11.40	\$93,000	\$9.30	\$9.30	\$18.60
\$58,000	\$5.80	\$5.80	\$11.60	\$94,000	\$9.40	\$9.40	\$18.80
\$59,000	\$5.90	\$5.90	\$11.80	\$95,000	\$9.50	\$9.50	\$19.00
\$60,000	\$6.00	\$6.00	\$12.00	\$96,000	\$9.60	\$9.60	\$19.20
\$61,000	\$6.10	\$6.10	\$12.20	\$97,000	\$9.70	\$9.70	\$19.40
\$62,000	\$6.20	\$6.20	\$12.40	\$98,000	\$9.80	\$9.80	\$19.60
\$63,000	\$6.30	\$6.30	\$12.60	\$99,000	\$9.90	\$9.90	\$19.80
\$64,000	\$6.40	\$6.40	\$12.80	\$100,000	\$10.00	\$10.00	\$20.00
\$65,000	\$6.50	\$6.50	\$13.00				

**STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM**

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.

Policy 33683-G

SECTION A: Employee/Employer Information

Employee/Retiree Last Name:	First Name:	MI:	Social Security Number:	Birthdate: (MM/DD/YYYY):
Employee/Retiree Home Address:			Email Address:	Home Phone:
				Alternate Phone:
Employer Name:				Employer Phone:
Employer Address:				

SECTION B: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)

ACTIVE FULL-TIME EMPLOYEE: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of \$30,000 and a maximum of \$100,000. The employee and employer each pay 50 percent of the monthly premium.

- ☐ **New Employee** – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.
- ☐ **Late Enrollee Applicant** – Applications made after initial 31 days of employment will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life. (Employee must also complete the Minnesota Life GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form.)

Date of Employment: _____

- ☐ **RETIRED EMPLOYEE:** Life benefit amounts are limited to \$5,000, \$10,000 or \$20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

Date of Retirement: _____ COVERAGE AMOUNT REQUESTED: ☐ \$5,000 ☐ \$10,000 ☐ \$20,000

- ☐ **DISABLED EMPLOYEE:** Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months. (Employee must also complete the Minnesota Life NOTICE OF DISABILITY and ATTENDING PHYSICIAN'S STATEMENT forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

NOTE: You cannot designate your life insurance beneficiary on this form. To designate your life insurance beneficiary, please follow the instructions below:

1. Log in to your myBlue site, <https://myblue.bcbssms.com>, and click on the My Benefits tab.
2. Scroll down to the Life Benefits section below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on the site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through the myBlue portal.

If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the policy.

If you do not have Internet access, contact Minnesota Life toll free at **877-348-9217** to request a paper beneficiary designation form.

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone
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SECTION D: Authorization and Certification

I am applying for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Insurance Company, Group Policy #33683-G, and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

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

Employee/Retiree Signature (Required)

Date

SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)

☐ **Waiver of Coverage** – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

☐ **Cancellation of Coverage** – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.

Employee/Retiree Signature

Date

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT <http://KnowYourBenefits.dfa.ms.gov/> OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	GROUP NUMBER:	INFORMATION VERIFIED: (INITIAL AND DATE)

**Mississippi State & School Employees'
Life Insurance Plan**

Group term life and accidental death & dismemberment (AD&D) benefit

Active full-time employees

Insurance products issued by:
Minnesota Life Insurance Company

Designate your beneficiary today!



We strongly encourage you to designate your beneficiary as soon as possible, even if you believe the selected individual may receive the benefit by default. Designating a beneficiary speeds payment and ensures the proceeds from your policy will be distributed according to your wishes.

To designate your beneficiary online:


1. Log into Blue Cross & Blue Shield of Mississippi: **bcbssms.com**
2. Click on the "My Benefits" tab
3. Click on the "Life Benefits" section
4. Click on the link "Click here to update your beneficiary information"
5. Click "I agree" to go to Securian Financial's LifeBenefits to add, view or update your beneficiary
6. Click "View details or make changes"
7. Enter the name(s), address and the respective benefit percentages for each beneficiary
8. Securian will mail you a confirmation letter after you complete your designation

Need assistance?

Instructions and/or forms for designating a beneficiary may be found on Securian Financial's website: lifebenefits.com/plandesign/mississippi or call **877-348-9217**.

Your basic coverage

Basic coverage (automatically enrolled)

	Basic term life and AD&D 2x base annual pay	<ul style="list-style-type: none">• Maximum coverage: \$100,000• Includes matching AD&D benefit
--	--	---

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life Insurance Company to Mississippi State and School Employees' Life Insurance Plan. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage. All elections or increases are subject to the "actively at work" requirement of the policy.

Insurance products are underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. Products offered under policy form series MHC-96-13180.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its affiliates.

Securian Financial Group, Inc.
securian.com

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F77223-66 Rev 6-2018 DOFU 6-2018
517949



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Office of Human Resources 601.359.3511

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.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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 Mississippi Department of Education		4. Employer Identification Number (EIN) 64-6000758	
5. Employer address 359 North West Street		6. Employer phone number 601.359.3511	
7. City Jackson	8. State MS	9. ZIP code 39205	
10. Who can we contact about employee health coverage at this job? Angela Bailey			
11. Phone number (if different from above) 601.359.1733		12. Email address abailey@mdek12.org	

Here is some basic information about health coverage offered by this employer:

•As your employer, we offer a health plan to:

☒ All employees. Eligible employees are:

All full-time employees and all part-time employees who work at least 39 hours per week.

☐ Some employees. Eligible employees are:

•With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Coverage for all full-time and 39 hour part-time employees includes dependent care coverage as well.

☐ We do not offer coverage.

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

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

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

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

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

☒ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
Tobacco Use Attestation Form

All sections of the form below must be completed in order for the form to be processed. Please print in blue or black ink.

LAST NAME:	FIRST NAME:	MI:	LAST FOUR OF SSN:
HOME ADDRESS:	CITY:	STATE:	ZIP:
PERSONAL TELEPHONE NUMBER:	PERSONAL EMAIL ADDRESS:		

- Please initial the appropriate box below to indicate whether or not you use tobacco on a regular basis.
- If you are a regular user of tobacco, please indicate whether or not you are interested in receiving information about the Mississippi State and School Employees' Health Insurance Plan's (Plan) free tobacco cessation programs.

NON-TOBACCO USER	
<div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block; vertical-align: middle;"></div> I attest that I do not regularly use a tobacco product in any form (cigarettes, cigars, pipe, oral tobacco products, etc.).	
I certify that all information provided by me on this form is complete and accurate.	
_____ Signature	_____ Date
TOBACCO USER	
<div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block; vertical-align: middle;"></div> I acknowledge that I regularly use a tobacco product in some form (cigarettes, cigars, pipe, oral tobacco products, etc.).	
<div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block; vertical-align: middle;"></div> I am interested in receiving information about tobacco cessation programs offered by the Plan.	
I certify that all information provided by me on this form is complete and accurate.	
_____ Signature	_____ Date

Form Submission:

- If you are an **active employee**, please return your form to your employer's Human Resources Department.
- If you are a **non-Medicare retiree or COBRA participant**, please mail or fax your form to:

Blue Cross & Blue Shield of Mississippi
P.O. Box 23734
Jackson, MS 39225-3734
Fax: (601) 664-5342

For more information visit KnowYourBenefits.dfa.ms.gov

Keep smiling

Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at deltadentalins.com.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.⁴ Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care⁵, you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist



PPO



NON-PPO

¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

⁵ Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

Benefit Highlights: Delta Dental PPO TM

Plan Benefit Highlights for: Mississippi Department of Education

Group No: 22185

Effective Date: 2/1/2025

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics, if applicable?	Gold Plan: \$50 per person each calendar year Platinum Plan: \$50 per person / \$150 per family each calendar year			
	Yes			
Maximums D & P counts toward maximum?	Gold Plan: \$1,000 per person each calendar year Platinum Plan: \$2,000 per person each calendar year			
	Yes			
Waiting Period(s)	Basic Services None	Major Services Gold - N/A Platinum-12 Months	Prosthodontics Gold - N/A Platinum-12 Months	Orthodontics Gold - N/A Platinum-12 Months
	Gold Plan		Platinum Plan	
Benefits and Covered Services*	Delta Dental PPO dentists[†]	Non-Delta Dental PPO dentists[†]	Delta Dental PPO dentists[†]	Non-Delta Dental PPO dentists[†]
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %	100 %	100 %
Basic Services Fillings	80 %	80 %	80 %	80 %
Endodontics (root canals)	0 %	0 %	50 %	50 %
Periodontics (gum treatment)	0 %	0 %	50 %	50 %
Oral Surgery	80 %	80 %	80 %	80 %
Major Services Crowns, onlays and cast restorations	0 %	0 %	50 %	50 %
Prosthodontics Bridges, dentures and implants	0 %	0 %	50 %	50 %
Orthodontic Benefits Dependent children to age 19	0 %	0 %	50 %	50 %
Orthodontic Maximums	N/A	N/A	\$1,000 Lifetime	\$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

† Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Rates			
Low Plan		High Plan	
Enrollee only	\$21.86	Enrollee only	\$38.68
Enrollee + Spouse	\$43.70	Enrollee + Spouse	\$77.27
Enrollee + Children	\$48.07	Enrollee + Children	\$85.02
Family	\$71.01	Family	\$123.46

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Customer Service
800-521-2651

Claims Address
P.O. Box 1809
Alpharetta, GA 30023-1809

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_HILO_DDIC (Rev. 9/10/2024)

Stay Connected



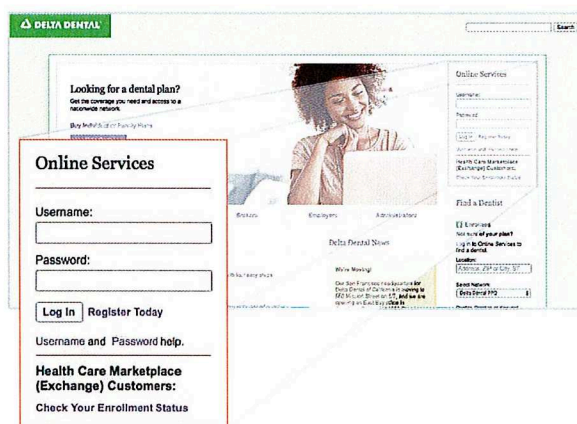
At **deltadentalins.com**, all the information you need is at your fingertips. You can check your plan details, find an in-network dentist and more.

Create an account

1. Go to **deltadentalins.com**.
2. Click on **Register Today** in the **Online Services** section.

With an online account, you can:

- Check your plan details and eligibility
- Review claim statements and plan documents
- View or print your ID card



Find a dentist

1. Go to **deltadentalins.com**.
2. In the **Find a Dentist** section, enter your address and select your network from the drop-down menu.
3. Click **Search**.

Browse Yelp reviews, check office hours and see the address on a map.



For more online resources,
turn the page.



deltadentalins.com/enrollees

Download the app

1. Open the **App Store** or **Google Play**.
2. Search for “**Delta Dental**.”
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

Review your plan details, pull up your ID card and try out the musical toothbrush timer.



Get answers

Got a question? We've got answers.

Learn how your dental plan works:

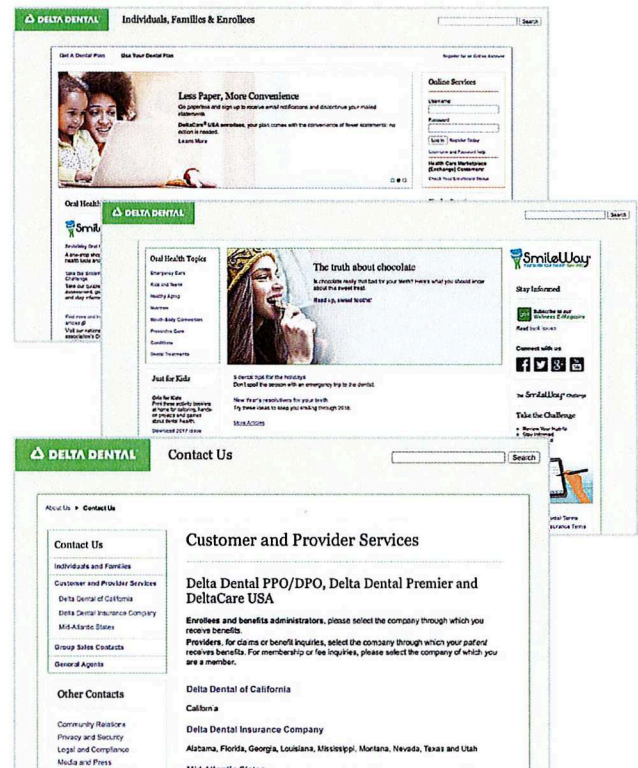
Visit deltadentalins.com/enrollees for the 101 on dental benefits.

Improve your dental health:

Check out mysmileway.com for the latest recipes, articles and videos.

Contact Customer Service:

Submit an online question at deltadentalins.com/contact.



Website available on
desktop, mobile and tablet

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. These enterprise companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 78 million people in the U.S. The website deltadentalins.com is the home of the Delta Dental companies listed above. For other Delta Dental companies, visit the Delta Dental Plans Association website at deltadental.com.

Delta Dental Enrollment Form
Mississippi Department of Education
Group # 22185

Effective Date: _____

Please complete the following information.

Social Security #	Last Name	First Name	MI	Date of Birth / /
Home Address		Home Phone # ()		Sex M F
City	State	Zip Code	Business Phone # ()	

List all Eligible Dependents that are to be covered.

First	Mi	Last	Sex	Date of Birth
Spouse:			M F	/ /
Child:			M F	/ /
Child:			M F	/ /
Child:			M F	/ /
Child:			M F	/ /

Please Circle Your Choice-Monthly Rates

	EE Only	EE+Spouse	EE+Child(ren)	Family
Low Plan (Gold)	\$21.86	\$43.70	\$48.07	\$71.01
High Plan (Platinum)	\$38.68	\$77.27	\$85.02	\$123.46

Status Change Information

Is this a qualifying -Please list qualifying event _____
 Add the dependent(s) listed above - Effective date ____/____/____
 Delete the dependent(s) listed above - Effective date ____/____/____
 Terminate employee coverage Effective date ____/____/____
 Name Change (From) _____ (To) _____
 COBRA- Effective date ____/____/____
 Transfer from sub. Loc # _____ to sub. Loc # _____ Effective date ____/____/____

Waive Coverage _____ **Date** _____

I wish to enroll in the plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X _____ Date: _____

BrightVision Expanded 4

powered by Superior Vision

Benefit	Description	Copay ¹	Frequency
Eye Exam	Focuses on your eyes, vision and wellness	\$10	Every 12 months
Prescription Glasses	<i>Options below</i>	\$10	-
<i>Frame</i>	\$130 frame allowance at network locations Plus 20% off any amount over your allowance ²	included	Every 12 months
<i>Lenses and enhancements</i>	Clear plastic single-vision, bifocal, trifocal or lenticular lenses Polycarbonate lenses for dependent children	included	Every 12 months
<i>Lens upgrades²</i>	Scratch coat	\$15	Every 12 months
	Ultraviolet coat	\$12	
	Tinting - solid	\$15	
	Tinting - gradients	\$18	
	Polycarbonate	\$40	
	Blue light filtering	\$15	
	Digital single vision	\$30	
	Progressive Lenses (Standard / Premium / Ultra / Ultimate)	\$55 / \$110 / \$150 / \$225	
	Anti-Reflective (AR) Coating (Standard / Premium / Ultra / Ultimate)	\$50 / \$70 / \$85 / \$120	
	Polarized	\$75	
	Plastic photochromic lenses	\$80	
	High Index (1.67 / 1.74)	\$80 / \$120	
Prescription contacts³ <i>(in addition to glasses)</i>	Fully-covered fitting, evaluation and follow-up ⁴ or \$50 allowance for specialty contact lens fitting ⁵	\$10	Every 12 months
	\$130 allowance for contacts		
	Plus 20% off any amount over your allowance on conventional contacts or		
	10% off any amount over your allowance on disposables ²		

Extra member savings²

Complimentary Everplans subscription (worth \$75/yr) to organize life's most important details so they're safe and easy to get to in an emergency.
 15% off standard laser vision correction or 5% off promotional prices at LasikPlus® locations nationwide.
 Save over 40% on premium hearing aids through Your Hearing Network, plus other offers and promotions⁶
 No more than \$39 on routine retinal imaging as an enhancement to an eye exam.
 After initial benefit use: 30% off additional exams and eyeglasses; 20% off lens options, contacts, misc. options; 10% off disposable contacts

Out-of-network coverage¹

Exam - ophthalmologist	up to \$34	Single vision lenses	up to \$32	Progressive lenses	up to \$57
Exam - optometrist	up to \$26	Bifocal lenses	up to \$46	Lenticular lenses	up to \$90
Frames	up to \$65	Trifocal lenses	up to \$57	Contacts	up to \$100

1. Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements. 2. Not insured benefits - prices listed reflect discounts, in which some network providers may not participate. 3. Visually required contacts are covered in full in-network and up to \$210 out-of-network. 4. Applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. 5. Applies to new contact wearers and/or a member who wears toric, gas permeable, or multi-focal lenses. 6. Over 40% off pricing as referenced in the Consumer Guide to Hearing Aids. Discount varies depending on product. This offer is only good at participating Your Hearing Network provider locations and cannot be combined with any other offer or discount. If differences exist between this document and the plan contract, the contract will prevail.



Enrollment/Change Form

VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

P.O. Box 1424 Milwaukee, WI 53201

Please print and complete all sections.

GROUP/EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)											
Group/Policyholder Name				Group Number		Location		Effective Date		Date of Hire	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name			First Name			M.I.	Date of Birth		Social Security Number
Home Street Address				City/State/Zip				Home Phone ()		Work Phone ()	
E-mail Address									Cell Phone ()		
FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (Enroll) T: Terminate C: Change (Change of name or coverage)											
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Spouse)			First Name			M.I.	Date of Birth		
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Dependent)			First Name			M.I.	Date of Birth		Child handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Dependent)			First Name			M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Dependent)			First Name			M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Dependent)			First Name			M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Dependent)			First Name			M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No
NOTE for Vision: Members that waive coverage at initial enrollment or in the new eligibility period and/or terminate coverage, may be subject to additional benefit limitations, upon enrolling.											
I elect the following coverage(s):											
<input type="checkbox"/> Vision											
<input type="checkbox"/> Employee Only \$ <u>\$ 9.13</u>											
<input type="checkbox"/> Employee + Spouse \$ <u>\$18.66</u>											
<input type="checkbox"/> Employee + Child(ren) \$ <u>\$16.46</u>											
<input type="checkbox"/> Employee Family \$ <u>\$25.59</u>											
<input type="checkbox"/> Waived due to other coverage											
<input type="checkbox"/> Waive											
Do you or any of your dependents have other vision insurance?										<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please give: Policyholder _____ and Insurance Company: _____											
Employee Signature: _____						Date: _____					

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION TO OBTAIN INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

BENEFITS AVAILABLE THROUGH PAYROLL DEDUCTION

DENTAL/VISION

***Delta Dental – Kim Porter**

(601)982-0331

***Bright Benefits – Kim Porter**

(601)982-0331

***Open Enrollment period applies if you decline coverage at initial employment/eligibility which is the first 31 days of employment**

FLEXIBLE SPENDING MEDICAL & CHILD CARE BENEFITS

Glynn Griffing & Associates

(601)982-0331

IMPACT & AFFORDABLE COLLEGE SAVINGS PLAN

State Treasurer's Office

(601)359-5258

CREDIT UNIONS

MS Public Employees Credit Union

(601)948-8191

Statewide Federal Credit Union

(601)420-5535

EMPLOYEE COURTESY FUND: This fund was established to pay for flowers and gifts for employees/family member by voluntary contributions of a fixed amount on a monthly basis through payroll deduction.

DIRECT DEPOSIT: Once an employee accumulates and maintains a balance of twenty (40) hours of personal leave, they may choose to have their paycheck direct deposited into their bank account.

TAKE TIME TO REVIEW YOUR BENEFITS

Your benefits review is the best opportunity of the year to make changes to your benefits package and ensure your coverage continues to meet your needs. An American Fidelity account manager can help you review your coverage and find a plan that works best for you and your family.

Your enrollment dates:



**Schedule your
appointment today:**

<https://enroll.americanfidelity.com/28FCA958>



Has your information changed?

New address or bigger family? A lot can change in a year and it's important to verify all of your information is up to date during your benefits review.

Demario Smith

South Mississippi Branch Office
101 Lake Court, Suite A
Flowood, MS 39232
800-956-1468 • 601-932-8090
demario.smith@americanfidelity.com

Available Benefits:



Disability Insurance

americanfidelity.com/disability



Life Insurance

americanfidelity.com/life



Cancer Insurance

americanfidelity.com/cancer



Accident Insurance

americanfidelity.com/accident



Hospital GAP Plan Choice® Insurance

americanfidelity.com/gap-insurance



Healthcare Flexible Spending Accounts

americanfidelity.com/fsa

Limitations, exclusions and waiting periods may apply.

AMERICAN FIDELITY 
a different opinion

americanfidelity.com

Mississippi Department of Education Employee Activities Committee Fund

An Employee Activities Committee (EAC) fund has been established to pay for funding activities for participating employees. The fund will be supported by voluntary employee contributions of a fixed amount on a monthly basis. Only those employees who choose to participate by regular contributions will be eligible for the benefits of the program.

Each participating employee will make a monthly contribution of \$1.00. The monthly contribution will be collected through payroll deductions.

**Mississippi Department of Education
Employee Activities Committee Fund
EAC FUND**

Name: _____ **Home Phone:** _____

Home Address: _____

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

Office Name: _____

I authorize my employer to deduct a total of \$1.00 from my salary each payroll period and make payment of this amount to the Mississippi Department of Education Employee Activities Fund. This authorization may be terminated after 12 months by written notice to my employer.

Date: _____ **Signature:** _____

OR

I do not wish to participate in the Mississippi Department of Education Employee Activities Fund.

Date: _____ **Signature:** _____

Completed forms should be return to Human Resources Office.

**Mississippi Department of Education
Employee Courtesy Fund Policy
(Revisions Effective July 1, 2018)**

An Employee Courtesy Fund (formerly the Flower and Gift fund) has been established for participating members of the Mississippi Department of Education to show support during a time of bereavement, hospitalization and upon retirement of the contributing member. The fund is supported by voluntary employee contributions of a fixed amount on a monthly basis. Only those employees who choose to participate by regular contributions will be eligible for the benefits of the program.

The Employee Courtesy Fund committee will be composed of an eight-person team participating in the governance of the fund. The committee shall be charged with reviewing the policies and making necessary changes, overseeing the finances of the fund and other duties as situations arise. The Chief of Staff will serve as the chairperson of the committee and the executive assistant to the Chief of Staff will serve as secretary/treasurer. The other six members will be designees from the four deputy areas and two recommendations from the State Superintendent.

The committee will meet as requested by the chairperson. A quorum of members will be required to conduct business of the fund.

Each participating employee will make a monthly contribution of \$1.00. The monthly contribution will be collected through payroll deductions and turned over to the secretary-treasurer no later than the fifth working day of the succeeding month. Any changes regarding the payroll deduction for the Employee Fund must be submitted in writing to MDE payroll office on or before the 12th of each month in order for the change to be effective for that month. Employees wishing to make a change will do so in the Office of Human Resources.

To request a benefit, the participating employee must complete the Employee Benefit Request Form, available on the Office of Human Resources' web page under forms and submit to HR along with supporting documentation (hospital statement, bill, obituary, leave form, etc.). Participating members have 60 days from time of qualifying event to submit a request, complete with supporting documentation. If the request is not submitted within 60 days of the qualifying event, the request will not be approved. The maximum hospital benefit per Courtesy Fund member is four (4) claims within a one-year period, with the one year beginning with the first occurrence.

Hospitalization is a monetary benefit of (\$50.00). The benefit covers the contributing employee and family members listed below:

- Spouse
- Child or Stepchild
- Parent or Stepparent

Memorial is a monetary benefit of (\$75.00). The benefit covers the contributing employee and family as listed below:

- Spouse
- Child or Stepchild
- Parent or Stepparent
- Sibling
- Grandparent
- Grandchild

**Mississippi Department of Education
Employee Courtesy Fund Policy
(Revisions Effective July 1, 2018)**

In the event that the memorial is for a contributing employee, the monetary gift will be provided to the beneficiary listed on the contributing employee's PERS form.

Retirement is a monetary benefit for a contributing employee of \$10 per year of membership with a max of (30) years participation in the fund.

A verification of years of participation in the fund from the Office of Human Resources or Accounting must be attached to the Employee Fund Benefit Request form.

Mississippi Department of Education
Employee Courtesy Fund Policy
(Revisions Effective July 1, 2018)

Name _____ Home Phone _____

Home Address _____

City _____ State _____ Zip _____

Office _____ Bureau _____

PLEASE COMPLETE ONE OF THE FOLLOWING:

I have read the attached Employee Courtesy Fund policy and hereby authorize my employee to deduct a total of \$1.00 from my salary each payroll period and make payment of this amount to the Mississippi Department of Education Employee Fund. This authorization may be terminated after one (1) year of full participation, by written notice to my employer.

Date _____ Signature _____

***** OR *****

I have read the attached Employee Courtesy Fund policy and do not wish to participate in this fund.

Date _____ Signature _____

**MISSISSIPPI DEPARTMENT OF EDUCATION
EMPLOYEE BENEFITS REVIEW**

In addition to your pay, you receive the following benefits:

Paid Time-Off

Holidays - Guaranteed 10 paid holidays per year. Additional days may be allowed as designated by the Governor. The holidays are as follows:

New Year's Day	Independence Day
Robert E. Lee's/Dr. Martin L. King Day	Labor Day
Presidents' Day	Veteran's Day
Confederate Memorial Day	Thanksgiving Day
Memorial Day	Christmas Day

Vacation - Personal leave which can be used for vacations, physician appointments, days off for personal business, or for the first day of an illness and is accrued on a monthly basis beginning with the first month of employment. Accrual rates are based on years of continuous service as follows:

1 month to 3 years - 12 hours per month
37 months to 8 years - 14 hours per month
97 months to 15 years - 16 hours per month
Over 15 years - 18 hours per month

Medical - Major medical leave which is used beginning the second consecutive day of illness is also accrued on a monthly basis beginning with the first month of employment. Accrual rates are based on years of continuous service as follows:

1 month to 3 years - 8 hours per month
37 months to 8 years - 7 hours per month
97 months to 15 years - 6 hours per month
Over 15 years - 5 hours per month

Part-time employees earn personal and major medical leave hours each month on a pro-rated basis based on the number of hours worked each month.

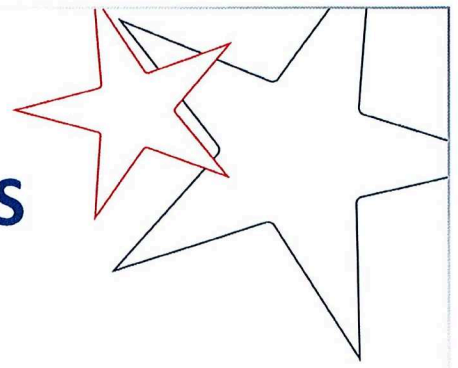
Retirement Related

Social Security (FICA/Medicare) - State puts in 7.65% of the employee's pay to match the contribution of the employee.

Retirement - Each month a set percentage is deducted from employee's pay for retirement purposes.

OFFICE OF COMMUNICATION AND GOVERNMENT RELATIONS

New Hire Information



Emergency Text Alert System

MDE employees are encouraged to sign up for MDE's emergency alert texting system to receive announcements about closures due to severe weather or other emergencies. To sign up, text **mdek12** to **877-876-8686**.

Official Email Signature

All employees are required to use the official MDE email signature. Use this format when adding your email signature to your email account:

YOUR NAME, *Your Title*

Office Name

601-359-3513 | mdek12.org



MISSISSIPPI
DEPARTMENT OF
EDUCATION

1. Use your mouse to select the signature above, right-click and select "Copy." If you are unable to copy the MDE logo, download it from this page: mdek12.org/OCGR/brand/logos.
2. Create a new email message.
3. On the Message tab, choose Signature > Signatures.
4. Paste copied email signature in signature area. Customize signature with your name, title and name and phone number for your office or division.
5. Enter a name for the signature profile, such as "Official," and click OK.
6. Under Choose default signature, select the newly created email signature for "new messages" and "replies/forwards." Click OK to save your signature.

Note: Contact OTSS at mdenet@mdek12.org for assistance with setting up your email signature on your computer or mobile device.

Professional Photo in Microsoft 365

All employees must upload a professional photo of themselves to Microsoft 365 for use in MDE's communication platforms (i.e., email, Teams). Contact OTSS at mdenet@mdek12.org for assistance if needed.



MISSISSIPPI
DEPARTMENT OF
EDUCATION

Office of Communication and Government Relations
New Hire Information • January 2023 • mdek12.org

Brand Guidelines

Preserving the integrity of the Mississippi Department of Education brand is vital to maintaining a strong reputation and identity for our organization. MDE brand guidelines and best practices ensure the agency is represented consistently. Visit mdek12.org/OCGR/brand/logos to find instructions for the proper use of the MDE logo and for formatting documents.

Official MDE PowerPoint Template and Other Documents

The official MDE PowerPoint template must be used for all MDE presentations. You may download it from the MDE Brand Guidelines page: mdek12.org/OCGR/brand. Refer to this webpage for instructions for formatting other documents.

Upcoming Events Calendar

All major MDE public events should be listed in the “Upcoming Events” calendar that is accessible from the MDE home page: mdek12.org/events. This includes Commission, Board and Task Force meetings as well as major MDE conferences (Literacy Summit, Elevate Teachers Conference, etc.). Please submit event details to mdenet@mdek12.org to have your event listed in this calendar. Staff should consult this calendar before scheduling public events.

Holiday Proclamations

The list of state holidays is accessible from the MDE Human Resources webpage: mdek12.org/OHR. To help keep track of state holidays, add them to your calendar. Legal holidays that fall on a Sunday will be observed the following day. The Governor may proclaim additional days in observance of Thanksgiving and the Christmas season. MDE employees will receive notice of any such proclamations by email.

Other

Instructions about other communications services are available on the webpage, How to Access Communications Services: mdek12.org/ocgr/hacs.



**MISSISSIPPI DEPARTMENT OF EDUCATION
DRESS, APPEARANCE AND OFFICE ETIQUETTE
POLICY**

The Mississippi Department of Education (MDE) takes pride in providing quality services to the public, as well as to local and state entities. In doing so, our employees come in contact with a wide circle of individuals. We must be conscientious in matters of our conduct, clothing choices and grooming during office hours as well as while attending business-related functions held after hours. This policy is established in an effort to promote a professional image and provide a more positive work environment. MDE strives to represent excellence in service and performance.

To ensure that the impression we make reflects our commitment to excellence, the following are policies and guidelines for appropriate dress and grooming for the workplace.

Office Etiquette

- Decorate your office with taste and keep our workplace free of unnecessary clutter
- Conduct yourself in a professional manner at all times
- Respect co-workers personal and private spaces
- Use of personal cell phones/Blue-tooth devices should not interfere with department business

Dress Etiquette

Beginning July 1, 2013, these guidelines shall be followed throughout the year, except for those times when an exception to this policy has been granted by the employee's immediate supervisor and/or by declaration by the department head.

Attire to be worn Monday through Friday of each week will reflect a professional look. For men this will consist of slacks, khaki slacks, sweaters, polo-style shirts, vests/cardigans, button-up shirts with/without tie and coordinating shoes. A sports jacket and tie are recommended for meetings with an outside party. For women, the professional look will consist of dresses, suits, skirts and slacks with coordinating blouses, sweaters, vests, tops, and jackets. Cropped/ankle pants (length of the pant are below the calf) may be worn if they are tailored and reflect a professional look.

Dress shoes (heels, flats, boots, sandals, etc.) are appropriate. However, flat heeled "flip flops", rubber shoes, house slippers, moccasins, tennis shoes, "crocs" or other recreational shoes are not permitted. Capri pants may be worn with coordinating blouses, sweaters, vests, tops and/or jackets provided the length of the pants are not shorter than five (5) inches below the knee. Capri pants should not come above the knee when seated.

Appearance Etiquette

For men: sideburns, mustaches and beards should be neatly maintained at all times. Hair styles for men and women should be neat and well-kept. Any body piercing, except women's earrings, should be covered. Garments which are **tight and/or ill-fitting** are inappropriate, as are **mini skirts, skirts with high slits, or visible undergarments**. Clothing for all staff should be clean, pressed. Men's and women's clothing should be tasteful and well-coordinated. **Employees should be careful not to apply too much fragrance (cologne or perfume) in the office. This restriction is necessary because some workers are hypersensitive to fragrance due to allergy conditions.**

Exceptions

Exceptions to the Dress Etiquette policy are for those employee's whose primary work assignment requires them to move or maintain equipment or work outdoors (i.e., certain MIS technical staff, property managers, mailroom workers and building and grounds maintenance staff). Other exceptions include office cleaning/packing/moving days. These situations should be discussed with and approved by an employee's supervisor.

Unacceptable Clothing

The following is a list of clothing items that generally do not fall within the concept of professional dress etiquette and is by no means exhaustive. Sweat suits, wind suits, warm-up suits and other athletic attire; house shoes, slippers, shower shoes, plastic sandals, flip-flops, running shoes, walking shoes, cross trainers and other athletic shoes; denim, jeans, shorts and tee-shirts.

Responsibility

Each supervisor will be responsible for maintaining the department's dress policy in his/her work area. Should the supervisor determine that an employee's dress or grooming and general appearance is inappropriate; the supervisor **will** require the employee to **leave** the worksite and **return** with more appropriate dress or grooming. The employee **must** take personal leave for the time away from the office. Violations of this policy **will** result in an issuance of a Group Two Offense reprimand of Insubordination.

Accommodations

There may be instances where modifications to these guidelines are necessary. The department will work with any employee whose medical condition requires clothing that does not conform to the department's policy.

If you are uncertain if an article of clothing may be appropriate to wear to work, please ask yourself the following questions:

1. Does my appearance instill confidence to my clients that I am a professional?
2. Does my clothing fit? For example, does the top or blouse reveal too much cleavage, or are the pants, slacks, skirts, dresses, etc., too tight to wear in the workplace?
3. Is my clothing distracting to my clients and/or co-workers?
4. Is my clothing clean and pressed?
5. Do I look successful?

Frequently Asked Questions about Office Etiquette

I'm freezing (or burning up). Can I bring a portable heater (or fan) to work?

The Department of Finance and Administration (DFA) has a policy regarding electrical appliances. The policy states employees can bring fans to work as long as the fan contains a tag stating it was made in accordance with the Underwriter's Laboratory requirements (UL listing). However, DFA requires employees to submit a doctor's statement to the Office of Human Resources that a heater is needed for medical reasons. Once this is provided to Human Resources, the department will purchase a heater for the employee.

Is it appropriate for an employee to wear a blue tooth headset during the workday?

Department-issued cell phones do not include a blue tooth headset, so an employee who is wearing a headset gives the appearance he/she is conducting personal business. Headsets should not be worn continually throughout the day; however, incidental use that does not interfere with department business is appropriate, with the permission of the employee's immediate supervisor.

Can an employee bring his/her children to work?

Employees should provide care for their children away from work for the duration of the workday. Normally if there is an interruption in childcare, an employee uses personal leave and stays home with their children. *In an unplanned interruption of that care when the employee cannot be absent* (due to a project deadline or something of a similar nature), children may accompany their parent for brief periods of time. These occurrences should be brief and rare.

What is the department's opinion about visible tattoos or piercings?

Employees are encouraged to use discretion concerning body tattoos and piercings, and in the presence of our customers tattoos and body piercings should not be visible.

I see some people wearing athletic shoes when they are working. Can I wear them too?

There are times when an employee has a medical reason for wearing a certain type of shoe. These situations are a matter of discussion for the employee, their supervisor, and HR. Other than for a medical reason or for getting exercise during breaks and lunch, employees should wear shoes that reflect a professional image.

My work space is a cubicle. When the people around my office use speakerphones I can hear them. There are also times when someone walks into my office and immediately begins talking to me, and my concentration is broken at a critical point in my work. Help!

Please realize employees who are working in cubicles have to block out "noise" on a daily basis. Be considerate of them as you interact within hearing distance of cubicle offices. The same courtesy should be extended to all employees, whether in walled offices or cubicles.

CERTIFICATION OF ACKNOWLEDGEMENT

Dressing for success not only reflects your position at the Mississippi Department of Education, but it is a reflection of who you are.

These policies and procedures, along with examples, are provided as a guideline to help employees understand the Department's requirements of appropriate dress and grooming. If an employee has questions about specific types of clothing, the examples above, or other questions in general related to dress and grooming, he/she should check with his/her supervisor.

I acknowledge that I have received and understand the Mississippi Department of Education's Office, Dress and Appearance Etiquette Policy.

Employee Name (Print) Date

Signature Date

Human Resource Officer or
Authorized Representative Date

MISSISSIPPI DEPARTMENT OF EDUCATION

Dress Down- Casual “Jean” Friday

Effective September 1, 2023, the MDE is implementing an optional privilege of dress-down Fridays when MDE employees may wear casual “jean” attire. MDE employees are expected to dress appropriately while still maintaining a professional appearance. This shall not apply if MDE employees are meeting with external parties.

Casual jeans may be worn with an appropriate blouse/sweater, or collared shirt. Office acceptable jeans are defined as denim that is neat and clean and that is NOT distressed, cut-off, ripped, paint-splattered, ill fitting, excessively baggy, sequined, and/or does not contain cutouts or patchwork. Acceptable jeans may be worn with boots, athletic-type sneakers/shoes, loafers, sandals, flats, or pumps. House shoes, slippers, shower shoes, plastic sandals, and flip-flops, are strictly prohibited.

All employees shall continue to adhere to the Mississippi Department of Education’s Office, Dress and Appearance Etiquette Policy, in all other instances, Monday through Thursday.

Employee Signature:

Date:

MISSISSIPPI DEPARTMENT OF EDUCATION (MDE)

Outside Employment Procedures

PURPOSE:

To avoid a Conflict of Interest, any outside employment of an employee of the Mississippi Department of Education (MDE) shall have specific written approval of the employee's Immediate Supervisor, Department Director, and Chief. The approval verifies no conflict of interest exists with the employees outside employment and current agency employment.

GENERAL:

Outside employment is defined as any compensatory work secondary to your MDE employment. This excludes an assignment with a Reserve Component of the Military Forces.

The Approval of Outside Employment form shall be submitted by an employee at (1) the time of appointment; (2) when previously approved employment is being permanently discontinued or the nature and/or scope thereof are/is being changed; (3) when any outside employment has not been approved; or (4) when requested to do so by the Director of Human Resources or by any supervisor of an employee.

Restrictions – The outside employment of an employee may be approved, if, and only if, this outside employment is to be performed in accordance with the following restrictions:

1. On a day that an employee is scheduled to work for the MDE, the secondary employment can only be performed outside the employee's normal working hours unless, before performing the outside activities, the employee has obtained a signed and approved leave slip.
2. The outside work is not to be performed at a location where the employee will be reimbursed, in whole or in part, by the MDE for his/her travel to that location. For example, if the employee's post of duty is Jackson and because of his/her duties and responsibilities as a MDE employee, he/she must travel to Laurel and will therefore be reimbursed for his/her mileage from Jackson to Laurel, the employee cannot take advantage of this reimbursement and work his/her outside employment while in Laurel on that day.
3. Use of information to which an employee has access as a MDE employee for performing an approved outside employment is strictly prohibited.

Advising Immediate Supervisor of Possible Conflict of Interest -An employee has an on-going duty to report to his/her immediate supervisor any incident or occurrence where the performance of his/her duties and responsibilities as a MDE employee may result in a possible conflict of interest.

Denial or Withdrawal of Approval of Outside Employment for Work Related Reason - Nothing in the foregoing provisions shall guarantee an employee approval of outside employment. Discretion lies with the agency if outside employment is approved, such approval is subject to being withdrawn at any time for any work-related reason, including, but not limited to, the possibility of a conflict of interest.

Failure to comply with this policy may result in disciplinary action that may include termination of employment with this agency.

TO: Carol Hodge
Human Resources Manager

FROM:

RE: Approval of Outside Employment

DATE:

In accordance with Section 15.5 of the *Mississippi State Employee's Handbook*, I am requesting approval for outside employment as described below:

Employer: _____
Work Schedule: _____
Total Weekly Hours: _____
Title of Position: _____
Description of Duties: _____

I understand that the use of the Mississippi Department of Education's (MDE) equipment, information, vehicles, and supplies in outside employment is prohibited, and that outside employment must not affect an employee's work hours, interfere, or conflict with an employee's regular duties, raise any ethics concerns, or necessitate long hours that may have an impact on an employee's working effectiveness.

I further understand that it is my responsibility to notify you of any change in the above-described employment including such time as I discontinue my outside employment.

Employee Signature: _____ Date: _____

Supervisor: _____ Date: _____

Bureau Director: _____ Date: _____

Approved _____ Disapproved _____

Chief

Date



FRAUD, WASTE AND ABUSE

It is the policy of the Mississippi Department of Education to thoroughly investigate all suspected cases of fraud, waste, and abuse. All reports of suspected fraud, waste and abuse will be handled in the strictest confidence. Informants may remain anonymous but are encouraged to cooperate fully with investigators and provide as much detail and evidence of the suspected fraud, waste, or abuse as possible. State law grants certain protections to whistleblowers, and any retaliation against employees who report suspected fraud, waste and abuse is strictly prohibited (See Miss. Code Sec. 25-9-173).

Fraud is defined as the use of one's occupation for personal enrichment through the deliberate misuse or misapplication of the employing organization's resources or assets. Examples of fraud include breach of fiduciary duty, bribery, concealment of material facts, theft of money or physical property, theft of secrets or intellectual property, and other statutory offenses.

Waste is defined as the loss or misuse of State resources that results from deficient practices, system controls, or decisions. An example of waste is not taking advantage of an available prompt pay discount.

Abuse is defined as the intentional, wrongful, or improper use of resources or misuse of rank, position, or authority that causes the loss or misuse of resources, such as tools, vehicles, computers, copy machines, etc. Examples of abuse are receiving favors for awarding contracts to certain vendors, requesting employees to perform personal errands for a supervisor or manager, and misusing the employee's position for personal gain.

Any employee or contractor who receives a report of suspected fraudulent activity must report this information immediately upon discovery. The report of suspected fraud, waste or abuse should not be mere speculation, and should be made in good faith. Any employee who knowingly makes a false report will be subject to disciplinary action. Reports must include enough information to support an investigation. To report suspected fraudulent activity, go to the MDE Home webpage and click the "Report Fraud, Waste, and Abuse link <https://internalaudit.mdek12.org/fraud>. Fill out and submit the electronic form. Your form will be directed to the Bureau of Internal Audit for review.

As appropriate, the Office of the State Auditor or appropriate law enforcement entity shall conduct investigations of potential fraud by MDE employees, vendors, contractors, sub-recipients or sub-allocants. If necessary, employees and others reporting fraudulent activity will be contacted for additional information.

Suspected fraud, waste and abuse may be reported directly to the Office of the State Auditor through their website at <http://www.osa.state.ms.us/>. The contact form is located at <http://www.osa.ms.gov/fraud/>.

Acknowledgment of Receipt:

Signature

Print Name

Title

Date



CODE OF ETHICAL CONDUCT

The Mississippi Department of Education is committed to protecting the safety, health and wellbeing of all employees in our workplace. This commitment includes protecting those employees who make disclosures they reasonably believe evidence serious health or safety violations, policy violations, abuse of authority, fraud, waste, or gross mismanagement of the agency's resources or mission.

Employees should disclose questionable actions to the Director of Compliance or the Director of Human Resources and will not be subject to workplace reprisal or retaliatory action.

Personnel matters for which other remedies exist are excluded from this policy. This includes grievances, appointments, promotions, reprimands, suspensions, dismissals, harassment, and discrimination.

Mission

The Mississippi Department of Education provides leadership through the development of policy and accountability systems so that all students are prepared to compete in the global community.

Vision

The vision of the Mississippi Department of Education is to create a world-class educational system that gives students the knowledge and skills to be successful in college and the workforce, and to flourish as parents and citizens.

Public Service

The employees of the Mississippi Department of Education are responsible for providing essential services for state government. No job is too large or too small for this agency in pursuit of its mission, and every job is important because we want to make sure government works for our citizens.

When you accepted employment with the Mississippi Department of Education, you accepted a job in public service. We are a public service agency. We expect our employees to be good stewards of Mississippi's financial and physical resources. We expect our employees to be respectful of their co-workers and customers. We also expect our employees to embody the public-sector competencies that have been adopted by the Mississippi State Personnel Board. These competencies are quoted directly from Mississippi State Personnel Board job

descriptions, and were agreed upon by subject matter experts. Below are characteristics or traits that should be exhibited by all MDE employees.

Integrity and Honesty: Demonstrates a sense of responsibility and commitment to the public trust through statements and actions. Models and demonstrates high standards of integrity, trust, openness and respect for others. Demonstrates integrity by honoring commitments and promises. Demonstrates integrity by maintaining necessary confidentiality.

Work Ethic: Is productive, diligent, conscientious, timely, and loyal. Conscientiously abides by the rules, regulations, and procedures governing work.

Service Orientation: Demonstrates a commitment to quality public service through statements and actions. Seeks to understand and meets and/or exceeds the needs and expectations of customers. Treats customers with respect, responding to requests in a professional manner, even in difficult circumstances. Provides accurate and timely service. Develops positive relationships with customers.

Accountability: Accepts responsibility for actions and results. Is productive and carries fair share of workload. Focuses on quality and expends the necessary time and effort to achieve goals. Demonstrates loyalty to the job and the agency and is a good steward of state assets. Steadfastly persists in overcoming obstacles and pushes self for results. Maintains necessary attention to detail to achieve high level performance. Deals effectively with pressure and recovers quickly from setbacks. Takes ownership of tasks, performance standards, and mistakes. Has knowledge of how to perform one's job. Knows the organization's mission and functions and how it fits into state government.

Self-Management Skills: Effectively manages emotions and impulses and maintains a positive attitude. Encourages and facilitates cooperation, pride, trust, and group identity; fosters commitment and team spirit; works effectively and cooperatively with others to achieve goals. Treats all people with respect, courtesy, and consideration. Communicates effectively. Remains open to new ideas and approaches. Avoids conflicts of interest. Promotes cooperation and teamwork.

Interpersonal Skills: Shows understanding, courtesy, tact, empathy, and concern to develop and maintain relationships. Demonstrates cross cultural sensitivity and understanding. Identifies and seeks to solve problems and prevent or resolve conflict situations. Encourages others through positive reinforcement.

Communication Skills: Receives, attends to, interprets, and responds to verbal messages and expresses information to individuals or groups effectively. Receives other cues such as body language in ways that are appropriate to listeners and situations. Considers the audience and nature of the information; listens to others, attends to nonverbal cues, and responds appropriately. May make oral presentations. Communicates ideas, suggestions and concerns, as well as outcomes and progress throughout the process of an activity. Provides thorough and accurate information.

Self-Development: Adapts behavior or work methods in response to new information, changing conditions, or unexpected obstacles. Seeks efficient learning techniques to acquire and apply new knowledge and skills; uses training feedback, or other opportunities for self-

learning and development. Develops and enhances skills to adapt to changing organizational needs. Remains open to change and new information and ideas.

Confidentiality: Limits the sharing of information to authorized individuals. Exercises good judgment and care at all times to avoid unauthorized or improper disclosures of confidential information; uses confidential information solely for the purpose of performing services as a trustee or employee of the agency.

Acknowledgment of Receipt:

Signature

Print Name

Title

Date



RELATED PARTY AND NEPOTISM

The Mississippi Department of Education recognizes that Related Party Transactions and Nepotism are in violation of State law, are not in the best interests of the public, and can present potential or actual conflicts of interest.

A related party is defined as a relationship in which one party has significant influence or control over another party. These relationships may lead to a conflict of interest, either implied or actual. Section 25-4-3, Miss. Code Ann. (1972), defines a public servant as any elected or appointed official of the government, officer, director, commissioner, supervisor, chief, head, agent, or employee of the State, political subdivision or any other body politic, or any individual who receives a salary, per diem, or expenses paid in whole or in part out of government funds. Section 25-4-105, Miss. Code Ann. (1972), prohibits a public servant from being involved in any related party transactions to obtain financial benefits for any relative or any business with which he is associated.

The following activities may indicate a related party transaction:

- Acting as a contractor, subcontractor, or vendor, or having a material interest in an entity serving as a contractor, subcontractor, or vendor, for the governmental entity the public servant is associated with;
- Acting as a purchaser at a government sale of the governmental entity the public servant is associated with;
- Accepting compensation to influence a decision of the governmental entity the public servant is associated with;
- Using or disclosing information gained in the course of employment as a public servant for financial benefit.

If an employee or contractor becomes aware that they or a family member may be involved in a related party transaction the employee or contractor should immediately complete the Related Party Questionnaire located under forms on the Human Resources webpage (www.mdek12.org/Forms/RelatedParty) and submit it to the Director of Procurement.

Nepotism is defined as favoritism or patronage granted to relatives without regard to merit. Section 25-1-53, Miss. Code Ann. (1972), prohibits the hiring of any person related by blood or marriage within the third degree as computed by civil law. These persons include parents, grandparents, great-grandparents, children, grandchildren, great-grandchildren, siblings, nieces and nephews, and aunts and uncles.

In accordance with this law, the Department of Education prohibits the hiring of such family members in the following situations:

- There is a direct reporting relationship;
- The immediate family member will be working in the same program area and in the same work site; or
- The immediate family members will occupy positions in the same "decision making" process which would compromise internal controls (i.e. decisions regarding approval of contract, payment of fees, or acceptance of proposals).

Any employee involved in the recruitment and selection process should not be an immediate family member of a prospective candidate. Any applicant who withholds or gives false information regarding personal relationships may be terminated, and any employee involved in the hiring process who knowingly violates this policy may be disciplined up to and including termination. Supervisors should not supervise immediate family members where there may be a conflict of interest arising from personal relationships.

Acknowledgment of Receipt:

Signature

Print Name

Title

Date

MISSISSIPPI DEPARTMENT OF EDUCATION

General Rules of Conduct

Employees are to engage in the conduct listed below and may be disciplined or dismissed for excessive abuse. This list is not exhaustive.

Work Policies (Section 7.0 of Employee Procedure Manual)

A. OFFICIAL DUTY STATION

- Each employee will be assigned on their employment date an official duty station. (An official duty station is defined as a location an employee reports to work at least 80% of the time. For most Department of Education employees, the official duty station is the town/city in which his/her office is located.) An employee's official duty station is subject to change based on the requirements of the job.

B. EMPLOYEE WORK SCHEDULES

- State law requires that all state offices be available to the public for services from 8:00 a.m. to 5:00 p.m., Monday through Friday.
- All full-time employees are expected to work eight (8) hours per day, forty hours per week.
- All part-time/hourly employees shall be provided with a schedule of working hours.

C. FLEXIBLE WORKING SCHEDULE (ONLY IF APPROVED AND APPLICABLE)

- The Department has implemented flexible working schedules between the hours of 7:30 a.m. and 5:30 p.m. each day. All employees are expected to work the core hours of 8:30a.m. - 4:00 p.m.
- To obtain a flex-time schedule, the employee must submit a written request to his/her immediate supervisor.
- The supervisor must submit the flex-time request to all approving levels and the appropriate MDE Management Team member (office director) must concur with the schedule. Supervisors will be responsible for ensuring that all branch and/or division functions will be carried out when they recommend authorizing flex-time for an employee.
- If an employee is absent, other office staff may be required to temporarily change their work schedules to assure proper staffing is sustained.

- Flexible work schedules must be approved in advance and must be in effect for a six (6) month period. Any alterations to a previously approved flex-time schedule must be requested in advance. These requests should follow the procedures established above.

D. LUNCH PERIOD

- Can only be taken between the hours of 11:00 a.m. – 2:00 p.m.
- Employees are allowed either 30 minutes or one hour for a lunch period depending on their daily scheduled time or flex-time schedule. The supervisor has the responsibility of scheduling the lunch period for employees so that work flow is not interrupted.
- Employees taking lunch breaks in excess of the allotted time will be charged with personal leave or leave without pay if the employee does not have accrued personal leave. Employees are not permitted to work during the lunch period in order to make up time for being late or to accumulate leave time.

E. BREAKS

- Can only be taken between the hours of 9:00 a.m. – 3:30 p.m.
- Employees are permitted to have one break in the morning and one break in the afternoon, neither of which is to exceed 15 minutes between the hours of 9:00 a.m. 3:30p.m. Breaks are a privilege rather than a right and should never interfere with deadlines or work schedules.
- The supervisor has the responsibility of scheduling these breaks for employees so that the work flow is not interrupted and each division is attended at all times.
- Employees cannot forego breaks for the purpose of accumulating this time for use at a later date, nor can employees arrive late for work and depart early and substitute this time for a break. If not taken at the authorized time, breaks are forfeited.
- Breaks cannot be tagged on to your lunchtime (i.e. if your lunch break starts at 11:30 a.m., you cannot take a break at 11:15 a.m.).

F. ATTENDANCE AND TARDINESS

- Employees are expected to report to work on time and to maintain regular attendance.
- Planned absences should be scheduled in advance (Section 8.0 of Employee Handbook).
- All unexpected absences and tardiness should be reported to the employee's immediate supervisor before or no later than the time employee is scheduled to report to work.
- Such notification should be made directly to the employee's supervisor or to other supervision personnel. Voicemail messages are unacceptable; however, a text message is acceptable to your immediate supervisor's personal cell phone.

- » It is the employee's responsibility to secure approval from his or her supervisor before leaving the work site for any reason during the assigned work hours. If such absences become necessary, the employee shall give the reason and indicate an estimated time of return.

G. TIME REPORTING

- All Fair Labor Standards Act (FLSA) non-exempt employees (secretarial and support personnel) of the Mississippi Department of Education shall be required to complete a monthly time sheet.

H. ALCOHOL AND CONTROLLED SUBSTANCE USE (Drug-Free Workplace)

- It is the policy of the Mississippi Department of Education to maintain a drug and alcohol abuse-free workplace.
- The Department has adopted the policy that all areas it occupies will be tobacco-free.
- The following policies are related only to those employees, applicants, and contractual workers subject to 49 C.F.R. Part 40 and the Omnibus Transportation Employee Testing Act of 1991.

I. SAFETY PROGRAM

- It is the objective of the Mississippi Department of Education to conduct all operations as safely and efficiently as possible.
- Training activities coordinated by the safety officer will improve the safety of employees and visitors.
- All employees will report all accidents/incidents and health hazards as they occur.

J. WORKPLACE VIOLENCE POLICY

- The Mississippi Department of Education is committed to the prevention of workplace violence and the promotion of a safe environment for its employees and the public it serves.

K. LEAVE POLICIES

- All full-time employees of the Mississippi Department of Education shall be provided, in accordance with the policies established by the State Legislative and the Mississippi State Personnel Board, the following types of leave: personal, major medical, military, administrative, family and medical (FMLA), compensatory, and leave without pay.
- Chronic Leave can ONLY be used for doctor's appointment or hospital stay related to that particular illness. Chronic Leave can only be used for the length of time a staff

member is at the doctor (i.e. 8:00 a.m. – 10:00 a.m.) Chronic Leave cannot be used for a full eight (8) hour shift.

L. LEAVE REQUESTS

- Requests for any type of leave, except medical emergencies, must be made in advance utilizing the Leave Request form.
- The employee must receive prior approval of the leave request from his/her supervisor or their designee before being absent from the office.
- An employee may request accrued leave at any time; however, the granting of personal leave requested is at the discretion of the employee's supervisor.
- Supervisory personnel have both the authority and responsibility to review and/or question any leave request.
- The supervisor's decision to approve or not approve leave is final

M. FIRE DRILLS

- When the building fire alarm sounds or an evacuation order is issued everyone should immediately use the nearest exit to leave the building.
- The outside rally point for the Central High School building is the West Street sidewalk in the front of the building.
- All personnel are to remain at the rally point until the "all clear" is announced, thereafter, it is safe to reenter the building.
- All fire alarms will be treated as real emergencies and the building will be evacuated.

N. ENTRANCE AND EXIT HOURS

- Badges allow for entrance through the dock area and the double doors from 6:00 a.m. to 6:00 p.m.
- Employees can enter through the glass doors after 7:00 a.m. Monday – through Friday. On weekends employees must enter through the dock area or through the double doors.
- Each badge recipient is assigned an access code by their supervisor, which dictates when they will be able to enter the building.

O. HOLIDAYS

- Employees will receive ten (10) legal holidays and any other days proclaimed a holiday by the Governor or the President of the United States. (Certain state holidays do not apply to employees of the Schools for the Blind and Deaf and School Attendance Officers work on the basis of a school calendar)

New Year's Day	January 1 st
Robert E. Lee's Birthday/	
Martin Luther King Jr's Birthday	3 rd Monday in January
Washington Birthday	3 rd Monday in February
Confederate Memorial Day	Last Monday in April
Jefferson Davis' Birthday/	

National Memorial Day	Last Monday in May
Independence Day	July 4 th
Labor Day	1 st Monday in September
Armistice or Veteran's Day	November 11 th
Thanksgiving Day	4 th Thursday in November
Christmas Day	December 25 th

P. DEFERRED LEAVE FOR A STATE HOLIDAY

- Time off will be awarded at straight time when worked on an official state holiday for exempt and non-exempt employees. Prior approval must be received by completing a Compensatory Leave form. (This does not apply to employees of the Schools for the Blind and Deaf, School of the Arts and School Attendance Officers work on the basis of a school calendar).

Q. HEALTH AND LIFE INSURANCE

- As a benefit, employees are provided a life and health insurance plan.
- Employees can obtain a life insurance policy and 50% of the cost is paid by the State of Mississippi.
- The plan provides employees and their dependents with many options for health and life insurance coverage, all employees are provided a Summary Plan Description that describes in details the benefits, eligibility and how to use the Plan.

R. COBRA COVERAGE

- COBRA, know as (Consolidated Omnibus Budget Reconciliation Act) allow coverage to continue if the cost is paid by the individual.
- Under certain circumstances, an employee may continue coverage under the group health insurance plan after termination up to 18 months or for qualified dependents (i.e. a child who has not reached a certain age) up to 36 months

S. WORKERS' COMPENSATION

- Employees are covered by workers' compensation insurance.
- On the job injuries or while travel, employees are entitled to financial and medical aid under this insurance program.
- Injuries must be reported within one working day of the accident to assure maximum coverage.
- Injuries should be reported to supervisor and the Human Resources office, Suite 203 of the Central High School building.

T. CAFETERIA PLAN

- The cafeteria plan provides a tax benefit; payments are made prior to calculating the taxable monthly salary.
- Employees are provided a cafeteria plan; payroll deductions are made for any allowable insurance coverage elected by employees to procure through this plan.

- Flexible spending accounts are also available as part of this plan, these accounts are Dependent Care and Medical Reimbursement.

U. SOCIAL SECURITY

- Employees are provided old age, survivors and disability insurance (OASDI) coverage (Social Security) by the Federal Social Security Administration. Participation is mandatory for each employee and deductions are made through payroll.

V. DEFERRED COMPENSATION

- Employees are provided a supplemental, voluntary savings plan administered by the Public Employees' Retirement System (PERS) Board of Trustees offering tax advantages to participants.
- Employees may choose to participate in the plan to set aside part of their salary each year.

W. FLOWER AND GIFT FUND

- This fund was established in order to send flowers or gifts to its members or their appropriate family members.
- Employees may choose to participate in the flower and gift fund to which the employees voluntarily contribute.

X. EMPLOYEE PARKING

- Parking is available in the Robert E. Lee Building parking garage on Lamar Street.
- Employees must have a parking decal on their car.
- Decals are issued by the Office of Capitol Facilities, DFA through the Office of Human Resources.

Y. ADDITIONAL INSURANCE , CREDIT UNIONS AND OTHER BENEFITS

- Other types of insurances (cancer, dental, hospitalization, etc.) are available from various companies and payroll deductions is provided for these plan but the employees are responsible for contacting the companies in which he/she may be interested.
- Employees and their dependents may join Statewide Federal Credit Union and the Mississippi Public Employees' Credit Union. Payments to the Credit Unions can be made through payroll deductions.
- Employees and their families are provided comprehensive counseling services at no cost to use if and when the need arises.

Acknowledgement of Policy & Procedures Overview

General Rules of Conduct

As an employee of the Mississippi Department of Education, I have been provided an overview of the policy and procedures of the agency and I agree to abide by all policies and procedures.

Employee Name (Print)

Employee Signature

Date

Technology and Security Training Acknowledgement for New Employees

I acknowledge that I will be notified by the Office of Technology and Strategic Services (OTSS) regarding mandatory Technology and Security Training. I will complete these trainings within three (3) business days of receiving the notification. I understand that failure to do so may result in immediate suspension of my account and any necessary personnel action up to and including termination.

Employee Name (Print)

Employee Signature

Date




**STATE OF MISSISSIPPI
DEPARTMENT OF EDUCATION**

Lance Evans, Ed.D.
State Superintendent of Education

MEMORANDUM

TO: All MDE Employees

FROM: Lance Evans, Ed.D. 
State Superintendent of Education

SUBJECT: Drug Free Workplace Act of 1988

DATE: November 19, 2013

The purpose of this memorandum is to inform you of the Drug Free Workplace Act of 1988 which was signed into law by President Reagan on November 18, 1988. This law requires all direct federal grant recipients to maintain a drug-free workplace or risk losing their federal funding. This law became effective March 18, 1989.

The Department of Education is required to notify employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantees workplace. Employees may be suspended without pay for up to thirty (30) working days, demoted, or dismissed for the first occurrence of any of the above acts.

Each employee of the Department of Education must sign a statement acknowledging that the employee received a copy of this memorandum and is aware of actions that will be taken against the employee for violation of such prohibition. Each employee is herein notified that as a condition of employment with the Department of Education, he or she will abide by the terms of this policy statement and notify the Department of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

The Department of Education has established a drug-free awareness program to inform employees about the dangers of drug abuse in the workplace. This program will restate the Department of Education's drug free workplace policies and penalties that may be imposed upon the employee for drug abuse violation occurring in the workplace. Information is available regarding the names of drug counselors, rehabilitation and assistance programs. You may call the Human Resources Office at 359-3511 to obtain this information.

ACKNOWLEDGEMENT
DRUG FREE WORKPLACE ACT OF 1988
MEMORANDUM

I have received a copy of the Drug-Free Workplace Act of 1988 Memorandum from the State Department of Education dated November 1, 2013. I am aware of actions that may be taken against me for the unlawful distribution, manufacture, dispensing, possession or use of a controlled substance at my workplace. I agree to abide by the policy terms set forth in the Drug-Free Workplace memorandum as a condition of my employment with the Mississippi Department of Education.

NAME

DATE

TO: MDE Employees

FROM: Carol Hodge, Director *CH*
Office of Human Resources

DATE: July 1, 2017

RE: Mississippi Department of Education Policies and Procedures

Please be advised that a copy of the Mississippi Department of Education's (MDE) Policy and Procedures Manual can be found on our website at [www.mdek12.org/Human Resources](http://www.mdek12.org/HumanResources). This Manual is designed to serve as a general guide and contains the rules, policies, and procedures of the MDE for all employees and contract workers.

The most up-to-date version of this manual is always located on the MDE website, and a copy is also maintained in each program office. It is your responsibility to read and become familiar with the contents of this manual. Any questions you have should be directed to your immediate supervisor.

.....

As an employee of the Mississippi Department of Education, this is to acknowledge that I have been informed of the MDE Policies and Procedures Manual, and I agree to abide by all policies and procedures contained therein.

Employee Name (Print)

Employee Signature

Date

Central High School Building
359 North West Street
P.O. Box 771
Jackson, MS 39205-0771

Phone (601) 359-3511
Fax (601) 576-2185
mdek12.org

Mississippi Department of Education
Confidentiality Agreement
And
State Agency Information

This Agreement is made this ___ day of _____, 20__ by and between the Mississippi Department of Education (MDE), an agency of the State of Mississippi, and _____(Employee).

WITNESSETH:

WHEREAS, Miss. Code Ann. § 25-1-100, provides that certain personnel records and other personnel information maintained by the MDE are exempt from the provisions of the Mississippi Publics Records Act of 1983; and

WHEREAS, Miss. Code Ann. §§ 25-61-9 and 25-61-11, specifically allows certain confidential or privileged information to be exempt from the requirements of public accessibility; and

WHEREAS, Miss. Code Ann. § 25-9-101, authorized the establishment in the State of Mississippi a system of personnel administration based on sound methods of personnel administration governing the establishment of employment positions, classification of positions and the employment conduct, movement and separation of state employees; and

WHEREAS, Miss. Code Ann. §73-52-1, provides that applications for licensure in the possession of a public body, such as the MDE, shall be exempt from the provisions of the Mississippi Public Records Act of 1983; and

WHEREAS, there are a number of federal and state laws that govern the protection of education records including the following: The Family Education Rights and Privacy Act (FERPA), (20 U.S.C. § 1232g, 34 C.F.R 99); Individuals with Disabilities Education Improvement Act or 2004 (IDEA) (20 U.S.C. § 1400 *et seq.*); the Richard B. Russell National School Lunch Act (42 U.S.C. § 1751 *et seq.*); the Mississippi Public Records Act of 1983 (Miss. Code Ann. § 25-61-1, *et seq.*), and Mississippi statutes which protect the confidentiality of education records such as permanent records, cumulative folders, disciplinary records and records of special education students (Miss. Code Ann. §§ 37-15-3, 37-15-6 and 37-23-137).

WHEREAS, Miss. Code Ann. § 37-1-9(2) authorizes the MDE to exempt from the provisions of the Mississippi Public Records Act of 1983, investigative reports compiled by the State Board of Education, the MDE, the Licensure Commission, or the Commission on School Accreditation in the process of investigating alleged misconduct; and

WHEREAS, the MDE treats personnel records and other related information including applications for employment as confidential information; and

WHEREAS, the MDE treats education records and other related information including, but not limited to, cumulative folders, disciplinary records, special education records, and free and Reduced Lunch records, as confidential information; and

WHEREAS, the MDE treats certain communications, documents, data, and records obtained during audits, including but not limited to, statewide assessment administration monitoring, accreditation audits, cyclical monitoring, as confidential information; and

WHEREAS, Employees of the MDE may collect and use information during their employment regarding applications for state employment, state Employees, independent contractors, student records, and other information the MDE considers as confidential or privileged information, including but not limited to, electronic and/or non-electronic correspondence, documentation and/or data; and

WHEREAS, unauthorized disclosure of said information by Employees may cause the MDE to be liable for civil remedies and criminal penalties; and

WHEREAS, unauthorized use or disclosure of said information by Employees for any purpose outside their intended use might be directly or indirectly detrimental to the MDE or any associated affiliates; and

Now THEREFORE, in consideration of employment with the MDE and the State of Mississippi, I agree to the following:

I. Agency Information

I understand that I am employed in a position of trust and confidence with the MDE by virtue of my access to personnel records, student records, licensure records, investigative records, communications, and/or other confidential or privileged agency information. I hereby pledge that I will use my best efforts and greatest diligence to protect and maintain the security of said records and other confidential or privileged information of the MDE.

I shall not, either during my employment with the MDE and/or State of Mississippi, *or thereafter*, directly or indirectly, use, make copies or notes of, destroy, or disclose to others for my own benefit or the benefit of another, any of the MDE's personnel records, student records, licensure applications and records, investigations records, communications, or other confidential or privileged information, whether the information is acquired, learned, attained, produced, or developed by myself alone or in conjunction with others, unless required by the MDE in connection with my employment in accordance with Agency procedures or any expressed written consent of the MDE. I make the same pledge with respect to all disclosures made to me by the MDE, or its agents, during my employment and regarding the personnel records, student records, licensure applications

and records, investigative records, and/or other confidential or privileged information of all State agencies or others with whom the MDE has a business relationship including independent contractors.

I also agree that all notes, memoranda, letters, forms, files, data, rubrics, records, contract papers, and other documents that are made or completed by me or which were available to me while employed at the MDE concerning any personnel record, student record, licensure application, investigative record, and/or other confidential or privileged information are to be kept private and not disclosed to others except as authorized by the MDE in writing or as necessitated by the duties, responsibilities and business of the MDE pursuant to established procedures. I understand, acknowledge and agree that such notes, memoranda, letters, forms, files, data, rubrics, research, records, contract papers, and other documents are the exclusive property of the MDE and MDE retains all rights, titles, and interest in said property, and I agree to deliver same to the MDE upon the termination of my employment or at any time at the MDE's request.

I understand that I shall be required to disclose such data and information as is publicly available. I understand that all such disclosure must be made in accordance with Agency policies and procedures.

II. Miscellaneous

I understand that nothing in this agreement shall be construed and interpreted to impair my right or the right of the MDE to terminate the employment relationship. I also understand that my obligations under this agreement will continue whether my employment with the MDE is terminated on a voluntary or involuntary basis, or with, or without cause.

This agreement supersedes any and all prior understandings and agreements regarding the same or similar subject matter hereof, which I may have entered into with the MDE or other State Agencies with relation to my employment by the State of Mississippi.

This agreement may not be canceled, altered, modified, amended or waived, in whole or in part, in any way, by verbal statement, representation, or other agreement made by any other Agency employee, or by any written document signed by any Agency employee other than the State Superintendent of Education by an instrument in writing.

I understand that if any part of this agreement shall be held to be void, invalid, or unenforceable, it shall not affect the validity of the balance of the agreement. This agreement is made in the State of Mississippi, and its validity, construction, interpretation and effect shall be governed by the laws of the State of Mississippi, without regard to the place of performance.

In making this agreement, I acknowledge that if I breach this agreement, such conduct will constitute and be grounds for disciplinary action. I also acknowledge that I have been afforded the opportunity to seek separate and independent advice from counsel of my choosing.

Employee Name (Please print)

Employee Signature

Date

ENTRY and EXIT CHECKLIST

The Entry/Exit Checklist must be completed by the immediate supervisor and employee on the first day of employment and prior to the terminated or transferred employee's last work day. The employee and the immediate supervisor must account for all items and equipment listed below and the equipment listed on the attached inventory sheet(s). If all items and equipment are not accounted for, the immediate supervisor shall assume total responsibility for any unaccounted for items or equipment. Additionally, the immediate supervisor shall assume total responsibility and liability if this process is not completed.

RECEIVED

RETURNED

_____	_____	KEYS
_____	_____	I.D. Badges/Building Access Card
_____	_____	Telephone, Gas or other Credit Cards issued by MDE
_____	_____	Cell Phones
_____	_____	UNIFORMS
_____	_____	TOOLS
_____	_____	Assigned equipment, not on inventory (documentation attached)
_____	_____	Parking Decal

We certify and verify that all items listed above and the equipment listed on the attached inventory sheet has been issued to the employee on the date listed. (Entry)

EMPLOYEE SIGNATURE

DATE

SUPERVISOR SIGNATURE

DATE

We certify and verify that all items listed above and with the equipment listed on the attached inventory sheet are accounted for at the time of employee's last work day. (Exit)

EMPLOYEE SIGNATURE

DATE

SUPERVISOR SIGNATURE

DATE

OFFICE OF: _____