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:_______________________________________

_______________________ WORK PHONE:_______________
City State Zip

NEXT OF KIN:_______________ RELATIONSHIP:_______________
(Name)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
	City or town, state, and ZIP code		

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, 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 most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

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. Expect to work only part of the year;

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

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

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.

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . **1** $ ________

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . . **2** $ ________

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

Form 89-350-20-3-1-000 (Rev. 09/20)

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:	1. Single	☐ Enter $6,000 as exemption . . . . ▸	$
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	2. Marital Status (Check One)	(a) ☐ Spouse **NOT** employed: Enter $12,000 ▸	$
		(b) ☐ 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	☐ 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 ____)	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 ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ 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 . . . . ▸		$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, 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-2058 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

1. **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

2. **Claiming personal exemptions:**

(a) Single Individuals enter $6,000 on Line 1.

(b) 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).

(c) 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)

(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.

(e) 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.

(f) 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.

3. **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.

4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION.

6. 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 BENIFIT OF EXEMPTION.

To comply with the Military Spouse Residency Relief Act (PL111-97) 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.):

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

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

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

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

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

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

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

Please bring (2) Forms of ID for
E-Verify

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.

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

LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
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.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B
Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
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

AND

LIST C
Documents that Establish Employment Authorization

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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
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. Native American tribal document
5. U.S. Citizen ID Card (Form I-197)
6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
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.

Acceptable Receipts

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

List A:
- 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

List B: Receipt for a replacement of a lost, stolen, or damaged List B document.

List C: Receipt for a replacement of a lost, stolen, or damaged List C document.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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.

❶ 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

❷ 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)

❸ 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
				☐ M ☐ 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
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

❹ 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*: ______________

❺ 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*: ______________

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, *fax* www.pers.ms.gov

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.

❶ Member/Retiree Information

First Name: ______________________ MI: ______ Last Name: ______________________ ☐ Member ☐ Retiree

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

❷ 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)

❸ 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
________	________	________	________	☐ P ☐ S ______ %	☐ M ☐ F
________	________	________	________	☐ P ☐ S ______ %	☐ M ☐ F
________	________	________	________	☐ P ☐ S ______ %	☐ M ☐ F
________	________	________	________	☐ P ☐ S ______ %	☐ M ☐ F
________	________	________	________	☐ P ☐ S ______ %	☐ M ☐ F

❹ 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*: ______________________

❺ 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*: ______________________

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, *fax* www.pers.ms.gov

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
Effective January 1, 2024

Legacy - Initially hired before 1/1/2006

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

	LEGACY EMPLOYEES				HORIZON EMPLOYEES			
	BASE		SELECT		BASE		SELECT	
ACTIVE EMPLOYEE	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	$459	$0	$479	$20	$459	$0	$507	$48
Employee + Spouse	$961	$502	$1,050	$591	$961	$502	$1,078	$619
Employee + Spouse & Child(ren)	$1,223	$764	$1,313	$854	$1,223	$764	$1,341	$882
Employee + Child	$589	$130	$680	$221	$589	$130	$708	$249
Employee + Children	$792	$333	$881	$422	$792	$333	$909	$450

*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		HORIZON RETIREES	
RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	BASE	SELECT	BASE	SELECT
Retiree	$527	$550	$842	$872
Retiree + Spouse (Non-Medicare)	$1,105	$1,207	$1,688	$1,798
Retiree + Spouse & Child(ren) (Non-Medicare)	$1,406	$1,509	$1,887	$1,998
Retiree + Child	$677	$751	$992	$1,073
Retiree + Children	$909	$952	$1,224	$1,274
Retiree + Spouse (Medicare)	N/A	$774	N/A	$1,096
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$975	N/A	$1,297
RETIRED EMPLOYEE - MEDICARE ELIGIBLE	BASE	SELECT	BASE	SELECT
Retiree	N/A	$224	N/A	$224
Retiree + Spouse (Non-Medicare)	N/A	$881	N/A	$1,150
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	$1,183	N/A	$1,350
Retiree + Child	N/A	$425	N/A	$425
Retiree + Children	N/A	$626	N/A	$626
Retiree + Spouse (Medicare)	N/A	$448	N/A	$448
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$649	N/A	$649

	LEGACY		HORIZON	
COBRA	BASE	SELECT	BASE	SELECT
Participant	$468	$488	$468	$517
Participant + Spouse	$980	$1,071	$980	$1,099
Participant + Spouse & Child(ren)	$1,247	$1,339	$1,247	$1,367
Participant + Child	$600	$693	$600	$722
Participant + Children	$807	$898	$807	$927
COBRA DISABILITY EXTENSION	BASE	SELECT	BASE	SELECT
Participant	$688	$718	$688	$760
Participant + Spouse	$1,441	$1,575	$1,441	$1,617
Participant + Spouse & Child(ren)	$1,834	$1,969	$1,834	$2,011
Participant + Child	$883	$1,020	$883	$1,062
Participant + Children	$1,188	$1,321	$1,188	$1,363

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**	**ZIP**
Primary Telephone Number	**Secondary Telephone Number**	**Personal Email Address**		
Marital Status ☐ Single ☐ Married	**Gender** ☐ Male ☐ 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? ☐ No (Horizon) ☐ Yes (Legacy)

If yes, please list your most recent (pre-1/1/06) employer and dates of employment: ______________________________

If married, is your spouse a Plan participant? ☐ Yes ☐ 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:	**Coverage Type**:	**Coverage Option:** (Choose Only One)	**Do you have Medicare?** ☐ Yes ☐ No
☐ Employee - Legacy	☐ Enrollee Only	☐ Base	**Medicare Number:** __________
☐ Employee - Horizon	☐ Enrollee + Spouse	☐ Choice	☐ "A" Effective Date: __________
☐ Retiree	☐ Enrollee + Child	☐ Select	☐ "B" Effective Date: __________
☐ COBRA	☐ Enrollee + Children		**Reason for Entitlement:**
☐ Surviving Spouse	☐ Enrollee + Spouse & Child(ren)		☐ Age ☐ ESRD ☐ Disability

Are you a tobacco user? ☐ Yes ☐ No If yes, are you interested in participating in the Plan's free cessation program? ☐ Yes ☐ 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 ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐
Insurance Company Name address & phone #:	__________	__________	__________	__________
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:

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 ☐ Male ☐ Female				Employed? ☐ Yes ☐ No
2.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
3.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
4.	☐ Son ☐ Daughter				☐ Child under 26 ☐ 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

☐ **Add Enrollee**: ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of Coverage due to Divorce
☐ Other: ____________________ Requested Effective Date: ____________________

☐ **Add Dependent(s)**: ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Other: ____________________
(List all dependents in Section E.) Qualifying Event/ Effective Date: ____________________

☐ **Change Coverage:** ☐ Base Coverage ☐ Choice Coverage ☐ Select Coverage

Drop Dependent(s): ☐ Divorce ☐ Deceased ☐ Other: ____________________
Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date

Other Changes (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: ____________

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 *my*Blue site, **https://myblue.bcbsms.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 *my*Blue 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

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)

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

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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.

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[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			4. Employer Identification Number (EIN)
Mississippi Department of Education			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

☐ 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

☐ I acknowledge that I regularly use a tobacco product in some form (cigarettes, cigars, pipe, oral tobacco products, etc.).

☐ **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

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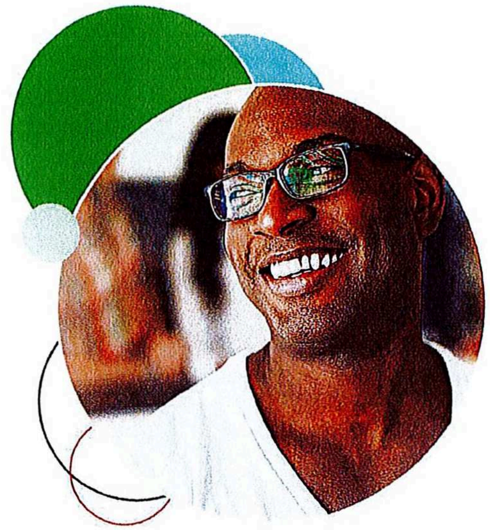
DELTA DENTAL



Keep Smiling

Delta Dental PPO™

Stay in network to save

Visit a dentist in the PPO[1] 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**.

If you can't find a PPO dentist, consider a Delta Dental Premier® dentist. These dentists have agreed to set fees and offer another opportunity to save.

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 to provide 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 Care[5], you can save as much as 50% on LASIK procedures and more than 60% on 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

PREMIER

NON-DELTA DENTAL

[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.

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HL_PPO-PRE #129455V (rev. 10/20)

Benefit Highlights: Delta Dental PPO™

Group name: Mississippi Department of Education

Group no: 22185 **Effective date:** 02/01/2023

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 D&P?	Platinum Plan: $50 per member / $150 per family each calendar year Gold Plan: Plan: $50 per member each calendar year Yes		
Maximums D&P counts toward maximum?	$2,000 Platinum Plan and $1,000 Gold Plan per member each calendar year Yes		
Waiting periods	**Basic services** Gold Plan: None Platinum Plan: None	**Major services** Gold Plan: None Platinum Plan: 12 months	**Orthodontics** Gold Plan: None Platinum Plan: 12 months

	Gold Plan		Platinum Plan	
Covered Services*	PPO dentists**	Non-PPO dentists**	PPO dentists**	Non-PPO dentists**
Diagnostic & preventive services (D&P) Exams, cleanings, x-rays, sealants, fluoride treatment and space maintainers	100%	100%	100%	100%
Basic services Fillings , simple tooth extractions and sealants	80%	80%	80%	80%
Endodontics Root Canals	Not Covered	Not Covered	50%	50%
Periodontics Surgical and Non-surgical	Not Covered	Not Covered	50%	50%
Oral surgery	80%	80%	80%	80%
Major services Crowns, inlays, onlays and cast restorations, bridges, dentures and implants	Not Covered	Not Covered	50%	50%
Orthodontics For dependent children only	Not Covered	Not Covered	50%	50%
Orthodontic maximums Lifetime	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's maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Delta Dental Premier® dentists and program allowance for Non–Delta Dental dentists.

Monthly Rates From 02/01/2021 – 01/31/2025	Gold Plan	Platinum Plan
Enrollee only	$21.22	$37.55
Enrollee + Spouse	$42.43	$75.02
Enrollee + Children	$46.67	$82.54
Family (EE, Spouse, & Child(ren))	$68.94	$119.86

Dental Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30023-1809

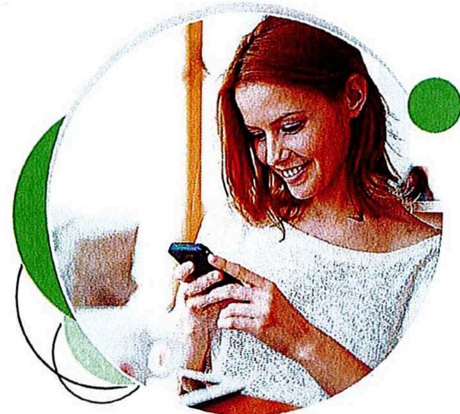
Customer Service
800-521-2651
deltadentalins.com

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

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.

DELTA DENTAL

Stay Connected



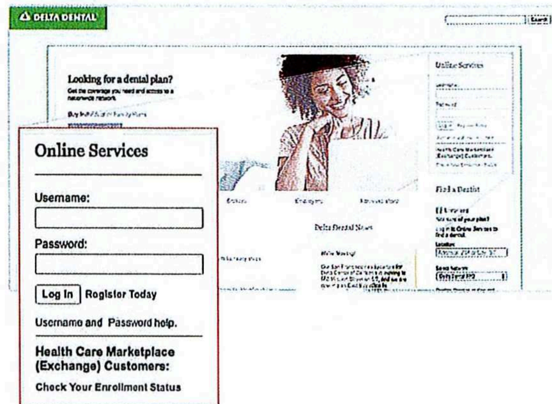
At **deltadentalins.com**, all the information you need is at your fingertips. You can check your plan details, find an in-network dentist and more.

Create an account

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

With an online account, you can:

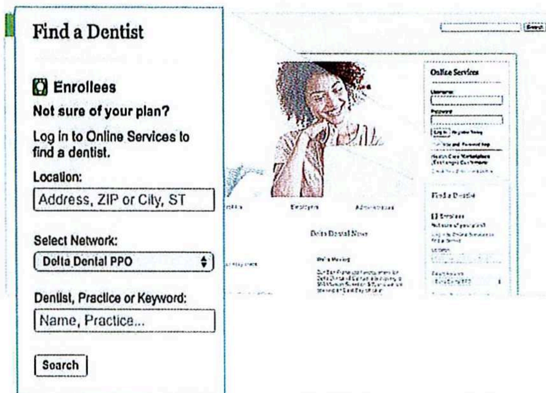
- Check your plan details and eligibility
- Review claim statements and plan documents
- View or print your ID card



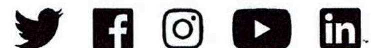
Find a dentist

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.

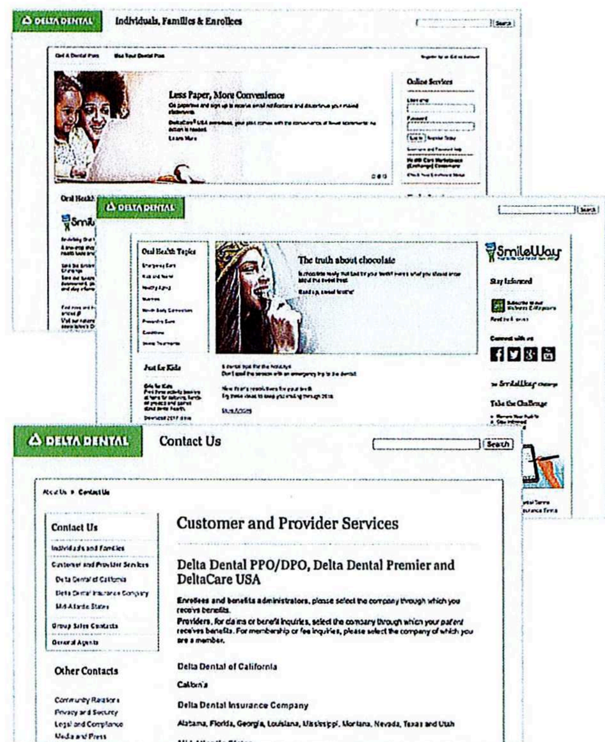
Improve your dental health:

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.

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EF30 #121175N (rev. 05/19)

Delta Dental Enrollment Form
Mississippi Department of Education
Group

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)	**$21.22**	**$42.43**	**$46.67**	**$68.94**
High Plan (Platinum)	**$37.55**	**$75.02**	**$82.54**	**$119.86**

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:

Clear vision and healthy eyes are critically important to general wellness. With personalized, quality eye care and eyewear options that suit your lifestyle, welcome to...

BrightVision Expanded

Powered by Superior Vision

BrightBenefits

Log in to review benefits at any time

Visit BrightBenefits.com to register your account. Once logged in, you'll be able to review a summary of plan benefits, view and print ID cards, and find a network eye care professional.

No ID card needed

You will need your name, birthdate and member ID number (or social security number). If you do want an ID card, provide an email address when you enroll, and we can email it to you at any time. You can also view and print IDs from your account at BrightBenefits.com.

If you need assistance...

If anyone on your plan has questions about how to access their vision benefits, visit BrightBenefits.com/contact or call us at 1 (844) 549-2603 Monday - Friday 7 a.m.-8 p.m. CST and Saturday 10 a.m.-3:30 p.m. CST.

What makes this plan popular?

Large network with 110,000 points of access across the U.S.[1]

Variety of in-network retail options

1. BrightVision Expanded uses the Superior Vision network of providers. Access count from superiorvision.com, Oct. 2020. Products in the state of New York are underwritten by Commercial Travelers Life Insurance Company. Policy form number CVIGRP 2020. In all other states, they are underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. Policy form number NVIGRP 2020 or NVIGRP-SV 2019. OEBVEXP0321

BrightVision Expanded 4

Mississippi Department of Education

Benefit	Description	Copay[1]	Frequency
Eye Exam	Focuses on your eyes, vision and wellness	$10	Every 12 months
Prescription Glasses	*Options below*	$10	-
Frame	$130 frame allowance at network locations Plus 20% off any amount over your allowance[2]	included	Every 12 months
Lenses and enhancements	Clear plastic single-vision, bifocal, trifocal or lenticular lenses Polycarbonate lenses for dependent children	included	Every 12 months
Lens upgrades[2]	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 contacts[4] *(in addition to glasses)*	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 savings[2]

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 promotions[6]
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 coverage[1]

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

Coverage	Monthly premium
Employee	$8.38
Employee & spouse	$17.12
Employee & child(ren)	$15.10
Employee & family	$23.48

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. Products in the state of New York are underwritten by Commercial Travelers Life Insurance Company. Policy form number CVIGRP 2020. In all other states, they are underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. Policy form number NVIGRP 2020 or NVIGRP-SV 2019. OEBVEXP4RATES21

Lasik*Plus*

No need to worry about contacts and glasses.

Get LASIK Now!

Lasik*Plus*, the featured provider, has locations nationwide and offers extra value to you, such as:

- Free LASIK exam (over $100 value)
- All LASIK procedures are 100% bladeless
- Guaranteed Financing‡

All other in-network providers extend 15% off standard price or 5% off promotional price.

USE YOUR $800^ SAVINGS ON LASIK

TO SCHEDULE YOUR FREE LASIK EXAM,

Call 1-833-983-2020 or visit BrightBenefitsLasik.com

BrightBenefits™

Not an insured benefit.

Copyright© 2020 LCA-Vision, Inc. dba Lasik*Plus*®. ^ Savings is $400 per eye on a VISX Custom LASIK or Wavelight Wavefront-Optimized with Lifetime Advantage Plan. Limited time offer. Discount may not be combined with any other discount. . ‡Financing Options Guaranteed: Excludes Ft. Lauderdale, Northville and Oklahoma City Lasik*Plus* locations. Certain conditions apply. Down payment varies based on FICO score. Interest rate varies by length of term selected. See website for details.

FOCUS ON HEARING HEALTH

What to Know about Hearing Loss

Recognizing the signs of hearing loss

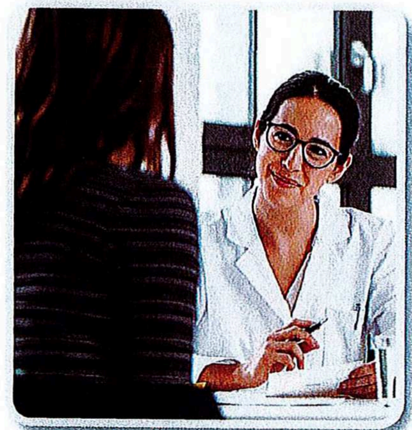
Signs of hearing loss can develop slowly over time, or they can begin suddenly. Struggling to hear certain sounds or syllables is a telltale sign of hearing loss.

An estimated 30 million Americans suffer from hearing loss and could benefit from using hearing aids.[1] Left untreated, hearing loss can have significant effects on communication abilities, quality of life, social participation and overall health.

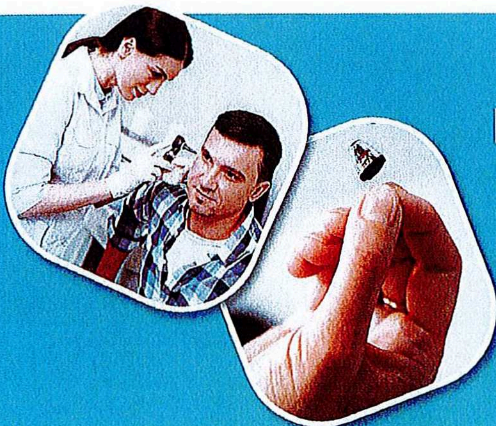
If you think you're experiencing hearing loss...
Schedule a hearing exam to find out if you have hearing loss. Call Your Hearing Network at 1-833-826-4705 to connect with a local hearing provider and obtain your free, no obligation hearing examination.

What to expect at a hearing exam...
Your hearing provider will examine your ears, conduct a comprehensive hearing test, and provide an explanation of your results. You will learn about your type and degree of hearing loss and have the opportunity to talk with your provider about your hearing concerns.

How is hearing loss treated?
Most hearing loss conditions in adults are treated with hearing aids. The type and style of hearing aid depend on the level of hearing loss, lifestyle and personal preferences of the individual. Talk with your provider about treatment options, and find out how today's discreet Bluetooth and smartphone enabled hearing aids can improve your hearing and wellness.



Our nationwide network of highly skilled and licensed hearing healthcare professionals provides patients with access to quality care and service. Schedule an appointment today with a local provider in your area.



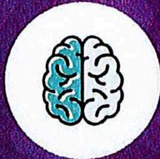
BrightBenefits members receive up to a **$200** mail-in rebate after purchase of select devices[2]

Impact of Hearing Loss

Studies have shown that hearing loss affects emotional, psychological and financial well-being. In fact, when untreated, hearing loss can lead to:

- Impaired memory and ability to learn new tasks
- Reduced alertness and increased risk to personal safety
- Reduced job performance and earning power
- Irritability, negativism, and anger
- Fatigue, tension, stress, and depression
- Avoiding social events

Hearing loss is linked to serious and costly health issues such as:



DEMENTIA AND ALZHEIMER'S

Moderate hearing loss triples the risk for dementia, while individuals with severe hearing loss are 5 times more likely to develop dementia. Caring for those with Alzheimer's and other dementias totaled an estimated $277 billion in 2018, making it the most expensive disease in America.[4]

DEPRESSION

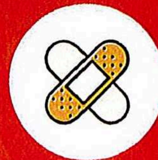
Untreated hearing loss is associated with an increased risk of depression, especially between the ages of 18 and 69. Major depressive disorder (MDD) affects 15 million adults and costs more than $210 billion per year.[4]

INJURY-CAUSING FALLS

Even mild hearing loss triples the risk of an injury-causing fall, with the risk increasing by 140% for every additional 10 decibels of hearing loss. Falls are the leading cause of accidental death of Americans over the age of 65. Medical costs from falls are $30-$50 billion a year.[4]

WORKPLACE INJURIES

Hearing loss can inhibit or prevent your ability to recognize hazards, which poses a risk to your safety. It is also the most common work-related injury, with over 20 million workers exposed annually to hazardous levels of occupational noise.[4]



Contact Your Hearing Network today!
Call 1-833-826-4705 to schedule an appointment with a provider in your area.

In partnership with
BrightBenefits.

A discount program for BrightBenefits members featuring...

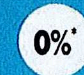
A FREE annual hearing exam for members 21 and older.

Up to 40% off national prices on high-performing hearing devices and 10% off accessories.[3]

3-year manufacturer's warranty, including loss and damage coverage.

1-year supply of batteries for FREE with each hearing aid purchased.

1 year of follow-up care at no additional cost.



Interest-free financing available.[5]

*Representatives are available to take your call Monday - Friday between 8:30 am - 8:00 pm eastern time. [1]National Institute on Deafness and Other Communication Disorders (www.nidcd.nih.gov/health/statistics/quick-statistics-hearing). [2]Rebates are valid only on product technology levels 3, 4, 5 and may not be used with any federal or state funded reimbursement programs. Rebates are not valid on returned hearing aids, please allow 60 days for receipt of the mail-in-rebate. [3]Over 40% off pricing as referenced in the Consumer Guide to Hearing Aids, details available on request. 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. [4]As referenced in America's Benefit Specialist, June 2020 issue. [5]Approval based on credit. This is a discount offering for Bright Benefits members. It is not an insured benefit.

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
MS Department of Education				

☐ A ☐ T ☐ C	Sex ☐ M ☐ 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)

	Sex	Last Name	First Name	M.I.	Date of Birth	Child handicapped?
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (Spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (Dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (Dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (Dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (Dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (Dependent)	First Name	M.I.	Date of Birth	☐Yes ☐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):

☐ Vision

- ☐ Employee Only $ $ 8.38
- ☐ Employee + Spouse $ $17.12
- ☐ Employee + Child(ren) $ $15.10
- ☐ Employee Family $ $23.48
- ☐ Waived due to other coverage
- ☐ Waive

Do you or any of your dependents have other vision insurance? ☐ **Yes** ☐ **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
Calendar Year 2023

CANCER-INTENSIVE CARE

AFLAC- Kent or Julie Tullos	(601)925-9963
Colonial - Beverly Sparks	(601)594-1184
AIG - Glynn Griffing & Associates	(601)982-0331

HOSPITAL INCOME

AFLAC- Kent or Julie Tullos	(601)925-9963
Colonial - Beverly Sparks	(601)594-1184

DENTAL/VISION

*Delta Dental – Debbie Whittington	(601)982-0331
*Bright Benefits – Debbie Whittington	(601)982-0331

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

SALARY PROTECTION (Short-Term Disability)

AFLAC- Kent or Julie Tullos	(601)925-9963
Colonial- Beverly Sparks	(601)594-1184
USABLE – Debbie Whittington	(601)982-0331

LONG-TERM CARE

AFLAC- Kent or Julie Tullos	(601)925-9963
USAble – Glynn Griffing & Associates	(601)982-0331

BURIAL INSURANCE

Transamerica Life – Elizabeth Veal	(601)355-7489

LIFE INSURANCE

AFLAC- Kent or Julie Tullos	(601)925-9963
Colonial - Beverly Sparks	(601) 594-1184
New York Life (term and whole life) Cindy McBride	(601)607-1600

PRE-PAID LEGAL SERVICE- Beverly Sparks (601)594-1184

TAX-SHELTERED ANNUITIES

Deferred Compensation - LaTaura Wilson	(769)610-5753

FLEXIBLE SPENDING MEDICAL & CHILD CARE BENEFITS

Glynn Griffing & Associates Debbie Whittington	(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

FLOWER AND GIFT FUND This fund was established to pay for flowers and gifts for employees/family member by voluntary contributions of a fixed amount monthly through payroll deduction.

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

Mississippi Department of Education

PARTICIPATION AGREEMENT FOR CAFETERIA PLAN **Effective Date: 1/1/2024**

Name:

SSN: **DOB:** **Pay Cycle:** Mo (12) **Department:**

Address: **City:** **State:** **Zip:**

Phone:

NEW Elections: 1/1/2024 to 12/31/2024

Option 1. Medical Reimbursement Account

____ ***YES*** I elect to contribute $__________ for the Plan Year, which is $__________per pay period to fund my account that pays qualified Out of pocket healthcare expenses that are not covered by my employer's health plan or any other health plan.

____ ***NO*** I decline this option this year.

_____ (Initial) **Debit Card Agreement.** I understand that the Benefits debit card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan, and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the Benefits debit card, I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck.

Option 2. Dependent Care Account

This pays for daycare expenses for a dependent child, adult, or elder, so that you may work. eligible services include: nursery school, nanny and/or before/after school care, and day camp through age 12, day care for a disabled adult or child, Elder daycare for parent or dependent.

_____ ***YES*** I elect to contribute $__________ for the Plan Year, which is $ __________ per pay period to fund my account that pays qualified dependent day care or elder care expenses

____ ***NO*** I decline this option for this plan year.

Option 3. Agreement to save taxes on Insurance Premiums

☐ **No change. Keep same selection as last year.**

_____ ***YES*** On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

____ ***NO*** **I decline this option for this plan year.**

IMPORTANT: Please read the following before signing this enrollment form. My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections (selected above) set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I understand that the take care flex benefits card is available to pay only qualified expenses and that qualified expenses paid with the card can not be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the flex benefits card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee Signature______________________________ **Email** ____________________________________ **Date**________________

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.

EAC Fund
Rev: 10/30/13

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

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

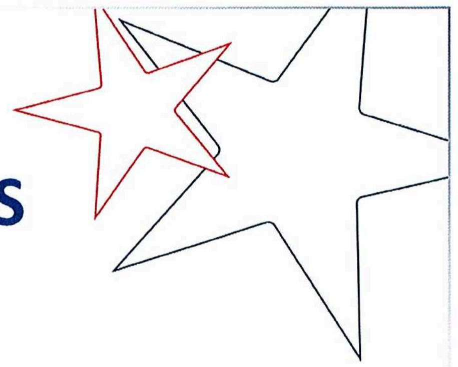
Medical - Major medical leave which is used beginning the second consecutive day of illness is also accrued on a monthly basis beginning with the first month of employment. Accrual rates are based on years of continuous service as follows:

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*

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.

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 DEPARMENT 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, expect 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 Date
Authorized Representative

Adopted August 31, 2023

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:

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

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

P. <u>DEFERRED LEAVE FOR A STATE HOLIDAY</u>

- 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. <u>HEALTH AND LIFE INSURANCE</u>

- 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. <u>COBRA COVERAGE</u>

- 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. <u>WORKERS' COMPENSATION</u>

- 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. <u>CAFETERIA PLAN</u>

- 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 my 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)

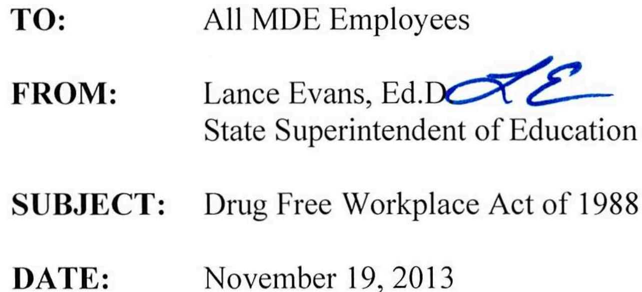
____
Employee Signature

____
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.

POST OFFICE BOX 771 • JACKSON, MISSISSIPPI 39205 • TEL: (601) 359-3512

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. 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 of1983; 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 or 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: ____