KING'S COLLEGE

WILKES-BARRE, PENNSYLVANIA 18711

Revised 4/2007

Application for Employment

We consider applicants for all positions without regard to race, color, sexual orientation, religion, gender, national origin, age, marital or veteran status, the presence of the non-job-related medical condition or disability or any other legally protected status.

Please Print

Date_____ Social Security No._____

Name_____Telephone No._____
Last *First* *MI*

Address_____
Street *City* *State* *Zip Code*

+

What position are you applying for?_____

How did you learn about us? Advertisement ❑ Friend/Relative ❑ Website ❑ Other_____

Do you have any friends or relatives who are currently working for King's College? Yes ❑ No ❑

If yes: Name(s)_____Relationship_____

Are you over the age of 18? Yes ❑ No ❑ If no, can you provide required proof of your eligibility to work? Yes ❑ No ❑

Are you currently employed? Yes ❑ No ❑ Were you previously employed by King's College? Yes ❑ No ❑

On what date would you be available to work?_____

Have you ever been convicted of or plead guilty to a felony or misdemeanor?
explain:_____
***A conviction will not necessarily disqualify you from the job for which you have applied.**
Are you legally eligible for employment in the U.S.A? Yes ❑ No ❑
If hired, you are required to submit proof of work eligibility.

Education

High School_____Years attended_____
Name *Address*

Course of Study_____ Did you graduate? Yes ❑ No ❑

College/Technical School_____Years attended_____
Name *Address*

Course of Study_____ Did you graduate? Yes ❑ No ❑

Other (Specify)_____Years attended_____
Name *Address*

Course of Study_____ Did you graduate? Yes ❑ No ❑

We Are An Equal Opportunity Employer

(Over)

Employment History

List below present and past employment, beginning with your most recent. Include job-related service assignments and volunteer activities. You may exclude organizations, which indicate race, color, sexual orientation, religion, gender, national origin, disabilities or other protected status.

1. Employer: _____Phone_____
Name *Address*

Dates: From_____ To_____ Salary: Starting _____Final_____ Supervisor _____

Job Title _____ Reason for Leaving _____

May we contact this employer? Yes ❑ No ❑ Duties Preformed_____

_____

2. Employer: _____Phone_____
Name *Address*

Dates: From_____ To_____ Salary: Starting _____Final_____ Supervisor _____

Job Title _____ Reason for Leaving _____

May we contact this employer? Yes ❑ No ❑ Duties Preformed_____

_____

3. Employer: _____Phone_____
Name *Address*

Dates: From_____ To_____ Salary: Starting _____Final_____ Supervisor _____

Job Title _____ Reason for Leaving _____

May we contact this employer? Yes ❑ No ❑ Duties Preformed_____

_____

Are there any other job related experiences, skills, or qualifications which will be of special benefit in the job for which you are applying? _____

_____

Are you physically/mentally able to perform the duties of the job you are applying for? Yes ❑ No ❑
If No, what reasonable accommodation could be made? _____

References

(Please give name and telephone number of three references not related to you.)

1. _____

2. _____

3. _____

The facts set forth in my application for employment are true and complete. I understand that, if employed, any false statement on this application may result in my dismissal. I further understand that this application is not a contract of employment, nor does this application obligate the employer in any way if the employer decides to employ me. My employment may be terminated at any time with or without reason or notice by the College or myself. I hereby authorize King's College to investigate my personal history and financial and credit record through any investigation or credit agencies or bureaus of you choice, if job related.

_____

Signature of Applicant

We Are An Equal Opportunity Employer

Direct Deposit Application & Change Form

☐ **New Application** ☐ **Change** ☐ **No Changes (sign and return)**

I authorize my employer to deposit my paycheck each payday directly into the account named below. I understand that I must give advance notice to allow reasonable time for my instructions to be executed. If ever an incorrect amount should be entered into my account, I authorize my bank to make the appropriate adjustment (s).

Name (Please Print)

Home Address

City State Zip Code

Social Security No.

Home Phone

Signature

This authorize will remain in full force and effect until Payroll receives thirty (30) days prior written notification from me of change or termination.

Complete this section for deposit your pay in a Savings or Checking Account

Bank*

Branch Address

Account Number

☐ Savings ☐ Checking

ABA NUMBER (first nine digits only)

Your ABA number appears at the bottom of your checks between the markings indicated above.

Please attach the following, depending on the type of account involved:
For existing checking account: A personal check with the word "VOID" written in large letters in ink across the face of it. Do not sign the check.
For existing savings account: A deposit slip from your bank.

***The bank you specify must be a member of the National Automated Clearing House Association.**

Attach VOIDED Check here

New applications and changes in banks used for current deposits will require a 30 day Pre-note period through the clearing house. During the Pre-note period you will receive a check for two semi-monthly pay periods before the direct deposit takes effect.

Date Completed by Payroll Dept.:

CLGS-32-6 (8-11)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

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

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
King's College			240804602
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (**No** PO Box, RD or RR)			
133 North River Street			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
Wilkes Barre	PA	18711	570-208-5900
MUNICIPALITY (City, Borough or Township)			
Wilkes Barre City			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE
Luzerne	400907		1.000%

CERTIFICATION

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

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

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

www.newPA.com

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $

2 Enter: { $12,700 if married filing jointly or qualifying widow(er) / $9,350 if head of household / $6,350 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2017 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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 who claims no withholding allowances; 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 possessions 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.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

_____

Tax Year

APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

- A copy of this application for exemption from the Local Services Tax (LST), and all necessary supporting documents, must be completed and presented to your employer AND to the political subdivision levying the Local Services Tax where you are principally employed.
- This application for exemption from the Local Services Tax must be signed and dated.
- **No exemption will be approved until proper documentation has been received.**

Name: _____ Soc Sec #: _____
Address: _____ Phone #: _____
City/State: _____ Zip: _____

REASON FOR EXEMPTION

1. _____ MULTIPLE EMPLOYERS: Attach a copy of a current pay statement from your principal employer that shows the name of the employer, the length of the payroll period and the amount of Local Services Tax withheld. List all employers on the reverse side of this form. **You must notify your other employers of a change in principal place of employment within two weeks of the change.**

2. _____ EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN _____ (municipality or school district) WILL BE LESS THAN $_____: Attach copies of your last pay statements or your W-2 for the year prior.

   If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the prior year.

3. _____ ACTIVE DUTY MILITARY EXEMPTION: Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.

4. _____ MILITARY DISABILITY EXEMPTION: Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.

EMPLOYER: Once you receive this Exemption Certificate, you shall not withhold the Local Services Tax for the portion of the calendar year for which this certificate applies, unless you are otherwise notified or instructed by the tax collector to withhold the tax.

Tax Office: _____
Address: _____ Phone #: _____
City/State: _____ Zip: _____

IMPORTANT NOTE TO EMPLOYERS

1. The municipality is required by law to exempt from the LST employees whose earned income from all sources (employers and self-employment) in their municipality is less than $12,000 when the levied rate exceeds $10.00.
2. The school district for the municipality in which your worksite(s) is located may or may not levy an LST. If it does, the income exemption provided may differ from the municipality and can be anywhere from $0 to $11,999.
3. Contact the tax office where your business worksites are located to obtain this information.

Employment Information: List all places of employment for the applicable tax year. Please list your PRIMARY EMPLOYER under #1 below and your secondary employers under the other columns. If self employed, write SELF under Employer Name column.

	1. PRIMARY EMPLOYER	2.	3.
Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

	4.	5.	6.
Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

PLEASE NOTE:

All information received by the Tax Collector is considered to be CONFIDENTIAL and is only used for official purposes relating to the collection, administration and enforcement of the LOCAL SERVICES TAX.

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION STATED ON AND ATTACHED TO THIS FORM IS TRUE AND CORRECT:

SIGNATURE: _____ **DATE:** _____

KING'S COLLEGE

WILKES-BARRE, PENNSYLVANIA 18711

DEMOGRAPHIC DATA CARD

☐ Employee
☐ Non-employee

PERSONAL CONTACT INFORMAION

Name As it appears on Social Security Card	Last	First	MI
Address	Street	City, State	Zip
Phone	Phone	Alternate Phone	
Social Security Number			

DEMOGRAPHIC INFORMATION

Gender ☐ Female ☐ Male

Date of Birth (mm/dd/yyyy) / /

Are you Hispanic or Latino?
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
☐ Yes ☐ No

Racial Category or Categories: Please select the category(ies) with which you most closely identify (check as many as apply or none)
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White

Disability Status: ☐ Not Disabled ☐ Disabled Individual

Are you physically & mentally able to perform the essential functions of your job? ☐ Yes ☐ No

Citizenship Status:
☐ US Citizen (Native)
☐ US Citizen Naturalized
☐ Permanent Resident
☐ Non Resident Alien
Vista Type:
Exp. Date:

Marital Status:
☐ Married
☐ Widowed
☐ Single
☐ Divorced
☐ Legally Separated

EDUCATION INFORMATION

Degree	Month/Year	Major	Name of Institution

EMERGENCY CONTACT(S) INFORMATION

Name	Phone	Alternate Phone

I certify the information which I have provided, is complete and accurate to the best of my knowledge.

Signature: Date:

KING'S COLLEGE
WILKES-BARRE, PENNSYLVANIA 18711

INFORMATION CONFIDENTIALITY POLICY

Through the normal execution of their work, in their work/learning environment, and through written and verbal conversations as well as computer records, employees may have access directly or indirectly to employee, student, and alumni information and relationships. Any and all information obtained officially or unofficially concerning a student, employee, or alumni shall be treated and considered confidential information. Acts of disclosure of confidential information about a student, employee, or alumni to any unauthorized personnel or for any purpose that is not work related shall be regarded as grounds for disciplinary action up to and including immediate termination of employment.

As stated in the College's Professional Code of Conduct Policy, King's College sets high expectations for conduct of its administration, professional and support staff. As individuals and as employees of the College, we adhere to the values of the College which promote acting with integrity, respect for others, and responsibility setting high standards of professionalism for our services and ourselves and assuming accountability for our conduct.

The scope of this policy is intended to include all information that is related to the regular operations of a department and the College. It is intended to promote respect and cooperation among employees for all who we serve. The College does understand that on occasion it is necessary to share information regarding a student, employee, or alumnus of the College in order to facilitate the efficient operations of the department. In all cases, this information must be business related. If you are unsure if the information is related to this limited purpose, it is the employee's responsibility to request clarification from their supervisor, respective senior administrator, or the Human Resources Department prior to releasing any information.

Please note that this list is not exhaustive, but is illustrative of potential violations of the Confidentiality Policy of the College which can occur in either verbal or written communication.

1. Discussing any situation, information or event that has been identified by a supervisor or senior administrator of the College as confidential with any individual outside of your direct reporting line or human resources representative.
2. Spreading or repeating gossip or rumors regarding a co-worker, supervisor, student, or alumnus whether you have firsthand knowledge or not. Please note information that is business related and required for the efficient operations of the College and your department is permitted with your direct supervisor and/or the appropriate member of the senior administration as well as the Human Resources Department.
3. Discussing a grievance or disciplinary situation with anyone other than your supervisor, respective member of Senior Staff, or the Human Resources Department unless otherwise instructed to do so in writing.

Compliance with the confidentiality standards require all employees exercise care in assuring the secrecy of their respective computer system passwords; the physical security of their work area; personal relationships; individuals personal information; and the proper storage, transmittal, and disposal of College based information stored on any media.

The College at all times adheres to the Family Educational Rights and Privacy Act of 1974, as amended, with respect to the disclosure of student education records to the student, the student's parents, other College officials, and any other individual, agency or organizations, including officials of other schools or school systems, representatives of the United States Government, state and local government officials, and all other public and private organizations.

Every employee must obtain the authorization of his/her immediate supervisor or appropriate College official before releasing any information with respect to any student, employee, or alumni to any individual, agency organization, or College employee, so that compliance with the law may be assured. It is the employee's responsibility to gain the necessary clarification before releasing information when any questions related to business necessity are present.

Employees are required to review and sign this policy annually. All signed forms will be kept in the employee's personnel file. Employee's who violate this policy will be subject to disciplinary action under the Progressive Discipline Policy. The College reserves the right to terminate employment for willful misconduct when a breach of confidentially is deemed severe enough to disrupt the normal operations of the College, department, or employee.

This policy **does not** prohibit the discussion of wages and other terms and conditions of employment.

In addition, the college will provide each employee with an email account and/or a telephone extension. Please note that all correspondence that transpires on these accounts is property of King's College.

I have read and understand the College's Policy on Confidential Information and Confidentiality. I affirm that I will exercise diligence in the performance of my duties in accordance with institutional policy and will demonstrate respect for others by acting with integrity. Furthermore, I understand that violation of College policy will result in disciplinary action up to and including termination of employment.

Signature	Date
Name (Please Print)	ID # or SSN
Witness	Date

King's College Guidelines for Employees for Interaction with Minors

(A child or minor is defined as a person under the age of eighteen. This includes students seventeen years of age and younger.)

As King's employees, it is our duty to model and maintain appropriate professional relationships with children and minors. Even though our employment at the College may not bring us into routine or direct contact with children, some contact may still occur as part of our work at King's. For example, many first-year students are minors by legal definition during their first year at King's. Residence life staff and coaches, for example, encounter students under the age of eighteen in locker rooms and living quarters. Faculty members who teach dual enrollment courses are in regular contact with minors. Numerous events sponsored by the College itself (Open Houses, Athletic and Fine Arts events, etc.), or outside groups often bring children to our campus.

The following guidelines provide basic information about interacting with minors up to and including children who are seventeen years of age. These guidelines apply both on and off campus while representing King's College. While some of the guidelines presented here might not pertain directly to your employment at the College, it is important to be aware of these guidelines so that together we can exercise our common responsibility to protect the safety and welfare of children. Maintaining appropriate professional boundaries can help to identify and prevent child abuse. King's College maintains separate policies that outline employee reporting responsibilities, as well as clearance, training and education requirements: "Protection of Children Policy" and "Clearance, Education, Mandatory Disclosure, and Training Requirements for King's College Employees, Students, Vendors and Volunteers." These guidelines are intended to provide an additional resource to promote the safety of minors and the development of healthy, professional and appropriate relationships.

Guidelines

1) When organizing a College activity involving children not enrolled at the College, the person in charge of the event should consult the College's Child Safety Protection Officer to ensure that appropriate levels of supervision are present.

2) Children not enrolled at the College must have parental permission for the child's participation in the activity.

3) When facilitating programs for children, the program supervisors must ensure that each child's whereabouts can be accounted for at all times and that activities are conducted in open areas with appropriate levels of supervision whenever possible.

4) With the exception of medical or other emergencies, employees should not be alone with a child, particularly in an isolated or private setting. Follow the "rule of three." Always have at least two adults or one adult and two children present. This provides safety for the children in the event of an injury or other emergency and is most protective of the employee and the program. Professors and professional staff may meet privately in college offices with students enrolled at the College on matters related to their common work.

5) During sports camps and other organized activities involving young children, safety requires adult supervision in locker rooms, restrooms, and changing areas. When supervising showers or changing areas, or any circumstance in which a child may be dressing or undressing, two adult supervisors should be present nearby. Supervisors are always to respect the privacy of the child. In addition, supervisors should not undress in front of or shower with minors.

6) If the program involves overnight accommodations, never sleep in the same bed or share sleeping accommodations (e.g. hotel rooms, bedrooms, tents) with a child.

7) Whenever possible, require children to use the buddy system (each child is assigned to another child as a companion) when participating in an off-campus program. Children should not be permitted to leave the group by himself or herself.

8) Do not hit or strike a child in any manner. Do not use any form of physical discipline or verbally abuse a child. Regarding verbal abuse, for example, do not ridicule, demean, bully, threaten, or scream at a child.

9) Always respect a child's physical boundaries and use good judgment about physical contact. Physical contact is not always necessary or appropriate in conveying concern. When physical contact seems appropriate the least intrusive form that communicates concern and support ought to be chosen. While it may seem perfectly natural, at times, to initiate an appropriate form of physical contact (e.g. placing your hand on the shoulder of a crying child), remember that not all children are comfortable with physical contact; children have the right to reject displays of affection. Hugs, initiated by the child, are permissible, but ought not to be prolonged. Respecting the child's physical boundaries while remaining supportive is key.

10) Do not engage in any form of inappropriate contact, for example, holding a school-aged child on your lap for an extended period of time, or slapping a child on the buttocks. Do not engage in physical "play" (e.g. tickling or wrestling) with children.

11) Treat all children consistently and fairly and avoid displaying favoritism.

12) Use age-appropriate language. Do not curse and do not discuss sensitive personal matters, especially anything sexual in nature. If a child initiates a conversation that leads you to suspect child abuse, follow the guidelines in # 17.

13) Do not use alcohol or drugs or encourage the use of alcohol or other drugs with or in front of children.

14) Do not give gifts to children without the permission of the child's parents or guardians. If a child gives you a gift valued at $25 or more acknowledge receipt of the gift to the child's parent or guardian.

15) As a general rule, do not exchange any personal information such as phone numbers or e-mail addresses, and do not respond to or initiate any relationships with children outside of the program (e.g., do not "friend" children on Facebook, engage in other social media, exchange texts, or initiate any face-to-face meetings). Contacting students enrolled in one's courses or programs on matters related to the common work engaged is, of course, permissible, but it should be through official King's College email accounts. Any contact with minors through personal email, telephone, or social media must be with parental knowledge and permission.

16) If a child is initiating contact outside of the program setting, especially multiple times, inform your supervisor or department chairperson.

17) If you have reasonable cause to suspect child abuse, or a child discloses abuse to you, follow the protocols established in the College's "Protection of Children Policy." If a child is in immediate danger call 911. If the danger is not immediate contact the PA ChildLine hotline (800-932-0312) and the Executive Director of Campus Safety and Security.

18) Employees who have questions about appropriate boundaries should speak with their supervisors, department chairs, program director, the College's Child Safety Protection Officer, or the Executive Director of Safety and Security.

I, hereby, attest that I have read the attached guidelines, understand the contents of this document, and I will follow these guidelines in my interactions with children.

_____

(Name: printed)

_____

(Signature)

_____

(Date)

Notification to Employees of Their Rights and Duties Under the PA Workers' Compensation Act Section 306 (f.1)(1)(i)

The Pennsylvania Workers' Compensation Act requires that employees be given written notice of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. The text of this section is provided on the next page.

If you are viewing this electronically, your electronic signature will be your acknowledgement that you have been provided with your rights and duties; otherwise, you must acknowledge this with your signature and return it to your employer. You may keep a copy for your records.

Rights and Duties

As an employee of the commonwealth working at a location where a list of designated health care providers has been established and posted, you have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that the commonwealth is not liable for the medical bills incurred. Specific rights and duties are:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent they are explained above.

_____	_____	_____
Employee's Printed Name	Employee's Signature	Date

If you have any questions, ask your human resources office or call the Bureau of Workers' Compensation at 800.482.2383

Text of Section 306 (f.1)(1)(i): The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

Pennsylvania Workers' Compensation Information

To all employees:

The workers' compensation law in Pennsylvania provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, PA 17104-2501

Telephone number within Pennsylvania: 800-482-2383
Telephone number outside of this Commonwealth: 717-772-4447

TTY- 800-362-4228 (for hearing and speech impaired only)

www.state.pa.us, PA Keyword: workers comp.

I, _____,

employee of _____ (employer),

certify that I received, read, and understood the information provided above on my date of hire _____ (date).

If applicable:

I, _____,

employee of _____ (employer),

certify that I received, read, and understood the above information on _____ (the date of work-related injury or disease).

Kings College
133-137 North River St
Wilkes-Barre PA 18702
July 2016

PENNSYLVANIA WORK-RELATED INJURIES

If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prostheses, including training in their use.

In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the designated health care providers listed below:

Occupational Medicine
Concentra Medical Center
268 Highland Park Blvd
Wilkes Barre Township, PA 18702
570-822-8831

Occupational Medicine
MedExpress Urgent Care – Wilkes Barra
677 Kidder St Ste D
Wilkes-Barre, PA 18702
570-825-2046

Ophthalmology
Northeastern Eye Institute
190 Welles St Ste 206
Forty Fort, PA 18704
570-718-0590

Orthopedic
The Knee Center
744 Kidder St Ste 2
Wilkes-Barre, PA 18702
570-825-5633

Orthopedic
George Ritz MD PC
150 Mundy St Mac 1
Wilkes- Barre, PA 18702
570-824-2225

Chiropractor
Active Performance Chiropractic
3 N. River St Ste 104
Plains, PA 18705
866-793-9788

Durable Medical Equipment
Homelink
1-866-834-5630

General Surgery
Surgical Specialists Of Wyoming Valley
200 S. River St.
Wilkes-Barre, PA 18705
570-821-1100

Physical Therapy
Align Networks
Call for Scheduling
866-389-0211

Diagnostic Testing
One Call Care Management
Call for scheduling
800-872-2875

Pharmacy
All major chain pharmacies
Healthesystems BIN#012874
877-528-9497 if you need assistance

**(NOTE: If any of the health care providers listed above are employer, owned or controlled by the employer or the employer's carrier, it will be so designated by an asterisk next to the health care provider's name.)

You must continue to visit one of these health care providers listed above, if you need treatment, for ninety (90) days from the date of your first visit.

After this ninety (90) day period, if you still need treatment and your employer has provided a list as set forth above, you may choose to go to another health care provider. You **MUST** notify your employer of this action within five (5) days of your visit to the health care providers of your choice.

Your bills will be considered IF: your health care provider files written reports on a form prescribed by the Department (these reports must be filed within ten (10) days of commencing treatment and at least once a month thereafter, as long as treatment continues).

If one of the health care providers listed above refers you to another health care provider, your employer or its insured will pay the bill for these services provided they are reasonable and necessary.

If you are faced with a medical emergency, you may secure assistance from a hospital or health care provider of your choice.

If you have any questions, contact: _____

KING'S COLLEGE
TRANSFORMATION. COMMUNITY. HOLY CROSS.

Add: ☐ **New Hire**

Change: ☐ **Address** ☐ **Name** ☐ **Health** ☐ **Dental** ☐ **Vision**

Life Event: ☐ **Marriage** ☐ **Dependent Add/Term** ☐ **Other**
Life Event Date: _____

ENROLLMENT FORM FOR BENEFIT COVERAGES

Section I. – Employee Information

Social Security Number	Last Name	First Name	MI

Address	City	State	Zip	Phone Number

Date of Birth mm/dd/yyyy	Gender	Marital Status	Hourly/Annual Earnings	Date of Hire (start date)	Effective Date	King's Employee Id#
	☐M ☐F	☐Single ☐ Divorced ☐Married ☐ Widowed				

Section II. – Enrollment/Dependent Information

	Name (Last/First/MI)	Gender	Date of Birth mm/dd/yyyy	Social Security Number	Enrollment (check all that apply to each member)
SELF		☐M ☐F			☐ **Health** ☐ **Dental** ☐ **Vision**
Spouse ☐Add ☐Term		☐M ☐F			☐ **Health** ☐ **Dental** ☐ **Vision**
Dependent ☐Add ☐Term		☐M ☐F			☐ **Health** ☐ **Dental** ☐ **Vision**
Dependent ☐Add ☐Term		☐M ☐F			☐ **Health** ☐ **Dental** ☐ **Vision**
Dependent ☐Add ☐Term		☐M ☐F			☐ **Health** ☐ **Dental** ☐ **Vision**
Dependent ☐Add ☐Term		☐M ☐F			☐ **Health** ☐ **Dental** ☐ **Vision**

Section III. – Bi-Weekly Payroll Contributions

		Single	Parent/Child(ren)	Husband/Wife	Family	Waive
Highmark BCBS	**PPO Value Plan $300**	☐ $54.00	☐ $133.00	☐ $157.00	☐ $189.00	☐
Highmark BCBS	**PPO Core Plan $500**	☐ $80.00	☐ $200.00	☐ $225.00	☐ $282.00	☐
Highmark BCBS	**PPO Premier Plan $150**	☐ $108.00	☐ $240.00	☐ $280.00	☐ $355.00	☐

Dental Coverage - *Please choose one election for Dental*

Single	☐ $10.51
Employee + 1	☐ $19.05
Family	☐ $27.86
Waive Participation	☐

Vision Coverage - *Please choose one election for Vision*

Single	☐ $1.57
Family	☐ $4.38
Waive Participation	☐

King's College HR Office Use Only

Faxed to Creative Benefits	☐
Entered on Pink Sheets	☐

Continued on Reverse

Section IV. – Beneficiary Information

Social Security Number	Name (Last, First)	Relationship	Type	Percentage (Must total 100%)
			☐Primary ☐Contingent	
			☐Primary ☐Contingent	
			☐Primary ☐Contingent	
			☐Primary ☐Contingent	

Section VI. – Guardian Life, AD&D and Long Term Disability

x Long Term Disability Coverage
x Life Insurance Coverage
☐ Voluntary Life Insurance Coverage*
* Voluntary Life Insurance is in addition to the company paid benefit.
* If electing Voluntary Life you must complete a **Guardian Application**.

☐ I do not wish to elect Voluntary Life Insurance coverage at this time

Section VI – Signature

Please note that all medical, dental, and vision payroll deductions will be taken on a pre-tax basis by King's College unless otherwise instructed.

I understand that I cannot change or revoke my election for the medical, dental or vision coverage's as of any date prior to the next open enrollment period unless I notify my Human Resources office within 30 days of a qualified change in status. The information provided above is true and correct to the best of my knowledge and I accept the provisions that I have read and understood.

Employee Signature_____**Date**_____

If you have any questions about completing this form, please call Creative Benefits, Inc. at 1-866-306-0200 ext. 7996 and ask for Maria Cometa.
Or contact via email at mcometa@creativebenefitsinc.com

Creative Benefits, Inc.
strategies to insure your success

New Employee Paperwork Checklist

- Application for Employment
  *complete if you have not already submitted, reference to resume can be noted in applicable areas
- Direct Deposit Form (mandatory)
- Residency Certification Form
  *http://munstatspa.dced.state.pa.us/Registers.aspx-for assistance with PSD code
- W4
- I-9
  *applicable identification must be submitted in hard copy for review)
- Local Tax Exemption Certificate- **if applicable** ,
  *please review reasons for exemption listed on the form.
- New Employee Demographic Card
- Information Confidentiality
- Employee Guidelines for Interaction with Children
- Workers Compensation Packet
  *review and sign acknowledgments
- Universal Enrollment/Change form
  *double sided, must be completed and signed

Please note we will need all of the above forms to be filled out along with applicable identification before we can begin to process your first pay.