ATTALA COUNTY SCHOOL DISTRICT NEW EMPLOYEE FORMS

The enclosed forms must be completed in their entirely. Be sure to read the information on each form carefully and complete all appropriate sections. Do not forget to sign and date each form.

This packet includes:

1. Mississippi Employee's Withholding Exemption Certificate
   If the instructions do not provide enough information regarding your individual situation, you should speak with a tax consultant or contact the Mississippi State Tax Commission.
2. W-4 Employees Withholding Allowance Certificate
   Follow the instructions on the form or for further information, speak with a tax consultant or contact the Internal Revenue Service.
3. Employment Eligibility Verification Form I-9
   Complete Section 1 only. Please do not forget to sign the document. We need a copy of your driver's license or picture ID and your social security card.
4. PERS Membership Application Form 1
   When completing this form please use black ink. Complete sections 1, 3 and 4.
5. PERS Beneficiary Designation Form 1B
   Please use black ink. Complete sections 1, 3 and 4.
6. Application for Coverage-Health Insurance Plan
   You are a Legacy employee if you were initially hired by a school district or another state agency in Mississippi, before January 1st, 2006. If you were initially hired on or after January 1st 2006, you are a Horizon employee. Please read the included information carefully to determine your rate and make any decisions on your health insurance. If you do not want the health insurance please check the waive coverage box and sign the waiver.
7. UNUM Provident Life Insurance Enrollment form
   If you do not want this life insurance please sign the waiver on the back of this form.
8. Direct Deposit Authorization Form
9. Permission for Background Check
10. Code of Ethics signature sheet
11. Dental and vision enrollment forms if needed
12. Deferred Comp enrollment form if needed

Additional Information for you to keep:

13. New Health Insurance Marketplace Coverage Options and Your Health Coverage
    We are required to provide our employees with this information.
14. Know Your Benefits flyer
    This flyer gives you the phone numbers you need for the health insurance plan. Also on this flyer is the web site where you can download the health insurance plan document.
15. Notice of Privacy Practices (HIPAA)
16. Notice of Enrollment Rights
17. Continuation Coverage Rights Under Cobra
18. 403(b) Announcement to Employees

I,______________________________, acknowledged that I have received the forms listed
(please print your name)

above. ______________________________, ________________
(signature) (date)

If you have any questions please call me at 662-289-2801.
Thank-you and welcome to the Attala County School District.

Cherie Joiner
School Business Manager

Form 89-350-23-8-1-000 (Rev. 11/23)

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.

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

City or town, state, and ZIP code

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*.

(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

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.

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card **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		**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		**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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,

Reverification and Rehire (formerly Section 3)

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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: Attala County School District Employer No.: 0210 - 000

Employer Representative's Name: Cherie Joiner Employer Representative's Title: Business Manager

Employer Representative's Phone: (662) 289-2801 Fax: (662) 289-2804 E-Mail: cjoiner@attala.k12.ms.us

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

Employer Representative's Signature: ____________ Date *mm/dd/ccyy*: ____________

Beneficiary Designation

Form 1B – Revised 08/30/2022

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

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: Attala County School District Employer No.: 0210 - ________

Employer Representative's Name: Cherie Joiner Employer Representative's Title: Business Manager

Employer Representative's Phone: (662) 289-2801 Fax: (662) 289-2804 E-Mail: cjoiner@attala.k12.ms.us

Employer Representative's Signature: ______________________ Date *mm/dd/ccyy*: ____________

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

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

Social Security Number	**First Name**	**MI**	**Last Name**	**Employer Name**

Home Address	**City**	**State**	**ZIP**

Primary Telephone Number	**Secondary Telephone Number**	**Personal Email Address**

Marital Status	**Gender**	**Date of Birth (mm/dd/yyyy)**	**Date of Employment/Retirement**
☐ Single ☐ Married	☐ Male ☐ Female		

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	◯ Select	**Medicare Number:** ____________
☐ Employee - Horizon	☐ Enrollee + Spouse	◯ Base (HIGH DEDUCTIBLE)	☐ "A" Effective Date: ____________
☐ Retiree	☐ Enrollee + Child		☐ "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:

	1.	2.	3.	4.
Name of Individual Covered:				
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 ☐ 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: ______________

Print

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

ACTIVE EMPLOYEE	LEGACY EMPLOYEES BASE TOTAL PREMIUM	LEGACY EMPLOYEES BASE EMPLOYEE PORTION	LEGACY EMPLOYEES SELECT TOTAL PREMIUM	LEGACY EMPLOYEES SELECT EMPLOYEE PORTION	HORIZON EMPLOYEES BASE TOTAL PREMIUM	HORIZON EMPLOYEES BASE EMPLOYEE PORTION	HORIZON EMPLOYEES SELECT TOTAL PREMIUM	HORIZON EMPLOYEES SELECT 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.

RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	LEGACY RETIREES BASE	LEGACY RETIREES SELECT	HORIZON RETIREES BASE	HORIZON RETIREES 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	LEGACY RETIREES BASE	LEGACY RETIREES SELECT	HORIZON RETIREES BASE	HORIZON RETIREES 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

COBRA	LEGACY BASE	LEGACY SELECT	HORIZON BASE	HORIZON 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	LEGACY BASE	LEGACY SELECT	HORIZON BASE	HORIZON 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

STATE AND SCHOOL EMPLOYEES' Life AND Health PLAN

Know Your Benefits

The *State and School Employees' Life and Health Insurance Plan Document (*PD*)* contains the benefits and eligibility guidelines of the State and School Employees' Health Insurance Plan (Plan). You can find an electronic version of the PD on our web site, http://knowyourbenefits.dfa.state.ms.us under Publications. You can also find participating providers in your area, a list of covered wellness/preventive services, premiums rates, and much more on this site. If you do not have internet access, you may request a paper copy of the PD by calling the Office of Insurance at 601-359-3411 or toll free (866) 586-2781.

The Patient Protection and Affordable Care Act requires that group health plans provide participants with an easy-to-understand *Summary of Benefits and Coverage* (SBC) and a uniform *Glossary of Health Coverage and Medical Terms* (*Glossary*) commonly used in health insurance coverage. Coverage examples in the SBC illustrate how the Plan covers care for common benefit scenarios.

You can find an SBC for both Base and Select Coverage and the *Glossary* on the Plan's web site. You can also find the glossary on the new health care reform web site at www.HealthCare.gov and www.dol.gov/ebsa/healthreform. If you do not have access to the internet, you may request a paper copy of these documents by calling the Office of Insurance.

For questions about medical claims call	To certify a hospital admission or other service call -	For questions about prescription drug claims call	To find a participating provider call	For general questions about the Plan call
Blue Cross & Blue Shield of Mississippi	ActiveHealth	Catamaran	AHS State Network	Office of Insurance
(800) 709-7881	(866) 939-4721	(866) 757-7839	(800) 294-6307	(866) 586-2781

motivating MISSISSIPPI

keys to living healthy

State Of Mississippi

Alternate State Life Insurance Plan

1/1/2023

Underwritten by *Unum Insurance Company of America*

Administered by Millette Administrators, Inc., Moss Point, MS

Phone 1-800-456-8647 Ext. 0 for Questions &/or to Have a Policy Emailed to You

Basic State Public Employees Plan

A All employees must participate unless they sign a wavier in the Superintendent's Office.

B Your benefit is 2x your annual salary rounded to the next highest $1,000 with a minimum of $30,000 and a maximum of $100,000.

C Accidental Death & Dismemberment (AD&D) benefits included for Actives.

D Includes Wavier of Premium to age 65.

E The State pays for half the benefit.

F Active employee cost is $ 0.10 per $1,000/month. The State cost is $0.10 per $1,000/month for actives.

G Retirees pay 100% of their premium. The State does not contribute for retirees.

Supplemental Life Insurance To State Life Plan

I Supplemental Life is offered in addition to the Basic Life and is optional. Paid for 100% by the employee.

II Accidental Death & Dismemberment (AD&D) benefits included for employee only.

III Includes Wavier of Premium to age 65.

IV Employee must be actively at work to enroll for supplemental coverage.

V New employees may enroll within first 30 days of employment without evidence of insurability. Evidence of Insurability is required after 30 days of employment.

Active Employees

$10,000 for $ 4.00/month

$25,000 for $10.00/month

$50,000 for $20.00/month

Dependent Coverage $5.00/month Until Spouse's Age 70. At Spouse's Age 70, Premium Increases to $23.50/month

Spouse	$10,000*
Each Child over 6 months	$ 5,000**
Each Child live birth to 6 months	$ 1,000

* Dependent Spouse totally disabled on effective date will not be covered until no longer totally disabled.

** Unmarried dependent children to age 19 or 25 if enrolled as full-time student in an accredited school.

Retiree Life Benefits and Premiums

a At retirement, employee can continue life insurance as provided for in the policy.

b You are ***not*** eligible to elect retiree life insurance if you did not have the life insurance as an active employee.

c Maximum benefit of $50,000 Minimum benefit of $ 5,000

d **Premiums may be deducted from monthly PERS retirement benefit or, paid annually by direct pay.**

e Premiums per $1,000 are the same for all retirees regardless of age.

f A retiree may not increase the amount of coverage he/she had at the time of retirement.

g Retirees do not have the extra benefit of AD&D. There is no reduction of benefit at any age level.

h Benefit is Group Term life insurance and does not build cash value. Your life insurance benefit will not terminate as long as premiums are paid.

Benefit Amount	Premium	Benefit Amount	Premium
$ 5,000	$ 7.75/month	$30,000	$ 62.10/month
'$10,000	$ 15.50/month	$40,000	$ 93.20/month
'$20,000	$ 31.00/month	$50,000	$124.30/month

UNUM PROVIDENT

State of Mississippi

Active Employee & Dependents Enrollment Form for Basic Life Insurance and Supplemental Life Insurance

Policy #537377-060

Employee Name (Last name, first, middle initial)		Social Security Number
Employee Address (street, city, state, zip code)		Date of Birth
Gender ☐ Male ☐ Female	Date of Employment	Annual Earnings
Employer ATTALA COUNTY SCHOOL DISTRICT		Occupation

Employee Life Insurance Amount: $____________ Eligible Active Employees receive coverage of two times annual salary rounded to next highest $1,000, subject to a minimum of $30,000 and a maximum of $100,000.

Note: All employees are automatically covered for Basic Life and AD&D unless a waiver is signed. (waiver on back of this form)

I am: ☐ New Enrollee ☐ Late Enrollee (Evidence of Insurability is required) ☐ Changing Beneficiary

☐ Changing Name (previous name ____________) ☐ Adding Dependent(s)

Beneficiary Information

Designate your beneficiary(ies) for your Basic and Supplemental Life coverage below:

Name	Relationship to You		Benefit %
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	

If no primary beneficiary(ies) survive you, the proceeds will be paid to the surviving contingent beneficiary(ies).

SUPPLEMENTAL LIFE AND DEPENDENT LIFE INSURANCE:

Choose from the following for electing Supplemental Life Insurance: List spouse & dependents to be covered:

Employee Life and AD&D	DEPENDENT/FAMILY COVERAGE
☐ $10,000	Spouse.....................$10,000
☐ $25,000	Per Child....................$ 5,000
☐ $50,000	To 6 Months per Child....$ 100
☐ None	☐ I elect dependent coverage.
	☐ I decline dependent coverage.

Dependent Name	Relationship	Date of Birth

I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I hereby authorize my employer to deduct monthly, the appropriate life insurance premium and also I further authorize my employer to forward payment of such premium amount to UNUM or its authorized agent/representative on the first working day of each month to cover the cost of my life insurance. I understand that UNUM and/or its authorized agent/representative is responsible for billing my employer monthly for the appropriate premium amount. I further understand that I am responsible for notifying UNUM and/or its authorized agent/representative concerning cancellation, premium changes, policy questions, and/or general information. Employee and Dependents must be actively at work and not disabled for coverage to be effective.

Employee Signature	Date	Work Phone	Home Phone

STATE OF MISSISSIPPI WAIVER OF BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMEMT PLAN 537377

If you do not want to elect Life coverage at this time, please mark the box below, and complete the form at the bottom. Be sure to sign and date the form.

☐ I do not wish to enroll in the State Life Insurance Plan. I realize that if I choose to enroll at a later date, my application will be subject to Medical Evidence of Insurability.

Employee Name ______________________________ Social Security #____________________

School District or Community College ____

Signature ______________________________ Date ______________________

ATTALA COUNTY SCHOOL DISTRICT

DIRECT DEPOSIT AUTHORIZATION FORM

New **enrollee**__________ **Change bank account(s)**__________ (please check one)

I authorize the Attala School District to deposit my net pay directly into the account(s) listed below and authorize the bank(s) listed below to credit the same to such accounts. I further authorize the Attala County School District to initiate adjustments for any credit entries in error to the account(s) below and authorize the bank(s) listed below to credit and/or debit the same to such accounts.

Main Direct Deposit Account Checking _____ Savings ______
Depository/Bank Name ____
Bank Transit (Routing) No. ____
Account Number ____

Additional Direct Deposit Account Checking _____ Savings ______
Depository/Bank Name ____
Bank Transit (Routing) No. ____
Account Number ____
Amount to be deposited __________ (Residual will be deposited to Main Account)

Additional Direct Deposit Account Checking ______Savings ______
Depository/Bank Name ____
Bank Transit (Routing) No. ____
Account Number ____
Amount to be deposited __________ (Residual will be deposited to Main Account)

Attach a VOIDED check for each checking account listed above.

Employee Name (Please Print) ____________________________Date _______
Social Security Number ____
Employee Signature ____

New Direct Deposit and/or any changes made to your existing Direct Deposit may result in a paper check the first month. All changes to Direct Deposit must be submitted to the Payroll Department five working days prior to payday with the exception of the months of June and July in which special rules may apply. For these months, you will need to contact the payroll department for specific deadlines.

ATTALA COUNTY SCHOOL DISTRICT
Kyle Hammond, Superintendent of Education
100 Courthouse Building, Suite 3
Kosciusko, MS 39090

Phone: 662-289-2801
Fax: 662-289-2804

PERMISSION FOR BACKGROUND CHECK

Date ________________

I, ____________________________, give my permission for the Attala County School District to conduct a background screening check with law enforcement, the Child Abuse Central Registry, previous employers, and any other persons to determine my suitability in working with children. I understand that this permission is a part of my application for a position with the Attala County School District. I further understand that this information will only be used in regard to the above application.

Signature_________________________________

Address_________________________________

____

Date of Birth______________________________

ATTALA COUNTY SCHOOL DISTRICT

CODE OF ETHICS AND STANDARDS OF CONDUCT

SIGNATURE SHEET

This is to verify that I have received a copy of the Mississippi Educator Code of Ethics and Standards of Conduct.

____

Name (Please print)

____

Signature

____

Date

Standard 8: Remunerative Conduct

An educator should maintain integrity with students, colleagues, parents, patrons, or businesses when accepting gifts, gratuities, favors, and additional compensation.

8.1. Ethical conduct includes, but is not limited to, the following:
- a. Insuring that institutional privileges are not used for personal gain
- b. Insuring that school policies or procedures are not impacted by gifts or gratuities from any person or organization.

8.2. Unethical conduct includes, but is not limited to, the following:
- a. Soliciting students or parents of students to purchase equipment, supplies, or services from the educator or to participate in activities that financially benefit the educator unless approved by the local governing body
- b. Tutoring students assigned to the educator for remuneration unless approved by the local school board
- c. The educator shall neither accept nor offer gratuities, gifts, or favors that impair professional judgment or to obtain special advantage. (This standard shall not restrict the acceptance of gifts or tokens offered and accepted openly from students, parents, or other persons or organizations in recognition or appreciation of service.)

Standard 9: Maintenance of Confidentiality

An educator shall comply with state and federal laws and local school board policies relating to confidentiality of student and personnel records, standardized test material, and other information covered by confidentiality agreements.

9.1. Ethical conduct includes, but is not limited to, the following:
- a. Keeping in confidence information about students that has been obtained in the course of professional service unless disclosure serves a legitimate purpose or is required by law
- b. Maintaining diligently the security of standardized test supplies and resources.

9.2. Unethical conduct includes, but is not limited to, the following:
- a. Sharing confidential information concerning student academic and disciplinary records, health and medical information family status/income and assessment/testing results unless disclosure is required or permitted by law.
- b. Violating confidentiality agreements related to standardized testing including copying or teaching identified test items, publishing or distributing test items or answers, discussing test items, and violating local school board or state directions for the use of tests
- c. Violating other confidentiality agreements required by state or local policy.

Standard 10: Breach of Contract or Abandonment of Employment

An educator should fulfill all of the terms and obligations detailed in the contract with the local school board or educational agency for the duration of the contract.

10. Unethical conduct includes, but is not limited to, the following:
- a. Abandoning the contract for professional services without prior release from the contract by the school board
- b. Refusing to perform services required by the contract.

This code shall apply to all persons licensed according to the rules established by the Mississippi State Board of Education and protects the health, safety and general welfare of students and educators.

Ethical conduct is any conduct which promotes the health, safety, welfare, discipline and morals of students and colleagues.

Unethical conduct is any conduct that impairs the license holder's ability to function in his/her employment position or a pattern of behavior that is detrimental to the health, safety, welfare, discipline, or morals of students and colleagues.

Any educator or administrator license may be revoked or suspended for engaging in unethical conduct relating to an educator/student relationship (Standard 4). Superintendents shall report to the Mississippi Department of Education license holders who engage in unethical conduct relating to an educator/student relationship (Standard 4).

For more information:
Mississippi Department of Education
359 North West Street
Jackson, MS 39201
601-359-3513
www.mde.k12.ms.us

MISSISSIPPI EDUCATOR

CODE OF ETHICS

STANDARDS OF CONDUCT

MISSISSIPPI DEPARTMENT OF EDUCATION

Standard 1: Professional Conduct

An educator should demonstrate conduct that follows generally recognized professional standards.

1.1. Ethical conduct includes, but is not limited to, the following:
  a. Encouraging and supporting colleagues in developing and maintaining high standards
  b. Respecting fellow educators and participating in the development of a professional teaching environment
  c. Engaging in a variety of individual and collaborative learning experiences essential to professional development designed to promote student learning
  d. Providing professional education services in a nondiscriminatory manner
  e. Maintaining competence regarding skills, knowledge, and dispositions relating to his/her organizational position, subject matter and pedagogical practices
  f. Maintaining a professional relationship with parents of students and establish appropriate communication related to the welfare of their children.

1.2. Unethical conduct includes, but is not limited to, the following:
  a. Harassment of colleagues
  b. Misuse or mismanagement of tests or test materials
  c. Inappropriate language on school grounds or any school-related activity
  d. Physical altercations
  e. Failure to provide appropriate supervision of students and reasonable disciplinary actions.

Standard 2: Trustworthiness

An educator should exemplify honesty and integrity in the course of professional practice and does not knowingly engage in deceptive practices regarding official policies of the school district or educational institution.

2.1. Ethical conduct includes, but is not limited to, the following:
  a. Properly representing facts concerning an educational matter in direct or indirect public expression
  b. Advocating for fair and equitable opportunities for all children
  c. Embodying for students the characteristics of honesty, diplomacy, tact, and fairness.

2.2. Unethical conduct includes, but is not limited to, the following:
  a. Falsifying, misrepresenting, omitting, or erroneously reporting any of the following:
    1. employment history, professional qualifications, criminal history, certification/recertification
    2. information submitted to local, state, federal, and/or other governmental agencies
    3. information regarding the evaluation of students and/or personnel
    4. reasons for absences or leave
    5. information submitted in the course of an official inquiry or investigation
  b. Falsifying records or directing or coercing others to do so.

Standard 3: Unlawful Acts

An educator shall abide by federal, state, and local laws and statutes and local school board policies.

3. Unethical conduct includes, but is not limited to, the commission or conviction of a felony or sexual offense. As used herein, conviction includes a finding or verdict of guilty, or a plea of nolo contendere, regardless of whether an appeal of the conviction has been sought or situation where first offender treatment without adjudication of guilt pursuant to the charge was granted.

Standard 4: Educator/Student Relationships

An educator should always maintain a professional relationship with all students, both in and outside the classroom.

4.1. Ethical conduct includes, but is not limited to, the following:
  a. Fulfilling the roles of mentor and advocate for students in a professional relationship. A professional relationship is one where the educator maintains a position of teacher/student authority while expressing concern, empathy, and encouragement for students.
  b. Nurturing the intellectual, physical, emotional, social and civic potential of all students
  c. Providing an environment that does not needlessly expose students to unnecessary embarrassment or disparagement
  d. Creating, supporting, and maintaining a challenging learning environment for all students.

4.2. Unethical conduct includes, but is not limited to the following:
  a. Committing any act of child abuse
  b. Committing any act of cruelty to children or any act of child endangerment
  c. Committing or soliciting any unlawful sexual act
  d. Engaging in harassing behavior on the basis of race, gender, national origin, religion or disability
  e. Furnishing tobacco, alcohol, or illegal/unauthorized drugs to any student or allowing a student to consume alcohol or illegal/unauthorized drugs
  f. Soliciting, encouraging, participating or initiating inappropriate written, verbal, electronic, physical or romantic relationship with students.

Examples of these acts may include but not be limited to:
  1. sexual jokes
  2. sexual remarks
  3. sexual kidding or teasing
  4. sexual innuendo
  5. pressure for dates or sexual favors
  6. inappropriate touching, fondling, kissing or grabbing
  7. rape
  8. threats of physical harm
  9. sexual assault
  10. electronic communication such as texting
  11. invitation to social networking
  12. remarks about a student's body
  13. consensual sex

Standard 5: Educator/Collegial Relationships

An educator should always maintain a professional relationship with colleagues, both in and outside the classroom.

5. Unethical conduct includes but is not limited to the following:
  a. Revealing confidential health or personnel information concerning colleagues unless disclosure serves lawful professional purposes or is required by law
  b. Harming others by knowingly making false statements about a colleague or the school system
  c. Interfering with a colleague's exercise of political, professional, or citizenship rights and responsibilities
  d. Discriminating against or coercing a colleague on the basis of race, religion, national origin, age, sex, disability or family status
  e. Using coercive means or promise of special treatment in order to influence professional decisions of colleagues.

Standard 6: Alcohol, Drug and Tobacco Use or Possession

An educator should refrain from the use of alcohol and/or tobacco during the course of professional practice and should never use illegal or unauthorized drugs.

6.1. Ethical conduct includes, but is not limited to, the following:
  a. Factually representing the dangers of alcohol, tobacco and illegal drug use and abuse to students during the course of professional practice.

6.2. Unethical conduct includes, but is not limited to, the following:
  a. Being under the influence of, possessing, using, or consuming illegal or unauthorized drugs
  b. Being on school premises or at a school-related activity involving students while documented as being under the influence of, possessing, or consuming alcoholic beverages. A school-related activity includes but is not limited to, any activity that is sponsored by a school or a school system or any activity designed to enhance the school curriculum such as club trips, etc. which involve students.
  c. Being on school premises or at a school-related activity involving students while documented using tobacco.

Standard 7: Public Funds and Property

An educator shall not knowingly misappropriate, divert, or use funds, personnel, property, or equipment committed to his or her charge for personal gain or advantage.

7.1. Ethical conduct includes, but is not limited to, the following:
  a. Maximizing the positive effect of school funds through judicious use of said funds
  b. Modeling for students and colleagues the responsible use of public property.

7.2. Unethical conduct includes, but is not limited to, the following:
  a. Knowingly misappropriating, diverting or using funds, personnel, property or equipment committed to his or her charge for personal gain
  b. Failing to account for funds collected from students, parents or any school-related function
  c. Submitting fraudulent requests for reimbursement of expenses or for pay
  d. Co-mingling public or school-related funds with personal funds or checking accounts
  e. Using school property without the approval of the local board of education/governing body.