

CMS

RIVERHEAD CENTRAL SCHOOL DISTRICT



CHANGE OF NAME *and/or* NEW ADDRESS FORM

Date: _____

Employee Retirement System (ERS)

Payroll #: _____

Position: _____

Current Information on File:

Last Name _____ First _____ M.I. _____

Street Address/P.O. Box _____

City/State/Zip _____

Phone # _____ Cell # _____ Email _____

*Please update my file to reflect the following change(s):
(Check appropriate box to indicate change)*

Name Change

Last Name _____ First _____ M.I. _____

Address Change

Street Address/P.O. Box _____

City/State/Zip _____

Phone # _____ Cell # _____ Email address _____

Employee Signature _____ *Date* _____

Please send attached paperwork to the District Office ASAP

10 Cont'd **ENTER REQUEST(S) BELOW**

H. Change Retiree Payment status Change to: pension deduction (Rate ___ / ___) direct payment to agency (APAY)
 I. Correct Social Security Number Incorrect SSN: _____

11 **PREVIOUS COVERAGE INFORMATION**

If you were previously covered under NYSHIP or another health insurance plan (attach proof, i.e. insurance bill or letter stating former coverage), please complete this section.	Previous ID Number: _____	Date Coverage Terminated: _____	
	Enrollee's Name Under Which Previously Covered	Last	First Middle Initial

12 **LEAVE WITHOUT PAY AND RETIREMENT STATUS**

LEAVE WITHOUT PAY	<input type="checkbox"/> I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage. <input type="checkbox"/> I do not wish to continue coverage while I am on authorized leave. I wish to resume my coverage upon return to the payroll.
RETIREMENT/ VESTEE STATUS	<input type="checkbox"/> I understand the requirements for continuing medical insurance coverage as a retiree and wish to continue my coverage. <input type="checkbox"/> I understand the requirements for continuing medical insurance coverage as a vestee and wish to continue my coverage.

13 **REQUEST FOR EMPIRE PLAN CARD**

<input type="checkbox"/> DUPLICATE CARD (Previously issued card remains valid.) <input type="checkbox"/> REPLACEMENT CARD (Previously issued card(s), lost or stolen, become invalid.)	FOR	<input type="checkbox"/> ENROLLEE <input type="checkbox"/> ENROLLEE AND ALL DEPENDENTS <input type="checkbox"/> INDIVIDUAL DEPENDENT Name _____
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Personal Privacy Protection Law Notification

This information you provide on this application is being requested pursuant to Section 163 of the New York State Civil Service Law for the purpose of enabling the NYS Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by your Personnel Office and by the Employee Benefits Division, NYS Department of Civil Service, Albany, NY 12239. For further information relating *only* to the Personal Protection Law, call (518) 457-9375. For information related to the Health Insurance Program, contact your Agency Health Benefits Administrator. If, after calling your Agency Health Benefits Administrator, you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

AUTHORIZATION

I understand that if I voluntarily decline or cancel my coverage, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date, and I may be forfeiting the right to such coverage after leaving agency service (vest, retirement, etc.). I certify that the information I have supplied is true and correct. I understand that my failure to provide required proof(s) within 30 days may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a misstatement of fact or conceals any pertinent information, commits a crime which is subject to a \$5,000 penalty and the stated value of the claim for each violation. I hereby *authorize deduction from my salary or retirement allowance* of the amount required, if any, for insurance indicated above. This authorization shall be in effect until I revoke it in writing.

Employee's Signature (Required) _____ Signature Date (Required) _____

AGENCY/EBD USE ONLY

Action/Reason	Date of Event	Hire Date	First Eligibility Date	Agency Code	Date Eligibility Lost	Retirement System
Retirement Tier	Registration #	Pension Deductions		Date Entered on NYBEAS	Effective Date	
		Yes _____	No _____			

HBA Signature: _____	Date: _____
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Dental

CSEA Employee Benefit Fund Change of Address Form



CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516

EMPLOYEE INFORMATION (PLEASE PRINT)

Member's Name _____ EBF ID# _____

Daytime Phone # _____ Email _____

OLD ADDRESS

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

NEW ADDRESS

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

PLEASE NOTE:

When you have a change of address, you must contact the Membership Records Department at CSEA Headquarters.

CSEA Membership Records Department
1-800-342-4146

Employee's Withholding Certificate

2020

▶ **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.**

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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, when to use the online estimator, and privacy.

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); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents	If your 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 and 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)



Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your Social Security number				
Permanent home address (number and street or rural route)	Apartment number	Single or Head of household <input type="checkbox"/> Married <input type="checkbox"/>				
City, village, or post office	State	ZIP code				
Are you a resident of New York City? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you a resident of Yonkers? Yes <input type="checkbox"/> No <input type="checkbox"/>		Married, but withhold at higher single rate <input type="checkbox"/> Note: If married but legally separated, mark an X in the Single or Head of household box.				
Complete the worksheet on page 4 before making any entries. 1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 20) <table border="1"><tr><td>1</td><td></td></tr></table> 2 Total number of allowances for New York City (from line 35) <table border="1"><tr><td>2</td><td></td></tr></table>			1		2	
1						
2						
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.						
3 New York State amount		<table border="1"><tr><td>3</td><td></td></tr></table>	3			
3						
4 New York City amount		<table border="1"><tr><td>4</td><td></td></tr></table>	4			
4						
5 Yonkers amount		<table border="1"><tr><td>5</td><td></td></tr></table>	5			
5						

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date
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Penalty – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an **X** in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS A

B Employee is a new hire or a rehire ... B First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes No

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)	Employer identification number
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Instructions

Changes effective for 2020

Form IT-2104 has been revised for tax year 2020. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2020 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you do not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your

employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$107,650 or more during the tax year.

The employee is required to notify the New York State Retirement System of any name or address change. Please remove the following New York Retirement System forms from the packet and mail to the address indicated on them.

RS 5512 Change of Address Form

RS 5483 Change of Name Form

Return the remaining forms to the District Office.



Office of the New York State Comptroller
 New York State and Local Retirement System
 Employees' Retirement System
 Police and Fire Retirement System
 110 State Street, Albany, New York 12244-0001

Receipt Date

Office Use Only

Change of Address Form

For Active Members Only (*not retirees*)

RS 5512

(Rev. 9/04)

PLEASE PRINT CLEARLY USING CAPITAL LETTERS. USE ONLY BLUE OR BLACK INK. STAY WITHIN BOXES. LEAVE BLANK BOXES BETWEEN WORDS AND NUMBERS.

Registration Number (if known) - Social Security Number - - Date of Birth / /

Month Day Year

Last Name First Name M.I.

Old Address Information:

Street Address

City State Zip Code

New Address Information:

Street Address 1

Street Address 2

City State Zip Code -

Daytime Telephone Number

()

E-mail Address

Signature

Date / /

Month Day Year

This form cannot be processed without your signature.

Mail this completed form to:
 New York State and Local Retirement System
 Member & Employer Services - Registration
 110 State Street-Mail Drop 5-7
 Albany NY 12244



Office of the New York State Comptroller
New York State and Local Retirement System
Employees' Retirement System
Police and Fire Retirement System
110 State Street, Albany, New York 12244-0001

RECEIVED

Name Change Notice

RS 5483

(Rev. 2/11)

PLEASE PRINT CLEARLY USING CAPITAL LETTERS. USE ONLY BLUE OR BLACK INK.

Registration Number -

Old Name
Last Name
First Name
M.I. -

New Name
Last Name
First Name
M.I. -

Last 4 Digits of Social Security Number* Telephone Number -

Reason for Name Change (Fill in one circle):

- Change in Marital Status Court Order (Please provide Court Order) Religious (Please provide Court Order) Other (Please specify) _____

Member Signature _____ **Date** _____
Please sign with new name

PERSONAL PRIVACY PROTECTION LAW

In accordance with the Personal Privacy Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the failure to pay benefits. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member and Employer Services, New York State and Local Retirement Systems, Albany, NY 12244; telephone number (518) 474-8482.

***SOCIAL SECURITY DISCLOSURE REQUIREMENT**

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to Sections 11, 31, 34 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.