TRS

RIVERHEAD CENTRAL SCHOOL DISTRICT

CHANGE OF NAME *and/or* NEW ADDRESS FORM

Date: ______________________

Payroll #: ______________________

Position: ______________________

☐ *Teachers Retirement System* (TRS)

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*

State of New York
Department of Civil Service
Alfred E. Smith State Office Bldg.
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
PA HEALTH INSURANCE TRANSACTION FORM

PS-503.1 (2/07L)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION *(All employees must complete)*

1 Last Name First Name MI | 2 Social Security Number | 3 Sex ☐ Male ☐ Female

4 Street Address City State Zip

5 Date of Birth | 6 Telephone Numbers Home ( )________ Work ( )________ | 7 Work location and address

8 Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated | Marital Status Date

9 Covered under Medicare? Self ☐Yes ☐ No Spouse/Domestic Partner ☐Yes ☐ No Dependent ☐Yes ☐ No

10 ENTER REQUEST(S) BELOW

A. ☐ Request Enrollment- **Individual**		For Agency Use: *(Select Empire Plan Option)* 7 (core plus med & psych)_____ 8 (core only)_____
B. ☐ Request Enrollment- **Family** (Complete G)	List dependents in section G	For Agency Use: *(Select Empire Plan Option)* 7 (core plus med & psych)_____ 8 (core only)_____
C. ☐ Decline Coverage	For Agency Use only:	Process waive benefits transaction
D. ☐ Voluntarily Cancel Coverage		
E. ☐ Name Change	Previous Name was:	

F. ☐ Change Coverage Date of Event ____________

Change to FAMILY (Complete G)

- ☐ Marriage
- ☐ Domestic Partner
- ☐ First dependent child acquired
- ☐ Dependent returned to full-time student status
- ☐ Request coverage for dependents not previously covered
- ☐ Newborn
- ☐ Previous coverage terminated (Complete Section 11)
- ☐ Other ____________

Change to INDIVIDUAL

- ☐ I voluntarily cancel coverage for my dependents
- ☐ I voluntarily cancel coverage for my domestic partner
- ☐ Only dependent died
- ☐ Only dependent married
- ☐ Only dependent graduated
- ☐ Only dependent left school
- ☐ Divorce
- ☐ Only dependent disqualified by age
- ☐ Termination of domestic partnership *(Attach Completed PS-427.4)*
- ☐ Other ____________

G. DEPENDENT INFORMATION *(use additional sheets if necessary)*

Check One: A (Add), D (Delete), C (Change), Medicare (M)
Date of Event ____________

Is enrollee or spouse reimbursed by another agency? ☐Yes ☐ No

	Last Name First Name MI	Relationship	Date of Birth	Sex	Address *(if different)*	Social Security #
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						
☐ A ☐ D ☐ C ☐ M						
A D C ☐ M						

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

☐ I wish to continue coverage while I am on authorized leave. I understand that I will be billed for this coverage.

☐ 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

☐ I understand the requirements for continuing medical insurance coverage as a **retiree** and wish to continue my coverage.

☐ I understand the requirements for continuing medical insurance coverage as a **vestee** and wish to continue my coverage.

13 REQUEST FOR EMPIRE PLAN CARD

☐ DUPLICATE CARD
(Previously issued card remains valid.)
☐ REPLACEMENT CARD
(Previously issued card(s), lost or stolen, become invalid.)

FOR

☐ ENROLLEE
☐ ENROLLEE AND ALL DEPENDENTS
☐ INDIVIDUAL DEPENDENT
Name ____________________

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:**

RIVERHEAD CENTRAL SCHOOL DISTRICT
700 OSBORN AVENUE
RIVERHEAD, NY 11901
BENEFITS OFFICE (631) 369-6704

SELE-DENT, INC
CHANGE OF NAME / CHANGE OF ADDRESS FORM

Employee Information:

Member's Name:______________________________ I.D.#:__________________

Name Change:____

Old Address:

Mailing Address:____

City:____________________________State:________Zip Code:____________

Home Phone:__________________________Cell Phone:_____________________

New Address:

Mailing Address:____

City:____________________________State:________Zip Code:____________

Home Phone:__________________________Cell Phone:_____________________

Employee's Signature:____

Effective Date:____

Authorization: ____
Denise Boden, Benefits Administrative Assistant

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department (HR Dept.).

APPLICANT

Your Name (Last, First, Middle)		Group Name Riverhead Central Faculty Member Benefit Trust	Group Number(s) 430873	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation	

LIFE

For questions about the coverage options available to you, and any Evidence Of Insurability requirements, ask your HR Dept.

Life Insurance

☒ Life Employer Paid

DISABILITY

For questions about the coverage options available to you, and any Evidence Of Insurability requirements, ask your HR Dept.

Long Term Disability

☐ Voluntary LTD

BENEFICIARY

This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Add Dependent ☐ Delete Dependent
Date of add/delete ____________

☐ Name Change
Former name ____________

☐ Beneficiary Change
☐ Other ____________

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Fraud Notice - Only applies to Accident and Health Insurance (AD&D/Disability/Dental): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Member/Employee Signature Required ____________ Date (Mo/Day/Yr) ____________

Dept. - Complete this section. Retain form for your records.

...n ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $________ Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr

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

2020

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

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **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

IT-2104

New York State • New York City • Yonkers

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 ☐ Married ☐ Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an *X* in the *Single or Head of household* box

Are you a resident of New York City? .... Yes ☐ No ☐

Are you a resident of Yonkers? .... Yes ☐ No ☐

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)*	1	
2 Total number of allowances for New York City *(from line 35)*	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	3	
4 New York City amount	4	
5 Yonkers amount	5	

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

Employee's signature	Date

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

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.

Change of Address Form
Change of Name Form

Return the remaining forms to the District Office.

GRE-50 (4/17)

OFFICE SERVICES ONLY

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395

MEMBER NAME/ADDRESS CHANGE

INSTRUCTIONS: To change your name or address, please complete this form and return it to the System. Address changes should be submitted at least three weeks prior to the change taking effect. Please type or print all entries in ink. ***This form must be signed to be valid.***

EmplID # OR **Social Security Number** - -

First Name **MI** **Last Name**

PO Box, Apt. #, Lot #, Suite #, etc.

Street Address

City **State** **Zip Code** -

Phone Number ( ) -

Effective Date of Change / /
Month Day Year

If you have changed your name, please indicate former name below.

First Name **MI** **Last Name**

In order for us to change your name on our files, we require the following be included with this form:

1. A photocopy of your marriage certificate, court order or divorce decree stating legal change of name.

AND

2. A photocopy of your valid driver's license, passport, military I.D., or Social Security card issued using your new name.

SIGNATURE

Date / /
Month Day Year

IMPORTANT!

If you recently remarried or divorced, review your NYSTRS beneficiary designation, as you may need to update it. Print a *Designation of Beneficiary* (NET-11.4) form from our website at NYSTRS.org or request a copy be mailed to you by calling our Hotline at (800) 782-0289.